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health sector reform

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The views of staff on health system decentralisation

Tuberculosis kills two million people worldwide each year. The WHO recommended DOTS strategy for TB control is proving effective in many settings. But what is being done to avoid successful TB programmes being weakened by sector-wide health care reforms?

Health sector reforms typically include decentralisation. Unfortunately a recurring feature of these reforms has been a lack of consultation and dialogue between those responsible for health systems policy and those responsible for delivering specific programmes such as tuberculosis (TB) control.

In Nepal, reform of public services includes decentralisation that aims to bring more power to district level facilities. Although this devolution is not restricted to the health sector, there does not seem to be any dialogue between those responsible for cross-government decentralisation and those responsible for TB control activities.

Conscious of findings that indicate the importance of consultation to ensure ownership and informed decision-making, researchers at the UK's Nuffield Centre for International Health and Development conducted a study among TB control staff in Nepal. Group and one-to-one interviews were conducted at central government and district levels. Staff were asked for their views of the process of decentralisation, with the aim of uncovering those factors that influence: the extent to which decentralisation could be introduced; how decentralisation could be introduced; and how that decentralisation could be made effective.

Respondents adopted a balanced approach, with careful consideration of the 'pros' and 'cons' of decentralisation. Potential advantages raised include better:

- opportunities for social mobilisation
- management and problem solving
- resource mobilisation
- engagement with private and non-governmental organisation (NGO) providers.

Problems include:

- decentralised units would not recognise TB as a priority
- problems with drug supplies
- local political bias
- inadequate supervision of patients
- loss of technical and management effectiveness
- a fall in staff training provision.

National level respondents believed a restricted range of responsibilities would be devolved to the districts, whilst at district level respondents focused on the role of the regional level in quality control.

There was also concern that districts may choose not to follow national guidelines; that they may not be able to regulate the private sector; and that they may integrate TB with other programmes, therefore failing to recognise the high level of training needed for TB control staff. Implications for policy include:

- The implications of decentralisation for TB control have not been thought through. Policy dialogue and analysis are required to inform decision-making and develop a sense of ownership for staff.
- Respondents' awareness of the opportunities and threats posed by decentralisation suggests that consulting with health sector staff is crucial to effective policy-making.
- TB control managers should be proactive in seeking dialogue with those responsible for health systems policy, rather than passively waiting for policy to be declared and then dealing with its consequences.

A two-way process is needed to ensure both that decentralisation is adapted to the requirements of TB control, and that disease control specialists understand the broader picture of health and health systems.

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'Decentralisation and TB control in Nepal: understanding the views of TB control staff', Health Policy 73(2): 212-227, by J.N. Newell et al, 2005

Putting health policy into practice in South Africa

The successful implementation of health policy requires the backing of health care providers and patients. In South Africa, the introduction of free health care, although supported in principal by nurses and health facility managers, faced resistance as workloads increased and staff felt excluded from a centrally prescribed policy.

Frontline staff adopt day-to-day methods to cope with the pressures of high demand for their services. It is these mechanisms, that may effectively become public policy, rather than the decisions taken by central government. However, few studies have examined the influence of frontline staff on the implementation of changes in policy.

This study by University of Witwatersrand examines the influence of nurses and facility managers on the introduction of free health care in South Africa. The study gives particular attention to the personal and professional consequences of the policy for the nurses, the factors that influenced their responses to the policy, and what they see as the barriers to effective policy implementation.

Findings from the study include:

- Nurses believed the policy to be good for patients, but also reported that it had increased workloads.
- Nurses believed that patients abused the free health care system, and that many were 'not genuine patients'.
- Two issues were cited as central problems for delivery of free care: limited availability of drugs and other clinic supplies, and poor planning and communication.
- Nurses felt isolated, overlooked and excluded from the policy process.
- Staff and managers felt undervalued and disempowered by poor working conditions and low salaries.

The categorising and blaming of patients by nurses indicates how the latter's views and values influence their response to the policy itself. It represents a means of coping. For the least powerful patients, the benefits of removing financial barriers to treatment may have been counterbalanced by worsening provider attitudes. The researchers recommend that:

- communication, consultation and a shared understanding of policy goals between providers, patients and policymakers are crucial to prevent distortion of policies during implementation
- the role of facility managers should be strengthened and the important role of nurses and clinic teams during policy implementation must be recognised
- planning and management must be improved in ways that demonstrate respect and trust for nurses.

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'"We are bitter but we are satisfied": nurses as street-level bureaucrats in South Africa', Social Science and Medicine 59: 1251-1261, by L. Walker and L. Gilson, 2004

Health sector reforms and crisis in Argentina

During the 1990s, Argentina carried out wide-ranging health sector reforms. In 2001, the country plunged into economic and political turmoil. The capacity of the health sector to withstand this crisis is a useful test of the reforms, with lessons for countries undertaking similar changes.

Analysis by the University of East Anglia shows that Argentina applied many common elements of health sector reform (HSR), including:

- separation of provision and financing
- greater participation of non-state players
- more reliance on market forces
- decentralisation
- reform of social insurance funds.

Research globally has cast doubt on the effectiveness of some of these components. The paper looks at their impact in Argentina and concludes that HSR advocates could learn from this experience.

Argentina's health system consists of the public sector, social insurance funds and private health care. In the early 1990s, health indicators were poor despite relatively high spending levels. There was a breakdown in the functioning of the health system and its institutions, weak or non-existent regulation and a structure strongly biased towards curative care.

The HSR was applied at the same time as wider neo-liberal economic and social reforms. Strategies included:

- Introducing competition into the health insurance sector, whilst cutting employer contributions to social insurance and insisting on a minimum package of services.
- Promoting the self-management of public hospitals, whilst trying to improve management capacity and culture, increase local participation and recover costs.
- Cutting staff, reducing services, restructuring contracts and improving internal controls and regulation at PAMI, the health insurance fund for pensioners.

The impact of the reforms was fairly superficial, increasing the overall fragmentation and complexity of the health sector while failing to improve regulation or accountability.

The research suggests that the Ministry of Finance and World Bank made assumptions about market mechanisms, which did not consider problems like regulation and corruption. Reforms that did not contribute to the wider neo-liberal project were not implemented as rigorously as those which did. The HSR viewed the health sector in terms of separate components, overlooking cross-cutting problems.

By early 2002, following economic and political crisis, the health system faced virtual collapse, and effects on public health are predicted to be severe. Many aspects of the HSR in the 1990s conformed closely to reforms being implemented in other countries. But since 2001 the country has provided a less orthodox example. Positive lessons for other countries include efforts to rectify aspects of previous policy, by:

- restoring insurance contribution rates to levels reflecting resource needs
- restricting insurers attempts to select the most favourable individuals with expected losses below the premium charged in order to increase profits
- trying to control and monitor drug use and reduce the curative bias in services.

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'Health sector reform in Argentina: a cautionary tale', Social Science & Medicine 60: 1893-1903, by P. Lloyd-Sherlock, 2005

Health worker productivity in rural China

In China, sweeping economic reforms have taken place over the past two decades. Health facilities now rely less on government funding and more on user charges to cover costs. Health managers have gained greater control over human resources. Nevertheless, the question of improving staff productivity remains a major challenge.

Reducing costs and using resources efficiently have been central to health sector reform policies since the mid-1980s. In China, fewer people are using public health facilities, despite more staff having been recruited into the health sector. What impact has changes in staff levels had on staffing efficiency, health service costs and on the utilisation of services? Researchers from the Liverpool School of Tropical Medicine, UK and China's Fudan University studied changes in the productivity of China's rural health workers.

The researchers used data from the National Health Service Survey conducted in 1993 and 1998. Three indicators were used: the average number of outpatient visits per doctor per day; the average number of inpatient days per doctor per day; and the average number of equivalent outpatient visits per doctor per day, with one inpatient day being equivalent to 2.5 outpatient visits.

Research findings include:

- Average number of outpatient visits per doctor per day declined by 30 percent at county hospitals, and by over 35 percent at township health centres (THCs) between 1986 and 1994.
- The average number of inpatient days fell between 1986 and 1994. For county hospitals the highest drop (50 percent) was in the least developed rural areas, whereas for THCs the drop was more dramatic in the relatively wealthy areas.
- At county level the average number of equivalent outpatient visits per doctor per day declined from 12.2 in 1986 to 8.5 in 1994, after which the trend continued in the relatively wealthy areas only. At THCs the decline was continuous throughout the study period, with a slight reversal from 1994 in the relatively wealthy areas.
- The average number of health personnel per county hospital in 1997 was 167 percent greater than in 1992.
- Average expenditure per outpatient visit and per hospital admission rose dramatically. Use of outpatient and inpatient services at THCs reduced by 26 percent and 12 percent respectively between 1986 and 1997.

The declining productivity of doctors during the 1980s and 1990s is due to increased recruitment of staff, some of whom may be unsuitable or unqualified; the collapse of cooperative medical schemes during the 1980s; and increasing service costs which have resulted in declining use of public health facilities. Policy implications include:

- Managers need to control their facilities' resources effectively. This requires adequate incentives and legal rules to oblige managers to operate services sensibly and protect them from pressure to employ people unnecessarily.
- Managers need to reduce the number of unproductive staff on their payroll.
- Effective, affordable strategies are needed to retain good staff, particularly in rural areas. Managers need training in staff recruitment and selection skills.
- To increase service use, human resource management should increase productivity and improve the quality of services.
- Measures are needed to increase access to health services, including controlling drug prescriptions and the use of diagnostic tests, and increasing insurance coverage or finding an alternative.

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'Changing medical doctor productivity and its affecting factors in rural China', International Journal of Health Planning and Management 19: 101-111, by T. Martineau, Y. Gong and S. Tang, 2004

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