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Explanations of Performance and Reform Responses

1. Introduction

This chapter provides an overview of health sector reform in the five study countries. The policy context, content and process are each analysed (Walt and Gilson 1994). New Institutional Economics emphasises that most institutional change is incremental and slow and hence the historical structure of institutions will affect the speed and success of reform. Accordingly, the following section on context explores in some detail the historical development of the health system in the study countries. The contextual section also addresses macro-economic and social issues, describing trends in economic and social indicators and the design and implementation of structural adjustment programmes. Consideration of these broader contextual issues helps explain the health system performance described in the previous chapter.

Subsequent sections of this chapter describe and analyse the current contents of the health sector reform agendas and the processes through which reform agendas were constructed. The final section explores the relevance of alternative theoretical frameworks to explaining existing patterns of state intervention and proposed reforms.

2. Contextual factors

2.1 Historical development of the health system

All four core countries had in common a history of colonisation by Great Britain (in contrast, Thailand had never been colonised). They followed a general pattern that Western health services had been introduced by the colonial power, initially to cater for the needs of the military, civil service and settler communities (Zwi and Mills 1995). However, given the
prevalence of communicable diseases, protecting expatriates meant that
disease in the indigenous population had also to be addressed, and in
some areas, ensuring a workforce healthy enough to work productively in
plantations and mines was a consideration, though sometimes a weak one
because of the ready supply of unskilled labour (Packard 1990). Epidemics
in the late nineteenth and early twentieth centuries encouraged the
extension of colonial influence, and at a time when there was greater
confidence in the ability of medical science to conquer disease (Arnold
1988).

Amongst the four core countries, a number of common themes emerge
in terms of health system development, namely: a central role for the state
in health service provision, a strong bias towards curative and hospital
services, and the development of powerful constituencies within the
health sector. Interestingly, while each country after independence at
least formally espoused a strong state role in health, attitudes towards the
development of a private health sector varied between countries. Each of
these themes is considered next.

A strong state role

The very limited existence of private practice and charitable activities in
tropical colonies meant a greater role for the state, though hampered by
lack of resources. It was not until after the First World War that there was
significant expansion of state medical services in the tropical colonies,
and even then outreach was very limited. However, a close relationship
had been established between state power and Western medicine: Arnold
(1988) argues that in the colonies of Africa, Asia and the Pacific, medicine
was one of the most intrusive expressions of state power.

In Ghana health provision had long been seen as a legitimate and
necessary role of government. From the patriarchal outlook of the
colonial government, through the planned development and modernisa-
tion of the Nkrumah era and the authoritarian regimes of the 1960s and
1970s to the present day, health and health services have traditionally
been regarded as a responsibility of the state. Private financing and
provision were not banned, but neither were they encouraged or regarded
as the dominant agents of health sector development. In Zimbabwe a
strong state role in health has been emphasised from independence, and
is heavily rooted in the political ideology of socialism.

Western medicine was brought to India by the colonisers to protect the
health of the army and the European community. Indeed Ramasubban
(1982) argues that the protection of the army and the European civilian
population was at all times the highest priority of colonial health policy