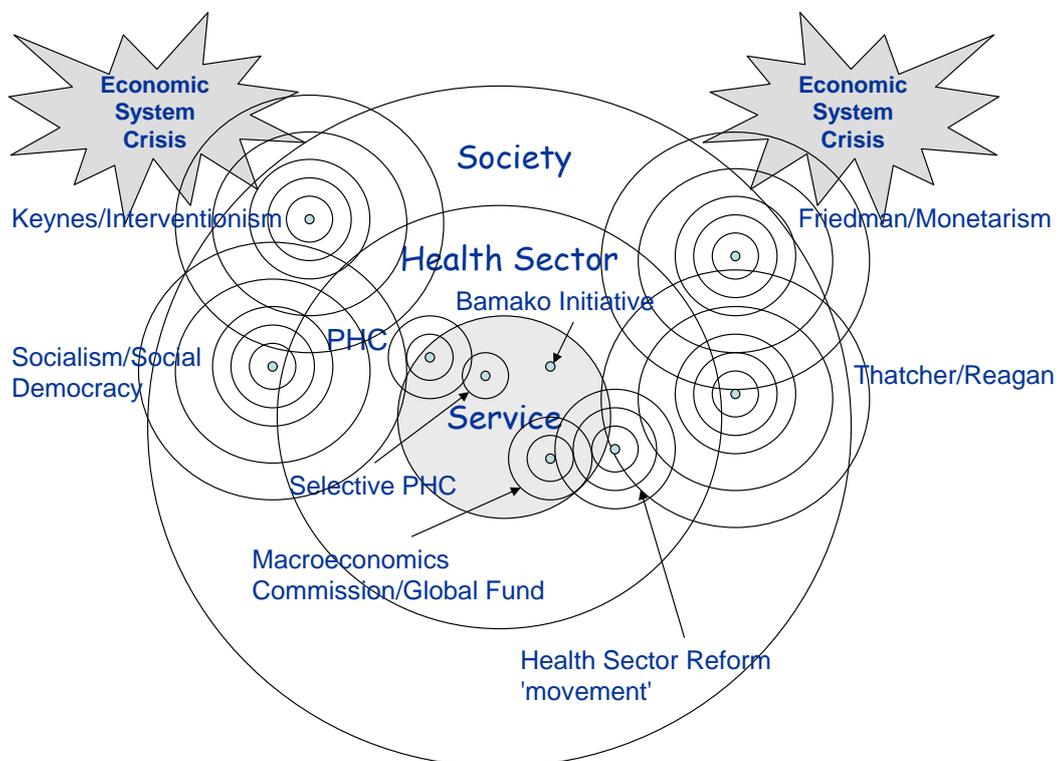

1990 - 2000: A Decade of Health Sector Reform in Developing Countries

- Why, and What Did We Learn?

Erik Blas



Dissertation at the Nordic School of Public Health, Göteborg, Sweden

**1990 - 2000: A DECADE OF HEALTH SECTOR
REFORM IN DEVELOPING COUNTRIES
- WHY, AND WHAT DID WE LEARN?**

1990-2000: A Decade of Health Sector Reform in Developing Countries - Why and What did we
Learn?

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Nordic School of Public Health

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Abstract

Objective: The overall aim of the work is to contribute to a better understanding of the dynamics between health sector reform policies and practices as well as the factors that determine and shape the thinking about global public health; and to try out a framework for understanding the inter-linkages and interactions between the determinants for and the elements of health sector reforms and their implementation.

Methods: The object of study was a contemporary phenomenon, consisting of a diverse array of interventions in many different directions and fields within a complex political, social and economic environment. It is difficult to attribute the effects of the reforms to any single intervention or to establish exact boundaries between the phenomenon and the context. Therefore, a multi-stage case study research strategy, based on the work of R.K. Yin, was chosen. The study involved two major sub-units of analysis, i.e., the macro and the micro level. Each of these involved several sub-units of analysis. The analysis of the micro level further comprised a cross-case analysis of 10 individual case studies conducted in six developing countries.

Results: Clear linkages were found between the greater societal processes and the shape and results of reforms during the decade. The reforms had not been completed in any of the countries studied, but appeared to be stuck with undesired effects, lacking energy to move forward. Contributing to this was the diminishing role of the state, which bordered abdication from public health in most of the countries, leaving the drive to the market and individual demands and interests. The net effect could well be a reversal of some of the public health achievements of the past - however, it was also found that reverting to dedicated disease control programmes would not be the answer, as these were found unsustainable and undermining the health systems.

Conclusion: There is a divide between libertarian and utilitarian values on the one side and communitarian and egalitarian values on the other. Thus, it is not just about public health practitioners not being good enough to implement, it is more so about what we want to achieve and what is acceptable respectively not acceptable and reaching compromises. This places the societal processes at centre-stage for public health. However, it is also about implementation, it is about how public health policy-makers and reformers can effectively dialogue and facilitate achieving consensus and translate the societal 'wants' and 'want nots' into managerial bites. Implementation becomes a process of constant adjustment and readjustment oscillating between political and technocratic levels.

Key words: Health sector reform, values, implementation, developing countries, international public health

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ABBREVIATIONS

ADA	Americans with Disabilities Act
AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacille Calmette-Guérin (vaccine against tuberculosis)
CTC	Close-to-client
CVI	Child Vaccine Initiative
DALY	Disability Adjusted Life Years
Danida	Danish International Development Assistance
DfID	Department for International Development
EIU	The Economist Intelligence Unit
EPI	Expanded Programme on Immunization
GAVI	Global Alliance on Vaccines and Immunization
GDP	Gross Domestic Product
GNP	Gross National Product
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
IMCI	Integrated Management of Child Illnesses
IMF	The International Monetary Fund
Lao PDR	Lao People's Democratic Republic
MCH	Maternal and Child Health
MNC	Multinational Corporations
MOH	Ministry of Health
NGO	Non-governmental Organization
NHV	Nordiska Högskolan för Folkhälsovetenskap (Nordic School of Public Health)
OCP	Onchocerciasis Control Programme
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OPEC	Organization of Oil Exporting Countries
PHC	Primary Health Care
PPP	Public-Private-Partnership
PRGF	Poverty Reduction Growth Facility
PRSP	Poverty Reduction Strategy Paper
QUALY	Quality Adjusted Life Years
RBM	Roll Back Malaria
SAP	Structural Adjustment Programmes
SHD	Sound Human Development
SIDA	Swedish International Development Authority
SWAps	Sector Wide Approaches
TB	Tuberculosis
TDR	UNICEF/UNDP/World Bank/WHO Special Programme for Tropical Disease Research and Training
UCI	Universal Child Immunization
UCS	Universal Child Survival
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
US	United States of America
USA	United States of America
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization

1. INTRODUCTION

Having seen initiatives, approaches and programmes come and go during my more than 20 years of involvement in international public health, I have been wondering: where do they come from and why do they go - often before they have had the time to prove whether they could deliver or not? Coming into public health as a novice from corporate management, I spent four years in Tanzania working with child immunization only a few years after the Alma Ata Declaration - I found that the physical infrastructures and a Primary Health Care (PHC) sign on one of the doors in the Ministry of Health were still there - but the systems and services were already falling apart. There were black markets for currency, food, drugs and almost everything else, and nothing in the shops. All of a sudden, the country accepted the conditionalities of the World Bank and almost over night the shops were filled up, but nothing happened to the health services, which continued at the mercy of the donors.

I became a '*curious participant*' rather than the '*professional stranger*' proposed by ethnographers (Agar 1996). I enrolled in a distance learning programme on development studies at Uppsala University to get a better understanding on how things were linked together, and I decided to pursue a career in international health development. My next job was with WHO, working on AIDS, which had started taking epidemic proportions during my years in Tanzania. There was no treatment for AIDS and it was very clear to me that there were strong social, economic, and societal determinants as well as consequences of the epidemic. I got to work with a large number of countries and saw similar patterns of denial, complacency, politicking and lack of understanding among politicians in general and health policy makers in particular which prevented the world from timely and effectively combating the epidemic. Later on, a lack of understanding of the broader public health aspects of AIDS by the top management of the Programme and in WHO, combined with internal United Nations turf battles and donor politics led, by the end of 1995 to the closure of the Programme and all staff, including myself, were kicked out.

Having to look for another employment, I got a job in Zambia working on what appeared to me to be the right thing to do, namely improving health and health service performance through a radical reform and overhaul of the entire health sector. The planned reforms seemed to make perfect sense and had a reasonable internal logic. However, while I was still in the country these reforms stalled without having achieved what they were set out to do, despite all the good will and intentions of both national and international actors. To me, the reforms came to a gridlock in 1997, while others claimed that they were still going on. However, personal communication with former colleagues in late 2004 indicated that I had been right in my feeling and that the formal final official death certificate was about to come. Danida's annual report 2004 confirmed the increasing risks related to corruption, lack of political commitment and back-stepping of the government (Danida 2005)

Out of these experiences, I began to ask myself questions like: If we know the right things to do, be it disease prevention or systems improvement - why is it that we do not or cannot implement them? Why is it that in an ever richer society, we say that we can no longer afford to provide health care to the people? Do we lack the skills or is

the issue rather of another nature, e.g., ideological? Do we move on to new approaches and initiatives because we are becoming more clever - or what?

I have also been intrigued in my studies by the fact that very few scholars go outside of quite narrow disciplinary or paradigmatic frames. This, I also found when starting my courses at the Nordic School of Public Health (NHV) in 1994. Most courses took their departure in the individual, rarely did they lift to a level of the *public* and the term *patient* was frequently used. This made me ask myself *what is public health?* Addressing the topic in a singular disciplinary manner is possibly justifiable in some circumstances. It brings order, an internal disciplinary logic and explanation model can be used, and, above all, it is easier to communicate using a common well established scientific language within a defined professional circle. BUT, that was not what I wanted. I wanted to bring all the little bits and pieces together to achieve a deeper understanding of the matter. I was often warned and advised to narrow the scope of my journey, especially when embarking on the Masters of Science project.

I got my inspiration during the work from a few individuals to whom I returned again and again in terms of both publication references and in mind.

- Halfdan Mahler, former Director General of the WHO, whose vision and leadership for the first time brought true public health concerns prominently to the global agenda, through Health for All and taking on the battles with the strong powers in relation to drug pricing and marketing of breast milk substitutes.
- Early on in my studies, Julio Frenk inspired me through his writings on the New Public Health and a conceptual framework bringing together the different elements of reform policy. He was an academician now turned politician.
- Michael R. Reich, who operates in the transdisciplinary field of public health ethics, politics, and management of implementation. In his work, he is trying to bridge between academia and practical application.
- Robert R. Yin, whose work to develop case study research into a scientific strategy for enquiring into the often extremely complex and multifaceted issues of real life.

In my current job in the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR), I have had an opportunity to submerge into, support and participate in more than 70 research projects on health sector reform, working with health policy and systems researchers from around the globe. This, together with other work leading to this dissertation has been a great learning process where I have had to clarify with myself my own values. The work represented herein has helped *me* to better understand 'public health' and it is my hope that others will also benefit somehow. However, I do accept and humbly understand that there are still far more questions than answers.

The overall objectives of the work at hand have been:

- to contribute to a better understanding of the dynamics between health sector reform policies and practices;
- to contribute to a better understanding of the factors that determine and shape the thinking with regards to global public health;

- to suggest and try out a theoretical framework for understanding the complex inter-linkages and interactions between the determinants for and the elements of reforms and their implementation.

The work at hand is presented in four parts. *Part One* proposes a conceptual framework and research strategy to be used for the enquiry into the phenomenon of health sector reform. *Part Two* looks at the contextual factors influencing the reforms approaching the question of why the reforms took place at that particular time and shape. *Part Three* summarises and discusses empirical findings from ten case studies from developing countries in which I have been deeply involved over the past years. The driving questions were what actually happened and what can we possibly learn from the experience of implementation. Finally, *Part Four* comprises an overall conclusion.

The below 11 articles have all been published in peer reviewed supplements of international journals in 2001, 2002, and 2004

- Article #1: **Blas, E.** 2004, "The proof of the reform is in the implementation", *International Journal of Health Planning and Management*, vol. 19, no. S1.
- Article # 2: Arbelaez, M. P., Gaviria, M. B., Franco, A., Restrepo, R., Hincapie, D., & **Blas, E.** 2004, "Tuberculosis control and managed competition in Colombia", *International Journal of Health Planning and Management*, vol. 19, no. S1.
- Article #3: Bian, Y., Sun, Q., Zhao, A., & **Blas, E.** 2004, "Market Reform: A challenge to public health - the case of schistosomiasis control in China", *International Journal of Health Planning and Management*, vol. 19, no. S1.
- Article #4: Suwandono, A., Gani, A., Purwani, S., **Blas, E.**, & Brugha, R. 2001, "Cost recovery beds in public hospitals in Indonesia", *Health Policy Plan.*, vol. 16 Suppl 2, pp. 10-18
- Article #5: Paphassarang, C., Philavong, K., Boupha, B., & **Blas, E.** 2002, "Equity, privatization and cost recovery in urban health care: the case of Lao PDR", *Health Policy Plan.*, vol. 17 Suppl, pp. 72-84
- Article #6: Zhan S, Sun Z, & **Blas E** 2002, "Economic transition and maternal health care for internal migrants in Shanghai, China", *Health Policy and Planning*, vol. 17, no. Supp 1, pp. 47-55.
- Article #7: Meng, Q., Li, R., Cheng, G., & **Blas, E.** 2004, "Provision and financial burden of TB services in a financially decentralized system: a case study from Shangdon, China", *International Journal of Health Planning and Management*, vol. 19, no. S1.
- Article #8: Mubyazi, G., Kamugisha, M., Mushi, A., & **Blas, E.** 2004, "Implications of decentralization for the control of tropical diseases in Tanzania: a case study of four districts", *International Journal of Health Planning and Management*, vol. 19, no. S1.

Article #9: **Blas, E.** & Limbambala, M. 2001b, "User-payment, decentralization and health service utilization in Zambia", *Health Policy Plan.*, vol. 16 Suppl 2, pp. 19-28.

Article #10: **Blas, E.** & Limbambala, M. 2001a, "The challenge of hospitals in health sector reform: the case of Zambia", *Health Policy Plan.*, vol. 16 Suppl 2, pp. 29-43.

Article #11: Zhan, S., Wang, L., Yin, A., & **Blas, E.** 2004, "Revenue driven TB control - three cases in China", *International Journal of Health Planning and Management*, vol. 19, no. S1.

The first article, '*The proof of the Reform is in the Implementation*' is a cross-case analysis of experiences from implementing health sector reforms in six developing countries and is thus a published, although somewhat narrower, version of the micro-level analysis presented in the dissertation. The remaining ten articles cover individual cases constituting an integral part of the dissertation. Each of these ten articles addresses specific aspects of the reforms in specific country situations. In addition to being 'data' for the overall cross-case analysis presented in Part Three, these articles represent case-studies of their own right with their own analysis, discussion and conclusions pertinent to the specific cases studied. The full articles are annexed

PART ONE

Part One proposes a framework for analysing health sector reforms as these were experienced during the 1990s. The framework consists of two main levels of analysis, i.e., a macro - or contextual level and a micro - or implementation level. Each level include several factors. Part One, further, discusses choices of research strategies and methods and ends up selecting Yin's model of case study as the most appropriate for addressing the objectives.

2. CONCEPTUAL FRAMEWORK

According to Julio Frenk the adjective 'public' in 'public health' does not designate a particular set of services, a form of property, or a type of problem, but rather a specific level of analysis: the population level. This is in contrast to clinical medicine which operates at the individual level and biomedical research which analyzes the sub-individual level. Public health research, following Frenk, thus encompasses two main objects of analysis: first, the epidemiological study of the health conditions of populations; second, the study of the organized social response to those conditions, in particular, the way in which such response is structured through the health care system (Frenk 1993). The work at hand is about the latter and how it manifested itself as a phenomenon during the 1990s.

Different terminologies have been used by different authors about the wave of changes with respect to health care provision experienced during the 1980s and 1990 throughout the world, e.g.: health sector reform (Berman 1995;Roberts *et al.* 2004); health care reform (Sen & Koivusalo 1998), this term is also used as the MESH-descriptor by PubMed for indexing the literature on the topic; and health systems reform (Frenk 1994;Harrison 2004).

Sen and Koivusalo criticized reformers and policy researchers for largely having ignored key contextual aspects of the reforms such as: the history of developing countries, the links to macroeconomic policies, and the ideological underpinning of the reforms (Sen & Koivusalo 1998). This, however, might be an argument for using the term 'health sector reform' instead of 'health care reform' as these authors do. The former indicates that one is dealing with one out of several sectors and that all these are elements of a greater whole. 'Health care reform' could mean anything from individual care, procedural and institutional to sectoral reform, but it does not have any connotation of societal transformation.

At any given time there are changes being devised and implemented within most institutions to adapt, align and improve performance and it is necessary to distinguish reforms from these continuous managerial change processes. At the *International Conference on Health Sector Reform in Developing Countries: Issues for the 1990s*, the following operational definition was proposed (Berman 1995):

- Health sector reform is the process of improving the performance of existing systems and of assuring their efficient and equitable response to future changes

- It is defined as sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector
- Health sector reform requires the successful management of political and social forces, as well as the application of sound technical analysis in the development of policies and actions
- There is no single strategy for health sector reform

From this definition it is clear that health sector reform requires action in several areas and has multiple objectives. While the above definition does not directly suggest any particular values, it is, however, clear that health sector reforms are never value-neutral as they include concepts such as 'efficiency', 'equity' and 'effectiveness', which will have to be assessed within a given society's value-frames.

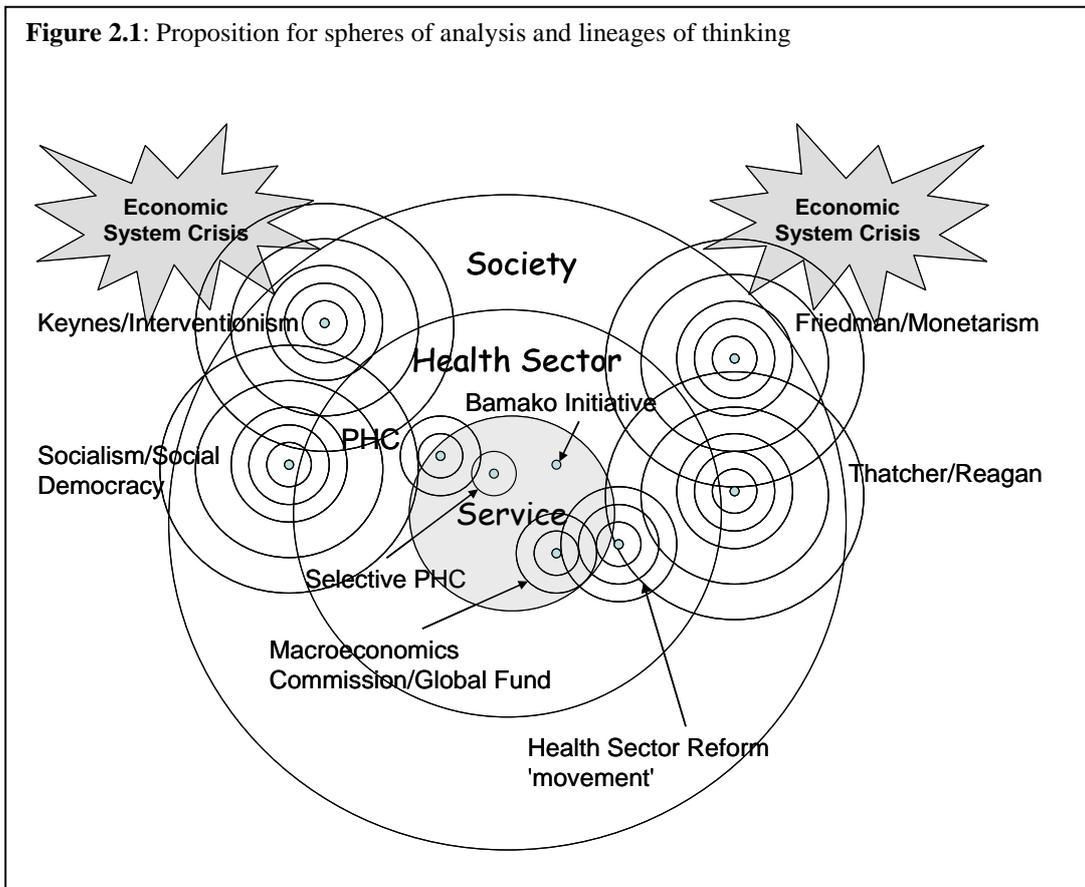


Figure 2.1 depicts three potential spheres of analysis: the service, meaning the individual health provider and facility, health programme, or e.g. a district health service; the health sector with the entire complex of health institutions, programmes, private and public providers, delivery, financing and regulatory systems and policies; and the society or multisector, being the national and international context in its entirety with globalisation, macro-economic policies, political systems and international agreements, etc.

The proposition is that what we observe at the service level is shaped by a complex series of developments linking each to the highest levels of theory, policy and economic circumstances. To state that the difference between the PHC reforms of the 1970s and the health sector reforms of the 1990s was that the former was supply

driven, while the latter was demand driven (WHO 2000) is an oversimplification, disguising that there are profound ideological differences between the two. The failure to acknowledge and take this into account in the design and implementation of reform might explain the similarities in reforms across the world and why the outcomes often do not match the expectations and why the world constantly moves on to new approaches.

The smaller partially overlapping concentric circles in Figure 2.1 indicate a proposed lineage from economic systems crises and theory of the 1930s and 1970s respectively. Via political thinking these link to the two major reform attempts of the 1970/80s and 1990/2000s with their influences across the three spheres of analysis, i.e. society, sector, and service. The selective PHC and the Bamako Initiative, stand out in the figure as somewhat detached from the two lineages. That is because, as we shall see later, while they in rhetoric and time were linked to PHC, they were actually shaped by the thinking underpinning the later health sector reform movement.

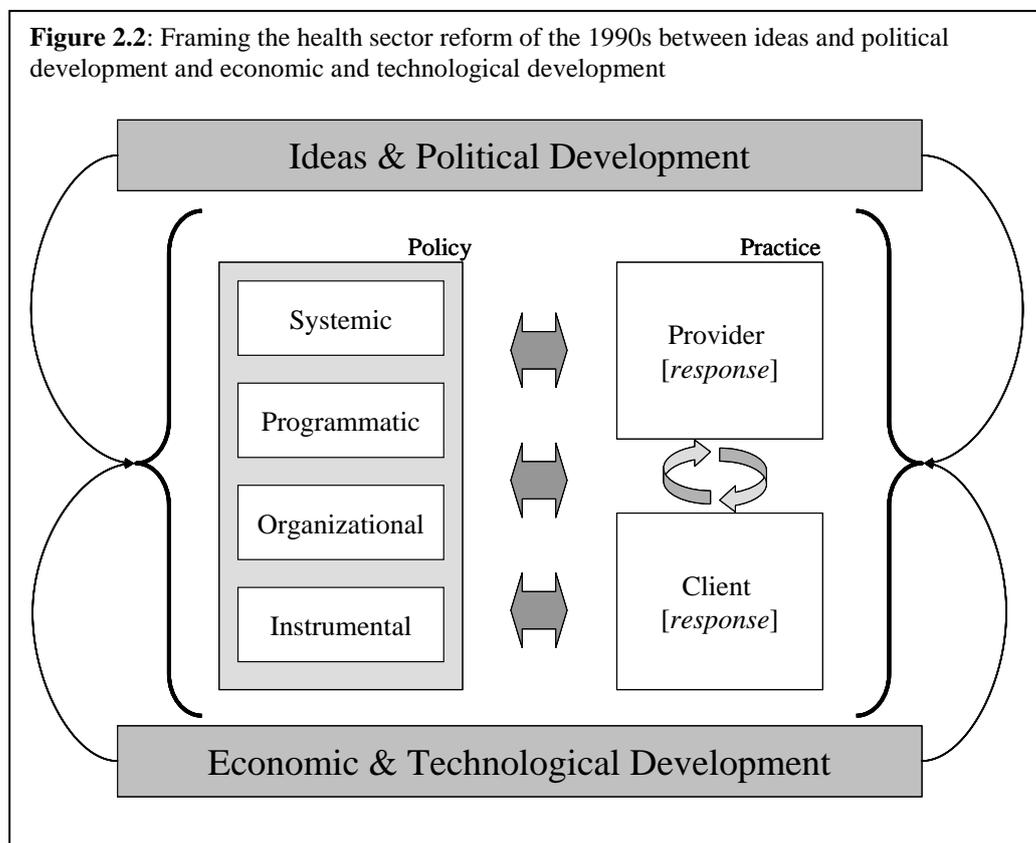


Figure 2.1 suggests a direct progression from basic ideas about the economy and the society to interventions at the service level. However, the economic, political and historical environment remains, continuously evolves and shapes the opportunities and challenges of reform. That is, as pointed out by Sen and Koivusalo (1998), often overlooked. Figure 2.2 proposes an overall framework for analysing health sector reforms with four main elements: *policy* as the reform strategies defined by the policy-makers; *practice* as defined by the responses to the policy by the providers and the clients of the health services; the *ideas and political development*; and finally the *economic and technological development*. The latter two sandwich the policy and practice between a soft mind and a hard reality.

2.1 Policy and practice

The policy framework which was proposed by Julio Frenk outlines four levels of concern: systemic, programmatic, organisational, and instrumental (Frenk 1994).

The *systemic level* deals with issues of equity, financing of services, roles of actors, decentralisation, etc. The *programmatic level* is concerned with increasing allocative efficiency, e.g. formulation and implementation of prioritized cost-effective essential packages of care, including, issues of what should or should not be provided using public resources. At the *organisational level*, the main objective is increasing technical efficiency, i.e. productivity and quality through improved management practices and more reliable supply-lines, etc. This also includes questions related to the so-called vertical or dedicated health care programmes, which has been a common approach among governments as well as development agencies in their support to public health. The *instrumental level* is about institutional intelligence, e.g. through improving information systems, conducting research, and about human resources development. The objectives and main issues for each of these four policy levels are summarised in Table 2.1, below.

Table 2.1: Policy levels, objectives and issues (Frenk 1994)

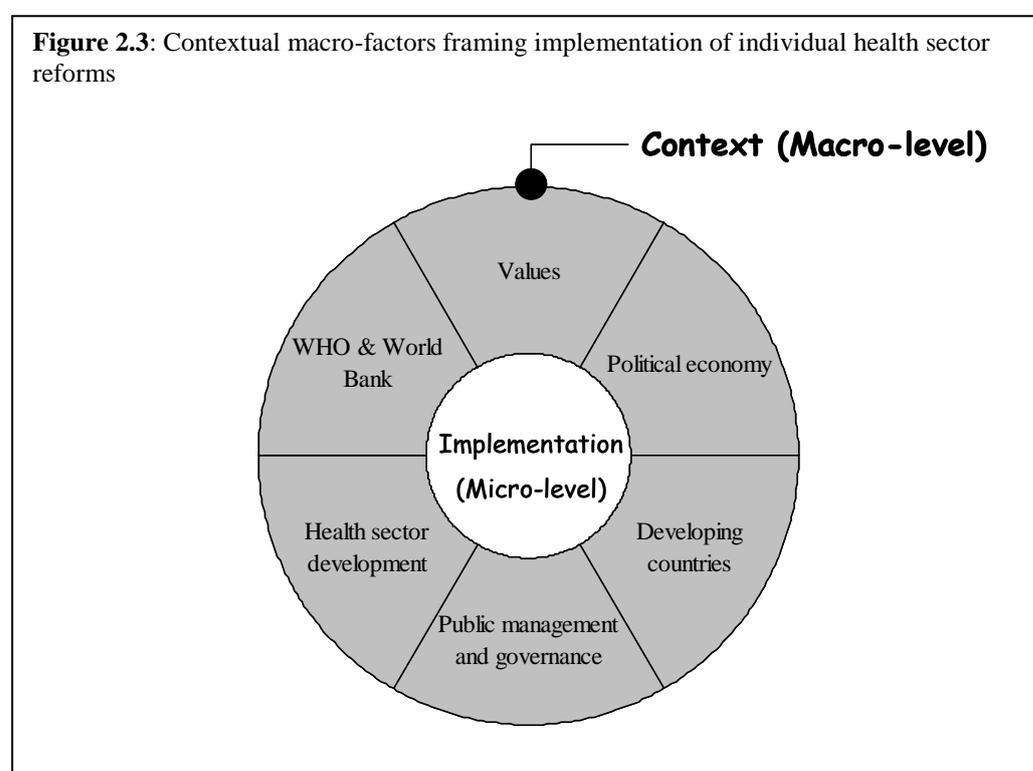
Policy level	Main Objective	Main Issues
Systemic	Equity	<ul style="list-style-type: none"> • Basis for population eligibility • Institutional arrangements: <ul style="list-style-type: none"> ▫ Public agencies involved in health care ▫ Levels of government ▫ Public/private mix ▫ Population involvement ▫ Resource generators ▫ Other sectors with effects on health
Programmatic	Allocative efficiency	<ul style="list-style-type: none"> • Priority setting • Cost-effectiveness of interventions
Organisational	Technical efficiency	<ul style="list-style-type: none"> • Productivity • Quality of care
Instrumental	Institutional intelligence for performance enhancement	<ul style="list-style-type: none"> • Information systems • Scientific research • Technological development • Human resource development

Policies are interpreted and translated by reformers, providers as well as by the clients of the health service. The latter two groups react and adapt to the policies as well as to the behaviours of each other. The practice, therefore, may end up far from the intent of the reformers. If the intelligence systems work, the reformers may adjust and modify policies and implementation strategies in order to achieve the overall goals of the reform based on information on how the system reacts to the policies. The providers and clients will then react to these adjustments and ideally some kind of equilibrium would eventually emerge. However, in reality, this may never happen because the contextual frame will continuously evolve.

2.2 The macro-level or context of action

While the policy and practice processes in isolation could be seen as technocratic processes, i.e. there is a best technical solution to the problem, the reality has been that the technocratic thinking is likely influenced by ideology and political power issues. E.g., how can it be that the whole world, all of a sudden, is implementing health care reforms, using more or less the same model? Further, is it a coincidence that this happens simultaneously with the break-up of the socialist economies? Some suggest that this is a result of increased globalization, not only of economies but also of ideas. At the national or local level political realities may pose constrain to or provide opportunities for reform and improving performance of health systems.

Some reforms have been accompanied by expansion of the respective national economies, while others have faced the contrary. Resources available for health are not only dependent on the development of the overall national economy but also on the economic policy, e.g., the role of the state in the economy. It could be expected that favourable economic circumstances would facilitate reform processes and that unfavourable ones would constrain. However, insufficient resources are often given as a reason for the need for reform, so most reforms have included some form of rationalisation, either by cutting back on services or by making the clients pay for services that were previously provided for free. The technological development can bring solutions to health problems – but it can also stretch the resources when options and possibilities increase and induce demands for ever growing sophistication at spiralling expenses, examples include diagnostics, cancer treatment and anti-retroviral drugs.



In addressing the above, it will be necessary to look into several issues which interplay in a complex manner:

- Trends with respect to main *values* will drive the thinking about the society, what are the responsibilities of the state and the individual - something that is likely to shape the way that public health functions are exercised
- The global *political economy* is likely to influence, not only the political and economic power centres, but also the periphery and to provide both opportunities and threats to efforts for improving health sector performance.
- The *developing countries'* specific situation in the world's political and economic order provides both opportunities and challenges to their development and therefore determines the options available for reform of their health sectors. Further, general thinking about 'development' is likely to shape the approaches taken to supporting specific health sector development
- At any given time different approaches to *health sector development* exist, each having proponents and opponents. However, it is likely that some approaches will dominate, i.e., constitute a mainstream around which the donor agencies, international lending organizations and politicians gather to push the reform agenda.
- Health sector development, in turn, is also closely associated with the broader thinking about how the *public sector* should be managed and governed. Health professionals often tend to see the health sector as their domain and something very special. However, the fact might be that health is just one, and not necessarily the strongest, among several public services.
- While the political economy and action by individual donor countries and organizations likely influence the agenda, the *World Health Organization* and the *World Bank* have specific mandates and powers to influence health sector development in particular in developing countries and the role these organizations take or do not take might make a difference.

Figure 2.3 illustrates how the above interrelated macro-issues encircle efforts to implement reform and change. They might drive the direction of change as well as the change processes themselves. They might provide opportunities for as well as constitute constraints to change. They comprise the context within which the reform implementers and possibly even individual countries have to operate with very limited ability to directly influence.

2.3 The micro level or focus on implementation

Between the policy and the practice elements of Figure 2.2, there are three horizontal block arrows, indicating a transformation from one to the other, i.e., implementation of the reform. To reform is to change; and change processes, whether at personal, family, organisational or societal level, are always difficult, often painful and frequently do not yield the expected results. Health sector reform is no different, it is a change process at the societal level that is extremely complex and the behaviours of the health-care system, the clients and the public are not easy to predict. Roberts *et al.* list a host of reasons why this may be so, including: general habitual resistance to change; differences in values, interests, and political philosophy; changing behaviours of doctors as a response to changes in payment schemes; imposed regulations that

might lead to change in reporting practice; etc. (Roberts, Hsiao, Berman, & Reich 2004)

Blueprints for reform, such as the one presented in the World Development Report in 1993 (World Bank 1993) can be, and often are, prepared at a drawing board without adequate empirical evidence (Abbasi 1999). To prepare a blueprint or a strategy for reform one needs technologies, i.e., a set of analytical and policy making tools, e.g., like those presented at the *International Conference on Health Sector Reform in Developing Countries: Issues for the 1990s* (Berman 1995). However, policy reforms that seek to change who receives valued goods in a society are inevitably political and are intrinsically linked to the value systems of the reform strategy formulators (Reich 1995). Reform implementation takes place in the real world with real people who have real problems, and is often incredibly complex. At the macro level, implementation, in particular in developing countries, will also be impacted by the evolution in the global political economy.

At the micro level, the implementers are faced with a multitude of problems, which are of a short-, medium- or long-term nature, difficult to predict, and are likely to change over time and space. The fact that implementation is so complex and often linked to contextual factors, however, does not preclude that there are commonalities across the countries and that general lessons can be learnt to inform future implementation and policy making procedures (Mahler 1986; Segall 2003).

The thinking and the tools for health sector reform were developed within the western market economies and have been applied in almost all corners of the world. One result is that countries as diverse as Kyrgyzstan, Sweden, Uganda, Vietnam and Zambia have used similar remedies and tools for addressing the problems of their hospital sectors, despite very different epidemiological and socio-economic situations and backgrounds (Blas E & Madaras 2002). However, very little scientifically based evidence has originated from developing countries demonstrating how successful the reforms have been, what were the difficulties of implementation, and how the changes have affected the lives of the populations in these countries. The vast majority of published evidence is still from the western market economies (Blas 2004). Further, implementers do not often write books or publish articles - they are more concerned with getting things done. Academics who do write, either do not understand the issues of implementation, do not want to know, or are not concerned. Could that be because they would then have to face so many issues, which do not easily fit into their explanatory models?

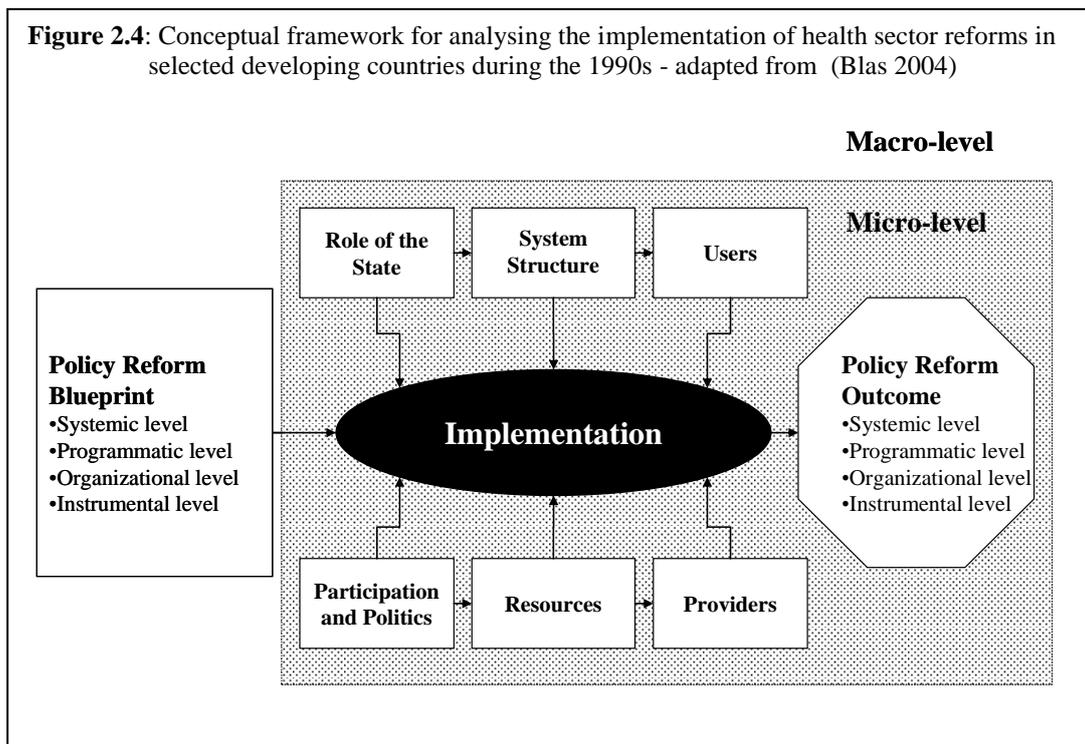
One noteworthy exception, however, is the World Bank/Harvard School of Public Health 'Flagship Course on Health Sector Reform and Sustainable Financing', which was launched in 1996 and its documentation later published in a book (Roberts, Hsiao, Berman, & Reich 2004). While the course and the book pays considerable attention to policy formulation, its uniqueness is related to the importance given to implementation, proposing five 'control knobs' available for the implementer to steer the reform: financing, payment, organization, regulation and behaviour.

- *Financing* refers to the mechanisms used for raising the money that pays for the activities in the health sector, including taxes, insurance, and direct payments by the patients

- *Payment* refers to the methods for transferring money to health-care providers, such as fees, capitation and budgets
- *Organisation* refers to the mechanisms used to affect the mix of providers in the health-care market, their roles and functions and how the providers operate internally, including measures affecting competition, decentralization, and direct control of providers making up government service delivery
- *Regulation* refers to the use of coercion by the state to alter the behaviour of actors in the health system, including providers, insurance companies, and patients
- *Behaviour* refers to influencing how individual patients and providers act in relation to health and health care.

The authors suggest that the effect of adjusting the control knobs can be measured by three intermediate performance indicators: efficiency, quality and access. These, in turn, contribute to the higher population based performance goals: health status, customer satisfaction, and risk protection. Over time, there will be many simultaneous and consecutive adjustments of the control knobs, up- and down-wards. Some of these adjustments will be done before the effects of previous adjustments have settled and/or are measurable; some will be done by different implementers with diverging readings and/or motives. Further, there are likely factors influencing the reforms other than what the implementers do and outside of their immediate control. While the control knob concept is useful for implementers in the action, *ex-post* it is likely difficult to attribute directly reform outcomes to particular events or single factors.

Figure 2.4: Conceptual framework for analysing the implementation of health sector reforms in selected developing countries during the 1990s - adapted from (Blas 2004)



An attempt to build on the policy analysis framework proposed by Frenk and briefly presented in Figure 2.2 and the idea of the control knobs proposed by Roberts *et al.*, a framework for analysing health sector reform at the micro-level is proposed in Figure 2.4. The framework is composed of three major parts: the *policies* that are supposed to be; the *implementation* itself; and *six key factors* that directly interact with, facilitate or constrain the implementation and mould the outcome. The six factors are:

- *The state* - the role that the state and its institutions play in the process. This includes parts of the financing and regulatory knobs
- *The system structure* - the way the systems are structured, in particular with respect to interaction between the different actors and levels of the health care system. This includes the organization knob.
- *The users* - the needs, behaviours and reactions of the population that uses or is targeted by the health services, whether sick or healthy. This includes the behaviour and payment knobs.
- *Participation and politics* - the involvement and influence of individuals and groups of people with their values, interests, philosophies and power relations. This includes the behaviour knob.
- *The resources* - the availability of and accessibility to resources. This includes parts of the financing and payment knobs
- *The providers* - the needs, behaviours and reactions of the institutional health care providers and their staff. This includes the behaviour, payment, and regulatory knobs.

The six factors are interlinked in several different ways, e.g.: the role of the state is likely to influence the system structure, which, in turn, may have an effect on the access to services for the users; participation and, in particular, the politics can determine the availability and allocation of resources, which, in turn may constrain or support the providers; the behaviours of the providers might impact on how the system operates and how the users experience the services; etc. In the implementation, they all come together in a complex interplay. The implementers might be able to influence the factors by turning the knobs, however, the factors might in cases not be amenable to adjustment by the implementers and, further, the system is not closed - but is open for interaction with the macro level.

3 RESEARCH DESIGN, STRATEGIES AND METHODS

The nature of the research as stated in introduction section is briefly summarised in Box 3.1. The enquiry is driven by why-questions seeking to better understand, i.e., find possible explanations why health sector reforms happen and take the shape they do.

The study is about a contemporary phenomenon, which consists of a complex array of interventions in many different directions and fields (table 2.1) and taking place within an even more complex political, social and economic environment (figures 2.2, 2.3, and 2.4). It would be difficult to attribute the reform's effect to any single intervention or to establish exact boundaries between the phenomenon and the context. The policy-makers and reform implementers might have some, but not full control over events, e.g., as illustrated in figure 2.4. However, researchers of health sector reform, in most cases, have no or very limited control of events and will have to study these in real life situations with all the difficulties this entail.

The overall intent of the study is to achieve a better understanding of a very complex situation, i.e., seeking explanations and attempting to answer questions of a how and why nature. It is therefore unlikely that a unidisciplinary, simple research strategy will reveal the information that is required for a comprehensive understanding of these complexities.

Box 3.1: Nature of the enquiry

Questions of curiosity: If we know the right things to do, be it disease prevention or systems improvement - *why* is it that we do not or cannot implement them? *Why* is it that in an ever richer society, we say that we can no longer afford to provide health care to the people? Do we lack the skills or is the issue rather of another nature, e.g., ideological? Do we move on to new approaches and initiatives because we are becoming more clever - or what?

The overall objectives:

- to contribute to a better understanding of the dynamics between health sector reform policies and practices;
- to contribute to a better understanding of the factors that determine and shape the thinking with regards to global public health;
- to suggest and try out a theoretical framework for understanding the complex inter-linkages and interactions between the determinants for and the elements of reforms and their implementation.

The proposition is that what we observe at the service level is shaped by a complex series of developments linking each to the highest levels of theory, politics and economic circumstances, which might explain the similarities in reforms across the world. The failure to acknowledge and take this into account in the design and implementation of reforms might explain *why* the outcomes of reform often do not match the expectations and *why* the world constantly moves on to new approaches.

3.1 Selection of study strategy

There exist a number of research strategies that are frequently used in the social sciences, including public health, e.g., experiments, surveys, case studies, archival and historical analysis. Each of these strategies can serve descriptive, explanatory or exploratory purposes, there are large overlaps and it may be difficult to distinguish and choose among them. However, selecting the optimal or most appropriate research strategy depends on the research conditions and might be easier after analysing the type of research questions being asked, the degree of control that the researcher has over events, and the focus in time.

Table 3.1: Selection of an optimal research strategy based on the research conditions (Yin R.K. 2003)

Strategy	Type of research question	Research Conditions	
		Requires control over events?	Focus on current events?
Experiment	How, why	Yes	Yes
Survey	Who, what, where, how many, how much	No	Yes
Case Study	How, why	No	Yes
Archival analysis	Who, what, where, how many, how much	No	Yes/no
History	How, why	No	No

While several variants of case study research exist, Robert K. Yin has developed the case study research into an accepted research strategy in, e.g., management,

education, public health, etc.(Yin R.K. 2003). He describes the case study in the following way:

- A case study is an empirical enquiry that
 - investigates a contemporary phenomenon within its real-life context, especially when
 - the boundaries between phenomenon and context are not evident
- The case study enquiry
 - copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result
 - relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result
 - benefits from the prior development of theoretical propositions to guide data collection and analysis

As searching for explanations about the contemporary phenomena surrounding health sector reforms clearly deals with events over which the researcher has little or no control, the most appropriate research strategy is the case study (table 3.1). The case study strategy, the way it has been defined by Yin, has the advantage that it can embed a range of sub-units of study, approaches and methods, including other strategies such as, e.g., surveys, historical and archival analysis. It can further deal with complexity, ambivalence and links can be traced over time. The case study strategy therefore appears ideal to achieve an in-depth understanding of a complex social phenomenon such as health sector reforms. The work at hand closely follows the case-study strategy as defined by Yin (2003)

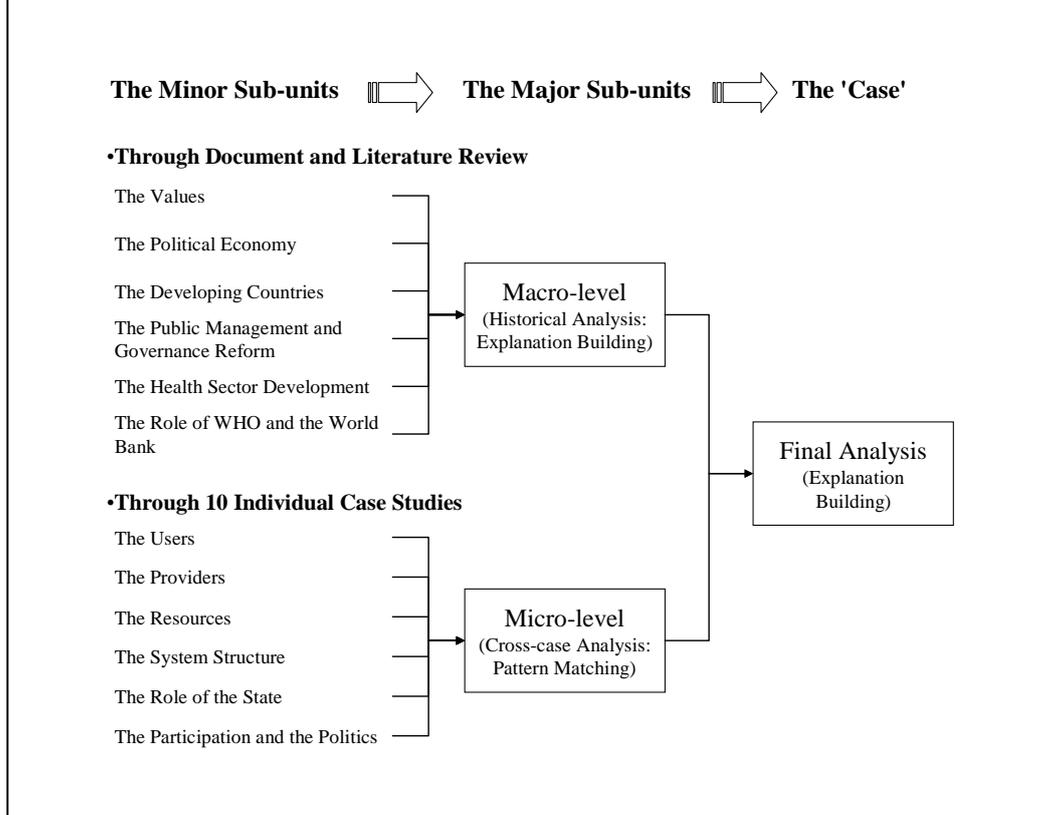
Case studies, according to Yin, can be classified into four generic designs (table 3.2), each having their strengths and weaknesses. The choice of which one to use depends on the theoretical proposition and the type and sources of data needed.

Table 3.2: Generic types of case-study design

	Single case design	Multiple-case design
Holistic (single unit of analysis)	Type 1	Type 3
Embedded (multiple units of analysis)	Type 2	Type 4

The theoretical proposition suggests that we are dealing with one phenomenon, which almost simultaneously manifests itself in different places and circumstances. It is also proposed that there are complex interlinkages between the micro and the macro levels. It will therefore be appropriate to use a multi-stage research strategy, with the main case being health sector reforms in the 1990s having two major subunits of analysis, i.e. the macro and the micro level. The overall design therefore is chosen as single-case embedded, i.e., Type 2. However, each of the major subunits of analysis will further encompass several minor subunits of analysis. The minor subunits relating to the micro level analysis will refer to different situations over time and space; therefore the input for the micro level analysis was chosen to come from a series of individual cases studies, each addressing one or more of the minor subunits, i.e., a type 4 case study. Figure 3.1 graphically summarizes the study design.

Figure 3.1: Outline of the multi-stage study strategy, its design and main analytical techniques



3.2 Study methods and analytical techniques

Final analysis

The final analysis is done using explanation building techniques discussing rival explanations (Yin R.K. 2003). Input to the analysis is the output from the macro and micro analyses described below. The results of the final analysis are presented in Part Four, Section 18.

Macro-level analysis

The macro-level analysis covers ideas, political, economic and technological development as described in Figures 2.1 and 2.2, The analysis, using explanation building techniques is done through review of a vast and diverse set of published literature, documents, news magazines and papers for each of the subunits: values, political economy, developing countries, public management and governance, health sector development and the role of WHO and the World Bank as identified above and explained in section 2. The results are presented in Part Two, with a discussion and conclusion in section 10

Micro-level analysis

The analysis at the *micro level* is done through a cross case analysis of a series of individual cases studies, which are discussed within a broader set of publications. The analytical approach is that of pattern matching (Yin R.K. 2003). First an analysis is done for each of the minor subunits and then a synthesis across the subunits. These analyses are presented in Part Three with a conclusion in section 17.

Table 3.3: Subunits addressed by each of the individual case studies. The emphasis of each case is indicated with an 'x' with the main focus in brackets.

Art #	Case Study Country, topic ¹	Subunits addressed						
		Case Study Type	Participation and politics	State	Structure	Resources	Provider s	Users
2	Colombia, TB	2	x	x	x	(x)	x	x
3	China, Schistosomiasis	2	x	x	x	(x)	x	x
4	Indonesia, Hospital	3	-	x	-	(x)	x	
5	Laos, Equity	4	x	x	-	x	x	(x)
6	China, MCH (equity)	2	x	x	x	-	-	(x)
7	China, TB District	4	-	x	(x)	x	x	x
8	Tanzania, Decentralization	4	(x)	x	x	x	x	x
9	Zambia, User-fees	2	x	-	-	x	-	(x)
10	Zambia, hospitals	2	(x)	x	x	x	-	-
11	China, TB - three models	4	-	x	(x)	x	x	x

Each of the individual case studies covers several of the identified minor subunits as schematically shown in Table 3.3 and uses a wide array of research methods (Table 3.4.). Detailed descriptions of the results as well as the methodologies for each of the individual case studies as well as an analysis for a subset of the studies are presented in Part Four in form of 11 published articles.

Table 3.4: Research methods used in each of the individual case studies. The methods of each case are indicated by an 'x' with the dominant method in bold and bracket.

Art #	Case Study Country, topic ¹	Research method used						
		Survey	Key informant	Focus groups	Rec. review	Second data	Doc. review	News media
2	Colombia, TB		(x)		x	x	x	
3	China, Schistosomiasis		x	x	(x)		x	
4	Indonesia, Hospital		x		(x)		x	
5	Laos, Equity	(x)	x	x			x	
6	China, MCH (equity)	(x)	x	x	x		x	
7	China, TB District	(x)	x		x		x	
8	Tanzania, Decentralization	(x)	x	x			x	
9	Zambia, User-fees	(x)					x	
10	Zambia, hospitals	(x)			x		x	x
11	China, TB - three models		x		(x)	x	x	

¹ (2) (Arbelaez et al. 2004), (3) (Bian et al. 2004), (4) (Suwandono et al. 2001), (5) (Paphassarang et al. 2002), (6) (Shaokang, Zhenwei, & Blas 2002), (7) (Meng et al. 2004a), (8) (Mubyazi et al. 2004), (9) (Blas & Limbambala 2001b), (10) (Blas & Limbambala 2001a), (11) (Zhan et al. 2004)

The case study research strategy allows the use of a multitude of research methods drawing from several sources of evidence to converge in a triangulating manner. However, in most cases, one method will have a more prominent role with the other methods providing supplementary information. The details for each of the ten case studies are provided in the articles in Part Four, however, a brief summary of the methods applied is provided below.

Surveys. Six out of the ten individual case studies used surveys as the dominant methods of data collection. However, the nature of these surveys varied greatly from a comprehensive survey on the situation and utilization of all the hospitals in Zambia to repeated household in-depth interviews and observations in Laos. Household interviews were also done in Tanzania, while in the China MCH-equity and TB district studies, users of MCH services and TB-patients were interviewed. In the Zambia user-fee study, a large survey was done to retrieve health service utilization data from the districts. A variety of statistical methods were applied to analyse the quantitative data, ranging from simple tabular descriptive statistics in the case of Laos and Tanzania to more analytical statistics in the cases of Zambia. The qualitative data originating from the semi and non-structured parts of the interviews were coded and content analysed (Agar 1996;Robson C 1993)

Key informant interviews were the dominant method used in the Colombia case to solicit views to elucidate the process of reform and the operation of the reformed system for TB control. However, key informant interviews were also used in seven of the remaining nine case studies mainly to seek explanations or clarifications to findings coming about from using other methods, but also, as in the case of Indonesia to assist in setting parameters for an economic analysis. The key informant interviews were semi- or non-structured and after transcription, they were coded and content analysed (Agar 1996;Robson C 1993)

Focus group discussions were used in four of the ten case studies to solicit ideas and views in order to give direction for further investigation and to confirm respectively reject interpretations of findings resulting from the use of other methods. The strength of focus groups discussions is that they can draw on each individual's knowledge and that in the discussions views are informed by the collective knowledge of the group. The weakness of this method is that the result will reflect the view of a particular group of individuals and is formed by the particular circumstances or, e.g., profession of the group. This has to be taken into consideration when selecting and composing the groups and in the interpretation of the outcome of the discussions. For this reason, focus group discussions were not chosen as the dominant methods in any of the above case studies and in all cases considerable efforts were made in the preparation, training in conduct and interpretation of the outcomes of the focus groups (Dawson, Manderson, & Tallo 1993).

Record reviews were chosen as the dominant method in three of the ten studies and as lesser method in further four of the studies. Patients' medical records were reviewed and analysed in all the China cases, while various service records were reviewed in Colombia and Zambia. Further, in Colombia, China (schistosomiasis and TB-district and three models) financial records of health facilities and/or ministries of health were reviewed and analysed using statistical or economic methods.

Analysis of secondary data was used as lesser methods in Colombia and in the China, TB-three model cases. In Colombia, this included secondary analysis of a cohort of

TB patients and in the case of China, secondary analysis of national TB surveys. Standard quantitative techniques were used for the analysis.

Document and archival review. All the cases various documents were reviewed, ranging from legal, and policy and programme guidelines to letters. The reviews were done to identify 'what ought to be' as well as, e.g., to investigate the historical evolution of thinking and action within the relevant areas of enquiry. Analysis of official and unofficial documents opens up many new sources of understanding because of their qualitative and often subjective nature (Taylor & Bogdan 1998)

Review of news media. New media are a kind of publicly available documentation and can be used in the same way as these in research (Robson C 1993; Taylor & Bogdan 1998). The Zambia hospital case study included a systematic review of news paper articles over the critical period of the health sector reform where the larger politics and public debate had a major influence on the faith of the reform. In using news media in research, one has to realise that the media play dual roles both as recorders and as active shapers of the public debate and opinion.

Personal records. The Zambia hospital case study further made use of personal records, mainly in form of daily diary recordings, notes from meetings capturing the progression in thinking, the internal debates and what is not said in the public room. These personal records often helped linking events and evolutions, which from an outside viewer's perspective did not have clear connections. These records were similar to an ethnographer's field notes and suffer from the same weakness as these, e.g., that at the time of recording one does not yet know what is important and therefore what to record and what not (Agar 1996). However, they can be a useful triangulating supplement to evidence from other sources

Finally, all the individual case studies also reviewed relevant national and international indexed and/or grey scientific and technical literature on the topics in question.

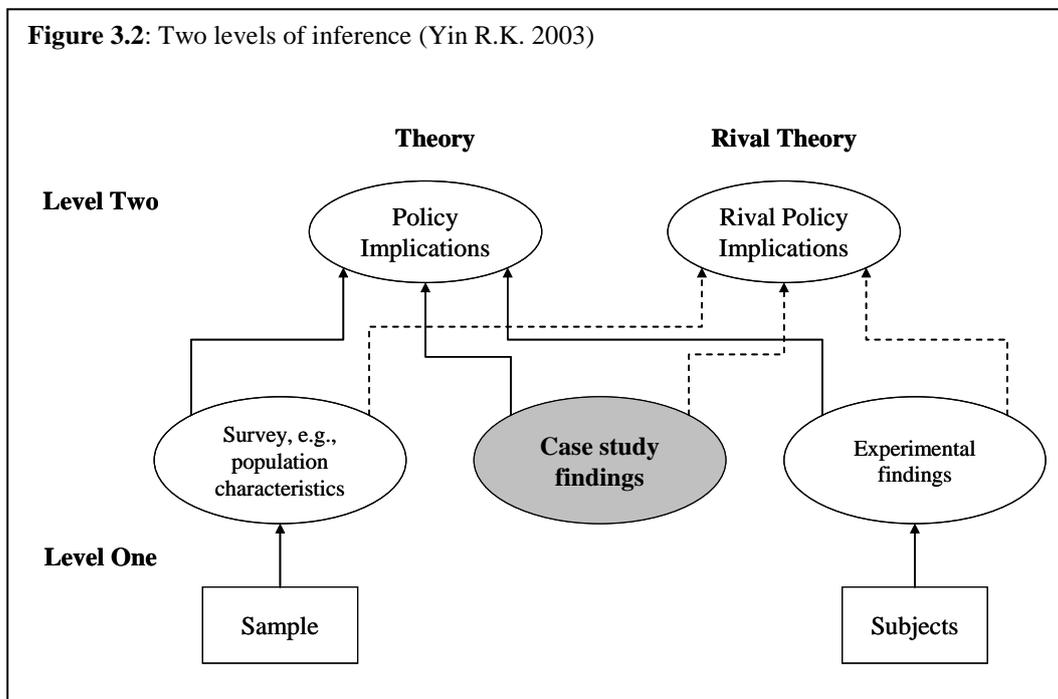
3.3 Generalisability and quality concerns

Yin defines two levels of inference, i.e., level one and level two, see figure 3.2. In level one inference, statistical generalization is made about population or universes based on empirical data collected on samples or subjects, the latter in experiments. Well-defined and widely taught quantitative formulas are available for level one inference, e.g. to determine confidence intervals, etc. Level one inference is relevant to case studies if these include sub-units using data from, e.g., surveys, record and document reviews, analysis of secondary quantitative data, etc.

In case studies, however, the main approach to generalisation is analytical, i.e., generalisation to theory or level two inference. Based on a previously developed theory empirical results from case studies are compared and if findings from two or more case studies support the same theory, then replication can be claimed. The analysis is more convincing if the findings from the same cases can be shown not to support equally plausible rival theories (figure 3.2)

Case studies are sometimes criticised and considered as less 'scientific' than other research strategies. However, much of this critique is grounded in that case studies are

sometimes poorly conceived and performed, disregarding the fact that they are often much more complex undertakings than many other strategies and studying much more complex phenomena. One common mistake by both those performing and those judging case studies is to view the cases as sampling units and thus expecting statistical generalisability (Yin R.K. 2003). Some have suggested that one reason why case studies are criticized may be that researchers disagree about the definition and the purpose of carrying out case studies; some regard them as supplements to other more rigorous qualitative studies, while others regard them as research strategies in their own right. Finally, there has been many poorly conducted case studies, thus leaving the approach open to criticism (Meyer 2001). Finally, some variants of case study research are viewed as unquestionably qualitative research methods founded on an interpretative, often explicitly anti-positivistic philosophy of science. Yin's approach is an attempt to make the case study strategy acceptable to the positivistic scientific community.



Four logical tests are commonly used to establish the quality of empirical social research. Because case studies are one form of such empirical research, the four tests, i.e., construct validity, internal validity, external validity, and reliability, are also relevant to case study research. For case study research one important revelation is, however, that several tactics will be used in dealing with these tests throughout the conduct of the study.

Construct validity, i.e., establishing correct operational measures for the concepts being studied. All of the case studies, with the exception of the Zambia user-fees study, had designs that drew significantly on different sources of evidence and built chains of evidence during the data collection phase. The Zambia user-fee study had as its all dominating method a survey and drew only secondarily on documents as a supplementary source of evidence. In the Colombia TB study, which had as its

dominant method key-informant interviews, the final phase of the study included a workshop of the key informants to review and validate the findings.

Table 3.5: Criteria for judging case study research design with the relevant tactics and an indication of in which phase of a study they can be applied - adapted from (Yin R.K. 2003)

Tests	Case study tactic	Phase of research in which tactic occurs
Construct validity	▪ Using multiple sources of evidence, triangulation	Data collection
	▪ Establishing chain of evidence	Data collection
	▪ Having key informants review draft case study report	Composition
Internal validity	▪ Doing pattern matching	Data analysis
	▪ Doing explanation-building	Data analysis
External validity	▪ Using analytical generalization	Data analysis
	▪ Theory in single case studies	
	▪ Replication logic in multiple-case studies	
	▪ Using statistical generalization (for relevant embedded sub-units)	Data analysis
Reliability	▪ Using case study protocol	Data collection
	▪ Developing case study data base	Data collection

Internal validity, i.e., establishing a causal relationship showing that one condition leads to another as distinguished from spurious relationships. This test is relevant only to explanatory studies and come into play every time an inference is made, i.e., when an event cannot be directly observed. Explanation building addressing rival explanations was used as a tactic in all the type 2 studies (see table 3.3) as well as in the macro-level and final analyses (see figure 3.1). Pattern matching tactics were used in the type 3 and 4 studies as well as in the micro-level analysis.

External validity, i.e., establishing the domain to which a study's findings can be generalized. External validity has been a major barrier in doing case studies, e.g., with critics stating that single or a few cases provide a poor basis for generalization. However, this is often due to the critics implicitly contrasting case studies to surveys, in which, if the samples are selected correctly, a statistical analysis readily generalizes the results to larger universes. In the cases studies underlying the work presented in this thesis as well as the overall analyses, the theories guiding the design and data collection were also used to identify the wider situations to which the results may be generalised. In the multi-case studies, i.e., type 3 and 4 as well as in the micro-level analysis, replication logic was applied to generalise beyond the individual case. A prime example of this tactic is the Laos equity study (article 5), in which both theoretical and literal replication tactics were applied. However, statistical analysis and generalisation tactics to the level of the cases were used for the subunits which included survey, record review and secondary data methods (see table 3.4)

Reliability, i.e., demonstrating that, e.g., the data collection procedures can be repeated with the same results. The goal of reliability is to minimise errors and biases in a study, thus ensuring that if later investigators followed the same procedures in conducting the same case studies, they would arrive at the same results. Two tactics

have been pursued in the underlying empirical studies, i.e., case study protocols and establishment of case study databases. While the protocols define and document the processes used in the research process, the case study databases captures and organises all the relevant data in such a way that these can be retrieved and analysed by others.

PART TWO

Part Two analyses the macro, or contextual level factors that frame the specific implementation of health sector reform in developing countries. The analysis of the macro level is organised according to the minor sub-units of analysis as depicted in figure 3.1. A macro level discussion and conclusion is presented at the end of Part Two in section 10

4 VALUES

Ethics is concerned with values of human qualities, actions and goals and can be expressed by terms such good, bad, right, wrong, duty, ought to, etc., and there is a long tradition in health of discussing the ethics in relation to the individual patient. However, there has been much less discussion on the values within public health, i.e., in relation to population groups and the society as a whole. One explanation for this could be that such discussions would have to take place at the intersection between natural sciences, ethics, social philosophy, culture, economics, and politics and thus be struggling with different conceptual rationales and explanatory frameworks. As explained by Roberts and Reich, there exists no agreed-upon ethical framework for analysing ethical dilemmas in public health, e.g., arising from the need to rationing scarce resources, influencing individuals to change their behaviours, and limiting freedom in order to diminish disease transmission (Roberts & Reich 2002)

4.1 Normative ethics

Discussions on values often distinguish between intrinsic values, i.e., values that are important in their own right, and instrumental values, which are important because they help achieving other goals. However, the distinction is not always clear. Health can be viewed as a value in itself, e.g., for the individual - but it could also be viewed as a means to improve, e.g., the economic productivity of a society. Similarly, it can also be debated whether equality and equity represent intrinsic or instrumental values. While, to some such discussions might appear esoteric they are important in public health because they lead to decisions about priorities, codes of conduct and who is responsible for what.

Deontological ethics focuses on the action itself, suggesting that one can appraise an action without considering its eventual consequences. *Teleological ethics*, on the other hand, views an action based on the consequences it leads to. Deontological and teleological ethical analysis would thus lead to very different results in public health, e.g., in relation to a decision whether to invest limited resources in capacity to save the lives of a few seriously ill patients or to invest in child immunization; in prevention of AIDS; or to providing antiretroviral drugs to patients already having AIDS. However, in the latter case both deontologists and teleologists could argue that AIDS patients should be provided with antiretroviral drugs. Deontologists could argue that, as there are effective means of relief available, it is a duty to help people suffering regardless of which consequences this might have for other people. Some

teleologists, on the other hand could argue that the gains to the society in form of the future contributions by the AIDS patients who would otherwise die or be unproductive are greater than investing the same resources in preventing new cases for occurring some time in the future. Other teleologists might argue that by extending the lives of AIDS patients, one increases the HIV prevalence and possibly the incidence, thus generating a potential threat to the society. While teleological reasoning might be difficult to reject, there are difficulties and most individuals and societies have deontological barriers that cannot be crossed. Also other questions arise from teleological ethics, e.g.: how can one know what will be the consequences of a given action; where are the limits for our responsibility in relations to people and time and does the responsibility include the coming generations?

Teleologists strive at maximising the utility or happiness in a given society. But, if one argues that an action is justified through its consequences, then one also has to address who should benefit from these consequences and here there are three alternatives:

- One self, i.e., *ethical egoism* which entails that one ought to always act so it benefits oneself. This is different from psychological egoism, which presumes that people are born to think primarily about themselves
- Others, i.e., *altruism*, which means that one should act to the best of others before oneself
- All, *universalism* which means that one should not differentiate between oneself and others but act so the happiness is increased and distributed according to certain criteria.

But - what should such criteria be? Should one pursue maximum happiness or is the value greater if the happiness is distributed in a just or fair way and what would be the balance of concern between utility maximization and a just or fair distribution? As many people have a sense that distribution can get too unfair, fairness is possibly one of the above mentioned deontological barriers.

Although commonly used in ethical reasoning, the terms just and fair are not very precise and encompass at least three principles, which are important to public health:

- All should get the same - *equality principle*
- Those who have most need should get the most - *needs principle*
- Those who can benefit the most should get the most - *merit principle*

It might appear that the equality principle is the only right one, but it is easy to see examples where the needs principle would prevail. However, on a teleological basis the merit principle would also make sense in many situations, especially in situations of extremely limited resources.

The teleological ethics appears to be able to resolve many problems, however, it also creates several others leading to demands for clear rules that all can accept and adhere to. This demand for rules is often used to argue for a deontological rule-ethics. However, on what basis and from where should such rules be drawn? The rules can be drawn, e.g. from religious or political authorities, or can be based on overarching principles. Examples of the latter are Kant's categorical imperative: "*Act always so*

that the principle for your action can be raised to a common law" or Rashdall's fairness axiom: *"I ought to assign what it good for one person equal value to what is good for any other human being"*. (Cited in (Hedin 1993) and translated from Swedish by the author). However, it is difficult to imagine that it would be possible to formulate rules which would apply to each and every situation.

4.2 The Society

Within social philosophy the overriding topic is what constitutes a good society and three main problems are discussed: the character and tasks of the society, human rights, and fairness. All of these, of course, influence how the society defines and operates its public health system. Three major perspectives of the good society emerge, i.e., utilitarianism from the teleological ethics and communitarianism and liberalism from the deontological ethics. Liberalism, which is concerned with rights, again can be split into libertarianism concerned with negative rights and egalitarianism concerned with positive rights.

Utilitarianism, the major category of argumentation within the teleological ethics was originally formulated by Jeremy Bentham [1748-1832] in 1789 and further developed by John Stuart Mill [1806-1873] and G E Moore [1873-1958]. While the first two considered happiness to be equated with pleasure, the latter developed a pluralistic value theory embracing, e.g., knowledge, beauty, and justice as intrinsic values (Hedin 1993). Within utilitarianism, there are two sub-groups, i.e., subjective and objective utilitarians. The former believes that wellbeing or happiness is best defined by each individual, based on his or her personal experience. The latter group doubts the validity of such subjective assessment and wants processes involving experts to define rational indexes for measuring the consequences. So, while the subjective utilitarians prefer the market to allocate resources, the objective utilitarians lean towards data-driven methods of resource allocation, such as Quality-Adjusted-Life-Years (QUALY) and Disability-Adjusted-Life-Years (DALY) (Roberts & Reich 2002).

However, as appealing this may sound, there are both practical and philosophical problems associated with the teleological line of thinking described earlier and in public health, a number of questions emerge in relation to allocation of resources. Many see results produced following individuals' subjective judgements as sometimes irrational, e.g., people often overemphasise new or heavily publicised risks, sophisticated hospital care is preferred to primary health care, curative care is preferred to preventive care, etc... The objective utilitarian view point is, however, also problematic and raises issues: who are the experts to decide on the indices; how to discount in order to prioritize between immediate and future gains; and, is health status the only aspect of well-being and can it be measured on a universal scale - or, is it in fact a subjective matter. Philosophically, there are objections to the utilitarian views on grounds that they lead to unfairness (Roberts & Reich 2002). Some philosophers claim that utilitarianism can be refined to what they call ideal utilism according to which happiness would be greater were it fairly distributed. Other philosophers dispute this and state that we are here dealing with a deontological demand and that it shows the shortcomings of the teleological ethics (Hedin 1993).

Box 4.1: The Oregon Health Plan

The Oregon Health Plan began in 1987 with the event of a seven year old boy, Coby Howard suffering from acute lymphocytic leukaemia and needing a bone marrow transplant. The state legislature had one year earlier discontinued support for organ transplant under the Medicaid, i.e., the state health programme for the poorest. The boy died under great publicity. Dr John Kitzhaber, an emergency room physician and presiding over the Oregon senate during the public debate surrounding the Coby Howard event became the driving force behind initiating the health plan. He wanted to address the twin problem of lack of insurance among the low-income people and denial of lifesaving treatment despite coverage of less effective therapies for less serious conditions. In 1989, the Oregon Health Service Commission was established, consisting of five doctors, a public health nurse, a social worker and four consumers of health care. The first approach was to use QALYs ranking with the lowest cost per QALY first and the highest at the bottom of the list. However, this led to many anomalies as reliable data was not available for all condition-treatment pairs. The Commission then turned to conducting a series of community meetings in which the public suggested utilities*. Two-third of the participants were health care providers, two-third were college graduates and only 5% were Medicaid recipients. A list of 13 'utilities' emerged from these meeting. Ranked according to the frequency in which the utility had been mentioned during the meetings, the first three were: prevention, quality of life, and cost-effectiveness. The Commission then used its own judgement to form three utility groups: essential to basic health care; valuable to society; valuable to an individual needing the service. After applying considerable further judgement by the Committee and paying due attention to the political feasibility, a ranked list of 709 condition-treatment pairs was presented in 1991 to the state legislature. Funds were only available to cover the first 587 items on the list, leaving the bottom 122 items not to be covered by Medicaid.

However, President Bush Sr. rejected the plan on grounds that it violated the Disabilities Act of 1990 and the Commission was told to eliminate any validation of quality of life. Further, two items were specifically challenged, i.e.: no liver transplant for alcoholic cirrhosis (line 690); and no life support for premature babies with extremely low birth weight (line 708). All references to quality of life were removed as well as any consideration of a personal responsibility for illness. A new list was produced consisting of 688 items of which 568 were funded. After some final minor modifications, the plan was finally approved by the Clinton administration in 1993 and implemented the following year

The Plan made 165,000 more people eligible for the Medicaid scheme out of which 100,000 had been enrolled by 1997. However, the rationed list was only directly adhered to for the 13% of patients whose physicians were paid on a fee-for-service basis by the state. The remaining 87% were enrolled in capitated health plans. These plans were paid capitation according to the rationed list but it was left to the individual plan whether to provide treatment below the cut-off line. The plans often do authorize care for diagnoses below the line. For example, in 1996, the Care Oregon review committee approved high-dose chemotherapy and bone marrow transplantation for a nine year old child with medulloblastoma, a \$75,000 treatment of unproven efficacy that was listed below the line.(Bodenheimer 1997;Honigsbaum *et al.* 1995) .

Although the process while ongoing was heavily criticized, when implemented, enrolling additional 100,000 beneficiaries it became quite popular, possibly because the ranked list made common sense. "*Most things at the top are important, and most things at the bottom are not so important*" (Bodenheimer 1997).

* Honigsbaum *et al.* use 'value' synonymously for 'utility'

The formulation of the Oregon Health Plan (Box 4.1) was a process aiming at rationing health services in order to provide more health to more people within the same resource frame, i.e., maximize utility. However, it is a good illustration of the number of difficulties encountered when applying teleological reasoning to a practical public health situation. *First*, the situation was triggered, not by a concern for maximizing utility, but by denial of lifesaving treatment to a particular individual, i.e., a deontological dilemma. *Second*, the process ran into difficulties due to lack of reliable data about consequences when it attempted to use cost of QALYs as the

ranking criterion, i.e., objective utilitarianism. *Third*, the process of asking the community to assess its utilities could be questioned due to that the participation in the meetings hardly could be said to be representative of the users of Medicaid, i.e., what was supposed to be a subjective utilitarian approach became possibly an 'objective' one. *Fourth*, the process entered into a number of no-go zones, representing deontological barriers, including: the conflict with the Disabilities Act, i.e., evaluation of quality of life had to be removed, the need to remove consideration of personal responsibility for illness as well as the proposed cut-off point for life support for babies with extremely low birth-weight. *Finally*, it could be argued that while the plan extended the right to health care to more people, it did not fully resolve the original ethical problem of Coby Howard. In this respect, the plan possibly rather obfuscated the problem. Although the rationed list had a clear cut-off point with respect to what the Medicaid finances, for the 87% of the enrollees who were covered through capitated plans, both the risks and the ethical dilemmas were transferred to these plans.

In the Oregon case there are numerous clear finger prints of communitarian ethical reasoning. For example the removal of quality of life reference due to the conflict with the Americans with Disabilities Act (ADA), despite the community meetings mentioned quality of life with the second highest frequency. The passing of the ADA itself had been an illustration of how policy activists and entrepreneurs had managed to change the definition of disabilities, shifting emphasis from the individual to the external environment, viewing people with disabilities as a minority group with certain bodily attributes no different from gender and skin colour, and which should not be discriminated against (Jeon & Haider-Markel 2001). The ADA was deliberately pushed through the Congress by disabilities lobbyists without the usual attention of the media, which the lobbyists believed would impede and not further the public's understanding of disabilities rights issues (Shapiro 1994). However, the backlash was exactly a lack of congruence between the values of the general public and the ADA as illustrated by the community meetings of the Oregon process. The fact that the original submission of the Oregon plan excluded transplant for alcoholic cirrhosis could be a reflection of those committee members making a moral judgement regarding the cause of the condition. Further, the non-acceptance of stopping life support from babies with extreme low birth weight could be traces of communitarian-religious influence.

Libertarians would seek to shorten the list of treatment provided through Medicaid as much as possible in order to reduce the need of tax-payment. In the literature reviewed (see Box 4.1) there were no clear indications of libertarian influence on the process. For egalitarians public health, including provision by the state of a minimum quantity and quality of service for each citizen is part of the individual's rightful opportunities. In the Oregon case, the Medicaid scheme itself was an expression of egalitarian values and so is the removal of denial of access, under the scheme, to treatment for conditions caused by one's own behaviour, e.g., liver transplant in case of alcoholic cirrhosis.

It seems that there are some consequences that we cannot accept, even if they contradict the demand for maximization of utility and happiness, i.e., there are some deontological barriers which cannot be passed, even if it means that the sum of the consequences is favourable. However, Roberts and Reich believe that despite

objections and possible shortcomings in the utilitarian analysis of consequences it will continue to play a central role in public health practice (Roberts & Reich 2002)

A practical utilitarian analysis, as in the case of the Oregon Health Plan, may in a complex manner be faced with deontological concerns and barriers significantly shaping the eventual outcomes of the process. These concerns and barriers can be divided into some which are concerned with individual or social virtues related to the communitarian social viewpoints. Others are concerned with the rights of individuals related to the libertarian and egalitarian social viewpoints.

Virtues involve an acquired ability to behave according to certain moral motives, which can be expressed in rules or duties and played a great role in the philosophy of the antiquity, e.g., Plato and Aristotle as well as among certain religious figures and non-western traditions. The focus is on what people are, i.e., the internal qualities rather than the external actions (Hedin 1993). The social viewpoint associated with virtues is *communitarianism*, which embraces the greatest diversity of substantive philosophical positions among the three social view points. *Relativist communitarians* see morality as inherently contextual with each community defining its own norms and argue for respecting each society's particular cultural traditions. *Universalist communitarians*, on the other hand, believe in a single true form of good society with its associated virtues and would try extending these virtues to all societies (Roberts & Reich 2002).

In public health there are several examples of communitarian thinking. The international movement towards primary health care has been viewed by some as based on communitarian perspectives aiming at providing health care to rural residents in poor countries without necessarily being concerned with cost-effectiveness of maximizing health within the society at large (Reich 1995). Also well-known are that certain communities do not accept general public health practices, such as, e.g., immunization and blood transfusions - not because they dispute the possible benefits, but because to them the intervention itself is wrong. The abortion debate, in particular in the USA, is another example; reference is made to God and to the moral conduct of the pregnant woman. Less well known and discussed are practices of smaller or larger communities not generally accepted as public health interventions. This includes: male and female circumcision, removal of healthy teeth, killing or starving to death the second born twin, widow cleansing, etc...

Social philosophical concerns about *rights* relate to the concept of the social contract, originally formulated by Thomas Hobbes [1588-1679], who believed that people are egoistic by nature, i.e., psychological egoism. The natural state is all against all. The societies originated, in his view, from voluntary agreements based on the insight that it served the best interest of oneself to cooperate with others under certain conditions. These thoughts were further developed by John Locke [1632-1704], who maintained that citizens must be guaranteed certain liberties and rights within a society.

The modern philosophical justification for rights is grounded in the doctrine of *liberalism*, which is rooted in the Enlightenment period, drawing particularly on the writings of Emmanuel Kant [1724-1804]. Kant argued, as opposed to the utilitarians, that each human being ought to be treated with respect, as ends in themselves, not as means to other individual's ends. The rights implied by the principle of mutual respect

can be interpreted in two different ways. *Libertarians* believe that only negative rights should be protected. They want a minimal state only to protect individual property rights and personal liberty - freedom of choice. *Egalitarian liberals*, on the other hand are of the view that freedom of choice does not have a meaning, unless one has the means to choose. They, therefore, believe in the positive right to a minimum level of services and resources. Positive-rights arguments generally lead to proposals for redistribution favouring those who are worst off from a lifetime perspective (Roberts, Hsiao, Berman, & Reich 2004). However, among egalitarian liberals, there are differing views on whether to see health care as a goods and service that people should be free to purchase, just as they purchase other goods, or whether the society has a special obligation for health. The big question is whether the government should be responsible for level of health status or for access to health care. This has important implications for the relationship between the state and the individual as well as for public health policy and practice.

True libertarians' interest in state-financed public health would be very limited. They are against redistribution of resources in the society, e.g., through taxing of income and assets for provision of free service to those who cannot afford to pay themselves. They also object to public health measures that restrict freedom of choice, including measures against drug use, limitations to abortion, enforcement of seat belts, smoking etc...

4.3 Equity

Equity and human rights have been discussed with varying intensity by the social philosophers over time. However, the discussions intensified in the 1980s and Hedin believes that among other reasons this is related to the neoliberals' need to legitimize the demand for protection of individual property rights and the right to keep acquired assets for own use, i.e., free of taxation (Hedin 1993).

The concepts of equity and altruism are sometimes confused; however they are distinct and have different implications for health policy. Caring and altruism are matters of preference and the level of provision is determined by the wealth of the society. Social justice - or equity, on the other hand, is not a matter of preference. The source of value for making judgement about equity lies outside, or is extrinsic to, preferences. Social justice derives from a set of principles concerning what a person ought to have as of right and requires that an equitable pattern of provision is ensured, irrespective of the sacrifice to the rest of the society. As such, the concept of equity emerges from a deontological rather than a teleological perspective, i.e., utilitarians are primarily concerned with maximizing the sum of individuals' utilities and less with how the utility is distributed.

With respect to access to health care, libertarians view this as part of society's reward system and would focus on the extent to which people are free to purchase the health care that they want. Those libertarians who are concerned about distributional issues emphasize minimum standards rather than equality. Egalitarians, on the other hand, view access to health care as a citizen's right and judge equity by assessing the extent to which health care is distributed according to need and financed according to ability to pay. It is clear, that depending on which perspectives prevailed in policy making,

the resulting health care system would be very different. It is also clear that where the different perspectives co-exist, which is mostly the case, this can lead to tension, trade-offs, and outright conflicts, e.g., in situations where efficiency in maximization of overall utility or freedom of choice are sought achieved at the same time as guaranteeing access to a minimum of level or an equitable distribution of care.

The above is closely linked to the size, role and function of the state as regulator and as collector and distributor of resources. As such, questions and concerns about equity are deeply rooted in political systems and traditions. It has been found that European policy makers are much more homogeneously based in egalitarian traditions than their American counterparts who are much more diverse and embracing more libertarian views (Wagstaff & Doorslaer 1993)

The Economist, a declared liberal news magazine wrote in a 2001-leader on whether inequality mattered. Its view was that narrowing inequality by imposing high taxes on the rich might please some but make few better off. However, "Focusing resources and policy on poverty would be worthwhile simply on humanitarian grounds. But also, the disadvantages of growing up in extreme poverty pose a challenge to a belief in equality of opportunity" (The Economist 2001).

Inequities are inequalities that are judged to be unfair, i.e. both unacceptable and avoidable (Whitehead 1992). Equity in health care means that health care resources are allocated according to need, health services are received according to need, and payment for health services is made according to ability to pay. (Braveman 1998)

Wagstaff and van Doorslaer attempted to make these definitions more operational by distinguishing between vertical and horizontal equity for the financing as well as the delivery of health care (Wagstaff & Doorslaer 1993)

Equity in the finance of health care requires that health care is financed according to ability to pay, i.e.:

- Vertical equity - persons of unequal ability to pay make appropriately dissimilar payments for health care
- Horizontal equity - persons of the same ability to pay make the same contributions

Equity in the delivery of health care requires that health care is distributed according to need, i.e.:

- Vertical equity - persons that are in unequal need are treated in an appropriately dissimilar way
- Horizontal equity - persons in equal need are treated equally, irrespective of personal characteristics that are irrelevant to need, such as ability to pay, race, gender, and place of residence.

However, a number of questions remain, in particular with respect to the definitions of vertical equity. What form should dissimilar payments take and what is meant by 'appropriate'? Should persons with greater ability pay more in proportional terms or just in absolute terms, if proportional should it be on a progressive or regressive scale? What to include under the term 'payment' in addition to the direct payment - transportation, payment for complementary services, etc? With respect to vertical

equity in delivery, questions remain regarding the precise form of differential treatment and the relationship between need and treatment.

Box 4.2 provides an example of how an ethical discussion can get confused with a technical discussion and also how the values of equity and human rights possibly disappeared, at least temporarily, from the agenda of WHO. The core of Braveman *et al's* critique was a concern about the implied removal of egalitarian values of equity and human rights from the world health agenda. Their argument centred on the measurement of fairness, which they claimed was not useful in guiding national policies because it hides the causes of systematic disparities between social groups in the society. They demonstrated this by showing lack of correspondence between the World Health Report 2000 measures and those used elsewhere. Murray, who came to it from an objective utilitarian perspective, did not pick-up or understand the values dimension of the arguments brought forward by Braveman *et al.* His response avoided altogether using the terms 'equity' and 'human rights', instead he addressed technicalities of the measurement and argued for a composite and aggregate measure, leaving it to health scientists to take this further.

Box 4.2: Equity or Equality - A Critique of the World Health Report 2000

The World Health Report 2000 scores overall attainment of health systems by combining various goodness and fairness criteria. Goodness is defined as the best attainable average level and fairness as the lowest feasible difference between individuals and groups. On the latter, the report used as indicators inequalities in child survival and in financial contributions (WHO 2000). The argument evolved around measuring inequality in overall child survival without reference to social groups. Braveman *et al.* demonstrated the poor correspondence between the relative ranking in the World Health Report measure and the poor:rich ratio and concentration index, used, e.g., in some World Bank publications. They concluded "Because the World Health Report 2000 does not measure differences in health between different social groups, it effectively removes equity and human rights from the public health monitoring agenda". (Braveman, Starfield, & Geiger 2001).

Murray who was the responsible for the World Health Report 2000 and the lead author of the Global Burden of Disease report series, in his response, concentrated on equality and the measurement itself: "*To most of us, inequality is the state of being unequal. Health inequalities exist when individuals' risks of death and poor health are unequal*". He claimed that in addition to Braveman *et al's* list of socioeconomic factors, there would be a host of similarly important factors influencing risk of death, including community level and genetic factors as well as factors related to the individual's informed choices. He stated that comprehensive approaches were needed for full understanding and compared the approach used in the World Health Report 2000 with the measures of income inequalities used by economists, e.g., Gini-coefficient. He was not concerned whether eventual inequalities were unfair, acceptable or avoidable, but stated about next steps: "*Health scientists can then help determine the causes of inequality and the policies and programmes that can be used to tackle these causes*" (Murray in a commentary published together with the above article)

A search in the PubMed database covering the period 1990 to Mid-July 2002 for "health care reform" yielded almost 13,500 articles. However, almost two-thirds of this research was published during the four years from 1993 to 1996. Assuming that it takes at least one year to publish results, this means that most findings date from before 1993/94. Given that the health sector reform process in developing countries was only getting started by then, it is hard to believe such numbers of significant lessons on large-scale reforms could possibly have been drawn from experience. It seems as if the academic community lost interest in writing about health sector reform at about the same time that it became possible to study its results. Equally disturbing is the fact that only 1.5% of all the research indexed by PubMed under the 'health care

reform' heading was addressing equity, equality, or fairness. The number of such articles has remained fairly stable at about 25 per year since 1994 (Blas & Hearst 2002). This is a disappointing number, given the emphasis on equity expressed at the International Conference on Health Sector Reform in 1993 (Berman 1995) and the concerns raised during the second half of the 1990s.

In an article in 2001, Davidson R Gwatkin of the World Bank called for a new wave of health sector reforms that were equity-oriented and conceived and executed with even more passion and determination than the efficiency-directed reforms of the 1990s (Gwatkin 2001). He presented three arguments to support his call:

- Significant reforms will require changes that are far deeper than commonly recognised in policy circles.
- Current movement toward debt relief in poor countries is creating a climate that is potentially more favourable to deeper change than was the climate of the recent past.
- Epidemiologists and health systems researchers can best help equity-oriented health policy makers take advantage of the present climate by developing an evidence base concerning intervention options for reaching the poor effectively.

Gwatkin further stated that, although researchers have contributed valuable conceptual frameworks for approaching these issues, they have not yet reached the heart of the matter, namely the identification of measures that can deal effectively with the inequalities that have been uncovered.

5. THE POLITICAL ECONOMY

During the period 1850-1870 the tree of economics bifurcated with one branch leading to the prevailing western economics and the other branch leading to socialist economics of, e.g., USSR and China. Initially, the western economics focused on microeconomics and lacked a developed macroeconomics (Samuelson 1976). This proved fatal when most of the world was hit by the stock market crash in 1929 and the Great Depression in the early 1930s led to a serious melt-down of the economy, including insolvency of thousands of banks, dramatic increases in unemployment, etc.. The response of governments, including the US-government of FD Roosevelt, from 1933 was increased direct interventions by the state in the economy. Under the *New Deal* programme, regulation, directives, welfare programmes, and subsidies to, e.g., the farming sector, and large public financing of infra-structure construction programmes were launched to boost the economy and provide social security. Labour unions were allowed to operate and grew stronger.

The publication of the *General Theory of Employment, Interest and Money* in 1936 by John Maynard Keynes finally provided the Western economy with the macroeconomic theory that was so much needed. The theory pointed to the role of the state through direct interventions in investment, supply and demand to influence the economic activity. It later formed the basis for development of other mainstream macroeconomic theories and further provided the theoretical underpinning for the mixed economies and the so-called welfare states. Subsequently, Keynes elaborated the *Keynes Plan* in 1943 suggesting the establishment of an international monetary

clearing union and forming the basis for the Bretton Woods-conference in 1944 in which 44 countries participated with the goal of creating stable economic conditions after the Second World War. In 1945, the International Bank for Reconstruction and Development (IBRD) and the International Monetary Fund (IMF), often called the World Bank Group were established.

During most of the 20th century three streams of thought concerning the political economy dominated the debates:

- *Neoclassical economics* with its analysis targeted towards the individuals, households and enterprises working its way up to the macro level. There is no differentiation between industrialized and developing countries, i.e., the same basis assumptions are made regarding consumers utility and producers profit maximization, as well as the central role of the market as determinants for economic behaviour. It is a part of the neoclassical thinking that the economic behaviour, price-setting and other conditions can be studied within the economic discipline alone. The pure neoclassical tradition came only seriously to have an influence in the international development debate in the 1980s after the breakthrough of the Chicago School in the mid-1970s, but it existed in parallel with the development economics mainstream from back in the 1940s with proponents such as Friedrich von Hayek.
- Contrasting the neoclassical economics is the *post-Keynesian* and *development economics*, whose focus is on macroeconomic structures and with the basis assumption that economic growth is closely associated with a structural transformation process. The developing countries are regarded qualitatively different from the industrialized countries, thus requiring development of particular methods and theory. The analytical perspectives stretch from mono to multidisciplinary approaches. The theoretical foundation took off from the earlier theories of Schumpeter, Keynes and Marshall.
- The *neo-Marxist economists* were partly interested in different macroeconomic phenomena than the development economists, but there are other obvious similarities. The neo-Marxists emphasized the particularities of the developing countries and what they termed peripheral societies in relation to both structural heterogeneities in general and the combination of specific production forms which they regarded distinct from those of the central capitalistic economies. Their approach was by definition multidisciplinary and they were occupied not only with the economy but with the politics in a society from a comprehensive perspective.

The events and the balance between these streams of thinking provided the context for and impacted in a significant way how health sector development was looked upon in the 1990s in the developing as well as developed countries.

The fruits of the post-Keynesian political economy during many years following the second world war were better working of the mixed economies with unprecedented growths in outputs and standards of living prevailing first in America, Scandinavia, England and the Netherlands and increasingly also in Japan and other Western countries. Together with a prominent role of *egalitarian values* this formed the foundation for the *welfare state*. However, one problem remained unresolved and that was how to find the perfect income policy which could ensure simultaneous full

employment and price stability (Samuelson 1976). This problem increasingly marred the Western economies giving rise to the phenomenon of *stagflation*, i.e., concurrent stagnation in economic activity and price inflation. Government interventions in form of, e.g., changes in spending in order to curb unemployment or inflation did not seem to have the only transient destabilising effect upon general business activity as predicted by the theory and the entire economy appeared out of control.

At the beginning of the 1960s, also the socialist countries were full of optimism and in April 1961, the USSR had beaten the USA by putting the first man in space and Khrushchev's famous remark "we will bury you" suggested that the USSR would surpass the USA in per capita production within ten years (Muravchik 2002). From the mid-1960s, the USA administration was increasingly losing control of both the economy and the war in Vietnam. The decision in 1965 to escalate the war and thereby increasing military expenditures by 25% without immediate measures to curb the budget deficit created a wage-price spiral momentum that it proved difficult to stop. In the early 1970s the problems were augmented with the Organisation of Oil Exporting Countries' (OPEC) oil boycott and subsequent rise in prices.

The 1970s became a period of crisis for the capitalism, the OPEC price rises seemed to challenge the hegemony of the West and the instability of the capitalist inflation contrasted markedly with the stability of prices in the communist world (Leeson 2000). However, if the prices in the communist world remained stable, the development was not going as the USSR twenty-second national party congress had planned ten years earlier and Khrushchev's prediction of overtaking the West by 1971 seemed far off. Gorbachev who, by beginning of the 1970, was a young regional secretary in the Stavropol region and member of the Central Committee, reflected during a visit to Western Europe "The question haunted me, why was the standard of living in our country lower than in other developed countries?" (Muravchik 2002).

A key tool to understand the mechanism of steering the Western economies at the time was the so-called *Phillips curve* which depicts the trade off between degree of unemployment and wage-price creep. The macroeconomic dilemma in a mixed economy is to supplement monetary and fiscal macro policy by an incomes policy designed to give itself a better Phillips curve, i.e., in the sense that it will permit a lower minimum level of unemployment at which the system can avoid undue price inflation. By 1970, all the Western countries seemed to be off the Phillips curve in the same direction and in 1971, the Bretton Woods system was effectively in ruins.

Since the mid-1960s, the Chicago school consisting of laissez faire libertarians, such as Friedrich von Hayek, Milton Friedman and others had been attacking the Keynesian model reminding the world of what it is that market pricing accomplishes, and what are some of the penalties to society from disregarding this. They criticised the pegged exchange-rate system of Bretton Woods as fatally flawed at its core in a world where countries will not inflate and deflate according to the old dictates of the automatic gold standard. They advocated for floating exchange rates, monetary targeting, low if not zero inflation, the abandonment of fine-tuning, lower taxes and less regulated markets. Friedman argued that if policy-makers attempted to keep unemployment below what he termed the 'natural rate of unemployment', inflation would increase as unemployment returned to 'natural' levels. The gravitational pull of the 'natural' rate of unemployment on the actual rate would ensure that any reduction

in unemployment purchased by inflation would be purely temporary. Likewise, if anti-inflation policies were required, policy-makers had only to temporarily push unemployment above the natural rate and this would control inflation. Friedman believed that, e.g., labour unions were contributing to keeping the 'natural level of unemployment' higher than it had to be. Now, within a very short time, Friedman's concept of the 'natural rate' of unemployment swept through the economics profession and the reduction of inflation took precedence over the maintenance of low levels of unemployment. The targeting of employment (or interest rates) was abandoned, replaced by faith in the ability of monetary targets alone to stabilize the economy.

By 1974, began what has later been termed the monetarist decade which lasted up to early 1985, when it was announced officially dead in a Financial Times lead article. During this period the belief was that essentially everything that can be done to control macroeconomic aggregates, i.e., inflationary gaps and epochs of depression and slow growth has to be done by control of the money supply alone. Fiscal policy was seen mainly as helping in shaping how much of the macroeconomic total was in the public as against the private sector and in shaping the trend of interest rate and of the consumption share of the Gross National Product (GNP) (Leeson 2000). Around 1980, there was an almost simultaneous shift of governments in USA, Great Britain and West-Germany. This brought Reagan, Thatcher, and Kohl in offices and changed the economic advisers to monetarists and micro-economists with background in the neoclassical economics. A large-scale rolling-back of 'big government' and rolling-in of the market and the private enterprises began.(Martinussen 1994).

With Reagan in office, the USA labour unions had lost the federal government backing enjoyed since the New Deal programme of the 1930. In 1981, the President permanently replaced striking air traffic controllers, this and further assaults on the labour unions, led to a rapid decline of membership. By 1999 only 9.4% of the private sector workers were organized in the USA. Also Thatcher in the UK, laid arms with and broke the power of the unions. The labour unions, which had significantly helped to redistribute wealth and build the middle-class societies and welfare states that characterized the mid-century Western countries faced severe defeats precipitating the massive re-concentration of wealth that became to mark the end of the century (Frank 2000).

By 1976, the British Labour government had faced an economic crisis of tremendous dimensions and had seen no other choice than to turn to the IMF for support. This was a political embarrassment of dimensions and the country had to submit to the fund's demands for austerity. Inflation was running around 25% and the government imposed 'income policy' to restrain prices and wages led to union rebellion with a wave of strikes during 1978-79, dubbed the 'winter of discontent'. Eventually, a public backlash dismissed the Labour government and brought a Conservative government to office in the spring of 1979. The new government was headed by Mrs Thatcher, a conservative ideologue, nicknamed the 'Iron Lady' who was determined to 'kill' socialism. Her anti-inflation policy drove up unemployment to double digits and triggered urban riots pushing her approval rating down to 28%, a historical low. A political rescue came in form of the Falkland crisis, where she ordered the British forces to fight until Argentina surrendered. The victory consolidated her power and provided a political momentum, which kept Labour out of office for three consecutive election periods (Muravchik 2002).

The forces set up by inflation and policy-induced recession nevertheless seemed to cause unpredictable chain reactions rather than the equilibrating forces that the natural-rate model optimistically expected. During the course of the 1979-83 UK Parliament, while the country was following a monetarist financial strategy, industrial output fell by over 11 per cent and unemployment rose from 5.4 per cent to 12.7 per cent. In 1985, when all time high weekly unemployment figures were released, the Prime Minister, Mrs Thatcher was asked if the natural-rate had been reached. She denounced that her government had ever adopted a monetarist strategy. Having lost one of its prime political supporters, soon after the above-mentioned article announcing the death of monetarism was published in the Financial Times (Leeson 2000).

However, it was not only in Britain that the political left learnt lessons during this period. In France, Mitterrand's 'Socialist Project for France in the Eighties' included, nationalising industries, creating new public sector jobs, and mandating increases in wages, pensions and welfare. Within one year after launching, the project had brought the French economy into a tailspin with stagnant outputs, collapsing trade balance, and soaring inflation, forcing a complete turn-around with all factions of the socialist party acknowledging the reality of economic struggle and the role of the private sector as a creator of social wealth. The lessons learnt in France together with the string of electoral defeats pushed the British as well as the rest of Europe's socialist parties to redefine their roles in the society. During this period, the British Labour Party realized the need for changes in the values and approaches of the party and began increasingly to come to peace with some elements of 'Thatcherism', including privatization of state enterprises, restrictions to labour union activities, etc... One of the major components was to redefine themselves as 'speaking' for the whole community, i.e., not exclusively for the labourers. This meant that the socialist parties began slowly to distance themselves from the labour unions (Muravchik 2002).

During most of the 1970s and beginning of the 1980s, the USSR had experienced a continued lack of development thus further widening the gap to the West. The increasingly geriatric political leadership displayed inability to address the problems. From 1982 and within the just three years, three leaders, i.e., Brezhnev, Andropov, and Chernenko died at the helm. Gorbachev, who succeeded, took over a run-down economy and production infrastructure as well as an ailing political system. The Chernobyl disaster, made obvious the technical and political deficiencies. Not only were errors revealed in design, construction, operation and maintenance - but officials were withholding information in order to minimize the embarrassment at the expense of the health of millions of citizens. The economic reform programme, which he had initiated under the banner of *perestroika* (economic reform) did not progress, most probably due to the servility attitude and behaviour of a rigid official system which had developed during seventy years of the Communist Party's rule. He realized that he could not bring about economic change without political changes and launched a reform programme under the watchword *glasnost* (openness) targeting the system itself. Gorbachev remained a true believer in the ideals of the revolution, however, he felt that they had been buried beneath a thick bureaucracy and needed to be recovered. He talked about pluralisms, recalled history books that had been tailored to official dogma, and pushed through a law on socialist enterprises. He withdrew the Soviet troops from Afghanistan and retreated from the empire as the communist regimes in

Europe toppled one after the other. In February 1990, the Central Committee approved his proposal to end its monopoly of power, agreeing to a multi-party system and ending its opposition to private property, thus abolishing the core of Leninism and Marxism. While Gorbachev succeeded in democratising the Soviet Union, he failed with his economic reforms. He decentralized and liberalised but his convinced 'socialist' mind did not allow him go for a wholesale privatization (Muravchik 2002).

At the time of Mao Zedong's death in 1976, China had one of the most bureaucratized social systems in the world, nearly all aspects of society and economy were under Leninist bureaucratic control (Yang 2001). The Chinese party's plenum in 1978 endorsed, Deng Xiaoping programme of '*four modernisations*' of industry, agriculture, the military and science. Deng, who had accented to power after the death of Mao Zedong in 1976, had already back in the early 1960s experimented with what was called the 'household responsibility' system in which, households and work teams were given small plots of land on which they were free to grow and dispose the produce against providing a tax to the state. He had then said: "it doesn't matter if the cat is yellow or black as long as it catches the mouse". However, during the Cultural Revolution, these experiments had come to a hold and he had been denounced as a 'capitalist roader'. The '*four modernisation*' rested on two pillars, i.e., economic liberalisation and openness to the outside. The household responsibility system became a legitimate form of '*socialist enterprise*', special economic zones were established and official slogans such as 'to get rich is glorious', 'socialism with Chinese characteristics'. This launched a continuing period of impressive growth. However, Deng maintained firm control over the society, not allowing free expressions of discontent, as shown by affirming the *four cardinal principles*: socialism, the dictatorship of the proletariat, leadership by the party, and Marxism-Leninism-Mao Zedong thought in 1979 and by the crack down on the demonstrators at the Tiananmen Square in April of 1989. However, the latter also resulted in a slow down in further modernizations, as Deng had to rely on party conservatives to politically recover from the event and the reaction from abroad (Muravchik 2002).

The systemic failures that had alarmed Deng and Gorbachev had in the first place been economic, but their courses of action quickly diverted. In Deng's China, the dictatorship of the Party remained in force while the economy was reformed. In Gorbachev's Soviet, the dictatorship of the Party ended, while the reform of the economy was left to his successors.

During the period of Keynesian revival, the original low-inflation Phillips curve was again at the heart of policy choices. The natural-rate model challenged its primary adversary, the high-inflation trade-off interpretation of the Phillips curve, and it was now challenged by models which invoke hysteresis, implicit contracts, insiders and outsiders, an expectations trap, efficiency wages, etc. Not all of these models deny that at any point in time a natural-rate of unemployment might emerge, but they tend to deny that the gravitational pull of any particular natural-rate is stronger than the gravitational pull of the actual rate of unemployment. The inflationary, respectively the disinflationary turmoil of the 1960s and the 1980s and the way that these were addressed, impacted in a lasting manner on the welfare state and the mixture of the mixed economy (Leeson 2000).

In Great Britain, an eighteen-month recession, the longest in fifty years, unemployment at about ten percent, and a national health services beginning to split apart, made the conservatives vulnerable. Further, Thatcher, due to internal feuding, had had to step aside leaving John Major - a compromise, at the helm. Up to the 1992 elections, the Labour Party had campaigned as a re-brand, swooped the red flag for a red rose and streamlined its campaign operations in 'Hollywood' style, which made some talking about 'designer' socialism. (Muravchik 2002). Labour led by a comfortable margin in the polls up to the elections. However, the voting day gave the Conservatives a fourth consecutive term in office and left the Labour Party leadership in confusion. The top-leaders, Kinnock and Hattersley accused the voters of having made a wrong choice, but Tony Blair emerged with a different view, he wrote, "The reason Labour lost in 1992, ...is simple: society had changed and we did not change sufficiently with it" (Muravchik 2002). Blair began to formulate and position himself and the 'New Labour' in a populist way, inspired and advised by Clinton's approach and victory in the USA. This included slogans such as "we must be tough on crime and tough on the causes of crime", talking about societal values, principles and morals. In 1994, the Labour leader, John Smith died of a heart attack and Blair took over on a platform of change. Within nine month of taking over, he had changed the Party's positions on taxes, inflation, minimum wage, private schooling and a variety of constitutional and international issues, decrying 'penal rates of taxation' for individuals as well as companies, stating that the latter would not invest without decent profits. He urged reduction in welfare, saying "a nation at work, not on benefit - that is our pledge", "the Labour party is now a party of law and order", "government don't raise children - families do", i.e., typical conservative values. He began to talk about 'the ethics of responsibility'. The poor needed to realise that the process of 'inner' transformation to adapt, flexibilise, retrain and reskill rested with themselves (Cameron & Palan 2004).

Having embraced the main tenets of the Thatcher revolution, Blair identified and highlighted with great oratory some smaller differences, e.g., endorsing a minimum wage, opposing certain privatizations within the health services, and lowering the age of legal consent in homosexual acts to match those of heterosexual intimacy. One of the most fundamental changes he made was the reformulation of Clause IV of the Labour Party's constitution, which was reprinted on the back of every party membership card. Since 1918 it had read: "...to secure for the workers ...the full fruits of their industry and the most equitable distribution thereof that may be possible upon the basis of the common ownership of the means of production, distribution and exchange". Within just three months after he had taken over the leadership, a special party conference revised the clause to read: "A dynamic economy, serving the public interest, in which the enterprise of the market and the rigour of competition are joined with the forces of partnership and co-operation to produce the wealth the nation needs and the opportunity for all to work and prosper, with a thriving private sector and high quality public services, where those undertakings essential to the common good are either owned by the public or accountable to them". Blair declared "The battle between the market and public sector is over" and in the run-up to the 1997 elections, in which Labour had its strongest support ever, he moved further to the right embracing Thatcherite privatisation and ideas with statements such as that he wanted to create "a nation of entrepreneurs", calling himself the 'entrepreneurs champion' and promising less labour market regulations than in the US (Muravchik 2002).

Contrary to Clinton, who had campaigned right and turned left when in office leading to a 1994 Republican back-lash, Blair stayed close to the stance taken during the elections. The most significant differences between the new Labour government and the previous Conservative one were moving Britain closer to the continent including signing the Social Chapter of the Maastricht Treaty and a constitutional reform, which included devolving power to the regional governing bodies of Scotland and Wales and removing most of the hereditary members of the House of Lords. He further won enactment of a minimum wage and made an array of small changes in the health and education sectors. However, on the large political scale, it was hard to distinguish Blair's 'Third Way' from the pre-Thatcher Conservatism and it was further to the right from what Willy Brandt had described as social democracy, namely the middle way between capitalism and communism.

Blair said that his Third Way was to forward four core values: equal worth (meaning civil equality or equal rights), opportunity for all, responsibility, and community that according to Blair implied 'strong government', which was not the same as 'big government'. A summit of leading social democrats of industrialized countries, Presidents Clinton and Mbeki of South Africa, and several heads of states in Latin America, held in Berlin in June 2000 issued a communiqué that almost word by word repeated the same four core values. The Summit was followed up by a declaration in September the same year by the social democratic prime ministers of Germany, the Netherlands, and Sweden, saying: 'progressive politics has been liberated from old attitudes' and called for 'active government', 'strengthening of civil society' and more help for poor countries within a context of 'sound macroeconomic policy', 'free trade' and an appreciation of 'responsibilities as well as rights' (Muravchik 2002)

The only important holdout among the socialist governments was the French, headed by Jospin, who, before he softened his stand, mocked the Third Way by calling it an 'excuse to abandon our socialist principles'.

In China, the state tended to grow until the early 1990s. Partial reforms and imperfections of the market invited for government interventions and the rapid economic growth provided the revenue for government expansion. This expansion, in turn, offered a fertile ground for political patronage. However, as market transactions grew and competition eroded the profitability of state enterprises, the various actors within government gradually lost their interest in the state enterprises (Yang 2001). It was not until, 1992, that Deng got the economic liberalisation back on track. The following year, the National People's Congress enshrined the phrase 'socialist market economy' in the constitution. While he encouraged, with impressive results, private initiative in the economic sectors, he never gave in on the political front and his last message to his comrades, before he died one year later, was "*The Chinese Communist Party's status as the ruling party must never be challenged*" (Muravchik 2002)

The drives for deregulations of markets, floating exchange rates, lower taxes, and a decreased role of state in the economy continued and had a major influence both on the thinking about and how, what has been termed the New Economy actually functioned up through the 1990s. Consolidation, downsizing, outsourcing, and just in-time delivery from sub-contractors became instruments for private companies to operate in the increasingly competitive international markets. Privatization, outsourcing, user-payments became means for public enterprises and services to

improve efficiency in the public sector. Underlying these instruments was a faith in the market as a mechanism or an 'invisible hand' to regulate demand and supply of all kinds of goods and services. "Everything is now thought of as a business of a sort. We are all 'in business' these days, be we a doctor or priest, professor or charity worker" (Management theorist Charles Handy, 1994 cited in (Frank 2000)).

Globally, production increasingly became organized by multinational corporations (MNC), which, by the end of the century were estimated to account for between 20 and 30% of all global outputs and maybe up to 70% of world trade. More and more, the mode of production shifted from the traditional subsidiary approach to joint ventures, strategic alliances and outsourcing in order to flexibly exploit the comparative advantages of different production sites. While MNCs previously often had been accused of providing poor working conditions for their employees, the worst conditions were now found among the domestic companies producing under contracts with the MNCs (Held *et al.* 1999). The globalization of production gradually shifted the balance of power away from national governments and labour and made the traditional tools for macroeconomic management, such as demand management and monetary policies less effective.

All these changes at the macro-level since the 1970s and continuing through the 1990s impacted significantly on the relative distribution of the control of and access to resources in the society. In the USA, income inequality grew to levels not seen since the Gilded Age around the 1880s. From 1979 to 2000, the family incomes of the lowest quintile grew by 6.4%, while those of the highest quintile grew by 70% and the top 1% grew by 184% (The Economist 2005c). In 2004, America's after-tax profits rose to their highest as proportion of the GDP for 75 years and it is estimated that for the G7 countries as a whole, the share of profit in national income have never been higher - the flip side being that labour's share has never been lower. With the integration of China and India into the world economy with their vast supply of cheap labour, it is likely that the global return on capital relative to labour will remain high for a foreseeable future (The Economist 2005b). In China, which increasingly has moved to a market-based economy since 1980, the income inequality has dramatically widened, i.e., the Gini coefficient² grew from 0.22 in 1980, to 0.39 in 1995 and 0.45 in 2002 (Meng *et al.* 2004b).

Although, many political parties still carry names of 'Socialist', 'Labour', and 'Social Democrats' they have given up most of the philosophies on which they were founded, now more accepting the markets, private enterprises and economic inequality than the parties of the of the Right in Europe in the 1950s and 1960s. The Socialist belief that state ownership and planning would prove more efficient than private competition, making socialism not only more just but also more productive than capitalism has gone. Today, it seems that all agree that the wealth required to sustain the public sector is created in the private sector.

The former divide between the Left' and the Right in politics has become increasingly less distinct and it is often hard to tell which political party stands for what. Instant media coverage and polling provides politicians with an almost live feed-back on their

² The Gini coefficient, a measure of income inequality, is a number between 0 and 1, where 0 means perfect equality (everyone has the same income) and 1 means perfect inequality (one person has all the income, everyone else has nothing)

'performance', thus tempting them to respond to the 'market' with the risk of focusing on short-term results or low-hanging fruits rather than the long haul and the more difficult to harvest results. A new profession of spin-doctors entered firmly into the political scene during the 1990s bringing with them methods which had long been used in marketing for branding of commercial products. Further, in addition to arguments of efficiency, out-sourcing, privatisation, corporatisation, decentralisation, marketisation of public services are also justified under a concept of 'freedom of choice'. Frank talks about "an ecstatic confusion of markets with democracy, markets with people, markets with empowerment, and markets with the globe itself" (Frank 2000). Politicians increasingly seem to have become followers or hostages of the public opinion rather than providers of alternative ideas and visions for betterment of the society, i.e., true leaders.

6. DEVELOPING COUNTRIES

In 1977, the Brandt Commission was appointed to look at ways developed and developing countries could overcome the economic crisis the world was facing in the 1970s. A major concern for the Commission was the mass-poverty which it suggested should be attacked addressing multiple sectors at the same time (SIDA 1980). Many of the recommendations of the Commission's report read similarly to the current thinking vis-à-vis the Millennium Development Goals. From the end of the Second World War up to the collapse in Eastern Europe and the Soviet Union at the end of the 1980s, the East-West conflict had a major influence on the events in many developing countries. The bipolar power balance between the two political blocks tended to emphasize a strong state and support militaristic and autocratic regimes as the two blocks tried to win-over and consolidate support, preventing developing countries from shifting to the other 'camp'. The situation, after the USA has become the all-dominating international strategic power, has shifted and the emphasis is no longer to 'win-over' and 'keep' but to open the markets and in this respect, rolling-back the state and strengthening democracy have become main tenets of the international politics.

6.1 Economic development

There are broadly speaking five distinct types interventions that a state can provide: *general legal and institutional conditions* for production and distribution, including legal regulation and enforcement of property rights, contracts, etc.; *macroeconomic policy*, including financial policy, income policy and currency policy interventions; *material and social structures*, including roads, railways, education and health systems; *operational control measures* and other direct interventions in the private companies' conditions; and a *direct participation in production* of goods and services. Most of the development agenda from the 1950s until the end of the 1970s was dominated by a state controlled development model. However, lack of results and the problems with the developing countries economic planning gradually worsened during the 1970s and 1980s, as it became clear that many of the theories on which they were based, were faulty or inadequate (Kock-Nielsen & Vilby 1992). This led to frustration among the planners and one could talk about a crisis in the economic planning. The fact that the crisis did not immediately lead to comprehensive changes, might be linked to that planning is not just a rational economic activity - but also has

clear political functions. The Swedish Economist Gunnar Myrdal believed, while combining economic analysis with analyses of non-economic societal phenomena, that the states as they existed in most developing countries were not suited to handle the challenges at hand, which, in reality were far more comprehensive and complex than generally assumed (Martinussen 1994)

Box 6.1: Many developing countries, in particular those dependent on raw material export, were particularly hard hit by the economic crisis of the 1970s. An example is Zambia, which at the end of the 1960s was relative prosperous with a positive trade balance and an annual economic growth rate of 11%. Between 1970 and 1982, its terms of trade had deteriorated so that in 1982 it needed to export four times as much copper compared to 1970 in order to purchase the same quantity of goods from abroad. By 1990, it had, per capita become the most indebted country in the world (Holm 1997). Zambia and South Korea had comparable incomes per person at independence about half a century ago. Today South Korea's is 32 greater than Zambia's (The Economist 2005a)

During the 1970s the buzz-words in the development debate had been 'solidarity' and 'aid on the recipients conditions'. In the 1980s the theme shifted to 'more efficient aid' with the assumption that the donors having a major responsibility for the resource transfer leading to results (Anderson, Heikensten, & de Vylder 1984). The neoclassical critique of the appropriateness of the states interference in companies' dispositions and the free market forces were provided with stronger impact towards the end of 1970s. It was argued, among other things that the success of, e.g., South Korea was due to the state abstaining from interfering in price-setting, international trade and operations of the private sector, but focusing on creating the macroeconomic conditions for the private sector, including investments in education and health (World Bank 1991)

Around 1980, many decision-makers in the member countries of the Organization for Economic Cooperation and Development (OECD), as well as in the World Bank and IMF had been convinced of the basic thesis that the market forces and mechanisms in all countries and under all circumstances would give a more optimal distribution of both production factors and goods and a balanced economy. They, however, acknowledged that 'market failures' could occur and that these were probably more profound in developing countries than in OECD countries. But they denied that this was a reason to operate with separate theories for developing countries. It was postulated that the effect of market failures were minimal compared to 'government failures', which was viewed as the biggest problem for advancement of developing countries. According to the World Bank (1992) the main symptoms of government failure included:

- Failure to make a clear separation between what is public and what is private, hence, a tendency to divert public resources for private gains
- Failure to establish a predictable framework of law and government behaviour conducive to development, or arbitrariness in the application of rules and laws
- Excessive rules, regulations, licensing requirements, and so forth, which impede the functioning of markets and encourage rent-seeking
- Priorities inconsistent with development, resulting in a misallocation of resources
- Excessively narrowly based or non-transparent decision-making.

The four main reasons for '*government failure*' were generally seen as: egoistic and calculating politicians and other actors, who form coalitions in order to steer distribution of resources to own advantage; corrupt behaviour among politicians and administrators; shortage or lack of competent administrators with the required insight in economic and business operations; and general shortage of knowledge about the private sector and its way of functioning (Martinussen 1994)

Through most of the 1980s, the neoclassical economists had a significant influence on the development debate and their recommendations were to a large extent followed by the World Bank and the IMF as well as by many bilateral development organizations. The 1980s witnessed a significant increase in the importance and influence of the World Bank and the IMF on macroeconomic policy formulation and implementation in developing countries. The Bank incorporated the neoclassical recommendations into the *Structural Adjustment Programmes* (SAP) which by 1983 had taken momentum and through conditionalities for loans to countries in the third world pressing governments into pursuing such policies. Furthermore, the IMF/World Bank's approaches to programme formulation, in line with neoclassical thinking, most often focussed exclusively on economic issues and the programme formulation teams generally included only economists from the Bank and from the host country's Ministry of Finance and Planning, thus frequently leaving out of focus social issues.

Box 6.2: In 1983, Zambia requested assistance from the World Bank through a structural adjustment programme for a long-term solution to its growing problems. As was the case in other countries, the loan condition included acceptance of a policy reducing the role of the state in the economy and increasing the emphasis on the private initiative and the free market forces. When, as part of the programme, the currency was auctioned in 1985, the value declined within 14 months to 15% of what it was prior to the first auction. Combined with governmental budget deficit, this resulted in dramatic increases in prices of all imported goods. As food shortages became rampant and prices rocketed, many people could not afford to buy even their basic food requirements and social unrest and violent demonstrations broke out in the capital. When the government, in 1986, tried to retake some control over the value of the currency, the IMF judged a breach of the conditionalities and postponed the disbursements of the adjustment loan. Several of the bilateral donors trusted the IMF analyses and withheld their disbursements as well, thus making the situation worse (Holm 1997).

A strong critique of the design and implementation of the SAPs came in the late 1980s from UNICEF that found the SAPs too insensitive to social issues and often had made bad situations worse, in particular for poor and vulnerable groups (UNICEF 1989). For many developing countries, the SAPs resulted in significantly increased debts and in Africa and Latin America, per capita spending on health and education declined by 25% and 50% respectively (Abbasi 1999). While recognizing the need for structural adjustments in many countries, UNICEF called for a human face to the programmes, claiming that adjustments which were not people-centred were wrongly conceived (UNICEF 1989). Towards the end of the decade, the pure neoclassical ideas had gradually been forced into retreat both in the theory debate and in the organization of the international development collaboration. It became viewed as a too extreme reaction towards the previous dominating state-led development model. Instead emerged a more balanced compromise between the state and the market driven model - a compromise, which became to set the agenda for the 1990s debate and development efforts. At the end of the 1980s many, in particular sub-Saharan African countries found themselves having returned to standards of living of a decade or more earlier. The decade has thus be characterized as a '*lost decade for*

development' (Martinussen 1994;Tarp 1993). While continuing to defend the SAPs, at the beginning of the 1990s, the Bank realised that the adjustments took longer than foreseen and that the adjustment programmes would not be enough to raise and sustain economic growth (World Bank 1994a)

The World Bank, which had started the 1980s with an almost uncritical promotion of the neoclassical viewpoints about the market and rolling back the government, ended the decade emphasizing the need for strengthening of the state apparatus capacity. The *World Development Report 1991* provided a discussion of the division of work between the state and the market, acknowledging that the state in the third world must continue to play a central, albeit slightly changed role. However, the underlying view was still a clear prioritization of economic growth in a private capitalistic system and the report called for a 'market-friendly' approach to development. The role of the state was defined primarily as where the market fails and the report defined indispensable government interventions as: maintenance of law and order, provision of public goods, investment in human capital, the construction and repair of infrastructure, and the protection of environment. It stressed that markets fail but so do governments. "To justify intervention it is not enough to know that the market is failing; it is also necessary to be confident that the government can do better" (World Bank 1991).

With regards to making available infrastructure and public amenities it is characteristic that much of the literature in the 1990s took over central elements from the neoclassical argumentation, it was emphasized that the states in the third world often lack the required administrative and technical capacity to undertake these tasks together with the other tasks they have. Combined with the view of inefficiency in the public sector, the question was raised whether many developing countries would not be better off by moving part of its tasks to the private sector. A shift of this nature would give the state the opportunity to compensate for potential market failures by paying for goods and services, which are beneficial to the society, but in themselves are not commercially viable. This form of division of work would further make it possible for the state to buy on behalf of the groups in the society that do not have the required purchasing power but have a need for the goods and services in question. It was also characteristic for the development debate of the 1990s that it started addressing the question of the political feasibilities for implementing particular economic reforms. In this connection it is interesting to note that both the Bank and UNDP judge the situation in many developing countries, that the interest groups, that will lose on privatisations and deregulation stand stronger than those groups, that will gain by these economic reforms (Martinussen 1994).

In response to generally disappointing growth rates from poor countries implementing structural adjustment programmes, which were often combined with increasing poverty levels, in particular in Africa, the World Bank and the IMF reconsidered towards the end of the 1990s their approach to poor and heavily indebted countries. They started tying debt reduction to development of a Poverty Reduction Strategy Paper (PRSP) explicitly linking debt-servicing to poverty, by obliging the governments to show how money saved by lower debt-servicing costs could be used to reduce poverty levels (EIU 2001)

A number of the poorest developing countries, such as Zambia seemed to be caught in a debt trap from which they were not able to escape. The PRSPs were a means to get

access to concessional loans through the Poverty Reduction Growth Facility (PRGF) or to benefit from debt relief under the Highly Indebted Poor Countries (HIPC) initiative. The PRSPs were conceived to be national planning frameworks for low-income countries with the stated purpose to foster economic growth and reduce poverty. They were frequently also used by bilateral donors, e.g., the Nordic countries and the UK that want to move away from individually funded project towards programme or budget support. Critique has been raised concerning the PRSPs, including that they contain some intrinsic tensions, e.g., between being country-owned development strategies or 'funding applications' to the World Bank, as they have to conform with the World Banks/IMF notion of 'sound economic policy'. Further, there is a potential tension between the PRSPs being advocacy documents or planning frameworks. With respect to health, questions have been raised whether they contain a health strategy for poverty reduction or a health strategy to meet the needs of the poor (WHO 2004).

Box 6.3: After change of government in Zambia by the end of 1991, a new structural adjustment programme commenced in 1992. In confidence, the disbursement of Official Development Assistance (ODA) immediately increased sharply (Blas E 2003). In Zambia, the share of government expenditures in GDP declined from 40% in the 1970s to around 20% by the mid-1990s (Blas & Limbambala 2001a). By beginning of 1996, many of the macroeconomic indicators had improved. However, the social problems had grown as had the criticism of the policy from economic analysts, donors, private sector as well as the increasing number of hungry and unemployed. Despite the good intentions, the government had not succeeded in increasing investments in agriculture, industry, and tourism. Many of the ills of the 1980s had just gotten worse and corruption among politicians and civil servants had increased. During the period 1991 to 1993, Zambia paid back to the IMF ten times the amount it invested in education. In 1994, the richest 10% of the population shared more than half of the total incomes, while the poorest 70% shared only 16%, and 76% of the total population was characterized as extremely poor (CSO 1994). By 1996, 'collapse' was the most frequently used word to describe the situation, regardless of whether one talked about the copper mines, the economy, productive or social sectors (Holm 1997). In July 2000, Zambia gets access to the debt-relief programme for HIPC against an interim PRSP. The programme for the first time included debt relief from the World Bank and the IMF (EIU 2001).

6.2 Governance

During the colonial period, the executive and judicial functions became well developed in most colonies, while the legislative power remained in the colonial power's home-base. No colony had by nature any real locally based parties or full parliaments responsible for their affairs and the civil service and the military systems were relatively overdeveloped compared to the legislative systems. This has had several consequences long after independence as the strong and well-established civil and the military services had to surrender control to political systems in their infancies. The situation did not change significantly in many developing countries in the 1960s, 70s and 80s. The hold which the colonial rule maintained on its subjects was largely psychological, which might explain why while many of the assumptions and values of the old colonial system have been abandoned, the structure itself is recognisably the same in several of the former colonies (Clapham 1985). In this respect, it is noticeable that those developing countries that have experienced economic and social change were mostly also those in which the organization and participation of the population

were strengthened as was the case in several Latin American and South-East Asian countries.

The borders between the colonies and, as a result, the post-colonial states, in particular in Africa and the Middle-East were not drawn on basis of ethnic or social criteria, thus making it more difficult to establish functioning unified popular organization in the post-colonial societies. On the contrary, many post-colonial states have been characterized by internal conflicts and difficulties in establishing democratic systems and when conflicts have first come out, they have tended to result in the most extreme factions taking control.

State-centred development theories began to re-emerge from the mid-1980s emphasizing that developing country states are very different, both in relation to their foundation in the society, their institutional form and their mode of intervention. Distinctions were made between three main forms of states (Martinussen 1994)

- The *predatory state* characterized by a disjointed and ineffective administration with very limited capacity for fostering economic and social development. The predatory state is further characterized by being in the pocket of the political power elite
- The *development state* characterized by a well developed Weberian bureaucracy with internal networks and a homogeneous administrative culture and significant capacity for shouldering all state functions from security to economy. The development state has considerable autonomy from the political power elite and the economic interest groups in the society
- The *capitalist development state* with four main characteristics: (i) political stability in the state administration; (ii) well developed division of work between the public and the private sectors under the strategic leadership of a public planning authority; (iii) extensive investments in education and a certain degree of distribution and redistribution of the economic growth; and, (iv) the state's respect for the market- and price mechanisms.

The democratisation processes are facing difficulties in many developing countries. There can be several explanations for this, including undemocratic traditions and lack of legitimacy of government. Some basic democratic principles, such as respecting the rule of the majority, might not be acceptable in a society, which is organized, e.g., along tribal, religious or ethnic lines. One group may not necessarily respect a decision by another group, regardless of how large a majority this other group might represent. Therefore, governments in such countries have to justify their existence and authority on very different principles.

Current governance in most developing countries is a result of complex processes with elements of local tradition and interaction with Western and other traditions and powers. The Western influence has happened over several generations during as well as after the period of direct colonial rule. There has been, over a very long time, a mutual influence with tradition so that today in all countries mixed forms of governance practices are the situation.

The divide and rule principle practiced in British colonial policy has, according to Hobsbawm and Ranger, (cited in Martinussen 1994) led to petrifying certain

traditional institutions while suppressing or dissolving others. One of the consequences has been the continuation of the conflicts between and influence of tribes in Africa. Hobsbawn and Ranger found that these conflicts and influences would have had much less importance, had the above divide and rule policy not been practiced. In some instances, traditions have been revived or even 'invented' as a reaction to Western influence - sometimes helped by local or national actors. For example, in areas with large Muslim populations, there has been a tendency to reject Western values and ideas about democracy.

In the Western way of thinking there is no logical theory behind the '*Islamic state*' in the sense of providing a causal analysis, starting from a description of how the reality is and how the different phenomena within this reality are interlinked. Such analysis will inevitably include assumptions or elements of how the reality ought to be organised, however, such value judgements have traditionally been down-played in the Western inspired analyses. The Islamic theories of the state, on the contrary, are wholly based on values (Hjärpe 1982). All exercising of power is in the end justified with reference to Allah's will and guidance, i.e., universalist communitarian values. According to Islamic fundamentalist views, all rules and guidance for both the religious and societal lives are given in the Koran, and what is left is for the ruler with assistance of the Ulamas to interpret these rules. In less fundamentalist views, it is only the ground rules, which are given and these need further inference and development. However, it is still assumed that religious leaders will play a major role in assuring the compliance of legislation and political decisions with Islam.

Outside the Islamic sphere, perceptions of divine sovereignty are less apparent as legitimizing theory. However, it is not very far from how the monarchic states were justified in Europe before the separation of the state from the Church. The Nordic monarchies to some extent still today are legitimised with reference to God. Further, the current mixing of religion and politics in the USA and elsewhere, including the talk about good and evil is also used to legitimise interventions by Western powers in countries which are grounded in different values.

The theories about African politics in the 1980s and 1990s increasingly emphasised the particularities of developing countries, regardless of whether they were grounded in liberalism or Marxism. Common was that they frequently included empirical investigations, which often changed views considerably, e.g., that the classes in Africa are not sufficiently advanced in their formation to play an important role; the international capital, despite setting important frames for economic development, does not necessarily exercise control of the state apparatus and the politics. The prevailing theories about political systems in Africa see these as inseparable combinations of non-formalised traditional structures with more formalised modern institutions (Martinussen 1994). The formal systems can vary from military dictatorship to parliamentary democracies. However, and regardless of the formal system, these theories point to that the actual political processes and the state operations to a large degree are determined by the prevailing social order. This, further, shows both great variance and remarkable similarity across the continent. The theories point to the prevalence of autocratic leaders who draw their power not from the Sovereignty of the People or other legitimising ideology, but from their access to public resources and goods which they can distribute to ensure political backing. They further, to some degree, base their power on control of the military forces. However,

these theories suggest that the distribution of resources through the social networks predominate over the repressive controls. A further central tenet in the theories is that the political top-leaders, in order to maintain power, have to form close alliances with the civil administration and, as a result, the latter, rather than being independent and rational bureaucracies become part of the political power structure. As a result, the civil administration, including allocation and distribution of public resources is not done in a way which is justified or legitimised in accordance with a traditional Western thinking and are often labelled corrupt and nepotistic.

7. PUBLIC MANAGEMENT AND GOVERNANCE REFORM

During the 1960s, government expenditures per capita rose in most countries and in many developing countries. This took place against a dramatic economic decline during the 1970s and 1980s (see section 5 and 6) and fundamentally questioned the effectiveness of large public bureaucracies and gave rise to the neo-liberal drive for reducing the role of the state and increase that of the market as described in section 5. During the 1980s, radical public sector reform programmes began first in the UK, USA, Australia and New Zealand, sparking a revolution in public sector management in developed, developing and transitional countries which was later further fuelled by the collapse of the 'iron curtain'. The focus was primarily on economy, efficiency, and the relation between the market and the state with an explicit emphasis upon the dominance of individual over collective preferences. Neo-liberal principles were applied to social as well as economic policy. The economic reforms focused on liberating the operations of the market from government interventions and the reform of the public sector followed the same logic, seeking to reduce the size and activities of the state. Many functions previously performed by public sector organizations were privatized and the remaining public operations were required to compete with private firms or become profitable. Further, local authorities were required to tender for work in competition with private suppliers. The main features of the reform are summarised in Box 7.1.

In the UK, the country with the most far reaching public management reform, the former unified public service organization had, by the mid 1990s broken into a series of about 130 free-standing agencies (Minogue 2000). A significant component of the public management reform was expenditure and cost reduction, however, it was often expressed in ways that disguised a reduction in output and service. Everywhere, citizens increasingly defined themselves as active customers of government services rather than active recipients and the terms commonly used reflected this consumerist orientation, e.g., empowerment, stakeholders, access, redress, value for money. The *new public management* represented a fundamental shift in public service values, but also offered an opportunity to policy makers searching for solution to the conflicting pressures to both improve service and reduce the state. However, an alternative view suggested that the policy elites saw the reforms as a means of entrenching and reinforcing their power at the centre while distancing themselves from the uneasy problems of implementation at decentralized levels or even for pursuing opportunities for political or personal gains. "There is a risk in new public management reforms that individual or group interests will maximize the gains, while the public will bear the losses. This would be deeply ironic, since a major theme in the neo-liberal critique was that government allows self-interested politicians and bureaucrats to abuse publicly provided resources" (Minogue 2000)

Box 7.1: The Public Management Reform

The revolution in public management focused initially on *efficiency* of public management and represented a paradigm shift from the old welfare assumptions about the state towards a more entrepreneurial model. In summary, it was based on ten principles:

1. Steer the ship, rather than row it
2. Empower communities, rather than simply deliver services
3. Encourage competition, rather than monopoly
4. Be mission driven rather than rule driven
5. Fund outcomes rather than inputs
6. Meet the needs of customers rather than the bureaucracy
7. Concentrate on earning resources, not just spending
8. Invest in prevention of problems rather than cure
9. Decentralise authority
10. Solve problems by making use of the marketplace rather than by creating public programmes

The changes in public management practice were to be established by:

- restructuring of the public sector, particularly through privatisation;
- restructuring and slimming down central civil services;
- introducing competition, especially through internal markets and contracting public services to the private sector;
- improving efficiency, especially through performance auditing and measurements

These changes were to produce a different kind of public management, characterised by:

- a separation of strategic policy from operational management;
- a concern with results rather than process;
- an orientation to the needs of customers rather than those of bureaucratic organisations;
- a withdrawal from direct service provision in favour of a steering or enabling role;
- a transformed bureaucratic culture.

Adapted from (Minogue 2000)

During the 1990s, there were growing concerns that at the level of service provision, the reforms reduced accountability, and at the level of government systems, institutions of accountability were weak or non-existent. "Issues of accountability, control, responsiveness, transparency and participation are, therefore, at least as important as issues of economy and efficiency. So, for citizens, are questions of law and order, which can only be guaranteed by a state - and a legitimate state" (Minogue, Policano, & Hulme 2000).

The World Bank in its support of structural adjustment programmes in the 1980s had found considerable tensions between economic benefits and political costs, as well as weak financial accountability leading to corruption and, in relation to decentralization, deterioration in the use and control of resources, including that national goals being distorted by local governments. Two forms of accountability at the micro-level were suggested to potentially reinforce macro-level accountability, i.e., *competition* providing the public an exit when dissatisfied with a service and *participation* which could enable the public proactively to influence the quality or volume of service. As a result and alongside with promoting deregulation and the working of the markets, the Bank started expanding participation and involvement of NGOs in the projects it financed (World Bank 1992). The Bank, whose mandate explicitly prohibits it from interfering in a country's internal political affairs and only take economic considerations into account in its decisions, increasingly found that it had to go beyond its traditional emphasis on public sector management suggesting four headings under which to assess its work in relation to governance as: public sector

management, accountability, legal framework for development, and transparency and information. Realizing the delicate balancing it had to do, its 1994 report 'Governance - the World Bank's Experience' stated " Thus, the Bank's call for good governance and its concern with accountability, transparency, and the rule of law have to do exclusively with the contribution they make to social and economic development and to the Bank's fundamental objective of sustainable poverty reduction in the developing world" (World Bank 1994b).

While the World Bank assumed a universally applicable approach to public management and governance and treads carefully with respect to the political aspects of governance, UNDP took a slightly different direction. The Programme defines 'sound governance' to include as essential elements: political accountability, freedom of association and participation, reliable and equitable legal frameworks, bureaucratic transparency, the availability of valid information, and effective and efficient public sector management. The Programme further underlined that sound governance to a large degree is culture-bound. "A crucial corollary is UNDP's role in helping poor countries to develop locally meaningful and acceptable views of what constitutes SHD [Sound Human Development], sound governance, and economic and public sector management" (UNDP 1995).

The UK Department for International Development (DfID) went further in defining the political components of 'good government' to include: legitimacy, suggesting that this is most likely to be achieved by a pluralist, multi-party democracy; accountability, which required officials and politicians to be answerable to the public, this will require a transparent system and a free press; competence in making and executing public policies and providing public services; and respect for law and protection of human rights should support the whole system of good governance (Minogue 2000).

The DfID call for good governance was grounded in several decades of British overseas development and domestic public sector reform experiences. In the domestic scene, the role of the state had changed in nature from one providing both policy advice and implementation to one of policy formulation and control. Bureaucratic control was exercised through series of standards, contracts, performance measures and targets, and audits. Democratic control was sought achieved through increased openness, consultation, charters, etc.. The citizen was viewed as a customer and satisfaction surveys and the role of choice were important components in holding service providers accountable. The role of regulation and audit changed from a primary concern with probity and professionalism to one concerned with efficiency, cost-benefit, and value for money and the government became a 'steerer' and 'enabler' of an increasingly wider range of actors responsible for service provision. Some started using the phrase 'the regulatory state' (Minogue 2000).

A question, however, remained how relevant and applicable these experiences were for the many developing countries that during the 1980s and early 1990s had embarked on efficiency-based public sector management reforms.

During the 1990s, the language of public sector development had changed from one of efficiency to one of effectiveness and from a universal model to one realizing that there is no one model applicable in all countries and situations. Away was also the belief that if the state was minimized, the market would automatically ensure

provision of the needed. The World Development Report 1997 *'The State in a Changing World'* reviewed the experiences and found that without an effective state, social and economic development was impossible. "An effective state is vital for the provision of the goods and services - and the rules and institutions - that allow markets to flourish and people to lead healthier, happier lives" (World Bank 1997b). It was found that establishment of performance-based public executive agencies along the lines of the British model was an effective model when there was clarity of purpose and it was accompanied with greater managerial accountability. However, in countries with inadequate controls and capacities, such as in many developing countries, there was reason for caution. Greater flexibility to public managers could merely increase corruption and arbitrariness without improvement in performance.

The World Development Report 1997 proposed a two-pronged strategy. First, to *match the state's role with its capability*, focusing on getting the fundamentals right, i.e., providing a foundation of law, a non-discriminatory policy environment with macroeconomic stability, investing in basic social services and infrastructure, protecting the vulnerable, and protecting the environment. Beyond these fundamentals, the state need not be the sole provider of services and cannot, according to the report, alone carry the burden of protecting households against economic insecurity. Second, to *raise the state's capability by reinvigorating public institutions* by providing incentives for public officials to perform better while keeping arbitrary actions in check. The report realised that managing a public bureaucracy is a complex business that does not lend itself to clear, unambiguous solutions. Three basic incentive mechanisms were proposed: effective rules and restraints to reduce corruption and discretionary authority; greater competitive pressure with respect to recruitment and promotion of civil servants, as well as in the provision of services; and increased citizens voice and partnership, e.g., through client surveys, citizen charters, public consultations, involvement of intermediary organisations, etc.

It was realised that reforms of the macro economic policy, e.g., exchange rates, fiscal and trade policy, although having political implications will not require overhaul of institutions and can happen relatively fast. Reforms dealing with regulation, social services, finance, infrastructure and public works cannot happen so rapidly, because they deal with changing institutional structures. This requires change in the way that government agencies think and act, often facing considerable opposition from political and civil service as well as interest groups. The central government, according to the report, will always play a vital role in sustaining development and the President of the Bank, in his foreword, describes the 'minimalist state approach' as an extreme view. To this, Minogue *et al* (2000) remarked that if the call for a reinvigoration of the state was echoed by other aid donors, the new millennium might see a return to the main idea of the 1960s, i.e., the developmental state.

8. THE HEALTH SECTOR

The 20th century experienced three major waves of health sector reforms (WHO 2000). During the 1940's and 1950's, a first generation of reforms established national health care systems, first in the richer and later in the poorer countries. These systems came under an increasing amount of stress during the 1960's due to escalating costs, mainly because of the growing volume and intensity of hospital care. During this period

disease control, e.g., for small pox, malaria, sleeping sickness, tuberculosis was mostly undertaken through dedicated programmes and campaigns. However, there was also a growing community development movement encouraging communities to identify and find solutions for their own problems in all areas of social life (van Balen 2004). A second generation of reforms promoted primary health care as a strategy to achieve affordable universal coverage, but this did not always satisfy local demand for perceived quality and responsiveness, and the emphasis on primary care often came into direct conflict with established medical systems that emphasised hospital care, furthermore, the economic situation in many developing countries worsened making reforms difficult to implement.

While the first and second generations of health reforms mainly emphasised the supply side, the third generation focused more on the demand side (WHO 2000). Starting, again first in the richer countries in the 1970s and 80s, it gained momentum in poorer countries during the 1990s, attempting to shift away from central budgetary allocations of resources to providers, and rely more on market or quasi-market mechanisms. However, several adjustments were made to the approach in the developed countries and also many poorer countries faced problems in implementation as approaches fell out of favour. The international health development aid agenda have, to a large extent, swung back to project-driven approaches by the beginning of the 21st century, characterised under the broad term 'scaling-up'.

This section's main focus will be on the thoughts, approaches and events of the third wave of reform in the 1990s with emphasis on developing countries (section 8.3). However, it is necessary also to briefly review the recent three decades of reform in the main developed countries (section 8.1), several of which were donors and highly influential actors of the reforms in many developing countries, often citing and transferring approaches and concepts from developed to developing countries. In order to get a fuller picture, the faith primary health care will also be explored (section 8.2).

8.1 Three periods of reform in the developed countries

During the 1960s and 1970s health care had gradually ceased to be seen as the sole domain of physicians and government administrators. Instead health care entered into an increasingly controversial and politicized area, resulting in more than three decades of continuous reforms and adjustments to the sector (Harrison 2004).

The debate of the period from late 1970s to early 1980s focused primarily on the need to contain costs and make publicly-funded health care more efficient and accountable. Cost had been rapidly escalating since the 1960s due to a growing demand for care, rising expectations, more sophisticated and complex technologies, and an aging population in most Western countries. This, combined with the recession hitting most of Europe and the USA during this period, increased competition for resources and weakened capacity and commitment of governments to pay for health care. The reform interventions were mostly confined to imposing budget ceilings and other governmental regulations of health expenditures and services in order to contain costs of care. The period had some success in capping cost escalations, but less progress

was made on redistribution of resources towards primary care, extension of preventive treatment, enhancement of quality and access to care, etc.

The second period of reform from mid 1980s and peaking during the early 1990s continued emphasizing cost containment and efficiency improvements. Different approaches were attempted in order to improve the allocative efficiency (Honigsbaum, Calltorp, Ham, & Holmström 1995). While continuing with these themes, the debate also included doubts about the efficacy of medical practices and technologies; criticism of the inequity in financing and delivering health care; concerns about the quality of medical care; and, above all, changing beliefs about government involvement in the delivery of public services. The reforms that occurred were inspired by neo-liberal economic theories and conservative political ideologies (see Section 4 and 5). The main reform component was less direct government involvement in provision of service and regulation and the introduction of market or quasi-markets. Hierarchical control by the government was being replaced by contracting within and between public agencies and outsourcing to private contractors. The belief was that competition among publicly-owned agencies or between public and private firms would create incentives for public services to become more efficient, to keep down costs and to be more responsive to the demands of the public. The thinking was influenced by pro-market health analysts, such as Ellwood and Enthoven and the New Public Management ideas (see Section 6), drawing on examples from organizational changes occurring in health care and many public services in the USA and UK. These ideas were strongly supported by the World Bank IMF and the European Commission (Harrison 2004).

Public bureaucracies were seen as bloated, unresponsive to public needs, and lacking accountability. It was argued that health organisations could be made more efficient and effective by separating of purchaser and provider functions, downsizing and privatizing, and applying management techniques that were originally developed by manufacturing firms and mass retailers of goods and services. The concepts of public-private partnerships took momentum within this environment. However, some of these thoughts challenged the social democratic traditions deeply rooted in many European countries. It brought about a basic dilemma as market-like conditions might sharpen inequalities in health finance and access, undermining national commitment to solidarity (Harrison 2004).

By the mid-1990s there were growing disenchantments and lack of optimism about the prospects for competitive reform, including marketisation of health services. While acknowledging the need for efficiency gains and cost control, the debate started to shift towards concerns about quality of care and improving the health and wellbeing of entire populations and communities, something that did not seem amenable to market solutions or could even be aggravated by competition among providers. This led to renewed attention to social and economic determinants of health and access to care and to the need for improving public health services as opposed to just reorganizing medical services. Attempts were made for involving patients and citizens in decisions about health care delivery and funding and to define the rights and responsibilities of citizens with respect to health.

Despite the pullback from competitive reform, decision makers did not lose enthusiasm for other types of business-like reform, nor did they revert to planning and

tight governmental control over the health system. However, the architects of these new programmes, along with many others were struggling to find ways to combine regulatory and market forces, and to coordinate and integrate the increasingly complex set of organizations and actors responsible for health care funding and provision.

Over the long run and in view of the original efficiency objectives, the reforms in the OECD countries were quite successful. With respect to cost containment, health expenditures as proportion of GDP levelled off during the 1980s and 1990s to 7.2% and 3.3% respectively from a base increase of 30.7% and 35% during the 1960s and 1970s (Harrison 2004).

8.2 Primary Health Care rise and demise

Primary Health Care as contained in the declaration of International Conference on Primary Health Care, held in Alma-Ata in 1978 arose from the finding that hundreds of millions of people, in particular in developing countries had an unacceptable health status and that the approaches pursued in most countries so far had not effectively coped with the problems. Further, it had been observed that some countries were doing far better than others with respect to key public health indicators, such as Tanzania, Sri Lanka, The Philippines and others. In particular impressive results had been achieved in China's community health programme providing basic comprehensive health care.

The Alma-Ata Declaration was endorsed by delegations from 134 governments and representatives of 67 United Nations, specialized agencies and nongovernmental organisations. Its health vision was 'Health for All by Year 2000' and its systems vision was "Primary health care is the hub of the health system. Around it are arranged the other levels of the system whose actions converge on primary health care in order to support it and to permit it to provide essential health care on a continuing basis" (WHO-UNICEF 1978).

The Declaration talks, see Box 8.1, about rights (paragraphs I and IV), about duties and responsibilities (paragraphs IV and V), and about inequalities which are unacceptable and of common concern. It is only in paragraph III that health is seen as a means to something else, i.e. economic and social development. It is therefore reasonable to suggest that the ethics of the Declaration is predominantly deontological. The reference in paragraph V to the direct government responsibilities for health as well as for the provision of adequate health and social clearly rules out libertarian perspectives. Whether the main perspective is egalitarian or communitarian, the latter suggest by Reich (1995), is another question. One the one hand, the term community in the text is used in a very broad sense, encompassing the whole world. On the other hand, the Declaration also acknowledges that primary health care reflects and evolves from conditions and characteristics of the country and its communities, i.e., it is not universal and PHC might have different meanings in different countries and communities.

Box 8.1: Excerpts from the ten paragraphs of the Alma Ata Declaration

- I: The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a *fundamental human right* ...
- II: The existing gross *inequality* in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically *unacceptable* and is, therefore, of *common concern* to all countries.
- III: The promotion and protection of the health of the people is *essential to sustained economic and social development* and *contributes* to a better quality of life and to world peace.
- IV: People have the *right* and *duty* to participate *individually* and *collectively* in the planning and implementation of their health care
- V: *Governments* have a *responsibility* for the health of their people which can be fulfilled only by the *provision* of adequate health and social measures. A main target of the *governments, international organisation* and the *whole world community* in the coming decades
- VII: Primary health care:
1. reflects and evolves from the *economic conditions* and *socio-cultural* and *political characteristics* of the *country* and its *communities* and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
 2. addresses the main health problems in the *community*, providing promotive, preventive, curative and rehabilitative services accordingly;
 4. involves, in addition to the health sector, *all related sectors* and aspects of national and community development ...
 5. requires and promotes maximum *community* and *individual self-reliance* and *participation* in the planning, organization, operation and control of primary health care...

(Extract and emphasis by the author) (WHO-UNICEF 1978)

The political and ideological underpinning of the concept was addressed already during the opening ceremony when, the then WHO Director General H Mahler threw a number of challenging questions to the attending governments, including: Are you ready to fight the political and technical battles required to overcome any social and economic obstacles and professional resistance to the universal introduction of primary health care? Are you ready to make unequivocal political commitments to adopt primary health care and to mobilize international solidarity to attain the objectives of health for all by the year 2000? (Basch 1990). Further, the indicator framework for monitoring progress had 17 health policy indicators in six areas, i.e.: political commitment, resource allocation, degree of equity of distribution, community involvement in attaining health for all, organisational framework and managerial process, and international political commitment (WHO 1981).

Obviously, health for all year 2000 was not achieved - but was the PHC a failure? The following two statements of the World Health Report 2000 seem to suggest that there was something intrinsically wrong with the design of PHC.

- "The multiplicity of meanings and their often contradictory implications for policy help explain why there is no one model of primary care, and why it has been difficult to follow the successful examples of the countries or states that provided the first evidence that a substantial improvement in health could be achieved at affordable cost".
- "The approach emphasized in the primary health care movement can be criticized for giving too little attention to people's *demand* for health care, which is greatly influenced by perceived quality and responsiveness, and instead concentrating almost exclusively on their presumed *needs*. The inadequate attention to demand

is reflected in the complete omission of private finance and provision of care from the Alma-Ata Declaration, except insofar as community participation is construed to include small-scale private financing" (WHO 2000).

According to some observers, the World Health Report 2000 marked the end of WHO's use of PHC as the means for the delivery of services in resource poor countries (Hall & Taylor 2003).

There could, however, also be other external factors contributing. First, only one year after the Alma-Ata Conference, Walsh and Warren published an article suggesting selective primary health care as an interim strategy for disease control. Their argument was that providing comprehensive primary health care would be too costly. Therefore, they suggested an approach selecting the most cost-effective disease control interventions chosen base on four criteria: prevalence, mortality, morbidity, and feasibility and cost of control (Walsh & Warren 1979). Their arguments were utilitarian by nature and heavily relied on economic data from the World Bank. This gave those believing in or wanting to continue existing or develop new vertical disease control programmes an excuse to do so. Over the following two decades, the world saw a proliferation and succession of programmes, e.g.: Expanded Programme on Immunization (EPI), Universal Child Survival (UCS), Universal Child Immunization (UCI), Polio Eradication, Child Vaccine Initiative (CVI), Integrated Management of Child Illnesses (IMCI), and Global Alliance on Vaccines and Immunization (GAVI), just to mention a few. These, all have in common that they are dealing with children and vaccination and they were all closely linked to one or both of the two lead organizations behind the Alma-Ata conference, i.e., WHO and UNICEF. Selective primary health care was intended as an interim strategy to quickly achieve select goals. However, it by nature was focused, leaving out 'difficult', yet critical elements of primary health care, such as: comprehensiveness and self-reliance; peoples' and multisectoral participation; and system's organisation and management. The selection of specific conditions for certain population groups was designed to improve health statistics, but abandoned Alma Ata's focus on social equity and health systems development and the interrelationship between health and socioeconomic development (Magnussen, Ehiri, & Jolly 2004). The fact that one select programme after the other have emerged and been able to attract funding during the more than 25 years since 1978, in itself provides evidence that the selective primary health care did not provide the promised 'quick fix'. The selective primary health care effectively took away power and control from the communities and brought them into the hands of donor agencies and central governments (Hall & Taylor 2003)

Second, the systems vision of PHC in which the entire health systems, including the hospitals were to evolve around and support PHC, proposed a shift in structure, resource allocation, as well as in the power relations within the systems, i.e., away from the hospitals and away from the physicians. In view of this, the Director General of WHO in 1986 decided to initiate action programmes to strengthen district health systems based on PHC (Mahler 1986). However, in 2004, a long-time follower of PHC concluded "...we certainly have underestimated the complexity of an integrated health system and the difficulty and cost to implement it. We also underestimated the conservatism of the medical establishment and the time the appropriation of the change by the actors involved requires in diverse circumstances" (van Balen 2004).

Further, PHC was dubbed 'primitive' health care (WHO 2000), something which was not conducive to building and maintaining political commitment.

Third, and possibly the most important obstacle to implementation and to achieving the targets related to the changes in the political economy of the world with its associated changes in values. PHC, as was seen in the analysis in Section 5 was formulated towards the end of an era, which had been greatly influenced by egalitarian and communitarian thinking. Those attending the Alma-Ata Conference and committing their organizations and governments were mostly public health people (WHO-UNICEF 1978). They had been trained and had practiced during the post war period and were possibly not too aware of or in agreement with what was in the making. At the same time or soon after the conference many developing countries were hit by serious economic hardships and/or experienced dramatic shifts in development paradigms, including the libertarian-based SAPs, which were later softened to more utilitarian-based development models. In many countries this meant rolling-back of the state and increased reliance on the market to deliver the goods, both shaking some of the very foundation blocks of the PHC concept. In the Declaration, governments were given clear responsibility for the health of its people and for providing health and social services - with the rolling back of the state; this was no longer possible in most developing countries. "For people to be intelligently involved in caring for their own health, they have to understand what leads to health and what endangers it" (Mahler 1986). In a market economy, meaningful active individual and collective participation in health planning and management would require massive educational programmes, much more sophisticated community organization, and wider democratization of institutions way beyond what was foreseen in the Declaration and what existed in most developing countries.

Apart from developed countries, notably in Europe, very few countries have been able to maintain the focus on the principles of PHC. China, which was used as a model for the PHC concept, already in 1980 began departing from the principles to pursue a marketisation of its health sector, leading to a steady reversal of some of what had been gained (Meng, Shi, Yang, Gonzalez Block, & Blas E 2004b). The overall performance of the Chinese health systems had dropped to number 144 out of the 191 countries assessed in the World Health Report 2000, while Cuba, which has consistently pursued the PHC approach, ranked 34, only overtaken by much more affluent countries (WHO 2000)

PHC did not fall from the health development agenda for technical reasons. The fall was ideological. Implementing PHC required appropriate technical tools, which had been developed - but even more importantly, it required an appropriate values environment, which existed in the 1960s and 1970s - but which did no longer exist in the 1980s when PHC was to be implemented on a wider scale. However, given the right conditions, as evidenced by Cuba, it could work. Studies, such as one in the Gambia cited by Hall and Taylor, comparing PHC with non PHC villages showed clearly better performance of the former (Hall & Taylor 2003). Even today - more than 25 years later, the concept continues to appeal to the more than a generation of health professionals all over the world who were brought up thinking primary health care. However, an environment conducive to implementing PHC in the form it was conceived in the Alma-Ata Declaration is unlikely to be recreated for some time, if ever, at least by health sector development efforts alone.

"Primary health care has struggled against economic crisis and adjustment and a neo-liberal ideology often adverse to its principles. To ascribe failures of primary health care to weakness in policy design, when political economy has starved it of resources, is to blame the victim" (Segall 2003). The PHC was established through experience, debate and consensus. "We have dared to define collectively a worldwide policy, and to agree on a strategy for giving effect to it, as no other sector has done, And we have done that on the basis of moral principles that transcend all geographical and political boundaries, and with respect for human rights that conform to universal standards" (Mahler 1986). However, what was to follow, i.e., the health sector reform movement was not (Hall & Taylor 2003).

8.3 The international development agenda for health sector reform in the 1990s

During the 1980s, curative services, most of which could be viewed as 'private goods', i.e., primarily benefiting the individual constituted 70% to 85% of all health expenditures in developing countries and likely about 60% of all government health expenditures. However, the combined per capita public and private spending on health in developing countries constituted less than 5% of that spent in developed countries and even if this was spent as cost-effectively as possible, it was unlikely to be sufficient to meet even the most critical health needs (Akin, Birdsall, & De Ferranti 1987).

It was also evident from the published literature that the economic stabilization and adjustment programmes had an adverse effect on health and nutrition in developing countries. The widely held belief among policy-makers that economic growth would automatically lead to substantial 'trickle down effects' favouring household nutrition and alleviation of poverty, at least in the short to medium term, did not appear to hold water. The main reasons being the redistribution of incomes associated with the adjustments and the cuts in public expenditures both of which were biased against the poor. It was suggested that the World Bank, the main proponent of the adjustment programmes should develop a set of policies to effectively address the twin objectives of growth and poverty alleviation (Weil *et al.* 1990).

In 1987, a World Bank policy study conducted by three Bank staff proposed an initial agenda for a health financing reform (Akin, Birdsall, & De Ferranti 1987). They identified the three main health sector problems as:

- *Allocation: insufficient spending on cost-effective health activities.* Current government spending alone, even if better allocated would not be sufficient to fully finance for everyone a minimum package of cost-effective health activities and although nongovernmental spending on health was substantial, not enough went for basic cost-effective health services
- *Internal inefficiency of public programmes.* Non salary recurrent expenditures for drugs, fuel and maintenance were chronically under-funded; a situation that often reduced dramatically the effectiveness of health staff. It further led to under-utilization of lower-level and overcrowding of the higher-level facilities

- *Inequity in the distribution of benefits from health services.* Investment in expensive modern technologies to serve a few continued to grow while simple low-cost interventions for the masses were under-funded.

While acknowledging that reform of how governments financed health would not solve all these problems, they suggested that such reform would go a long way. They proposed an agenda with four policy reform elements.

- *Charge users of government health facilities.* Institute charges at government facilities, especially for drugs and curative services. It was suggested that this would free resources equivalent of some 60% of government expenditures, which then could be reallocated for basic preventive programmes and first level care for the poor. It was acknowledged that redirection of freed resources would require a strong political commitment.
- *Provide insurance or other risk coverage.* Realizing that hospital charges could not be raised close to costs, the proposal included encouraging well-designed health insurance programmes to help mobilize resources for the health sector while simultaneously protecting households from catastrophic health care costs.
- *Use non-government resources effectively.* Encourage the nongovernmental sector to provide health services for which consumers were willing to pay. This encouragement could include providing temporary subsidies and administrative support, and reducing regulation and unnecessary paper work. In the longer term, the role of the government should focus on providing oversight, guidance, and developing the required legal frameworks.
- *Decentralise government health services.* Decentralise planning, budgeting and purchasing for government health services, particularly the services offering private benefits for which the users were to be charged. It was recommended to use the market incentives where possible to better motivate staff and allocate resources. The collected revenues should be allowed to be kept as close as possible to the collection points. Decentralisation was judged to be less likely to make sense for tax-supported public goods, such as immunisation and control of vector-borne diseases. However, it was also suggested that these could possibly be contracted out to local governments. However, this policy proposal came with the warning that it was less tried and likely not going to be easy, especially where administrative systems were weak and the quality of staff in remote areas was poor.

It was stressed that although some parts of the proposal might be more relevant than others depending on each country's situation it would work best if considered a package. How each of these policy reform elements of this package would address each of the three sectoral problems identified are summarised in table 8.1

The authors acknowledged that a successful reform would hinge on political commitment and decisions to reverse the trend allocating too much government health budget to high-cost hospital care with negative effect on the overall cost-effectiveness and on equity. However, without reforms of the financing, the necessary revenues might not be available to carry out the required political decisions for reallocation.

Table 8.1: The proposed policy package and the health sector problems from (Akin, Birdsall, & De Ferranti 1987)

Policy	Health sector problem		
	Allocation	Internal inefficiency	Inequity
Keep the present system	0	0	0
Institute user-charges	+	+	+
- <i>and</i> use freed government revenues to expand cost-effective services,	+	0	+
- <i>and</i> use new revenues to finance non-salary costs,	0	+	+
- <i>and</i> use differential charges to protect the poor and reduce existing subsidies for the rich.	0	0	+
Provide for risk coverage	+	0	+
Use nongovernmental resources effectively	+	+	+
Decentralise government health services	+	+	+

A milestone in providing a more comprehensive conceptual framework for the reforms in the 1990s was the publication of the *World Development Report 1993 "Investing in Health"*, which proposed that governments redirect to public health programmes and essential clinical services, about half of the government health spending that was previously going mostly towards low cost-effective services, including tertiary hospital care (World Bank 1993).

The Report identified the four main problem areas as

- *Misallocation.* Public money were spent on health interventions of low cost-effectiveness such as, e.g. surgery for most cancers, specialized tertiary care, while cost-effective public health programmes such as treatment of TB and sexually transmitted infections remained under-funded.
- *Inequity.* The poor lacked access to basic health services and received low-quality care and a disproportional share of government spending went to services benefiting mainly the affluent parts of the population.
- *Inefficiency.* Much of the money spent on health was wasted: brand-name pharmaceuticals were purchased instead of generic drugs, health workers were badly deployed and supervised, and hospital beds were under utilized
- *Exploding costs.* Particularly in some middle-income countries, the health care expenditures were growing much faster than income. This was related to an increase in number of general physicians and in specialists, new medical technologies, expanding health insurance linked to fee-for-service which together generated a rapidly growing demand for costly tests, procedures and treatments.

The proposal in the World Development Report 1993 was in the liberal tradition of the preceding World Development Reports. This meant that the market was given a great role. However, government role could be necessary and should, according to the report be guided by three rationales. First, whether a service was a *public goods*, i.e., one persons consumption did not leave less available for others, e.g., health information, or services with large *externalities*, i.e., where consumption by one individual benefited others, e.g., immunization, treatment of TB and sexually transmitted infections. Second, *poverty reduction*, e.g. through provision of cost-effective health services to the poor. "Private markets will not give the poor adequate access to essential clinical services or the insurance often needed to pay for such

services". (page 5). Third, to compensate for problems generated by uncertainties and insurance market failure. "The great uncertainties surrounding the probability of illness and the efficacy of care give rise both to strong demand for insurance and to shortcomings in the operation of private markets" (page 5).

The proposal to redress the situation is briefly summarised in table 8.2

Table 8.2: World Bank's proposed Three-pronged Approach to Government Policies for Improving Health, summarized by the author from (World Bank 1993)

Prongs	Premise	Proposed Action
<i>I. Foster an environment that enables households to improve health</i>	Household decisions shape health, but these decisions are constrained by the income and education of household members	<ul style="list-style-type: none"> - Pursue economic growth policies that will benefit the poor - Expand investment in schooling, particularly for girls - Promote rights and status of women
<i>II. Improve government spending on health</i>	The challenge for most governments is to concentrate resources on compensating for market failures and efficiently financing services that will particularly benefit the poor	<ul style="list-style-type: none"> - Reduce government expenditures on tertiary facilities, specialist training, and interventions that provide little health gain for the money spent - Finance and implement a package of public health interventions to deal with the substantial externalities surrounding infectious disease control, prevention of AIDS, environmental pollution, and behaviours that put others at risk - Finance and ensure delivery of a package of essential clinical care - Improve management of government health services through such measures as decentralization of administrative and budgetary authority and contracting out of services
<i>III. Promote diversity and competition</i>	Government finance of public health and of a nationally defined package of essential clinical services would leave the remaining clinical services to be financed privately or by social insurance within the context of a policy framework established by the government	<ul style="list-style-type: none"> - Encourage social or private insurance (with regulatory incentives for equitable access and cost containment) for clinical services outside the essential package - Encourage suppliers (both public and private) to compete both to deliver clinical services and to provide inputs, such as drugs, to publicly and privately financed health services - Generate and disseminate information on provider performance, on essential equipment and drugs, on the cost and effectiveness of interventions, and on the accreditation status of institutions and providers

The report took, as indicated by its title "Investment in Health", an investment, i.e., utilitarian perspective to health. It used terms such as 'value for money', 'cost-effectiveness', 'ratio of cost to health benefits' and introduced Disability Adjusted Life Years (DALY) as a measure for return on investment, i.e., the health intervention that will gain the most DALYs for a given amount spent will be the more cost-effective and therefore the best investment. The report estimated that in low-income countries, the burden of disease could be reduced by 32% with an investment of \$12 or 3.4% of the GDP per capita in essential public health and clinical services. This would constitute about twice the average overall government investment in health at the time of the report. The most sophisticated facility required to provide these essential services were to be a district hospital.

The Report 1993 was not particularly concerned with equity. Although the term 'inequity' was used, it was used interchangeably with 'poverty reduction' and the concern was not fairness or justice. The focus was on efficiency and effectiveness of investments in health with the goal of achieving economic growth. The call for investing public resources in health of the poor was based on a utilitarian argument: "The economic gains are relatively greater for poor people, who are typically most handicapped by ill health and who stand to gain the most from the development of

underutilised natural resources"(World Bank 1993). Equity as a positive rights concept does not fit easily within a teleological-utilitarian value frame. Human rights are of a deontological character and do not have other explanations than their self-evidence (Hedin 1993). The report, therefore, revealing a potential conflict of values had to make reference to access to basic health services as something that most countries viewed as a human right and something embodied in the 1978 Alma Ata Declaration.

During the 1990s, there were growing egalitarian-based concerns that efficiency-driven health reforms and reducing the direct role of the state, including the use of market-like mechanisms, privatisation and insurance financing in health care provision would lead to decreased social justice and fairness. Julio Frenk stated in his 1994 analytical framework, which was presented at the '*International Conference on Health Sector Reform in Developing Countries: Issues for the 1990s*' that equity should be the prime objective at the systemic, i.e., highest level of health policy reform, see Table 1 (Berman 1995;Frenk 1994). However, at the same time in the USA, the Congress failed to enact a comprehensive health care reform aiming at ensuring universal access to health care and Daniels et al wrote with reference to the American libertarian values, "We are so intent on protecting our rights as individuals to pursue 'life, liberty and happiness' free from interference by others or our government that we are unwilling to support each other even with regard to fundamental needs" (Daniels, Light, & Caplan 1996).

At the international level a number of activities were started to address these concerns, including the WHO-SIDA equity initiative (World Health Organization 1996) and funding from the Government of Norway for the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) to manage a research portfolio on health sector reform including equity (Blas & Hearst 2002). A World Bank guide from 1999 further listed 12 other ongoing international programmes addressing equity and health sector reform (Carr, Gwatkin, & Fragueiro 1999)

Buchanan addressed a similar concern in what he termed a 'just health care system', the core of which included: universal access; to an adequate level of care; and without excessive burden (Buchanan 1995). A just health care system, in his view would be one in which the better off were free to purchase services that exceeded the adequate level if they so choose, and the adequate level, whatever it turned out to be, would be a constrained benefit package - which would lack some services that could be of some net benefit to some. He argued that where the state lacked the financial resources and administrative know-how to achieve effective regulation of private operators, the normal competitive behaviour of providers would lead to an unjust health system, which among other things would arbitrarily concentrate the unavoidable burden of rationing on some individuals or groups. He argued that this was particularly the case in poorer, less-developed countries in which, e.g., the World Development Report 1993 promoted insurance-privatization. He found that although the report acknowledged the problem, it did not suggest any workable solutions, "...the World Bank report lamely suggests that in countries where this is the problem the solution is reliance on the professional ethics of health care providers". He found this particularly worrying as there was mounting evidence that "elites seeking better care for

themselves through private insurance arrangements are less likely to be vigorous advocates for improving access to care for the majority and especially the rural poor".

Despite acknowledging that in most low-income countries the overall resource envelope for health would not be sufficient to provide even the most basic preventive and clinical services, the report's emphasis was on reallocation rather on increasing the resource base, the latter being the focus of the 1987 policy study report (Akin, Birdsall, & De Ferranti 1987). When attempting to implement ideas of redistributing resources within health policy reforms, regardless of whether the arguments are based on deontological or teleological view points, it means that some will lose for others to gain. Inevitably one enters into the political arena as this kind of reform means challenging the power or values of groups in the society. The Report did not offer much in terms of how the proposed reforms could eventually be implemented and was criticized from the onset for being politically naïve, relying on a model of policy reform that assumed correct action would naturally follow from rational analysis, thus downplaying politics and ignoring the significant problems of implementation (Reich 1995). That it would be a challenge to implement the proposal, however, was acknowledged on the very last page of the report, suggesting that "In many cases countries will also need to enact fundamental political reforms designed to increase participation and to improve the accountability of governments for their health spending, service delivery, and regulator performance", calling upon developing countries and donors to join forces in making the ideas of the Report a reality (World Bank 1993).

Partly in a response to this need and call for donors and governments to join forces and partly based on experiences in Ghana and Zambia, a concept of Sector Wide Approaches (SWAPs) developed. The use of plural indicated that what was being pursued was not a single type of programme or aid instrument, but a variety of approaches to sectoral development. In January 1997, an informal meeting of bilateral and multilateral agencies concerned with sector wide approaches to health development took place hosted by the Danish Government and the World Bank. The aim was to improve the way that governments and donor agencies worked together on health development, primarily through pooling of their resources. The meeting resulted in the establishment of an International Technical Working Group on Health SWAPs and publication of the *Guide to Sector-Wide Approaches for Health Development* (Cassels 1997).

It was, however, remarkable that this guide had very limited links to the wider development issues prevailing at the time, in particular to the debate about good governance (Minogue, Policano, & Hulme 2000; UNDP 1995; World Bank 1997b; World Bank 1992). Although addressing governance issues, such as; increased scrutiny, political power and resistance, corruption, conflict of ideologies and values, need to consult and involve stakeholders, etc., the term 'governance' was not use one single time in the publication. This was particularly surprising as the guide did identify these issues as challenges to implementing the proposed changes.

By targeting and resourcing a particular sector, i.e., health, there was a potential risk that the health sector moved ahead of the other sectors in a country, which would not necessarily facilitate improving and sustaining overall good national governance and management systems. Further, the proposed pooling of resources, integration and

decentralization of public health programmes appeared to run counter the previous experiences and recommendation, e.g., from selective primary health care (Walsh & Warren 1979), the very specific recommendation of the 1987 policy study report (Akin, Birdsall, & De Ferranti 1987), as well as the World Development Report 1993 (World Bank 1993). The latter two, both suggested that specific central government focus should be given to key public health programmes and keeping these separate from clinical service provision. Given the faced challenges and the dilapidated state of the health sector in many countries, it would probably take some five to ten years for any sizeable impact on health outcomes to materialise. This period has now elapse for some of the early SWAPs, however, in the meantime the concept itself has come under threat by the many new global initiatives (Hutton & Tanner 2004), and by political development and poor governance in some countries, e.g., Zambia (Danida 2005).

SWAPs were definitely interesting for many donor agencies. Pooling of resources could ensure quicker disbursement of the funding, reduction of donor-recipient dependency, and greater insight into how the government spent its resources. However, it was less obvious that the recipient governments would be comfortable with greater external scrutiny, in particular given the complex and delicate political environments that many developing were operating within.

In 2000, the World Health Report 'Health Systems: Improving Performance' offered a framework meant for Member-States to measure their own performance, understand the factors that contribute to it, improve it, and respond better to the needs and expectations of the people they served and represented. Besides the defining purpose of improving and protecting health, health systems were proposed to have other intrinsic goals, i.e., fairness in the way people pay for health care and how systems respond to people's expectations with regard to how they are treated. With respect to health and responsiveness, achieving a high average level was not found good enough: "the goals of a health system must also include reducing inequalities, in ways that improve the situation of the worst off". Three key indicators were chosen to measure performance, i.e., *health*, *responsiveness*, and *fair financing*. The first two of these indicators had two aspects. First, *goodness*, expressing the highest attainable average level, and second, *fairness*, the smallest feasible difference among individuals and groups. Fair financing, as indicated by the name was only concerned with the distribution.(WHO 2000).

In her introductory message, the then Director General of the WHO stated: "I took the view that while the work in this area must be consistent with the values of health for all, our recommendations should be based on evidence rather than ideology". It was thus suggested that primary health care was based on ideology and what was proposed in the 2000-report was not. It went on about primary health care: "despite its many virtues, a criticism of this route has been that it gave too little attention to people's *demand* for health care, and instead concentrated almost exclusively on their perceived *needs*. Systems have foundered when these two concepts did not match, because then the supply of services offered could not possibly align with both" (page xiii).

The report was more about measuring how health systems performed than about how they could be improved. While the report did not suggest that the right action would

automatically flow once the evidence, it did suggest that evidence would be a crucial lever to make change happen. This was in line with earlier statements by the chief architect of the Report, Julio Frenk: "If evidence is clear and recommendations are rigorous, those who have the power to decide may be stimulated into action. At the very least, sound policy analysis places limits on the discretion of decision makers, who have to consider the costs of ignoring the available data. Absent such data, a policy may be incorrect and adding insult to injury the decision maker may not even know it. To *reform* it is necessary to *inform*, or else one is likely to *deform*" (Frenk 1995)

The report was strongly criticized from both political and scientific quarters and the Lancet published in May 2001 an article raising serious methodological concerns

- Data were unavailable to calculate measures reported for 70-89% of countries
- Although key informants came from only 35 countries, 191 countries were ranked on health-system responsiveness; and informants were not representative even of the 35 countries
- The measure of health inequalities does not reflect a conceptually sound or socially responsible view of fairness and does not differentiate among countries
- Important methodological limitations and controversies are not acknowledged
- 26 of the 32 cited methodological references are non-peer reviewed internal WHO documents and only two of the 32 references are by authors other than those of the World Health Report 2000
- The measures of health status have been widely criticized for their problematic implications for equity and under-valuing the lives of disabled people
- The multi-component indices are problematic conceptually and methodologically; they are not useful to guide policy, in part because of the opacity of their component measures
- Primary health care is declared a failure without examining adequate evidence, apparently based on the authors' ideological position
- These methodological issues are not only matters of technical and scientific concern, but are profoundly political and likely to have major social consequences

(Almeida *et al.* 2001)

The report proposed four vital functions of health systems to include: providing services, generating the human and physical resources that make service delivery possible, raising and pooling the financial resources used to pay for health care, and stewardship, and it concluded:

- Ultimate responsibility for the performance of a country's health system lies with the government
- Dollar for dollar spent on health, many countries are falling short of their performance potential
- Health systems are not just concerned with improving people's health but with protecting them against the financial costs of illness
- Within governments, many health ministries focus on the public sector often disregarding the - frequently much larger - private finance and provision of care

- Stewardship is ultimately concerned with oversight of the entire system, avoiding myopia, tunnel vision and the turning of a blind eye to a system's failings.

From a values perspective, the report was problematic as also indicated in the critiques by Almeida *et al.* It discarded PHC as being ideologically (values) driven, while it did not acknowledge its own [different] values base. The values of the report were clearly derived from teleological thinking and objective utilitarian viewpoints with all the problems this entails with respect to public health. There were close linkages to the World Development Report of 1993 in terms of thinking, methodologies, and overlap of authorship. Further, it was a question if it did not challenge the very values base of WHO and its staff.

In the following year, the Commission on Macroeconomics and Health appointed by WHO and led by the macroeconomist J. Sachs came with its report '*Macroeconomics and Health: Investing in Health for Economic Development*'. "We have found that extending the coverage of crucial health services, including a relatively small number of specific interventions, to the world's poor could save millions of lives each year, reduce poverty, spur economic development, and promote global security". As indicated by the title, there is no ambiguity that improving health is to be seen as a means to economic development. The report argued that annual investment of additional \$57 billion in 2007 raising to \$63 billion by 2015 in essential interventions against infectious diseases and nutritional deficiencies in low-income countries would, by 2015 result in direct annual economic benefits of \$186 billion (Commission on Macroeconomics and Health 2001).

Thus, the proposal sounded like a good deal. Two initiatives were suggested: (1) to scale up the resources spend in the health sector by low income countries by 2007 of about 50% and donors for the same year about four-fold, focusing on a limited set of interventions; and (2) tackling the non-financial obstacles that limited the capacity of poor countries delivering health services. Concerning the latter, the report proposed a system it called *close-to-client* (CTC) comprising health centres and what it called health posts. The report further suggested that national leadership coupled with capacity and accountability at the local level through strong community-level oversight and action would be vital for success.

How is that then different from PHC? In PHC health, equity and human rights were seen as ends by themselves, i.e., based on deontological thinking - in the report of the Macroeconomics Commission, health is a means to economic growth, i.e., a utilitarian view point. While the World Health Report 2000 included an albeit watered down concept of fairness, the view pursued in the Macroeconomics Commission's report was that average [goodness] would be sufficient. Now, does it matter? The answer, of course, depends on whether one subscribes to deontological or teleological ethics. But, it is clear, from the earlier discussions that the resulting health systems would be very different.

From the latter part of the decade a new kind of operators in public health, i.e., public-private-partnerships (PPPs) started mushrooming. They were mostly single purpose initiatives attempting to address issues that it was claimed that neither public nor private organizations alone were able to do. By year 2000, at least 60 significant PPPs

for health existed and WHO alone, was engaged in 12 different global partnerships. PPPs consist of at least one private for-profit and one not-for-profit or public organization. These partnerships are particularly seen as offering an innovative approach with a good chance of producing results where the markets fail to distribute health benefits to people who need them, especially to poor populations. However, partnerships come with problems and controversies of their own - some see them as diverting resources from public actions and distorting public agendas in ways that favour private companies (Reich 2002a).

The partnerships proliferated during a time when there was a concern about the ability of the public sector to provide efficient management, a drive to down-size the state and discontent, in particular in the USA, with the United Nations system. At the same time a massive built-up of wealth took place in private companies and with individual philanthropists who had earned their fortunes in the market and carried libertarian views about the role of the public sector and how business was to be done. Serious concerns have been raised about the potential impact of partnerships on international coordination in health and whether they undermine UN's aim for cooperation and equity among states. Particular concerns were raised in relation to the often narrow focus of these partnerships, the influence they might have on the setting of global standards and norms, as well as the question of to whom and how these partnerships were accountable (Buse & Walt 2002).

Was the agenda for reform in the 1990s clean or was it actually an unclear mix of different agendas? There seem to be clear conflicts between the equity and the efficiency agendas, freedom of choice (market), public health and responsibility for those who have no freedom of choice because they cannot afford or otherwise access services, and between egalitarian, utilitarian and libertarian view points. However, the overall trend was towards utilitarian based rationales and some discontent with the public part of the health sector and any sector for that matter at national and international levels. There was also a growing impatience as the changes initiated did not deliver the expected results as rapidly as wished. Some ascribe this impatience partly to the growing populism increasingly characterising the politics of the 1990s in general (Frank 2000). As a result, the decade ended, despite the declared intensions, possibly more fragmented than it had started.

The period around the turn of the millennium saw the launch of several initiatives fuelled by the thinking behind the Report of the Macroeconomics Commission to scale up fights against selected diseases, including: Roll Back Malaria, Massive Effort, the Global Fund to Fight AIDS, TB, and Malaria, 3by5, and several others. In many ways this is similar to what happened with the PHC - when it went selective. Most of these initiatives claim that they are in support of strengthening the health systems, while they in fact may be threats to these systems (Hutton & Tanner 2004). More recently, the United Nations has unveiled the results of its Millennium Project, which was also led by J. Sachs, calling for doubling of donor aid worldwide as its best guess at the costs of meeting the Millennium Development Goals. However, former and current officials from the World Bank express serious doubts if such big push would yield the expected results, referring to the World Bank approaches during the 1950s and 1960s, which, if they had been successful, would have resulted in Zambia today having surpassed an annual per capita income of \$20,000 rather than the current \$500 per head (The Economist 2005d)

9. THE ROLE OF WHO AND THE WORLD BANK

WHO and the World Bank are two very different types of organisations. WHO is a membership organisation with 191 member states. The representatives of the member states are ministers of health, who get together in the organisation's highest authority, the World Health Assembly. As such, WHO is political, it can and does set global health policies. The vast majority of its professional staff is from a medical background, from a tradition of focusing on the individual and having egalitarian or communitarian views. It has very limited resources of its own, i.e., from assessed contributions, most of which are tied up in infrastructure. The remainder of the available resources is from specified contributions. The organisation is not supposed to be directly involved with service provision, including funding of the same.

The World Bank, on the other hand, is answerable to its contributing members. According to its constitution it must refrain from being political. The vast majority of the staff are economists or bankers who are grounded in utilitarian or libertarian traditions. The World Bank, besides the contributions from its members, raises large amounts from the market, which it lends to countries for direct infrastructure or recurrent investments.

While WHO played its role at the centre of the health stage during the 1970s and 1980s, the centre of the stage appeared to be taken over by the World Bank during the 1990s.

9.1 The World Bank

The World Bank was, at its inception in 1944, meant as a mechanism to address the reconstruction problems in Europe after the Second World War. However, within the first two years after its establishment, emphasis shifted from post-war reconstruction to economic development. During its first many years, the Bank focused on large investments in physical capital and infrastructure as these were viewed as most likely to increase national income. However, with the changing development paradigms starting in the 1950s, i.e., a realization that physical capital played a less-than-expected role in economic growth and the arrival of Robert McNamara as President of the Bank in 1968, a slow process of moving towards investment in human resources took a firm foothold.

The late acknowledgement of the importance of the social sectors in development as well as the slowness of the move is likely related to the way the World Bank raises its funds, i.e., through the private financial markets and donations from wealthy countries. In 1961, its Chief Fundraiser stated in an interview: "If we got into the social field... then the bond market would definitely feel that we were not acting prudently from a financial standpoint ... If you start financing schools and hospitals and water works, and so forth, these things don't normally and directly increase the ability of a country to repay a borrowing" (Ruger 2005).

In 1973, McNamara requested a health policy paper from his staff, and things started to move. In 1974, the Bank was key instrumental in creation of the Onchocerciasis Control Programme (OCP), aiming at controlling river blindness to free up land for agriculture in Western Africa, in 1975 the health policy paper was published, and in 1978 it joined the Tropical Disease Research and Training Programme (TDR) as a co-sponsor together with UNDP and WHO. The World Development Report 1980 marked the official recognition of the shift of emphasis in the Banks portfolio. The report suggested that improving health and nutrition would likely accelerate economic growth. From only beginning direct lending for health in 1980, by 1983, it had become one of the largest funders of health programmes (Akin, Birdsall, & De Ferranti 1987;Ruger 2005).

With the policy study report '*Financing Health Services in Developing Countries: An Agenda for Reform*' in 1987 and later the '*World Development Report 1993 - Investing in Health*', the Banks legitimacy and key role in health sector policy was affirmed. The Bank draws its strength primarily from two sources. First, it has a Policy Research Department, which builds on its comparative advantage in economic and intersectoral analysis. The Bank has in recent years produced more than 210 country-specific health, nutrition and population studies and staff appraisal reports and hundreds of country strategy documents on related issues. Second, the Bank, compared with other international institutions has a main advantage in mobilizing financial resources and is now by far the largest external source of health, nutrition and population financing in low- and middle-income countries (Ruger 2005). However, the Bank's entry into the health field has not been without controversies and criticism:

- The *structural adjustment programmes* of the 1980s and 1990s, which, according to UNICEF estimates caused death of half a million children in a 12 month period due to significant drops in incomes and health expenditures. Further, the structural adjustment programmes appeared to need extension far beyond the original timeframes (Abbasi 1999).
- The *support for user-fees*, evidence showed reduced use of both necessary and unnecessary care, disproportionately affecting the poor and sick. The Bank has later stepped back from its support for user fees, although it still claims that these provide a tool for mobilizing additional resources (World Bank 1997a)
- The *promotion of privatisation and focus on the private markets* in the health sector. The Bank now admits that open markets and economic management are insufficient and that good governance and strong institutions are critical in eradicating poverty (World Bank 1997b;World Bank 1994b). However critics maintain that a clearer position on trade-offs between public and private financing and delivery of health services is required (Ruger 2005).
- The *introduction of DALYs into global health assessments*. Critics argue that the DALYs lack a sound theoretical framework and are inequitable because they value life years saved for the able-bodied more than the disabled, the middle-aged more than the young and the old, and currently ill more than those who will be ill tomorrow (Anand & Hanson 1997).

A late 1990s review by the Bank's Operations Evaluation Development Department of some 120 Bank projects found the Bank's health, nutrition and population portfolio to

be fragmented, of uneven quality and that the narrow focus on capital investment failed to achieve the significant institutional and systemic changes necessary for effectiveness. As a result, the Bank's emphasis has shifted to support for broader policy reforms (Ruger 2005)

9.2 The World Health Organization

The WHO was established in 1948 with the objective of 'attainment by all people of the highest possible level of health' and three main functions: to set normative standards, to provide technical advice and assistance, and to advocate for changes in health policy. However, it was not until the late 1970s that the advocacy role came to the fore and the organisation took a key role in influencing international health policy. Up to then, WHO had had a strict disease orientation, but with the appointment of a new visionary and charismatic Director General, Dr Halfdan Mahler in 1973 it began to address broader social and economic determinants of health. Three major public health policy initiatives resulted from his 15 years in office: health for all by the year 2000 and the Alma Ata declaration on Primary Health Care in 1977 and 1978 respectively; the launch of the essential drugs programme in 1977; and the international code on marketing of breast milk substitutes passed by the World Health Assembly in 1981. The latter two initiatives were highly controversial and brought WHO right into the middle of the political arena. In both cases, the United States accused WHO of interfering in global trade and the organization was exposed to extensive lobbying from the industry as well as political sides. USA, the largest financial contributor to the organization strongly opposed both initiatives and in 1985, partly in protest against the essential drugs programme, withheld its contributions to WHO's regular budget. Despite the US financial clout, Mahler skilfully and courageously steered the WHO through the process resulting in the Assembly upholding against the powerful vested interests (Godlee 1994a).

The next Director General, Dr Hiroshi Nakajima, who took office in 1988, retreated with WHO out of the controversies and into the safe waters of medical technology and biomedical consensus. The essential drugs programme, which, under Mahler had reported directly to the Director General, was demoted to a normal technical division in the organisation and its Director Dr Ernst Lauritsen was forced to leave. Furthermore, a fight that had emerged during Mahler's last years in office with UNICEF over the Bamako Initiative proposing that drug companies and health facilities should recover their costs by selling drugs at marked up prices to those people and countries who could afford and linking the generated revenues to the pay of health workers. Mahler strongly warned against this, however, Dr Nakajima did not take over this fight, his style of leadership was to avoid controversies and to the extent possible to keep the major interest groups happy and he steered WHO out of two other health controversies of the time, i.e., population control and tobacco consumption. Instead, he tried to launch what he called a 'new paradigm for health', however, very few, if any, inside or outside the organisation ever understood what it was about. To make matters worse, WHO was haunted by episodes of managerial and financial misconduct, some of which was directly linked to the Director General. Combined with a growing share of the organisation's resources coming from extra budgetary sources, WHO increasingly became dispersed and uncoordinated (Godlee 1994d)

With the retreat from the controversial aspects of public health into safer waters, the organization also failed to develop with and significantly influence the international public health thinking as it evolved during the 1990s. Lack of leadership and the fact that most of its staff was medical made it difficult to embrace a multisectoral approach to addressing health. This became most obvious with respect to the AIDS programme. During its first Director Dr Jonathan Mann, the Programme had set off in a multisectoral direction, while under its second Director, the Nakajima appointee Dr. Michael Merson, it attempted to find biomedical silver bullets, in the form of condoms and STD symptomatic treatment disregarding poverty, inequality, and other social and economic aspects of the epidemic. Together with the managerial problems this made the donors remove the Global Programme on AIDS from WHO to create the UNAIDS in 1995.

However, it was not only a matter of poor leadership by its Director General that made WHO ill-prepared to take a key role in facing the health challenges of the 1990s. There were issues inherent in its structures and funding making it a difficult organization to manage.

WHO is a membership organisation and during the 1960s and 1970s its membership increased dramatically by addition of many newly independent and often small and poor countries. Each of the 191 member states has one vote in the World Health Assembly. The result is that those countries which provide the majority of the funding have become a minority. They have responded by providing most of their contributions as extra budgetary funding, i.e., directly to technical programmes, during the 1990s frequently having a special status with their own management committees and outside the direct control of the Assembly. These programmes were competing for funds and had no interest in developing integrated and comprehensive approaches to health as this would mean their Directors losing power. An example of this fighting over turf, which led to the creation of GAVI is described in William Muraskin's book on the Children's Vaccine Initiative (Muraskin 1998).

Further, WHO is in several ways not one but seven organisations. It consists, in addition to its head quarters, of six regional offices, each with a regional committee comprised of health ministers of all the countries in the region. The regional committees elect the Regional Director for five year tenures. The Regional Director, in turn, selects the WHO country representatives. There is thus, an intricate power balance, leaving potential room for making political deals and exchange of favours. Above all, it leaves the country offices in a weak position. Many country representatives were without experience, power and resources to make a meaningful contribution and the organisation were often marginalised in the donor community at country level during the 1990s (Godlee 1994d;Godlee 1994b;Godlee 1994c)

A Danida sponsored evaluation of the efficiency of multilateral aid in Kenya, Nepal, Sudan and Thailand found WHO country programmes spread over many small activities, which filled gaps in the ministries of health in the respective countries but had limited impact on policy and health service. Contrary to this, the evaluation found that the World Bank, in the same countries had made analytically-based comprehensive and cohesive country strategies on basis of which significant funding was provided. However, the evaluation also found that the individual World Bank

projects tended to take a life of their own and not being well coordinated with other Bank projects and projects of other donors (Danida 1991).

Dr. Nakajima did not run for a third term and instead, Dr Gro Harlem-Bruntland was elected in 1998. Rather than having a health vision like Dr. Mahler, she had a management vision, wanting to address some of the structural and financial issues making WHO so difficult to manage the organisation. Her vision was of a corporate WHO, one with a common strategy and a united management. She curtailed the power of the Divisional Directors, ended most of the special programmes, introduced a unified budget and modern objectives-based planning and management systems. A process of decentralizing to country level was initiated, including development of country cooperation strategies and strengthening the country representative function. At the more outward looking front she picked three initial flagships in order to re-establish WHO's role and credibility in public health, i.e., rolling back malaria, addressing tobacco consumption, and an approach to addressing health systems performance.

However, she probably underestimated the internal resistance to change and the inertia of a big old bureaucracy. She probably also misjudged the willingness among donors and member states to change themselves. While they had criticized WHO, they might not at all have been interested in it becoming stronger, i.e., in global agenda setting as evidenced by their continued willingness to fund an ever increasing number of separate initiatives and partnerships. Dr. Bruntland decided not to run for a second term and left behind a half completed internal restructuring. Out of the three flagships, one, the tobacco convention got accomplished, while the health systems approach was met with critique as described above regarding the World Health Report 2000. The Rolling Back Malaria, according to an editorial in the Lancet, has not only failed, but may also have cause harm and the history of RBM might become a calamitous tale of missed opportunities, squandered funds, and wasted political will (Editorial Lancet 2005)

10. MACRO-LEVEL DISCUSSION AND CONCLUSION

The period since the Second World War has, in many ways been unique. The number of nation states increased significantly as colonial rule was phased out during the 1950s and 1960s and as several countries in particular in Euro-Asia split-up during the 1990s. Following the Second World War, a large number of international and inter-country organisations and bodies were created. At the beginning, the rich countries dominated, but as the number of countries and thereby the number of member states of many of these organisations increased, the voting balance gradually tilted towards the low and middle-income countries.

The first decades after the Second World War was an unprecedented period of growth in the industrialised countries, the mixed economies and the welfare state prospered. The model of growth built on the theories of Keynes, in which the state played a prominent role in the economic and social development. However, during the later part of the 1960s, in particular in the 1970s, the economy came into a period of crisis with stagflation and recession which seriously questioned the model for development and brought about a decade, where libertarian views heavily influenced the national and international agendas. With respect to the developing countries, what in the rear

mirror stands out are the structural adjustment programmes, which shook many developing countries in their political, social and economic foundations. Some of the consequences of these programmes were not acceptable to a great number of people. In particular, UNICEF was outspoken and demonstrated how these programmes 'killed' hundreds of thousands children.

As the model for development also did not fully deliver the desired economic results, or delivered them at too high political costs, in developed as well as in developing countries, it fell into political disfavour and was slowly modified and softened. However, the belief in the market to regulate demand and supply, with the implied less direct role of the state, continued to be very strong. This gave room for utilitarian views, which also see the market as having a central role.

Concomitant and intrinsically related to this, political crises emerged for socialist thinking and rule in the Soviet Union, which failed to rejuvenate itself and became stiffened, finally leading to collapse of the so-called East-block around 1990. In China, the Communist Party remained in power, but changed its social and in particular economic development paradigms and theories. This coincided with a political crisis in the west where the social democrats were forced to redefine themselves and move to the right. This meant an end of the bipolar world order offering socialist and capitalist development alternatives. It led to an acceleration of globalisation with increasing economic interdependencies between countries, including import-export dependency, cross-ownerships, and division of international labour/production processes; intensified communication - electronic, travel, education; further, global treats grew, real and perceived within health and related to terrorism and/or 'neo-imperialism' depending on one's viewpoint.

The economic crisis and political circumstances drove a values change towards libertarianism and utilitarianism. The general political move was to the right in most, if not all leading countries with a belief in the market to overcome inefficiencies in the economy as well as in the public services, and, to some extent, equating demand with need. However, strong background deontological value blocks remained or were promoted both in relation to positive rights, equity, etc. as well as in relation to communitarian, including religious values and virtues. Vehicles were in place for the dissemination of these ideas and changes through the international organisations, international development assistance, armed interventions, and globalisation, including improved communication, travel and economic inter-dependencies. Developing countries already weakened or constrained in their political development during colonial time were further put in a vulnerable situation due to the global economic crisis making many of them falling seriously behind plans and aspirations, making the governments unable to meet the growing expectations of their people and disappointing the aid-donor agencies.

With the collapse of the Soviet Union, the changed development approach and political situation in China, and the increased globalisation, the developing countries seemed to have only one option for development, namely adapting to and integrating into the global capitalist market. There was very limited room to divert from this path as the leading donor countries formed an increasingly politically homogeneous block where the traditional differences between the Left and the Right narrowed or disappeared altogether.

However, the public management and governance reform, including a reduced role of the state in service provision, outsourcing and privatisation, etc. was not a *prêt à porter* solution. Many iterations and changes occurred in both industrialised and developing countries. It was a period of trial and error and the suitability and impact continued to be questioned.

Health became to be seen as a commodity which could be traded and invested in and thus dealt with like any other commodity amenable to the same economic logic and investment calculus. This meant that PHC, as a practical and politically feasible approach, lost support outside a hard core group of believers almost before the ink of the Alma Ata Declaration had dried. In line with the general trends in public management, health sector development toned-down the role of the government and the public sector in service provision. The focus was on efficiency and cost-effectiveness, terms borrowed from the utilitarian and the business vocabulary and thinking of the public and private sectors converged with managers in both sectors using the same tools and being assessed by the same performance criteria.

Increasing economic inequities widened in developing as well as in developed countries with an unprecedented concentration of wealth in the hands of relatively few individuals and companies with two effects. First, a sizeable group of people in developed as well as in developing countries started to demand *and* were prepared to pay for direct and quick access to the best possible health care - without rationing, without queuing, and without being limited in their freedom of choice. Second, the concentration of profits and wealth has also given rise to rich individuals and companies entering into the public health field through direct monetary donations or donations of drugs at levels that previously had only been the case of governments. By their donations they are contributing to shaping the public health agenda both in terms of what they choose to support and in terms of bringing in the business values, which had earned them their wealth.

WHO lost territory and leadership to the World Bank during most of the 1990s, as a reflection of increasingly seeing health as a means rather than an end. This was further augmented by a leadership crisis within the WHO. However, the organisation regained some of its clout during Brundtland's tenure as Director General, possibly due to her ability to play the international political game as well as the WHO increasingly taking a utilitarian approach to health. At the same time, the Bank increasingly became more socially conscious, slowly realising the adverse side-effects of the libertarian/utilitarian treatment it had promoted during the 1970s and 1980s in particular with respect to equity, social stability and the absence or delay in providing the results expected, in particular in Africa.

The decade was also characterised by a growing populism with short-sightedness and political impatience leading to proposing and mobilising support for new initiatives, which promised brighter futures. It became more difficult to find support and preparedness to engage and continue the long and difficult haul to follow through what had already been launched to work and deliver. The result was a proliferation of new initiatives promising quick fixes by harvesting the low hanging fruits.

The blue print for health sector reform, as it was presented, e.g., in the World Development Report 1993, was a philosophically very complex concept and thus a true product of a time of ideological upheaval and transition. It tried to encapsulate both teleological and deontological values in one agenda. Teleological, in that the key goal of the agenda was to buy as much disability adjusted life-years (= economically productive capacity) as possible for a given amount of resources. Improving average health was a means in achieving that end with improving efficiency representing a broad set of strategies. Equity, according to this view point was seen as one among several cost-effective strategies, i.e., as a means to achieve a goal, the extent to which it should be pursued would depend on the cost-gain ratio. Equity, however, could also be viewed as goal in itself, an individual positive right - of access, a right to health, i.e. a deontological value. A scene of conflict unfolds as the deontological demand for equity is limitless while the teleological demand for efficiency is about setting limits. The use of the market mechanisms as proposed in the technical and political debates had two rationales, i.e., to improve efficiency - a subjective utilitarian-teleological view point; and a negative rights view point, i.e., 'freedom of choice' and 'freedom of business' - both representing libertarian-deontological perspectives.

The mixing of values probably made the blueprint palatable as one could read into it whatever one wanted. However, it would be difficult to implement and, as illustrated by the Oregon case, to take decisions regarding priority-setting and rationing, i.e., choosing between alternatives when these were assessed on incompatible values-scales. The buy-in to the blue-print could easily be lost when difficult decisions were to be taken and the view points came to clash with philosophical conflicts which could lead to reform processes stale-mating.

It is questionable if those developing countries that came out of the colonial period with incomplete or weak governance systems and facing a host of economic and structural problems were ripe to implement the sophisticated approaches proposed in the new public management, including rolling back of the state, outsourcing to private firms and contracting within the public sector as also suggested in the health sector reform blueprint.

Health systems do not shape the society - the society shapes the health systems. Health systems and problems in health systems are reflections of the society and its debates and have to respond to the needs and values of the populations. However, health systems should not just be reactive; there is both a need and a room for political activism in public health. Officials should take their part and can, as illustrated by Dr Mahler's WHO, be very successful in taking a proactive role in influencing the public agendas if the cause is right and the skills present to use the mechanisms at hand.

PART THREE

Part Three puts together and discusses the findings presented in the appended 10 individual cases addressing the micro-level and using the analytical framework proposed in Figure 2.4 and minor sub-units of analysis in figure 3.1.

The findings are presented and discussed starting from the users and working backwards to participation and politics, thus closing a circle. Part Three will end with a general discussion in light of the objectives of the reforms, as presented in Table 2.1.

11. THE USERS

The users are defined as those meant to benefit from the improvements in the health services. Users include both those who need treatment and care, as well as those who are healthy, but needs access to preventive services and to be protected from epidemic diseases, unhealthy environments and products, etc.

In several countries, the reform meant a shift from a supply to a demand driven health system, a shift which occurred either by design or by default. In a supply driven health system, the needs would be determined by the providers and the eventual government subsidies would flow to the providers based on some defined needs. In a fully demand driven health system, the users will translate their needs into demands, and provided they have the resources, these will then flow from the user to the provider as payment for the service provided. An eventual government subsidy would go to the demand side, i.e., follow the patient rather than the provider.

Colombia (Article #2) shifted by design through an increased emphasis on user-payment, i.e., various forms of insurance and direct out-of-pocket payment. In addition, the government subsidy shifted from the provider to the user side. This meant that if there was no articulated and financially backed demand, then there was no role for the provider. One result was that certain public health functions, such as contact follow up of TB patients, were no longer undertaken and it became complicated, e.g., to receive BCG vaccinations - something that had been straight forward under the previous system.

The shift from supply to demand driven health services in China (Articles # 3, 7 and 11) was more by default than by design - a considerable direct subsidy to the providers remained in place; however, this was far short of covering the costs and the providers became dependent on charging the users. The health services for schistosomiasis and TB control focused on satisfying the immediate demand of the individual patient and population-based functions, such as, prevention, case identification, patient follow up, etc. declined. The positive trend in control of schistosomiasis and TB from 1980 to mid-1990s might have been reversed as a result.

It has been argued that user-fees, if backed by an increase in quality of the services could, under certain conditions lead to an increase in utilization (Fiedler 1993; Litvack & Bodart 1993). In Zambia (Article # 9), decentralization combined with introduction

of user-fees had a profound impact on health service utilization. There was an immediate and sustained overall decline in general attendance as well as a change in the pattern of utilization with an increased use of health centres as opposed to hospitals for general admissions, vaccinations and deliveries with an overall increase in all three. This could be a result of improved quality at the health centres combined with prohibitive charges at the hospitals.

Uzochukwu demonstrated this point in a retrospective analysis of malaria service utilization in the studied health centres in Nigeria (Uzochukwu, Onwujekwe, & Eriksson 2004). However, they found that this was mainly due to the more affluent segments of the population using the services, thus an increased inequality. The exemptions from user-fees, which those unable to pay were supposed to get, in most cases did not materialise. Users did not know their rights and were not made available by the providers, as was the case in Laos (Article #5) and the vested interests of the providers did not give these an incentive to inform. Similar findings have been reported from several other studies (Kajula *et al.* 2004; Kivumbi & Kintu 2002; Meng, Sun, & Hearst 2002; Uzochukwu, Onwujekwe, & Eriksson 2004). In China (Articles #7 & 11), only a small proportion of the patients needing TB care were detected and received any treatment. As the availability of services, such as drugs, etc. was not a constraint, the low case detection rates could only be explained by a lack of action on the part of the providers and that poor people were delaying or not seeking care due to prohibitive costs. In Sudan, it was found, in an experiment where the level of user-fee for malaria diagnosis and treatment varied while the quality was kept constant, had a direct negative correlation between the level of user-fees and utilization and compliance. When the level of the fee was lowered, utilization and compliance increased (Zeidan *et al.* 2004).

A cocktail of asymmetrical information, user-fees and staff-bonuses was found in China (Articles #3 & 11) to lead patients to experience very different treatments depending on the resources they had available. Having more resources did not necessarily mean better treatment - only more. In TB care, it also meant that patients were not directed to where they would get the best and possibly cheapest care, but they had to go from one provider to the next, with each of them extracting charges. This was dissimilar to the managed competition approach pursued in Colombia (Article #2) where those affiliated to the best contributory insurance schemes received a seamless, five-star TB treatment, while those who were classified as poor and therefore qualifying for the subsidized insurance scheme, received an inconvenient, discount-type of service. This was found to have a direct bearing on the treatment outcome, with more cured and less death in the cohort of TB patients in the contributory insurance schemes.

The question of "fee or no fee for public health" can be answered neither in isolation nor from a purist's perspective. After the abolition of user-fees in Uganda, patients flocked to the health facilities to receive free malaria treatment. However, the abolition of fees had not been backed by replacement funding from other sources. The result was under-treatment, i.e., instead of more people being effectively treated, less people received appropriate treatment (Kajula, Kintu, Barugahare, & Neema 2004).

However, access to or inequities in access are not only related to the level of user-fees. For poor, uneducated, and marginalised populations there were found to be a host of

barriers of access. In Laos and China (Articles #5 & 6), it was found that lack of information about rights and opportunities as well as unfriendly attitudes of the public health service providers inhibited access for considerable parts of the population. A measurable worse outcome of pregnancies among migrant women in Shanghai, compared with the non-migrants women (Article #6).

From a user's perspective, services in general had not improved as a result of the reforms, instead access to treatment and care had become more difficult in terms of economic as well as other barriers and exploitation by the health services providers were common. Preventive services had moved down the list of priorities with the possible consequences of re-emergence of diseases once controlled through primary health care interventions. These outcomes were certainly not intended, either the design of the system was wrong or/and its implementation had gone astray. However, the example of Zambia, where utilization of public health services, albeit free, had increased as well as the Sudanese experiment showed that under the right conditions it is possible to introduce user-fees and at the same time improve public health service.

In general, those losing in the reforms appeared to be the public, and the poor and uninformed; while the possible winners were those who were lucky to be part of a professional financing and purchasing scheme. Several other researchers have documented adverse effects for the users of the increased marketisation of the health sector, including: an increased inequity (Gao *et al.* 2002; Pannarunothai & Mills 1997; Segall *et al.* 2002), that exemption measures for the poorest do not work (Kivumbi & Kintu 2002; Meng, Sun, & Hearst 2002), and that services actually received were adjusted to what the user could afford rather than what treatment he or she needed (Sepehri, Chernomas, & Akram-Lodhi 2003)

12. THE PROVIDERS

Market or business-like mechanisms, including greater prominence of the demand side, economic incentives to staff, user-fees and other service charges were introduced in several countries as a means to increase resources and to improve the efficiency of the sector. In most cases, this was found in the implementation to have had a number of undesirable effects on provider behaviours, particularly when seen from a public health perspective. However, the majority of these effects could be explained by economic rationality and could have been foreseen.

User-fees and service charges at facilities and bonuses at the individual staff and facility level are incentives to provide more of the output that produces income. Rational behaviour would mean shifting, whenever possible, attention from those activities which were not rewarded to those that were. In Colombia (Article #2), the public services were found to have been transformed into '*state enterprises*', i.e., doing what is economically profitable. Likewise in China (Articles #3 & 11) emphasis among staff and health facilities was to provide 'sellable' items, notably, drugs and tests.

The approach reportedly had been successful in increasing resources for facilities and income for staff as well as ensuring the availability of the 'sold' services. However, from a public health perspective, what was more serious might be what was not

emphasized. Within TB control (Articles #2, 7 & 11) it was found that the way providers were paid, i.e., through providing individual chargeable services, had had an adverse and measurable effect on case finding, contact tracing, observed treatment (DOTS), and follow up of the individual patient. In schistosomiasis control (Article #3) it had meant a shift away from primary and secondary prevention towards predominantly providing individual clinical services.

Several of the researches reported low morale and frustration among staff that led to the development of various 'survival strategies', which frequently resulted in a compromise in the professional objectives of their work. In Tanzania (Article #8) the lack of involvement of the peripheral health staff made these feel not being taken seriously by their superiors, contributing to a growing frustration possibly affecting their performance. Another important factor adding to staff frustration was under-funding, resulting in imposed compromises to what staff professionally perceived to be the right quality of service (Article #7). Understaffing, poor facilities and overly bureaucratic procedures complicated life for staff and posed barriers of access for patients in Laos (Article #5) and possibly contributed to alienating public providers from the patients. This, in turn, led the patients to experience the staff of public health facilities as unfriendly and they preferred to seek care from private health carers. Further, salary levels below a reasonable standard of living for staff or below that in comparable occupations can neither be encouraging nor motivating.

Observations similar to the above have been reported by other researchers (Espino, Beltran, & Carisma 2004;Kajula, Kintu, Barugahare, & Neema 2004;Kivumbi & Kintu 2002;Kivumbi, Nangendo, & Ndyabahika 2004). Each of these factors can, by themselves, explain the development of the commonly practiced institutional and personal '*survival strategies*'. The survival or revenue maximization strategies manifested themselves in several ways, all of them having in common that the patients had to pay more than necessary. Both the individual patient and the public health interests were pushed aside in order to generate more income to the health facility and its staff. In several cases, staff adapted regimens and procedures so that they could charge more.

Over-prescribing, over-treating, and over-testing were reported in abundance from the three Chinese studies (Articles #3, 7,& 11). Similarly, in Nigeria over-prescription was suspected practiced in the Bamako Health Centres (Uzochukwu, Onwujekwe, & Eriksson 2004). For these strategies to be successful, it is required that: charging for services is an established practice; inputs are sufficient and controlled by the provider; eventual revenue is controlled by and/or benefits the provider; there is an imbalance in information so that the patient/purchaser does not know what the correct procedures are; and poor supervision and oversight from public health authorities. These criteria were all fulfilled in the China cases and partially in Nigeria. In Tanzania, fees were less established, i.e., 95% of the total revenue originated from central or donor funds and supplies probably were insufficient to make it a viable strategy. In Colombia, a large part of the purchasing had been professionalized, i.e., for the contributory insurance scheme, the insurers effectively controlled each purchase and in many cases, also the direct provision. For the subsidized scheme, the insurers had effectively back-transferred the risks to the public providers who, therefore, would rather have an incentive to under- than to over-provide.

The three TB-programmes case study (Article #11) illustrated well how a system might adapt to attempts to make certain services more accessible to the public by making them free or subsidized. Each level of the system developed strategies that kept TB-patients for as long as fees could be extracted from them, and they were not timely referred to the appropriate level of diagnosis or to where they could receive free service. Those providers who were mandated and supplied to provide the free or subsidized service did so, but invented additional procedures, provided additional and more expensive drugs, or extended treatment beyond the recommended length of time in order to charge the patients and generate revenue.

The providers were found to have swiftly adapted to the incentives provided and focused on services which generated financial benefits. This often meant reducing availability of non-chargeable services, over-providing the chargeable ones, or diverting resources in order to provide staff bonuses as was the case in Indonesia (Article #4). This appeared not to have been noticed and adjusted for when implementing the reforms. However, while their behaviours might be explained by economic rationality, providers frequently compromised good ethical and public health practices. In none of the studies, were the supervisory and regulatory functions found to be performed to any acceptable level. Several other researchers have suggested that providers use market opportunities to gain at the expense of the patients and oversight where regulatory functions are not being performed adequately (Reich 2002b; Sepehri, Chernomas, & Akram-Lodhi 2003; Suwandono, Gani, Purwani, Blas, & Brugha 2001). The decline in the real value of health workers' salaries in many developing countries have been found by other authors to lower the morale and thus providing one possible explanation to the above (Kyaddondo & Whyte 2003; Segall 2003). Already in the 1980s, WHO's Director General had warned about the detrimental effect that linking drug prescription directly to the income of the health workers, however with the shift in directorship, the discussion was discontinued (see section 9) (Godlee 1994a)

13. THE RESOURCES

Resources are a key concern in health sector reforms, including how to contain and meet the increasing costs and how to allocate the available resources (Kutzin & World Health Organization 1995; The World Bank 1993). However, the resource envelope, may in many poor countries just be too small (Akin, Birdsall, & De Ferranti 1987) to provide much meaningful government service and to make any form of reallocation politically viable as was found in the case of Zambia (Articles #9 & 10). Further, resources and how they are generated are also critical components of the implementation process. Tanzania represented one end of the spectrum with 95% of all the albeit insufficient resources for the district health activities originating from central and donor budget support, thus only a small share of the total resources of the district health system were mobilized within the district. Sudan represents the other end of the spectrum, as ,e.g., all malaria services were directly charged to patients, regardless of the nature of the service and the situation of the patient (Zeidan, Mohammed, Bashier, & Eriksson 2004). Most other countries fall somewhere in between these two extremes.

The simplest form of budget support is found, e.g., in the Philippines where it was based on the previous year plus ten percent. Originally, the budget support system had been based on area plans. As resources had always been less than requested, the system had deteriorated into one where plans were neither produced nor requested (Espino, Beltran, & Carisma 2004). Another non-objective and non-performance based allocation of budget support was found in China (Article #3). Here, a large part of the government support for schistosomiasis control was based on the size of the programme infrastructure, in particular staffing level and pattern. Even without being sufficient to fully support the existing staff, this form of support had probably contributed to continuing an over-sized dedicated programme structure despite a changed epidemiological situation. Another structurally-based type of support was found Tanzania, where essential drugs were provided from the centre to the districts based on the number of health units (Article #8).

In Tanzania, where the vast majority of funding came from the government or donors, the main funding was based on preparation of district plans, i.e., objective-based. However, there were signs of this system gradually sliding in the same direction as in the Philippines. A number of factors were contributing to this, including: plans being developed according to where resources, rather than the needs were; the same plans being re-submitted year after year; lack of information to prepare truly needs-based plans; and, further, the actual implementation not following the planned. A performance, although not necessarily a needs-related system of subsidizing health services, was seen in the China schistosomiasis and TB control programmes (Articles #3, 7, & 11). In what remained of these vertical programmes, the costs of drugs and certain other inputs were to be covered in full or in part by government budget or loan money. However, problems were recorded as these funds dried up and resources to provide free services to patients or incentives to staff had to be drawn from other parts of the budget or terminated. Finally, funding based on achieving pre-set targets or passing an evaluation was also found in China. A number of problems were reported in relation to this type of funding, including the punishment of those who, for one reason or another, did not meet the target rather than being helped to perform better; further, there was no incentive to go beyond the pre-set target, regardless of the need; and, finally, the data could be manipulated.

In all the countries studied, health facilities charged for some or all of the communicable disease control services offered. While in Tanzania the income from service charges was minimal as compared to the overall budget, service charges constituted a vital proportion of the income for health facilities in Colombia and China. User-charges can be viewed from a technical-economical perspective, as a way of securing the resources needed for running public health services and for regulating, including re-directing the demand as was the case in Zambia. However, they also have ideological and political aspects as has been reported from Uganda, where these aspects overrode all other concerns, e.g., some donors put introduction of user-charges as a condition for providing support, and the President later, in the heat of an election, abandoned the fees altogether which pushed them into being covertly charged (Kajula, Kintu, Barugahare, & Neema 2004). In Colombia and China, service charges were claimed not only directly from patients but also from insurance providers or from public funds in the case of the uninsured in Colombia.

Problems relating to service charges, in addition to the administrative problems encountered, were found in China, Colombia and Laos. While user-charges may assist in making more services available, they were an access barrier for the poorer segments of the population (Articles #2, 3, 5 & 6). It was further found in a time-series analysis in China, that public structurally-based budget support was diverted to subsidize an expanding number of 'sellable' services marketed by the health facilities below the cost-price in order to generate more service charges (Article #3). Similar observations were made in Indonesia where provision of high-cost hospitals beds not only failed to generate revenues exceeding the costs, but diverted meagre budget resources into subsidizing services for the affluent (Article #4). In many cases, it seemed that services were provided to secure funding, rather than the other way round.

However, user-fees in communicable disease control might not be written off altogether as a means to increasing resources as suggested by some. Scrapping them, as was done in Uganda, will not make services more accessible unless funding from other sources is increased to match the shortfall in income (Kajula, Kintu, Barugahare, & Neema 2004). The experiment in Sudan with different levels of user-fees showed that if the price was set at the right level, it might be possible to get, all at the same time, more patients, more compliance, more revenue, and ultimately more public health impact (Zeidan, Mohammed, Bashier, & Eriksson 2004). Further, the experience in Zambia showed that although the overall general attendance declined, utilization patterns were changed and the use of 'free' public health services increased possibly increasing the overall efficiency of the sector (Article #9).

In most of the countries, general under-funding of the services occurred. However, despite the strengthening of the planning, control and reporting systems in some of the case countries, it varied from very hard to impossible for the researchers to find out how resources were actually spent. Nowhere, with the possible exception of Zambia, were the financial systems designed and set-up to allow accountability for how the resources were expended. This might be a reflection of a broader weakness in most developing countries in the capacity to generate, allocate, distribute, and analyse and map where and for what resources are spent, e.g., through establishment of the reasonably accurate national health accounts suggested by WHO and the World Bank (WHO 2003).

14. THE SYSTEM STRUCTURE

A major constraint to implementing reform can be the very reason to reform namely an unsuitable or unaffordable structure of the health system itself. A case in point was Zambia, where the hospital subsector during the colonial time as well as the period following immediately after independence had expanded significantly in an inequitable fashion and assuming a much larger health budget than could be maintained when the economic decline began. The inability to deal with this structural problem proved fatal to the Zambian health sector reform (Article # 10). Contributing to the inability was that the health system had been fragmented prior to dealing with the relatively 'over-sized' hospital sub-sector by splitting the managerial oversight between different management boards with strong local ties. Another systems legacy of the past constraining effective delivery of public health services was the population

registration system in China, which effectively excluded significant parts of the population in China from receiving antenatal care (Article #6)

Various forms of fragmentation of public health efforts to control TB were observed in Colombia and China (Articles # 2, 7 & 11). In Colombia, the separation of purchaser and provider functions and the contracting with different providers for provision of different services to the same patient, reportedly led to delays both in diagnosis and treatment, as well as a lack of follow up of the individual patient and their contacts. In the three programme study in China (Article # 11), it was found that the need to generate income at the provider level had led each provider to operate in isolation keeping patients under *their* treatment for as long as possible. In both countries, patients were thus made to deal with and experience a series of individual providers, rather than a cohesive system.

Another type of fragmentation of the public health response was also found in China (Article #7), in that the devolution of responsibility to the counties for the major part of financing of TB control had meant that the poorest counties with the highest relative burden of TB, had few resources for many patients, while the richer counties spent relatively large amounts on fewer patients. This most likely made the TB control efforts in the province and country as a whole less effective and cost-efficient than it could have otherwise been the case.

Information on the health situation and system performance was found to be lost in a number of different ways. In Colombia, the information systems had become driven by billing, i.e., reporting was done in order for a provider to be reimbursed from the patient's insurance. After 1998, it was almost impossible to obtain consolidated information about the inputs, outputs and outcomes of the public health efforts in TB control, including, e.g., information on BCG vaccination coverage. The information rested with a large number of actors organized according to several different, mainly affiliation, denominators. The system of performance targets in China was also found to distort information as well as possibly the performance itself because the achievement of certain targets was a determinant for the release of funding.

In Tanzania, parallel information systems existed relating to dedicated (vertical) disease control programmes and those responsible for the systems did not share information or make it available to local decision-makers. Furthermore, in Tanzania the national health information system had been designed to suit overall country and vertical programmes needs rather than the needs of a decentralised health system. This meant, e.g., that 'neglected' diseases such as African trypanosomiasis and lymphatic filariasis with only local occurrences, were not officially recorded in the health information system, and, consequently not considered when district plans were prepared and approved.

Excessive administrative procedures were found to have developed in the health systems dependent on central funding, i.e., in Uganda (Kivumbi, Nangendo, & Ndyabahika 2004), Tanzania (Article #8) and Laos (Article #5) as well as in the case of the market-based and diversified provider-purchaser system in Colombia. In Uganda, Tanzania, and Laos the increased bureaucratisation had emerged as an effort to prevent mismanagement and misappropriation of funds, while in Colombia, it had come about as a result of each provider-patient encounter often triggering not one, but

several business transactions. In all events, the patients appeared to suffer delays in or absence of diagnosis and treatment.

In Tanzania elaborate prioritisation and planning tools had been developed involving budget ceilings and scoring systems. Although the resulting district health plans at a first glance could appear rational, it turned out that the process was developing into something which was done on incomplete information to satisfy the central level in order to release funding rather than mapping and responding to the needs of the districts. The process could, therefore, be heading for the fate of the rural planning system in the Philippines which had withered (Espino, Beltran, & Carisma 2004)

Disease control activities which are implemented from a national level with fully or partly dedicated funding and parallel reporting, command and operational structures, are sometimes called vertical programmes. Two types of situations were seen with respect to this type of programme. The first situation, seen in Tanzania, was that the vertical programmes co-existed with the decentralised and integrated approach. The second situation was seen in China where the programmes had ended or were about to end. In both situations, a number of problems were observed.

In Tanzania, the vertical programmes had found a way to be placed high on the priority lists, also in areas where they were possibly less relevant than other communicable diseases and health problems, and this distorted priority-setting. Contributing factors included: greater national and donor attention, dedicated funding, a network of programme officers in the districts, and reserved space in the health information system. All of these made programmes and their diseases appear prominently in the district plans. Furthermore, the co-existence of the vertical programmes within a decentralized health system structure, where the authority is supposed to lie with the multifunctional district council, was found to cause managerial difficulties and tensions in addition to the priority setting problems.

In China, the dedicated central government and donor funding for respectively vertical schistosomiasis and TB control programmes had come to an end. Nevertheless, the schistosomiasis control programme remained with a huge infrastructure and staff. However, with the phasing out and eventual end of the loan and central government funding, and despite a continued dedicated funding from the local government, the infrastructure had turned into an income-generating vehicle for its staff, shifting focus from public health concerns into primarily providing clinical care chargeable to individuals or their agents. The analysis of two different 'vertical-programme' counties and one 'no-programme' county with respect to TB control revealed what can happen when well-intended dedicated funding and 'free-service' come to an end. In many respects, the 'no-programme' county came out stronger than the programme counties with positive trends in the key performance indicators. The 'vertical-programme' counties came out with perverted structures where the economic incentives produced revenue rather than public health.

There is an immense need to address the structural issues. Implementation of the reforms in had several of the countries led to fragmentation of the health system and services. Serious deficiencies in information flow and systems to guide implementation were apparent. Further, the vertical disease control programme, both when they operated and when they were no longer sustained, contributed to the

fragmentation and deficiency in information flow. In a number of cases, the structures created by the reform were found directly to work against the objectives of the reforms. The opportunities to improve services with properly designed and integrated decentralized systems are there (Segall 2003), however, the challenges to make them work may be greater than anticipated (Kroeger, Ordonez-Gonzalez, & Avina 2002)

15. THE ROLE OF THE STATE

In all of the studied reforms, reducing the role of the state, decentralisation and introduction of some sort of market for health care were part of the reform. Decentralisation of health services were done to provinces, districts, counties, individual health units, and, in the case of Colombia, it also included privatization. Two seemingly contradicting roles were observed: on the one hand, where the majority of resources were still originating from the central government, i.e., in Laos and Tanzania, the central level attempted to maintain control of the resources; on the other hand, in Colombia and China, the state, in the process of implementation, had to a large extent abdicated from the task of guiding and overseeing functions and actions of the local actors.

In Tanzania (Article #8) as well as in Uganda (Kivumbi, Nangendo, & Ndyabahika 2004), attempts were made to implement rigorous processes of planning, reporting and release of funds. The reasons were reportedly to curb misallocation and misappropriation. However, the reality was that the central level lacked information of the real health situation on the ground; and the financial and administrative management systems were not able to register what actually happened in the course of implementation. Further, providers adapted to and circumvented the controls set by the system, e.g., the same plans that had satisfied the centre and released the funds previously were resubmitted, and staff did what they needed to do and reported something else. The result was that the control, instead of regulating the public health response and content, became limited to a mechanistic-bureaucratic control of the administrative processes, leading to delays in access to and sometimes loss of resources. Thus, while the control might have led to increased process accountability, there was no evidence that it led to increased public health output accountability. In the Philippines, the provinces had earlier attempted to use a similar approach to planning and control for the rural health units. However, after a while the provincial governments had stopped asking for the plans, and the rural health units had stopped planning (Espino, Beltran, & Carisma 2004).

In Colombia (Article #2), it was found that at the same time as the health care system, due to decentralisation and diversification of providers and purchasers, became more complex, the public sector lost its public health know-how and leadership. The capacity for inspection, surveillance, guidance, and control declined and nobody pursued the public interest. Similarly, in Uganda (Kajula, Kintu, Barugahare, & Neema 2004) it was reported that the central state agent, i.e., the MOH, abandoned its role of directing and overseeing the decentralised implementation of the user-fee policy with serious consequences for both its application and sustainability. A lack of willingness or ability of the higher levels of the administration to provide leadership was also observed in the Philippines (Espino, Beltran, & Carisma 2004), where the local officials, several years after the reform, still had the impression that the central level was responsible for implementing the malaria control programme. In China

(Article #7), the important function of transfer-funding between rich and poor counties for TB control was not exercised; like in Colombia, it was left to the local authorities or even the individual providers to raise most or considerable parts of the funds required for both prevention and treatment of communicable diseases. The local authorities either would not or could not take the administrative nor political ownership with its associated risks.

In Tanzania, decentralisation meant the devolution of responsibility to multifunctional local governments, however, as these were still highly financially dependent on central funding, the reality was that their authority was limited with the MOH and the donors holding tight control of the resources. Theoretically, decentralization to a multifunctional body should facilitate the inter-sectoral action advocated for the effective control of several communicable diseases, including, e.g., malaria and HIV/AIDS. In practice, it appeared that in all the countries health remained a concern of the health sector only and specific problems of working across sectors were observed in both the Philippines (Espino, Beltran, & Carisma 2004) and in Tanzania, where this topic was studied in depth, a number of problems were observed, including: the leakage of authority related to the dual reporting, i.e., to the MOH as well as to the local council; tensions spanning from quarrels over resources, withholding of information, diversion of funds and misappropriation to attempt of coercion; general lack of clear definition of boundaries to exercising the power to decide on, e.g., use of health funds and vehicles; and lack of explicit proposals in the guidelines on how multisectoral action might come about. The difficulties of implementing multisectoral action probably became particularly apparent in Tanzania due to the central generation of resources, which, theoretically could be allocated in different ways for health and other actions, had the districts had the authority to do so. In Colombia and China, resources were mainly generated at the individual patient-provider interface and did not come within the reach of other sectors.

In contrast to the cases of Tanzania and the Philippines, in Zambia (Articles # 9 & 10), decentralisation took place to dedicated health boards rather than to multifunctional local governments. This reduced to some extent the problems of dual reporting as the local health boards were to report to a central board of health. However, as the establishment of these boards followed the general political and administrative division of the country, tensions quickly emerged with the health line and the broader political and administrative lines - again something which proved to have fatal consequences for the reform efforts. Further, a significant proportion of these boards were too small to efficiently provide the range of services expected by them from the political side, this further augmented the tensions.

The studies from China, Colombia, and Indonesia, all found non-optimal behaviours and practices developing among the providers, some of which were directly unethical and counterproductive to public health. In China (Articles # 3 & 11) and Indonesia (Article # 4), the public facilities had become vehicles for generating income to their employees, often compromising good ethical practices and equity concerns, and the state subsidizing what could be characterised as private business within a public facility. The state failed in China and Colombia to readjust these behaviours as the supervisory systems that had existed within the vertical TB, malaria, and schistosomiasis control programmes had not been replaced by systems appropriate for the new health system. In Indonesia, the basic financial and general information

systems were not in place to even detect what was going on, thus making attempts to regulate an illusion.

What, at first glance, had appeared as contradicting observations about the role of the State turned-out to be two sides of the same coin. The state had, in the process of implementing decentralization and increased marketisation, withdrawn rather than redefined its role. The state, including the Ministries of Health appeared neither to have the intelligence and regulatory means, nor the public health knowledge and leadership capacities to manage the implementation of a complex sectoral reform; and even less so, one that involved multisectoral engagement of public and private actors. "If the state is going to expand the role of the market in the health sector, then it must paradoxically also expand the role of the state in regulating the market. Otherwise, marketisation is likely to produce unintended and undesired consequences" (Reich 2002b). "The State needs to maintain a central role in managing market-based health systems and the interesting issue is the practical manner in which it carries out this task" (Saltman 2002).

16. PARTICIPATION AND POLITICS

Libertarians and subjective utilitarians, on the one hand, will argue that the individual's freedom to choose which health services to use and when is the ideal form of participation. The market therefore is an ideal form for participation. Frank called this argument for 'market populism' and stated the general premise as "From Deadheads to Nobel-laureates economists, from paleoconservatives to New Democrats, American leaders in the nineties came to believe that markets were a popular system, a far more democratic form of organization that (democratically elected) governments" (Frank 2000). Egalitarians, on the other hand, argue that freedom of choice is not meaningful if one does not have the means to choose, whether these means are economical, social or knowledge. The studies in Colombia, China and Laos (Articles # 2, 3, 11, 6 & 5) clearly showed that the poor did not possess the required means to exercise freedom of choice. In the case of TB control in Colombia (Article #2), Antenatal Care in China (Article #6) and general use of health services in Laos (Article #5), it was demonstrated to have a direct bearing on the health, life, and death of the individual 'participant'.

In Tanzania (Article #8) some limited participation of the communities in the priority-setting and change processes through already existing committees was found. However, the political channels appeared blocked, i.e., in taking matters forward to address the needs of the concerned populations. There could be a number of possible explanations for the situation, including:

- Poor education, making the representatives focus on immediate problems and needs, e.g., epidemics, overcrowding or absence of health facilities, and the lack of drugs and staff, rather than on the longer term issues, such as, disease prevention, the environment, individual and collective behaviours and practices, etc.
- Poor communication and frequent mistrust between health professionals and elected community leaders.

- It was questionable if the leaders represented the views and interests of the community or their own and their peers' interests.
- When, occasionally, requests were passed up, there was either no response or the response was that there were no resources.
- The hierarchy of committees was mostly used to pass decisions from the district level downwards for implementation.
- The lower levels of community organization, e.g., village committees and village government, had no authority over resources, no formal role in overseeing service provision, or taking decisions - they were mainly responsible for implementing what others had decided.

As a result, the districts plans reflected the national priorities and those of the district management rather than the needs of the community. A considerable level of frustration was recorded among the community members interviewed with respect to 'participation'. Similar observations were made in the Philippines (Espino, Beltran, & Carisma 2004), where the reform process had started earlier. Despite the idea of involving the political sector, i.e., the *Barangay* Captains, local health boards and local government, guidelines for how to involve them had never been provided and they were only minimally involved in malaria control. Similar to Tanzania, these bodies were primarily concerned with acute emergencies and money problems, and did not show much interest in health, including malaria control, which they believed was still the responsibility of a disestablished central control programme.

Common to both Tanzania and the Philippines was that the community committees or boards had limited, if any, control over resources, be it financial or human. This is in contrast to the case of Zambia (Article #9). Here, reportedly the community based health centre committees felt empowered by the reform and this had a direct impact on service quality and utilization. The above findings are also confirmed in an article comparing decentralization in Ghana, Zambia, Uganda and the Philippines, suggesting that while formal structures for popular participation existed in the latter three, it was only Zambia that experienced a participation that led to some improvement in quality of services (Bossert & Beauvais 2002).

From its inception, the reforms in Zambia were acknowledged to embrace two major political elements, i.e., the redistribution of resources and the decentralisation of power. However, as implementation strategies, tools and decisions were to be made explicit, these elements were toned down and more or less ignored in the heat of the 'greater' politics (Article #10). The question of *how* to redistribute resources from the higher level hospitals to the lower level, more cost-effective facilities was never addressed, leaving it to some future political decision. There were no advocates for underserved populations and none were mobilised by the reformers. With respect to decentralization, through the establishment of health boards, the reforms triggered a political process that went out of control, as the reformers were neither prepared nor equipped to handle the interfaces with national and local politics. As a result of a weakened central government exercising a divide and rule strategy, including increasing the number of districts and thereby district health boards by 40% during the first years of the reform. This drained resources by increasing overhead costs and complicating access to health service as well as contracting. The boards became political actors of their own with respect to the health sector and provided opposition politicians with platforms to launch broader attacks on the central government

In Uganda, disjointed political processes were found concerning the introduction of user-fees (Kajula, Kintu, Barugahare, & Neema 2004) with the MOH unwilling to take on the political risks and leadership role in formulating and pursuing strategies to tackle the processes associated with implementing the policy. The MOH lacked autonomy from the nation's political leadership and had a high degree of donor dependency with some of the donors pushing the introduction of user-fees as a condition for their financial support without acknowledging the political difficulties this would cause. Combined with the civil society, including the media and the NGOs, taking a wait-and-see position, this made user-fees an easy sacrifice in the run up to the Presidential elections when a presidential contestant challenged them.

In none of the cases studied, with the possible exception of the health centre committees in Zambia had specific efforts been made to foresee and manage the implementation processes associated with popular participation, ownership, and politics. Whether the involvement and influence of individuals and groups to express their needs and to shape the services is intentional, i.e., part of the reform design, or occurs as an unforeseen addition, these processes are important as they can forward, delay or directly obstruct implementation. The resulting services and systems need to be compatible with the values, interests and philosophies of the powerful groups in the society in order to be sustainable. Therefore managing the politics of implementation becomes a key to any reform implementation. Reich provided in his 1995 article an account for how the pharmaceutical reforms were vulnerable to events of the political cycles in Sri Lanka, Bangladesh, and the Philippines, highlighting the importance of timing and taking into account regime stability when introducing policy reforms, which are controversial.

17. MICRO-LEVEL DISCUSSION AND CONCLUSION

A key question is whether the health sector reforms of the 1990s were successful in dealing with the problems as these had become apparent at the end of the preceding decade. The main short-comings were then identified as: *insufficient spending on cost-effective health activities*, from both government and non-governmental sources; *internal inefficiency of public programmes* with non-salary recurrent expenditures for drugs, fuel and maintenance chronically under-funded, often reducing dramatically the effectiveness of health staff and leading to under-utilization of lower-level and overcrowding of the higher-level facilities; *inequitable distribution of the benefits from health services* with the poor lacking access to basic quality health services while a disproportional share of government spending going to services for the affluent; and *rapidly escalating costs* linked to the number of physicians, changes in technology and payment modes generating a growing demand for services (see section 8.3).

If one accepts the policy analysis framework proposed by Frenk (Table 2.1), one could approach an answer to the above key question by assessing the attainment of the four main objectives: *equity*, *allocative efficiency*, *technical efficiency*, and *institutional intelligence for performance enhancement*.

Equity. The study results univocally suggest that this objective has not been achieved. On the contrary, most of the cases presented in this work indicate that inequities have

grown as resources and health system attention has become directed towards those who can pay for the service. There are also strong indications that the interests of marginalised groups, whether these are geographical as in the cases of Tanzania and Zambia or migrant workers in China, are not looked after.

Allocative efficiency. There are no indications that the allocative efficiency was improved, regardless of whether one limits the view to the public sector spending alone or whether one looks at the society spending as a whole. While the public, in theory can decide to prioritise and reallocate resources towards more cost-effective interventions, the case studies suggest that this did not happen. In Zambia the downsizing of the hospital sector could not take place due to political reasons, including bad timing. In all countries, primary and secondary prevention received less emphasis, and there were strong indications suggesting that public resources in China as well as in Indonesia drifted into subsidising non cost-effective services in order to generate income for the employees of the institutions. Further, in particular in China and Colombia it was clear that what drove the choice of interventions provided to the individual patient was how much revenue they would generate, rather than a concern about cost-effectiveness. There may, however, be a glimpse of hope in the experience from Zambia, where a combination of the right circumstances, improved management and public participation reportedly led to a utilisation move from hospitals to lower level facilities and an increase in use of cost-effective interventions

Technical efficiency. It is very likely that the reforms meant an increase in productivity, i.e., increase in the units of certain outputs, namely those that were rewarded either through direct generation of revenue or through other performance related mechanisms. It is much more questionable if production of the right outputs increased. With regards to quality of care, the picture was less clear. When the client can vote with his or her purse, it is clear that the quality of the individual procedure will adjust so what the client feel, within his or hers economic means and understanding, is worthwhile. However, availability of drugs in small enough packs as the case of Laos, or many tests and long admissions as in the case of China cannot by any means be judged to constitute quality from a public health perspective, nor can the absence or deemphasising of preventive interventions as was the case in several of the countries studied.

Institutional intelligence for performance enhancement. In all studies absence of even basic information about the sector performance was found. In order to conduct the studies, the research had to go to the source documents at the health facility level. In none of the countries were adequate aggregate facility nor population based data and information available allowing policy makers and reformers to monitor achievement of the objectives of the reforms in order to timely adjust the implementation strategies and tactics. The reforms themselves had in several of the cases meant fragmentation and disruption of the information systems. The analysis of the scientific publications also showed, that if scientific research indeed took place with respect to health sector reform in developing countries, this was not published, retrievable or accessible to a wider audience.

It is noticeable from the above that the successes of the reforms were most clear with respect to achievement of the technical efficiency objective. This might be because

productivity or units produced is also what best lends itself a market or business approach. Quantifiable *outputs* can quite easily be translated to 'bottom-line' measures and we know from industry and commerce how to manage these production processes. It is much more difficult when it comes to *outcomes* and *impacts* with respect to health gains and access. Here, the very measure of achievement might be controversial as was the cases, e.g., with DALYs and equity. Further, and in particular with regards to public health outcomes and impacts it is much more difficult to attribute these to specific interventions and actions of, e.g., the individual provider and even to health sector policies. Both the feasibility and the results of such actions are influenced by several other factors, such as the political and economic situation, which, most often are beyond the control of the health sector reformers.

The reforms were not complete and had in all the countries found some sort of least-energy equilibrium, where implementation appeared to have stopped at a sub-optimal stage unable to move forward unless further 'change-energy' and know-how were added. The providers and users appeared to have adjusted to the policy changes in order to get the best out of it. However, as seen above, the objectives of the reforms had not been achieved and considerable renewed efforts and innovative thinking would have to be provided to take the reforms out of the deadlock. It was if the policy-makers and reformers had thought that once the 'right' policies and goals were set, then the implementation would happen by itself. A large number of the processes involved in reforming a sector require foresight, careful monitoring and evaluation, and continuous adjustment of the implementation strategies.

The role of the state had, in several of the cases, been reduced beyond what was desirable to a point where the term 'abdication' might be the best descriptor of the situation. The reduction of the role of the state had in most cases gone beyond what was intended in the design of the reform. Factors contributing to this 'additional' factual reduction in the role of the state were lack of ability or willingness to provide sufficient funding, lack skills and capacity of regulators and central level public health staff to manage implementation of the complex reforms, and inadequate information systems. Communicable diseases are a threat to the health of the whole or significant parts of the population and taking measures to protect the public against disease and exploitation by providers, etc. can only be done by the state. With the demographic and epidemiological transition in most countries of the world, non-communicable diseases are on the rise everywhere, calling for stronger preventive action and putting more pressure on the already burdened health systems, thus calling for stronger involvement of the state in both preventive action and in devising responses to the increased burden of disease caused by it. Rather than redefining its role, the state appeared in several of the countries to have withdrawn. Implementing a new role for the state, if it is no longer to be a direct provider of health care services needs careful planning and management. New competencies must be defined and implementation involving transitioning and up-scaling of certain competencies and capacities while down-scaling others, is not a simple or quick process.

Whether to take a dedicated disease control programme or a systems approach is a non-question. It is not a question of one or the other. The broad history of selective primary health care, as well as the case study findings on the dedicated or vertical health care programmes, has shown that there are no quick fixes and it is highly questionable whether the renewed attention to scaling up of dedicated control efforts

will fare much better. Effective and sustainable disease control cannot be done without effective health systems. Health systems cannot be developed without considering their purpose, including disease control and without grounding them in and challenging the values of the wider society. However, when changing from one to another way of operating, it is important to carefully plan, manage, and monitor the implementation process. Otherwise, one could end up with the worst from both lines of thinking.

Successful implementation of reforms in the health sector, not only requires that the new systems are appropriate for the situation and the objectives to be achieved, it also requires application of considerable dedicated managerial and leadership capacity and talent over a long period of time. Otherwise, undesirable effects might occur or the reforms might take wrong directions or stop before having achieved their objectives. While it possibly does not take a long time for things to get off track, it, as shown in the case of Zambia, it likely takes five to ten years or more to achieve measurable sustainable improvements in health sector performance. Such timeframes are longer than the periods that most developing country politicians are in power and senior officials in post. Further and unfortunately, it also seems that the world health development community operates in cycles of less than that, shifting to new approaches before the benefits of those initiated have materialised.

If it is questionable whether public health is amenable to the market even in managed or quasi-market forms - linking staff incentives to the generation of revenue clearly have detrimental effects on service provision and the public health outcomes. To improve health sector performance in public health, it will be necessary to think systems and shield off the parts that provides public goods and services with large externalities and link incentives to achievement of the desired outcomes rather than income. To do so, providing reasonable working and living conditions for health workers is a must. If health workers are frustrated, hungry and cannot feed, educate and clothe their children there is no hope of improving health sector performance.

PART FOUR

Part Four provides the overall conclusion to the work attempting to address the original broad questions as raised in the introductory section

18. OVERALL CONCLUSION

Having completed and documented in the preceding 17 sections a journey, which has taken me far and wide to distant corners of many disciplines and fields of inquiry; it is now time to get back home to see if I accomplished the objectives that I set for myself and to see if I brought back enough 'ethnographica' to address the questions that I asked myself at the onset of the journey.

I certainly feel that I have gained new insight and understanding of the dynamics between health sector reform policies and practices as well as of the factors that determines and shape the thinking with regards to global public health, and I do hope that the reader will feel the same way. Some of what I found, I knew already and I got confirmed. However, a lot was new and in particular the clear traces of big-picture linkages between and evolution of different phenomenon over time and space made it clear to me that as a public health policy worker, one cannot just operate at service or even sectoral level. One has also to work at the societal, i.e. macro level addressing both value issues, economic policy, and to lay arms with the political processes.

At the end of my journey, I realise, more clearly than ever, there is no one-to-one relationship between the questions and the answers. What appeared at the onset of the journey to be different questions turned out to be different aspects of the same question.

What is public health?

I fully subscribe to Julio Frenk's definition of public health, i.e., that its level of analysis is populations and that it has two objects of analysis, i.e., epidemiology of health conditions of populations and the organised social response to those conditions.

In addressing the latter, which is my particular object of interest, it is clear from the macro- and micro-level sub-unit analyses, presented in Part Two and Part Three, that one has to go far beyond the individual service, whether this being a hospital or a health programme. Public health researchers, policy-makers and practitioners have to engage even beyond the health sector in order to deal with the overall social and economic policies in the society while being wary of the values and politics ruling or battling with each other.

Public health is almost by definition political dynamite as it is hard to image any public health response that does not question how resources, power and control are distributed, utilised, or exercised in the society. The focus at the population level implies collectivism rather than individualism. Public health concepts and approaches, therefore, go well with values and viewpoints of objective utilitarians, egalitarians, and communitarians. However, they would go less well with the views of libertarians

and subjective utilitarians, as public health tends to be about influencing and regulating the market and limiting the individual's freedom of choice.

If we know the right things to do, be it disease prevention or systems improvement - why is it that we do not or cannot implement them?

I have not been convinced that we know the right things to do. We might know if a certain single intervention is efficacious, i.e., that it works, e.g., cures the patient or leads to a specific behaviour or systems response under particular conditions and assumptions. What we do not know is if it is effective, i.e., that it works in the real life settings and scales in which it eventually has to operate. The micro-level analysis in Part Three provides an almost limitless series of examples of how interventions and actions, which looked promising at the drawing board, in the real life situation turned out not to deliver the expected results or even to have direct adverse effects on public health.

One reason, why we might think that we know, could be that we think within clinical medicine or biomedical frameworks when we approach public health, not realising that when we address populations, we are dealing with social and group issues and not individual or sub-individual issues. Dealing with the latter requires a different mindset and tool box for analysis and action.

Why is it that in an ever richer society, we say that we can no longer afford to provide health care to the people?

The escalation of costs experienced during the 1960s and 1970s that triggered the wave of reform first in the developed countries and later in the developing ones, was driven by development in individual health care technology combined with an ideologically based large-scale shift of resources from the public to the private sector in most countries. Public health technology has not changed much in the past several decades and has for most part remained relatively cheap. Providing free access to the newest and best clinical care technologies would be very expensive and would require either, a significant increase in tax collection - something that would go directly counter to the overall trend, or a radical reallocation of public resources. With a shrinking share of the society's resources being in the public sector, competition has become fiercer and the health sector has not been strong enough to increase its share.

The macro-level analysis showed that the society might have become richer overall, but that the economic inequalities within the society have grown to unprecedented levels. According to utilitarian and libertarian view points, it makes perfect sense to say that above a certain threshold, however that is determined, health care is an individual responsibility. This would serve three purposes. First, it would let those who can afford and who decide to do so access to the best possible care. Second, health technologies would be allowed to develop as far as there was someone willing to pay. Utilitarians could argue that eventually these technologies would become cheaper and thus possibly affordable also to ordinary people. Third, it would permit health care to develop from a public service into a business, something which appeals to libertarians. However, to egalitarians and many communitarians these purposes might not be justified. As we saw, equity to them is not a matter of preference or relative to the wealth of a society but a matter of social justice and right.

But why is it that millions, if not hundreds of millions people around the world are asked to pay for public health services which it would be cost-effective to provide for free because of the externalities they provide. There could be several explanations for this. The mixed signals sent by the World Bank and several key donors, which, driven by ideology at some stage demanded cost-sharing and user-fees in various shapes and forms left ambiguities for policy-makers. Other explanations should be sought at the micro-level, e.g., the working and living conditions of health care workers make them exploit these ambiguities to interpret and apply policies in ways that meet their own needs; the political circumstances and power structures in a country makes it impossible to shift resources from less to more cost-effective services, notably from hospitals to primary care, including preventive and other populations based interventions; etc.

Do we lack the skills or is the issue rather of another nature, e.g., ideological?

While there clearly are ideological elements, as described above, it is also clear that we do not have the skills and tools to do the analyses required to develop and implement effective public health systems. This may partly be explained by our tendency to be myopic and self-sufficient both as individuals and as a profession. In the schools of public health most courses are organized around single disciplines - or even worse - around single analytical tools and approaches that are most suited for addressing individual level issues, rather than tools and approaches suitable for studying phenomenon at the population level.

We do have relatively unquestioned tools for simple epidemiological analysis of populations' health conditions. However, when moving beyond single conditions or taking more comprehensively determinants of health into account, these methods need to use composite, surrogate, or aggregate measures and soon find themselves in situations with more variables of interest than data points and severe difficulties in defining the boundaries between the phenomenon and the context. This is even more so if one wants to study the social response part of public health. While, health conditions might scratch the surface of values and views; addressing the social response to health conditions is, as we have seen, squarely in the court of values, perceptions, and politics. The controversy surrounding the World Health Report 2000 measurement of health systems performance is a good illustration of this.

The case study has a potential to become an important strategy in public health research, in particular due to its ability to embed sub-units of analysis and other research strategies. Further, case study research had the advantage of being able to draw on and incorporate into the analysis an unlimited range of sources of evidence, something which distinguishes it from most other research strategies. However, it needs to be further developed for application in public health and taught to students together with other approaches to multi-disciplinary research. Students need to know the language and methods of and acquire ability to work with other disciplines important to public health, such as, e.g., economists, political scientists, anthropologists, engineers, etc...

Public health practitioners also need to learn how to work the politics, either by becoming politicians with a public health platform; becoming public health activists;

or, learn, as employees how to work effectively with the politicians and the political processes.

Do we move on to new approaches and initiatives because we are becoming more clever - or what?

Selective primary health care in form of dedicated programmes is the only approach which has been given enough time to prove that it does not work - yet it is the one that we continue to return to. Comprehensive primary health care, as conceived in the Alma Ata Declaration was never given a chance to demonstrate if it would work outside of a very limited number of countries in very particular political circumstances. PHC was discarded almost before it was started because its values and political underpinning did no longer resonance with the prevailing views. Health sector reforms, according to the original blue print and including SWAps may still be supported by a few devotees, but the world has moved on to scaling-up of dedicated programmes, not so different from the old thinking behind selective primary health care. What remains of the health sector reforms in most places, as we saw in the micro-level analysis, are perverted health systems serving not the needs of the populations, but the needs of those operating the systems and the powerful groups in the society who benefit from the rolling back of the state. The micro-level analysis left behind an impression of a process which had not been completed, needing an injection of energy to move on to achieve its objectives.

Judging whether the health sector reforms of the 1990s were successful or not depends on what one's agenda was. If it was to commoditise health then the health sector reform move was a success, however, if it was to strengthen the health systems to provide cost-effective and equitable responses to the population's health conditions, then it is likely to be a no. The conceptual framework as well as the macro- and micro-level analyses presented in this dissertation depicts the health sector reform as an extremely complex undertaking which is dependent on broader issues of governance, including addressing small and large-scale corruption, etc. This means that health sector reforms would have to address 'dirty' or highly controversial issues with low likelihood of immediate success, i.e., there is no quick fix and the timeframe for sustained real change is at least five to ten years, or more. To run the proposed new health systems with contracting and marketisation of health services requires, as we have seen, development of sophisticated managerial tools, including breeding of a new cadre of managers, as well as new oversight and regulatory mechanisms.

In the populist environment, which emerged during the 1990s, it was easier and safer - in the short run - to go back to dedicated health programmes, even if knowing that they cannot be sustained and therefore probably will not deliver in the long run. The politicians can be seen as doing something that can relatively easily be defined and made visible to their voters, thus help keeping-up the opinion poll ratings and secure the next elections. In order to avoid criticism of being vertical, as often raised in connection to the dedicated programmes, most of the new initiatives, including those of scaling up do state that they will work within and strengthen the health systems. However, as they are meant to push through certain agendas and actions, this is almost an outright contradiction.

A decade of health sector reforms in developing countries - why and what did we learn?

There is no doubt that health systems around the world have significant room for and need of improvement. However, it is also quite clear that what happens is not driven and shaped by analysis and evidence only. Despite the rhetoric of evidence-based policy formulation, the rise and fall of new paradigms and approaches to health care delivery in countries are more often than not grounded in political and ideological views rather than on the experience that it can work. A possible exception was the primary health care movement, which was based on the experience that it worked at least in some countries. However, where it demonstrably worked was in socialist oriented countries, based on communitarian or egalitarian values and allowing considerable room for manoeuvring to community organization of health. Once the hegemony moved to the donor agencies or a central government or the dominant philosophical viewpoints shifted to libertarian and utilitarian, the primary health care concept was no longer viable.

This was precisely what happened during the late 1970s triggered by a world economic crisis and continuing up during 1980s and 1990s. In the health sector, the manifestation was first in the selective primary health care move, the Bamako Initiative, later in the Health Sector Reform concept of 1993, and finally in the scale-up movement of the new millennium. There are two main characteristics of the initiatives that followed primary health care. First, contrary to primary health care, these initiatives were not established through experience or a global debate and consensus - they were driven by individual organisations and interests. Second, they all have strong elements of the market, either to regulate demand and utilization or to generate resources for health either directly through payment for service or more indirectly through donations or public private partnerships.

When it comes to objectives such as equity and allocative efficiency, we appear still not to know how to manage, despite attempts by health economists and reformers to devise measures that would allow us to measure inputs, outputs, outcomes, and impacts. The proposed measures, e.g., DALYs proved to be controversial at both a practical and a philosophical level.

But, it is not just about being poor at implementing, it is also about what we want to achieve, what we are prepared to accept and what not. If, on the other hand, we want pursue a teleological route to reform the health sector as suggested by many health economists and public health theorists, we need to define and 'manage' our deontological blocks. If, on the other hand we want to pursue a deontological route, we need collectively to define the 'rule-book'. This brings us squarely into the interface between provider systems and behaviours and the political processes of the society.

In summary, the lessons that can be drawn for the research presented in this dissertation are that we were dealing with a divide between libertarian and utilitarian values on the one side and communitarian and egalitarian values on the other. Thus it is not just about us not being good enough to implement, it is more so about what we want to achieve and what is acceptable respectively not acceptable. This takes us into the societal processes as centre-stage for public health. However, it is also about

implementation, it is about how public health policy-makers and reformers can effectively dialogue and facilitate achieving consensus and translate the societal 'wants' and 'want nots' into managerial bites that can be handled by a health system.

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APPENDED ARTICLES AND REFERENCES

The below 11 articles are appended to the dissertation. The articles from the International Journal of Health Planning and Management are reprinted with the permission of John Wiley and Sons Ltd, UK and the articles from Health Policy and Planning with the permission of Oxford University Press, UK.

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