

Health sector reform

Research highlights

There is widespread evidence of significant gaps between health policies as laid down on paper by governments or ministries of health, and their implementation in practice. As a result, newly proposed and effective health interventions may fail to attain high coverage levels when implemented, and may not fulfil their potential to reduce mortality and morbidity.

Various factors enable or constrain the implementation of health policies. These include the content of the policy itself; the actors involved in implementation, and their interests and incentives; the context within which the policies are located; and, the process of policy implementation.

Introducing and sustaining equity-orientated health policies, such as increasing access to primary care services or targeting vulnerable groups, has been particularly difficult in many countries. This is because such policies often challenge the conventional ways of working within health systems, including the existing professional practices which influence both who can access health services, and the treatment and nature of care offered to different groups.

Despite the evidence of problems, there has been only limited international investigation of the factors which may explain the poor achievements of new policies intended to promote equity. The Consortium for Research on Equitable Health Systems has investigated these factors by examining the experiences of actors involved in implementing policy at different levels of the health system.



Research projects:

- **Kenya and Tanzania:** studies examining the implementation of the Integrated Management of Childhood Illness (IMCI) policy.
- **Thailand:** an assessment of the changes to budget allocation which accompanied the implementation of the Universal Health Care Coverage (UC) policy.
- **South Africa:** an investigation of the role of power and institutions in hospital level implementation of equity-oriented policies.
- **India:** a study examining the impact of Mobile Health Units (MHUs) on access to health care.
- **Nigeria:** an evaluation of a Community Based Health Insurance (CBHI) scheme in Anambra State; and, an analysis of the policy development and implementation of the District Health System (DHS) in Enugu State.

Implementation of Integrated Management of Childhood Illness (IMCI) strategy in Kenya and Tanzania

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Of every 1000 children born in Kenya and Tanzania, more than 115 will die before their fifth birthday. Whilst the five main causes of death - diarrhoea, pneumonia, malaria, measles and malnutrition - can all be managed in primary health care facilities, quality of care for these conditions is often inadequate.

In an attempt to reduce child mortality, the Integrated Management of Childhood Illness (IMCI) strategy was developed by WHO and UNICEF, and rolled out nationally in Tanzania in 1998 and Kenya in 2002. The strategy aims to improve the management of childhood illness by building case management skills through health worker training, strengthening healthcare delivery systems, and improving community practices related to child health.

The reports explore the IMCI implementation process and identify some of the challenges faced in Kenya and Tanzania.

Key findings

The research finds that Kenya and Tanzania have made some progress in rolling out the IMCI strategy; however, implementation remains highly inadequate. The three major challenges are: low training coverage; trained health workers' failure to follow IMCI protocols; and, barriers to access for community members.

Training coverage: IMCI was rolled out nationally in both countries and, although well over half of the districts had conducted training by 2007, there was significant variation in levels of IMCI training coverage. Districts were more likely to achieve high levels of IMCI training with strong district leadership and personal commitment to IMCI. These districts had greater access to external funds and encouraged policy adaptation to local circumstances. Sensitisation and training of district health managers in IMCI skills was found to increase commitment to IMCI.

Greater financial autonomy of districts in Tanzania also enabled higher levels of IMCI training in some districts; however, national training coverage remained low in both countries at less than 20 percent, far short of the World Health Organisation recommended 60 percent. The reasons for low coverage include:

- High training costs with the training of one health worker costing approximately \$1,000 due to the duration of training and a high facilitator-to-participant ratio.
- Poor implementation of lower cost options such as pre-service and on-the-job training, resulting in a reliance on short-course in-service training.
- Limited funding in Kenya due to ongoing reliance on donors whose focus and priorities are shifting.
- Limits set to the amount of the district health budgets which can be spent on training in Tanzania.

Failure to follow IMCI protocols: Evidence suggests that IMCI trained staff often fail to follow case management guidelines; for example, few children are checked for general danger signs of severe disease, less than half have their weights checked against the growth chart, and referral rates are low. Poor adherence to strategy guidelines stems from several factors, including: inadequate supervision, understaffing, a lack of job aids, frequent drug shortages, inappropriate facility lay out and negative staff attitudes.

Policy recommendations to improve IMCI implementation in Kenya and Tanzania include:

- Achieve rapid scale up of IMCI training by encouraging lower cost training options such as shorter and non-residential courses. Improve implementation of pre-service and on-the-job training.
- Radically improve IMCI supervision and conduct IMCI case management observations at least once a year for all trained staff.
- Address under-staffing, infrastructure constraints, and drug shortages at health facility level.
- Secure additional funds for IMCI by raising the profile of child health among doctors and local politicians, advocating the benefits of an integrated approach in Kenya, and encouraging greater district flexibility in financial management decisions in Tanzania.

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Policy-makers should assess the feasibility of new health policies and ensure they are designed to work in health systems which are less-than-perfect, as well as identifying any key aspects of the health system which will require strengthening to ensure successful implementation. (Kenya)

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Access to health services in under privileged areas: a case study of mobile health units in Tamil Nadu and Orissa, India

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Mobile Health Units (MHUs) are portable and self-contained vehicles that provide medical services to people who live in remote and inaccessible areas. In India, MHUs usually consist of a physician, a pharmacist, an auxiliary nurse midwife and a paramedic. The purpose of the research was to assess the role of MHUs in providing access to health services in Tamil Nadu and Orissa States, and to identify factors that affect the implementation of MHUs. The research was based on interviews with key stakeholders, primary survey data from communities using MHUs, direct observations and secondary data.

Findings from the community survey show that:

- 80% of the population had used MHUs during the past 3 months and, of this population, 90% travelled less than one kilometre to reach the services.
- Despite satisfaction with the location of MHUs, problems remained with the timing and regularity of visits. In several sites, MHUs reported only once a fortnight or once a month, and, as a result, there was often no effective follow up of patients.
- On average, MHUs covered 40-60 patients over 3 hours, and the amount of time spent with each patient was 3 minutes.
- Factors contributing to the poor performance of MHUs include: the slow process of recruiting health personnel, insufficient government commitment to funding MHUs, lack of NGOs' involvement in running MHUs, and a lack of clear planning and execution of field visits by MHUs.

The report concludes that MHUs do serve the health care needs of poor people and have reduced geographical barriers to access in under-served areas; however, the quality of services provided remains questionable.

Recommendations

- The state government should set aside a budget for MHUs and ensure expenditure for this amount.
- Governments should undertake some operational research with a view to improving the performance of MHUs. This can include studies on scheduling of vehicles and visits to various sites so as to maximise coverage.
- Sustained efforts should be made to improve the planning capacity of district level health officials.

Investigating the role of power and institutions in hospital-level implementation of equity-orientated policies

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This report tells the story of policy implementation in two South African district hospitals located in different provinces. It focuses on two equity-orientated policies: the Uniform Patient Fee Schedule (UPFS) which aims to ensure that patients treated in public hospitals in any area of the country are uniformly billed or, where allowed, exempted; and the Patients-Rights Charter (PRC) which provides patients and health workers with a description of the national expectations concerning standards of service to be provided in facilities (patient rights), and patient responsibilities in relation to those standards. The purpose of the research was to analyse how power exercised in decision-making influenced the implementation of these policies, and to determine the key institutional influences that drive decision-making around equity-oriented policies.

Key findings

- The exercise of discretionary power by implementers (hospital managers, nurses, clerks etc.) clearly influences implementation practices and policy outcomes.
- The practice of UPFS implementation is geared towards revenue generation. As a consequence, few exemptions were given to patients and those who could not pay became debtors.
- The hospitals' experiences of the implementation of the PRC differed: at one facility, the PRC was explicitly implemented and widely accepted by staff; at the other facility, there was less support for PRC implementation activities. Managerial trust and traditions of team work were key factors that affected the implementation of this policy.
- Policy implementation is more difficult when the values embedded in policies (such as challenging provider power over patients, or exempting those patients which clerks believe can or should pay for care) conflict with the interests or values of the implementers.
- Providers and patients always need to work together to ensure effective policy implementation.

Conclusion and recommendations

The report concludes that the framing of policies, or the meaning given to them, can affect implementation experiences. Policies which are focused on generating revenue, such as the UPFS, may take precedence over concerns about financial access. Management styles and workplace trust are also found to be important factors that influence the implementation of policies. For instance, they can help to foster a sense of buy-in and reduce resistance to policy implementation from health staff. These conclusions point to the necessity of:

- Deliberately engaging with the tacit elements of policy implementation, for example, by developing strategies to manage health workers' fears and anxieties.
- Recognising the potential influence of organisational culture, namely workplace traditions and history, over the practice of policy implementation.
- Developing co-operative relationships between providers and patients to support policy implementation.

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Co-production - the need for providers and patients to work together - is key to health care provision and policy implementation. Successful co-production can stimulate the morale and motivation of health workers, as well as positive attitudes and behaviours towards patients and, correspondingly, affirmation from patients for health workers. (South Africa)

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Local level responses to budget allocation under the Universal Health Care Coverage policy in Thailand

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The Universal Health Care Coverage (UC) policy was a major reform in Thailand. It established a national health insurance scheme which all Thai citizens were entitled to and reduced geographical and financial barriers to accessing health care. The major effect on state health providers was a change in budget allocation, with budgets being linked to the number of UC beneficiaries rather than to the costs of providing care.

This study explains how health care providers and managers at local level responded to national changes in the budget allocation of the UC scheme; identifies the main factors that shaped these actors' responses; and, explores the extent to which equity concerns were taken into account in decision making on the budget arrangement at local level.

Key findings

- The implementation of the UC resource allocation tended to involve a bottom-up approach. Decision-making powers were delegated to Provincial Health Boards and Boards of Contracting Units for Primary Care (CUP).
- The results of the decisions depended on how power was distributed among members of these Boards and their relationships with each other.
- The responses of the local actors depended on the pressures they faced, with levels of available health resources presenting the main cause of difficulty in implementing the UC policy.

Recommendations for successful implementation include:

- The provincial authority should promote consensus in decision-making and demonstrate progress in implementation.
- In resource reallocation, a budget increase should not exceed providers' capacity to absorb new funds. By contrast, a budget decrease should not result in too great a gap between current expenditure levels and the budget. Phasing of budget changes is recommended.
- CUP Boards require capacity strengthening to respond to the new budgetary system, especially in relation to the supervision of health centres in planning for disease prevention and health promotion services.
- Health centres require capacity strengthening to absorb increased budgets from the new system of budget allocation.

Community Based Health Insurance Scheme in Anambra State, Nigeria: an analysis of policy development, implementation and equity effects

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Community-based Health Insurance (CBHI) is a not-for-profit type of health insurance that has been used by poor people to protect themselves against the financial risk of illness. In CBHI schemes, members regularly pay small premiums into a collective fund which is then used to pay for health costs if they require services. This study explores the CBHI policy development and implementation process in two sites in Anambra state and identifies the factors which had an impact on its implementation.

Key Findings

The research shows that the CBHI scheme was conceived and promoted by one individual. It was implemented over 10 pilot sites but implementation stalled a year later when this person was removed from power. The report identifies some reasons why the policy was not successful:

- At the time that the policy was formed, few stakeholders were involved and, as a consequence, the implementation of the policy lacked support.

- There was no attempt to gain support from health workers, many of whom also sell drugs and might lose out from such a scheme, thereby presenting a likely source of conflict.
- In one site, local political leaders did not effectively address poor CBHI scheme management and this deterred community support for the scheme.

Recommendations for planning and implementing new policies:

- Efforts should be made to develop sufficiently widespread backing among groups (both within and outside the Ministry of Health) with the power to sustain implementation.
- Appropriate legislative backup must be developed in order to sustain implementation.
- It is important to manage the interests and values of those local actors who can either sustain or block implementation.
- In designing policies that will be implemented at the local level, the power dynamics between local community actors should be taken into consideration.
- Political engagement at a local level should be developed, for example, by assigning managerial roles to local actors.

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The District Health System in Enugu State, Nigeria: an analysis of policy development and implementation

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The District Health System (DHS) is a form of decentralization that was introduced in Enugu state as a policy to reform the health sector. Prior to this initiative, the health system was centralised with minimal community level input into decision making processes. The research investigates the policy development and implementation of the DHS in two district health authorities, and identifies factors that have impeded or facilitated implementation in these areas.

Key findings

- The implementation of the DHS has initiated radical managerial and structural changes within the health system, including physical infrastructure renovation and improved health worker motivation.
- Successful reform of the DHS was enabled by strong political and bureaucratic leadership, combined with considerable and dedicated resource investment from the government, and donor support.
- Several factors impede the successful implementation of health sector reforms, including: not involving key stakeholders such as local government in policy decision-making; and, state and local governments not paying their counterpart funding levels and not employing sufficient numbers of health workers to cope with the increased work load.

Recommendations

The paper concludes that in the design and implementation of new policies, such as the DHS, efforts should be made to engage important actors, political favouritism should be minimised, and dedicated funding should be committed by the government. In addition, attention should always be paid to health worker morale and commitment in order to ensure effective implementation.

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