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ODA/DFID SUPPORT TO HEALTH SECTOR REFORM AND HEALTH MANAGEMENT: SYNTHESIS STUDY

The contribution of DFID to promoting health sector reform can be effective, although the greatest success occurs when DFID support ties into a national strategy for reform which is supported by both the government and donors.

MAIN FINDINGS

- DFID¹ has responded to changes in the Health Policy agenda and in particular the shift to support for policy and institutional reforms. This was clearly reflected in the developing bilateral programme in the 1990s but less so in DFID's support to multilaterals.
- Until recently, DFID's overall portfolio has focused almost exclusively on promoting greater technical efficiency of service provision. Equity was an explicit objective in few projects. Little justification was given for the relative neglect of significant areas, including the demand for health services and regulation of the private health care providers.
- In countries where Governments were already committed to reform, the success and impact of DFID health policy reform and management projects have been greatest.
- DFID programmes, if willing to commit long-term, have shown that they can help create a national constituency for reform. Entry points need to be carefully selected and interventions designed to take into account local circumstances and political and institutional constraints. Application of standard technocratic models has in some instances created problems. This requires DFID country teams to take a more sophisticated approach to political and institutional analysis when assessing the prospects for reform than was apparent in many countries during the study period.
- With two exceptions, health outcomes have improved consistently in DFID priority countries during the 1990s². Few DFID projects can demonstrate a contribution to this improvement. DFID and project staff focused excessively on contractors' performance and not enough on ensuring that outputs remained relevant to achieving project purposes.

¹ Until 1997, DFID was known as the Overseas Development Administration (ODA). DFID is used as a synonym for ODA in this report.

² Applies to countries where data are available.

BACKGROUND

1. A key aim of this synthesis study is to provide guidance to those currently designing and implementing new projects and other forms of health sector support in partner countries. The analysis, and guidance, is based on a set of propositions which the evaluators have tested against documentary and other evidence, drawing on a programme of evaluations of the effectiveness of DFID support for health policy and systems guidance development from 1988 to 1998³.

Evolution of DFID Policy: A Brief Synopsis

2. The 1978 Alma Ata commitment to Health for All by 2000, with its global strategy for Primary Health Care, underpinned most national health policies in developing countries and most donors' aid strategies in the 1980s. By 1992, there were signs of growing disillusionment with the simple prescriptions of Primary Health Care, as many projects aiming to improve service delivery foundered due to poor policy and institutional environments.
3. In 1993, health sector reform became one of four priority themes for DFID's health and population support. The objective was to improve the effectiveness and efficiency of the use of resources by supporting policy and institutional reforms. This has led donors to question how assistance to the health and other sectors could best be managed to support the reform process. In particular, it has driven developing thinking on sector-wide approaches (SWAPs).

³ Principally the Health Planning Project in Pakistan, the Health Sector Adjustment Project in the Caribbean British Dependent Territories, and two research work programmes at the London School of Hygiene and Tropical Medicine, and the Liverpool School of Tropical Medicine

4. Bilateral spending has reflected these general trends in DFID health policy. Over time spending on health policy and systems development has increased. This trend is less clear cut for funding through multilateral agencies, reflecting the lack of a coherent DFID policy on multilateral funding and little agreement with multilaterals on how to approach health policy and systems development. The new consensus around sectorwide approaches creates an opportunity for DFID to take a more coherent approach to its funding through multilaterals.

FINDINGS

Policy Environment

5. Where governments have had a clear policy and commitment to policy reform, impacts of DFID support have been greatest. In countries with an acknowledged commitment to reform, the conducive policy environment is sometimes taken for granted. Assessments of individual projects' success have, on occasion, failed to pick up significant impacts, in particular their contributions to creating a conducive environment and to the process of health policy and systems development in general.
6. Where the policy environment does not appear to be encouraging, there is evidence that continuing engagement by donors can help promote the reform agenda over time⁴.

Reform processes just starting in Bangladesh and Orissa State, India would have been delayed if donors had withdrawn support and awaited governments' changes of heart.

7. Such approaches have had most success where project staff and advisers have a firm grasp of political

⁴ Reform processes just starting in Bangladesh and Orissa State, India would have been delayed if donors had withdrawn support and awaited governments' changes of heart.

and institutional realities and have selected, and managed, interventions to match these. In both the Pakistan and Caribbean projects reviewed, design appears to have been based on set ideas of "what works". In both cases, the entry points chosen proved to be inappropriate.

8. Evidence emerging from DFID's current portfolio seems to indicate that, in some cases, work on specific health problems may provide an appropriate entry point (Russia); in other cases, where support for fullscale radical reform is lukewarm, or not fully developed, DFID by remaining engaged, has helped to promote change through demonstration effects e.g. by supporting functional departments within Ministries of Health. The appropriate entry point will therefore vary according to local conditions and the stage of reform.
9. The outcomes of projects focusing on advice and the dissemination of ideas is determined as much by contextual factors that limit or favour change as by the quality of advice provided and the approach advisers adopt. There are many examples of knowhow projects which delivered a quality product but external circumstances prevented clients from acting on the advice.

Consultants successfully gained local commitment to rationalising health care in Bishkek, Kyrgyzstan, despite the difficult political and institutional environment by involving as many stakeholders as possible and tailoring technical advice to local political realities.

10. By contrast, some others were judged to have worked, despite a difficult political and institutional context, because of the inclusive and politically sensitive approach the consultants followed. Failure to recognise that approaches which work in the UK may

be inappropriate elsewhere, was also found to have caused problems.

11. Inclusion of participation and gender equity in project design has had little impact on their successful adoption in public sector health systems, except where the prevailing policies and practices of partner governments have been favourable, for example in South Africa. Evidence from multidonor programmes, for example, SAPP1 in Pakistan, suggests that such issues can be addressed at the strategic level more successfully.

Outcomes and Impact

12. With only two exceptions, health outcomes have improved consistently in DFID priority countries during the 1990s. Few of the individual projects reviewed have been able to demonstrate a contribution to this improvement.
13. Projects supporting improvements in Human Resource Development (HRD) policy and management have had a notable lack of success. Evidence suggests that to be successful, such projects need to operate in a context where health service reform is embedded within a comprehensive public sector service reform programme.
14. For many projects examined, the objectives appear to have been set according to a required formula, with no real prospect of demonstrating the intended outcomes. While many projects identified improved health status at the goal level, most did not identify how these impacts would be measured. Few projects identified equity of service provision as an objective. Either no systems were in place to facilitate the setting of appropriate objectives and outcomes or logframes did not adequately accommodate the full hierarchy of causal links between inputs and

outcomes. There are indications that the shift towards sectorwide approaches provides a framework for tackling the evaluation shortcomings identified and addressing the perennial problem of attribution.

In future, developing national capacity to assess sector level impacts should be the aim of both governments and external agencies. Project evaluation should focus on verifying causal linkages between project success and sector level impacts.

Portfolio Balance

15. Until recently, projects have focused on improving the technical efficiency of health provision. Where equity has been a project objective, it has mainly been interpreted in narrow ways – for example, shifting resources from tertiary to primary care. The evaluators contend that in many countries lasting improvements in peoples’ health requires work on several fronts: direct investment in health outcomes; work on policies and systems; and strengthening demand. They conclude that DFID may not have always got the balance right. DFID’s health portfolio has largely focused on the supply side, and, barring some exceptions, little attention has been paid to the demand for health services. Justification of such great focus on the supply side by DFID depends on evidence that other partners or donor agencies were addressing the demand side, and this was not apparent in the evidence presented.
16. DFID is missing opportunities to support health policy and systems development in some important technical areas. Given evidence from many countries about the poor quality of much private care, more might be done to assist governments to provide appropriate, effective regulation and monitoring of the private sector. DFID

is involved in a relatively limited way in hospital management, despite the high proportion of available resources hospitals consume.

Health Systems Research

17. Most DFID-supported research by UK academic institutions in this area confirmed what was already known and had limited impact on national policies. It is unrealistic, however, to think in terms of a simple linear relationship between a

specific research programme and policy change. The evaluation of the two research programmes suggests that there are notable exceptions to the conclusion of a general lack of impact. Both research programmes evaluated were judged to have been influential in different ways and at different levels.

For research to have influence, not only do the correct topics need to be selected but a wider range of methods and approaches are required.

Project Management

18. The way contractors have been managed has contributed to the poor performance of some projects. In the Pakistan and Caribbean projects, too much responsibility for defining and implementing the interventions was devolved to the contractor. DFID’s monitoring of these projects focused excessively on the contractor’s performance against agreed outputs, not enough on whether the outputs remained appropriate.

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KEY LESSONS

- DFID support to health sector reform and management has been most successful when supporting government policy.
- In the absence of a national reform agenda, developing support for fundamental reform takes time. Judging whether it is worthwhile for DFID to support a process for creating support for reform is difficult and requires that the country team has a capacity for insightful institutional and political analysis.
- Projects can be useful in demonstrating the potential benefits of reform and creating support. The use of technical assistance to policy development and dissemination, where the consultants adopt an inclusive and politically sensitive approach and blueprint and technocratic fixes are avoided, can prove effective. The same can be said of projects that enhance performance in an area where positive outcomes are not overly reliant on reform in other parts of the system. Examples include strengthening transport systems, equipment management and drugs and supplies.
- Projects that require fundamental change to be effective, such as in human resource development, should be avoided if demonstrating benefits of change is the objective. Evidence is that they usually fail unless embedded in a comprehensive public sector reform process.
- Projects are the wrong entry point for addressing gender inequalities. Indications are that gender is more effectively addressed within multi-donor sector level strategic initiatives.
- Further work focused on increasing understanding of how to manage the process of creating relatively successful partnerships would contribute to country teams' abilities to assess the possibilities for reform where reform is not high on national agenda.
- Attempts to trace direct causal links between changes in health outcomes (particularly at a national rather than a local level) and an individual donor's interventions are usually misguided. Where a donor's projects and programmes are clearly set within an appropriate national sector strategy, to which the partner government and other donors are committed, it is feasible to demonstrate convincing logical links between good performance at the project level and national health outcomes. To accomplish this would require evolution in the way DFID programme staff use logframes. It also requires increased support by donors to many partner countries, to increase their capacity to collect and analyse the data required to measure and manage the health care system's performance.

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This evaluation study was undertaken by an independent team (Dr Andrew Cassels and Dr Julia Watson). The views expressed in the study are those of the evaluation team and do not necessarily represent the views of HMG. For further information see "ODA/DFID Support to Health Sector Reform and Health Management: Synthesis Study" (Evaluation Report EV594) obtainable from DFID Publications, PO Box 190, Sevenoaks, Kent, TN14 5SP, telephone 01732 748661, Fax 01732 748620, email dfidpubs@eclogistics.co.uk. This report will also be accessible via the Internet in due course.

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The Department for International Development (DFID) is the UK government department responsible for promoting development and the reduction of poverty. The government first elected in 1997 has increased its commitment to development by strengthening the department and increasing its budget.

The central focus of the Government's policy, set out in the 1997 White Paper on International Development, is a commitment to the internationally agreed target to halve the proportion of people living in extreme poverty by 2015, together with the associated targets including basic health care provision and universal access to primary education by the same date. The second White Paper on International Development, published in December 2000, reaffirmed this commitment, while focusing specifically on how to manage the process of globalisation to benefit poor people.

DFID seeks to work in partnership with governments which are committed to the international targets, and seeks to work with business, civil society and the research community to this end. We also work with multilateral institutions including the World Bank, United Nations agencies and the European Community.

The bulk of our assistance is concentrated on the poorest countries in Asia and sub-Saharan Africa. We are also contributing to poverty elimination and sustainable development in middle income countries in Latin America, the Caribbean and elsewhere. DFID is also helping the transition countries in central and eastern Europe to try to ensure that the process of change brings benefits to all people and particularly to the poorest.

As well as its headquarters in London and East Kilbride, DFID has offices in many developing countries. In others, DFID works through staff based in British embassies and high commissions.

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ISBN: 1 86192 333 3