CHAPTER II

LITERATURE REVIEW

This chapter reviews the literature related to the issue addressed in this study. Firstly explore the evidence of problems on laboratory supplies in developing countries that give the negative impact to the services. The main section describes about the actors in the health scene, both national and international that interact in the decision-making and the performance of the services. In each section, the literature reviewed will emphasized on the health financing allocation and incentives that link the power and interests of these actors. The actors influence will also be discussed.

1. Laboratory Problem in Developing Countries

The problems of laboratory supplies in many developing countries are similar. Carter, J. (1996) presented the problems of lab services in Kenya, ineffective laboratories services performance was caused by the poor quality equipments; commodities; availability of facilities and inappropriate technology used in the labs. The problems mostly purchase equipment without consult with the professional user, but recommended by the pharmaceutical companies or manufactures of the product. Mostly the donated equipments cause problems because of shortage of maintenance

services, spare parts. The new equipment donated usually face the technical problem due to the low knowledge of staff, and for the second hand, the problem is unable to repair. Carter end up his article with some important recommendations:

1) The technique use should be adapted to the existing resources; the condition of facility and the common illness of the area.
2) Purchasing equipment should be carefully selected by consider on the need of the local laboratory professional rather than commercial manufacture. The important thing has to consider on the maintenance services, spare part and the staff knowledge.
3) To avoid problems from the equipment gift(new or used) from the donors , the recipient should asked for manual, spare parts and training in using equipment if not should not accept.

Problems of laboratory supply system in Cambodia were clearly presented in two national workshops on laboratory supplies management in 1997. These two workshops were related, the first one was to identify the problems of lab supplies and the second was proposed strategies for improvement. Each workshop was conducted through three days period. The key members attended were the representatives from all laboratories at central level include the representative from five provinces. The problems found from the discussion were on the poor condition and inadequacy of the reagents and material supplies and the important thing were the duplication of work of many programs on the laboratory services with the lack of coordination

among all laboratory agencies. The strategies addressed on the management of supplies stock control, distribution, and information exchange in the system of supplies. The workshops only looked at the weakness of the MoH laboratory responsible persons. All the members agreed that the weaknesses of MoH laboratory suppliers influenced the condition of laboratory supplies, therefore, the recommended strategies were directed for strengthening the responsibility and improve the management of supply (procurement, distribution, supervision) of the MoH laboratory planers. In practice, there were many players influence the condition of lab supplies not only the MoH officers but the workshop did not addressed. |Dealing with only one player was not sufficient to change the worse situation of laboratory supply. This is the weakness of the workshop.

To improve and promote the essential health technologies in South-east Asia Sharma BK. et all (1994) looked at the issue of laboratory services in many developing countries. The problem found were similar, inadequate resources, unavailable or low quality of equipment pull downs the quality of services that hamper effective therapies, diseases surveillance, control epidemic and unusual infection. The laboratories in the countries of South-east Asia region are not well developed due to inadequate supplies (reagent, equipment), lack of education program for refresher the personnel and quality control. To strengthen the lab services, Sharma B. K. and his team identifies the disadvantage and advantage from the model and structure of health laboratory in those developing countries. The authors examined the countries that

laboratory structure have divided to public health laboratories and clinical laboratory face the problems of duplication of equipment staffs, failure in making the best use of resources and difficult in monitoring the performance. A lot of resources are wasted at administration and technical level by creating and maintaining the independence network of laboratories in two separate programs. This situation was similar as Cambodia. Sharma B.K. et al recommends that the single administration will be able to reduces the wasteful and duplication of supplies. Established guidelines for each level will be facilitate appropriate supplies. The article provided the management model of successful operation of health laboratory services for the developing countries that have 13 cores points. The purchasing and supplied policy is one of the important factors in effective performance of lab services. The centralized purchasing system mostly causes the problem unless the country has good condition of storage.

The ineffective of health services performance is problem in many developing countries. A recent study of Bodart C. et al (2001), about the improvement of health services performance in Burkina Faso in Sub-Sahara Africa presented the illness of health system both curative and preventive. The phenomenons were shortage of health supplies; skilled staff and improper distribution. The symptoms found in this studies were over centralization of the resources that leading to allocation and technical inefficiency; strong bias of public spending in health (resources allocate in urban more than rural); lack of clarify the budget in three levels of MoH, province and district and high cost of pocket pay. Many sources of finance internal and external

make the difficulty for health authority to cope with due to the lack of flexibility in financial management inside health sectors and the lack of coordination of foreign donors in allocating aid funds. The study shown that the stakeholders were the most influencing factors in the process of health allocation. The MoH policy makers introduced the sectors wide approach (Swap) strategy to cope with the financial allocation management, but the study found that the SWap is impossible for the current situation of Bukina Faso.

> "Swap is the new way of working between donors and recipient government in which they together in partnership take a sector- wide approach to planning and financing health services, based on the set of the policies that they all accept, a single combined budget for the sectors and where appropriate system for common management of resources."

2. Financial Resources and Actors

Availability and adequacy of financial resources is critical to the success of implementation. In least developed countries the health budgets are extremely low requiring help from many international donors; therefore, health care financing is considered as a complex, multiple faceted system with the multiple internal and external actors. From the point of view of a WHO study group, when financial support comes from multiple sources, it probably will have conflicting objectives, and there is a danger of the lack of coordination due to the different interests of the

stakeholders that nearly always cause wasteful or duplication spending. The conflict mostly happens between the central and local health authorities, MoH and other government sectors, and MoH with the international donors. A good understanding about the group of actors involved in financial system is very important in planning and implementing health policy effectively (WHO, 1978,p.9). In additions to this idea, Walt G. et al (1999) also found that, the nature, interests, intentions and relationships of the health actors are the most influential factors in health services financial resource development affect the effectiveness of health services performance. Strengthening the coordination among these actors is required to ensure the good SWap strategy (p.207).

3. The Influence of Key Actors in Health Services

The key actors in health services consist of all levels of actors involved in the issues including, government policy makers, donors, health bureaucrats, health professionals and so on. The magnitude of influence depends on the interests and the powers of the actors. Walt G. (1994).

3.1 The Bureaucracies

Many developing countries use a central planning model to manage resources allocation to all health services including laboratory. Therefore, the central bureaucracies involve in influencing on health services performance through financial allocation process.

3.1.1 Economic Planners

How do the bureaucracies influence the health services performance? When there are funding decisions to be made for health, many decision makers are involved according to the policy of state and the MoH financial policy. Government economic planners are the first group of actors in deciding the amount of budget for the total health sector. From the economic planning model, Burki (1992) reported that, the planning bureaucracy was instrumental in securing steady and strong economic growth, despite major political and economic threats to the state. This skill has earned the economic planners a powerful role in decision making for national development. Laporte (1992) noted that the role of economic planners has typically exceeded that of politicians in determining national development strategies. According to Laporte, the influence of economic planners on the health sector results from the application of their planning model to the public health sector which is characterized by, first, an ad hoc style (no clear strategies). Second, the public health sector relies on the private sector to facilitate growth. Third, the public health sector characterized by the absence of a mechanism to incorporate the view of the constituents and to counter the power of civil bureaucracy.

3.1.2The Health Bureaucracy

The key health bureaucracy consists of decision makers and managers at the central, provincial, and district levels. The central level of health bureaucrats create health

policy and coordinate the national health programs. The next level (municipal, provincial and district) are concerned about implementation. The relationship of resource allocation, planning, implementing, and evaluating among these bureaucrats affects the quality of service performance in the health sectors.

Anderson J. (1984) mentioned the nature of the actors or interest groups as follows,

> "everyone tried to do something for their interests; those who were successful in the past try to protect their gain, those who failed want to try again and others want to prevent the successes of the first two group"

It is the reality in many low income countries that each group of the bureaucrats will seek benefit from the process of investing resources in the health sectors. They try to used their power or to pressure the decision making process on budgeting and planning to direct the system the way toward their interests. Therefore, funding approval is usually dependent on the interest of the bureaucrats. The major consequences of this process are the likelihood of ineffective used of resources. Budget might go to non-priority areas and might affect to utilization or sustainability of health services.

Evidence of the above argument is found in the studies of Lafond A. (1995) about the health stakeholders in Pakistan. The study aimed to identify the influence of the health stakeholders group, including the bureaucrats in health and economic planning, in the health system by looking at the process of investment in health. Some parts of the findings were based on fieldworks of two other research studies in Pakistan (Lafond

and White 1995; Smithson1995). The findings were that, the health system in Pakistan was influenced by many actors such as economic planners,health bureaucrats, medical professional associations, and politicians The evidence of the effects of these actors are described in the following:

1) The economic planners influence derived from their decisions on providing funds to the health sectors. Pakistans planners do not give high value to the public health system and always maintain low level allocations to the health sector. This result from the perception of the planners that the health bureaucracies were not adept in using health resources effectively.

2) The influence of the health bureaucracies was shown in the complexities of the relationship within the Health Directorate, Secretariat and health planning cells. These people usually managed to function in a unified way to preserve their roles and power in the decision making process. The autonomy in resource allocation for each of the health agencies is very limited; therefore, to increase secure resources, the health officials at the implementation level have to do something to meet the demand of these key persons.

3) The medical professional associations are very powerful in Pakistans, they try to promote urban based, hospital care over rural health care and emphasized infrastructure expansion over the quality and continuity of ongoing services. The aim is to prevent losing income from the private beds and have technology available for the government facilities Therefore, they try to defeat plans and proposals for budgets that do not support hospital.

4) Elected politicians have power to interact with health bureaucrats or economic lanners to steer resources toward their geographical constituency. They used their political authority through many mechanisms to ensured that district development advisory committees approve the investment projects that has been promised to their constituenciness. In most cases, the politicians push the government to build new health facilities in their localities, a visible testament to their commitment to constituents.

Lafond concluded in her study that, sustainability of health care depends on a supportive political context as well as political skill to deal with pressure groups. The effective use of health resources needs skill to balance local demand and prevent distortion of resource allocation. Any attempt to reform must consider the group actors that perpetuate neutral quality investment patterns, and not just address financial allocation.

Another study by Henderson L. (1995), in Nepal provided clear evidence of the influence of top government policy-maker in health services. The author presented health system problems on created when the new government policy actors in Nepal sought large input from the donors for the health sector without the capacity to control these resources. The government did not clarify the role of the donors in the health sector and accepted grants according to the interest of donors without seeking information about health need from MoH. Evidence from the performance of health

services in Neplal showed that donors operation are negatively affected regarding the sustainability and utilization of resources. The MoH of Nepal has nothing to do with this situation as the top government actors are more powerful and the agreements were adopted at this level.

No evidence was found in the study that the government policy makers and MoH bureaucrats were aware about these problems and tried to do something to improve the situation. The article recommended that the government policy actors be more realistic about technical, logistical and financial capabilities when accepting international assistance, and that they use aid in a more rational, and less self – interested manner.

Macrae.J et al,(1995) and Hiscock, J. (1995). found similar situation in Uganda and Ghana. The government bureaucracies were involved in causing inadequate and inappropriate investment of health resources. The reason is these people are far from the problems and the real situations at the implementation level. The policies or the decisions made according to their interest and power were usually not appropriate to priority needs. Their decisions may have affected the performance of the health programs and made the programs fail or ineffective. The common thing was a wasteful and duplicative use of budget. The study recommended that the government policy makers should have clear policies or mechanisms in managing the external funds properly.

3.2 Operational Health Managers

Operational health managers have responsibilities in the implementation of strategy decisions from the health policy makers; but in general, they have the least power and experienced the most pressure which comes. It might from the health policy makers, and local government authority. Gilson (1992), illustrates the tension of the district medical officers in Tanzania, who have responsibilities for daily operation of the health centers and district hospital (supervision and supplies), but they do not have the power to make decision on key resources. The District Executive Director is in charge of 70% to 80% fund received from the central level for district health services, and 20 to 30% go to the district health administrators for hospital used. However, the supervisors and personnel responsible for services deliveries are not responsible for budget allocation and do not receive financial incentive thus negatively affecting their services.

3.3 The Health Professionals

Health professionals are responsible for health services performance. The quality of service delivery mainly depends on the health professionals who work at the grassroots level. The efficiency of their performance is related to payment they receive. In the economic model of compensation, Baker, Jensen and Murphy note that, "higher performance required greater effort " (1988,p.594). People cannot

perform well unless they satisfied with the income.

In human resources management literature, effective performance is related to pay based on; 1) expectancy, meaning that payment is of sufficient value and well distributed to recipients so it motivates them to work (Vroom, 1964); 2) equity, meaning that reward is equal for staff who perform at the same level (Adams, 1963). In the low income countries, these concepts mostly are difficult to meet in the public heath services because of national economic constraints.

Much of the literature provides the evidence that low performance of public health services is related to inadequate payment of the health professionals. Fronczak,(2000) conducted a survey of district health services in Cambodia. The result indicates that poor pay is the most common rationals for the inability to manage health staffs and to hold staff accountable, while working 2-3 hours per day is an accepted norm. The health officials cannot enforce discipline or accountability when they do not pay staff and do not even provide a budget sufficient to support the provision of basic services.

Health staff do not receive wages sufficient to cover the living cost, the average salary of health workers is ranges from 8-15 US$ per month, while estimated household expenditure ranges from 80-120 US$ per month in the area outside of the capital city (NPHRI,1998). Furthermore, payment of salaries is usually late (2-3 months in general). This means that, day-by-day the living expenses of the health staff must be derived from private activities. To supplement to their low salary, the health

professionals are engaging in private practice, while they are in the public sector. Therefore, effectiveness of public activities decreased due to the staff bring more interest on their private work than their public services duty.

Another example is from the study of Matinez,J. and Martineau,T.(1998). The researchers point out that the most important issue in services delivery is the performance of the staff. It is difficult to make staff perform the services well, unless they have an adequate living wage. In Magna Carta, The Philippines, the health personnel seek other forms of income augmentation to compensate their needs by undertaking private activities either after or within official working hours and charging for giving expanding services; for use of government equipment for private purposes; and for the government provided commodities.

This article discussed on the possible strategies to improve the performance of health personnel such as punishing staff who break the rules, increasing salaries. and for reducing the staffs to raise the salaries for the rest. The strategies in this study are difficult to achieve because increasing salaries will affect the government budget system. Punishment is also difficult while the administrators have good relationships with the staffs and the request for penalty has to pass through many legislative offices. The results of the above studies are key issues for policy makers or health planners to consider and required putting human resources interests before any further health investment.

3.4 The External Actors (International Donors)

The major external funder of health sector investment in low income countries today is the World Bank (Buse, 1993-1994). WB was interested in health in the broadest sense, they considered that direct involvement in health was necessary to attack poverty, increase the productively of poor, and support and strengthen the budget capacity in the recipient countries to give opportunities to address the population issue. The WB essentially complement to the activities of WHO (WB 1980:p.61).

In contrast, Buse (1993) stated that,

> " In practice, lending for health services strengthened the Bank's overall standing in the health sector. Operationally, the changes provide bargaining leverage, legitimacies and an implicit vehicle for population related activities as required by the particular country context. Moreover, increased project sponsorship and policy analysis is credibility as an influential actor."

If this statement appears to describe the potential negative influence of the bank or international donors. It was assumed that there are harmonizations to the recipient countries from the international aid, especially in the developing countries.

Information leaked from the WB report 1992 " Effective Implementation: Key Development Impact" contained criticism from a national policy makers on psychological pressure. They complained that, they felt pressured to take loans that ended up with the conditions the country had no way of honoring and consequently

the contract could not be implemented. They argued the Bank s staffs appear more driven by pressure to lend than a desire for successful implementation (Chattrjee, 1992).

Ineffective performance of health services is caused by donors lack of concern of with the priority needs of health services at the implementation level. Most of the donors ignore with the current situation of health needs in the recipient countries. They tend to invest in only in health projects that they willing to fund and those are not necessary to meet the priority need of the MoH. In fact, the basic structure of their intervention has already been decided before the discussion for agreement take place (Henderson,1995).

The influence of the donors more or less is result of the state administrators or the bureaucrats of the Ministry of finance because the agreement with donors is made at this level while implementation of the health program has to be done by the MoH. The donors and the alternative ministries do not anticipate with the problems that occur during implementation. So, This causes the pressure on the implementation and pulls down the development process. Fiedller(1988) showed a case in El Savador where the MoH received a loan in the amount of 30US$ millions from the Inter-American Development Bank (IADB) to built health infrastructure. Although this was for new construction, there was no improvement of the existing dilapidated health facilities. The Bank just wanted new and expanded structures with no concern

about maintenance; therefore, the MoH budget for building maintenance and repair was squeezed. Fiedller concluded that,

"The IADB was a victim of the MoH's recurrent crisis (because facilities construction depreciated prematurely due to inadequate maintenance and repair) but also the cause of the crisis".

The proliferation of aid agencies to support health often required recipient countries to separate the budget system in implementation. As evidence, donors in many countries preferred to support only vertical program such as TB, ML, Leprosy, Family planning, AIDs, EPI and so on. This produced the obstacles and difficulties for health authorities in administrative control during implementation of health projects due to the competitive demand by donors. (Clif 1988; Walt G. et al 1999; Fryatt 1995; Henderson 1995, Hiscock J.1995; Buse 1994).

The influence of donors on the effectiveness of health services was measured in the study of Lafond A.(1995) She conducted the research about the sustainability of health systems where donors were active in 5 low income countries (Nepal, Pakistan Uganda, Vietnam, and Ghana). Her study took three years to review the donor's policy and practice focusing on the process of change in the performance of health services. She used the indicators to measure the sustainability of the health system's capacity to continue transforming resource input with effectiveness. The finding was that the capacities of the health services were effective over time with minimum external input. The author concludes that Health systems in developing countries are operating under increasingly hostile conditions. Therefore, it is important for parties

to understand the fundamental constraints and devise ways to improve the chances for lasting and positive health sector change. Policy implications toward strengthening the government sectors should be clarified.

The donors power comes from their financial clout. The budget donors can do whatever they want; they can even be inactive or change the health policy (Walt G.1994). A donor stated that, " as if the beggar could not be chooser" (Hiscock J.1995 p.34). This statement presents the power of donors in health services and the weakness of the government. Of course, donors come with a certain amount of money, which attracts the government, therefore, government, mostly accept it under the donor's conditions, that usually have a negative effect or are harmful to the health service. For example, from the study of Henderson P.(1995) in Nepal donors reduce their input or cut off certain activities without warning. The McH has to find fund at the last minute, this will cause the program to suffered and the program activities to collapse if the funds are not found.

Another case was, three donors providing funds to the same activities in a district health office. The second donor based its assumption about the others' proposed work on a two year old project document. The MoH did not point out this situation until the second donor's consultant concluded the project proposal. At the same time, the third donor decided to finance in the same project; therefore, a single Nepali project served by three expatriate advisors.

"Looking a gift horse in the mouth: the shifting power balance between MoH and donors in Ghana" This is the title of the study of Hiscock, J. (1995). She examined the donors effect on the health sectors in Ghana. Ghana faced the same situation as Nepal that the donors determine the financial resources in hea th services without the involvement from the MoH. The difference was the Ghanaian MoH has developed effective strategies to confront the problems caused by the donors influenced. Several key health officers of the Ghanaian MoH analyzed the situation of foreign aid and realized on the disadvantages and the harmonization from the donors operation behaviors in health sector. They also notice that, the agreement of aid made between government and donors usual did not meet the health sector priorities. Many disadvantage found stimulated the key Ghanaian MoH officer to build up the internal strength by setting the alternative strategies to direct donors and proposed to government for approving the new health policy that allowed the MoH to decided on foreign aid. Finally, the MoH Ghana succeeded in control ing and directing the donors' investment toward MoH's need; and many donors became more cooperative and maintain a flexible relationship with the MoH formula. The reason for this success was because of the strength of the MoH in establishing a policy to address the role of donors, and to strengthen the capacities to the MoH related to donors, and to use with the experience in the provision of basic health services and a strong commitment to public health. Political and economic stability provided a platform for the MoH to plan with confidence and consider long term development.

3. Conclusion

The health sector in many developing countries were very weak. The studies found problems of ineffective of health services caused by the lack of coordination in provision of health. Some authors looked at the management process, planning, implementing the health supplies. But in many literatures, the authors pointed out the problems are related with all types of stakeholders and their practices. The investment process was controlled by the few key stakeholders at the decision-making level including internal and external stakeholders neglected each other's needed.

Any attempt to improve the effectiveness of health services must look at the actors or groups that perpetuate poor quality investment patterns. But evidence from the literature proves that reorienting the present health system to change the situation is difficult as these actors seem resistant to the existing practice.

WHO (1997) has recommended the SWap strategy for resources management for introducing to the countries that have many donors support. However, the experience in Burkina Faso showed that SWap not realistic in Burkina Faso. This strategy may be effective for the long-term perspective of health development.

The effective and efficient use the resources needs skill in balancing the power and interest of the actors. The lesson learned from Ghana is important and should be applicable for many developing countries where the political situation is stable