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Health Sector Reform: Issues and Opportunities

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Health sector reform deals with fundamental change of processes in policies and institutional arrangements of the health sector, usually guided by the government. The experience of many countries clearly shows that the success of reforms depends on how the process is applied, and by whom, rather than how the contents are formulated. Sustained information and education on health sector reform is needed to generate wider political and public understanding as well as support. Continuous monitoring and review of health systems development is also required. Research to provide valid scientific evidence for strengthening the processes and mechanisms of health sector reform is also essential. Research might involve, for example, strategies for publicizing or marketing reforms to policy makers, providers, and the general population; and ways that government can anticipate and plans for the reactions of organized interest groups. The major research issue may be to deal with the political process—what are the effective strategies for the political management of the reform process?

Keywords: health sector, efficiency, reforms process, sustainability, governance

Introduction

Health sector reform is a sustained process of fundamental change in policies and institutional arrangements of the health sector, usually guided by the government. The process lays down a set of policy measures covering the four main core functions of the health system, viz., governance, provision, financing, and resource generation. It is aimed at improving the functioning and performance of the health sector and, ultimately, the health status of the population.

Health sector reform deals with equity, efficiency, quality, financing, and sustainabilityin the provision of health care, and also in defining the priorities, refining the policies, and reforming the institutions through which policies are implemented.

This paper tries to make on evidence the main issues needed for a valuable health sector reform (Section 2) and the main conditions must be imposed to a successful strategic support for change (Section 3).

Issues in Health Sector Reform

From an analysis of health sector reform in many countries, it is seen that there is no consistently applied, universal package of measures that constitute health sector reform. *The process of reform is also proceeding rapidly in many countries.* While considering *health sector reform*, new forms of relationships among the components of health systems can be developed to make complex changes and interactions. During the last few decades, most of these efforts were being spurred principally by a desire to improve equity and quality of care, to expand coverage, to decentralize health care management, and also to contain costs. The *reforms sometimes are*

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highly political and fiercely contested processes. In some countries, the reforms became more complex due to the presence of a wide range of contracting partners, including external agencies. While every reform experience is country-specific and usually based on solid evidence, there are important lessons to be learnt from comparing options, identifying common issues addressed and the tools used, and evaluating effects of various reform initiatives.

Most countries usually focus attention on the *contents* of the reform, rather than on the *process*. This focus on content runs the risk of equating health sector reform with one set of prescriptions, e.g. the introduction of market mechanisms; user charges; establishing joint management bodies with low responsibility; reducing the size of the public sector, cost-containment, and redistribution of resources. The reform usually ignores the question of feasibility of implementing the change. What is needed is to increasingly understand the issues in *reform processes* to complement what has been learned about the *content of reforms*. Such an understanding might lead to the development of strategies for publicizing or marketing reforms or identification of ways that governments can anticipate and plan for the reactions of organized interest groups.

Health Care Financing Reforms

The most striking reform in the health sector concerns securing sustainable financing for health care. When health sector investment is analyzed, it is seen that the situation over the past few decades has not changed with regard to low investment in health.

According to recent national health accounts data as reported by WHO, the total health expenditure in most countries is around 2-8 per cent of their GDP. The proportion of government contributions as a percentage of total health expenditure in most countries ranged from 20-60 per cent, depending on the growth of private health care systems in respective countries. A worldwide study on external assistance to the health sector during 1972 to 1990 revealed that smaller and poorer countries received more funds from external assistance in health sector per capita than larger and richer countries.

The national health accounts provide useful insights for governments to review how they can and should allocate public resources for health, what should be the level of public and private expenditure, and how private resources can be mobilized for public health expenditure.

A careful analysis could be made to determine what types of financing strategies are to be adopted, e.g. mobilizing financial resources within the health sector, outside the health sector or improving the use of existing resources. Health care financing reforms have to be initiated in order to ensure equitable access and efficient and effective health care. An appropriate mix of private and public health care and financing mechanisms have to be established, so *that the two sectors complement each other, to yield best results.*

Alternative health financing reforms such as cost-recovery and cost-sharing schemes, user fees/charges, community financing, health cards or voucher systems, subsidized payment schemes, contracting services, social insurance schemes, and private insurance,etc., are some examples of changes in financing mechanisms introduced under the umbrella of health sector reform. Most countries have concentrated on the contents of reforms in health care financing rather than on the processes resulting in failure or delays in implementation.

The fundamental principle of financing reforms is that health care funds (either for private health care or for community health prevention and promotion) are raised from the people according to their ability to pay, *and not according to health need.* It is also equally important that *funds are spent according to health need, and not according to ability to pay.* Everybody is entitled to pay an equal share of disposable income. This not only depends on the *share* of disposable income spent on health, but also the *methods* of financing, such as

general taxation, insurance, or out-of-pocket payments. *Fair financing* deals with whether funds are raised through a progressive collection mechanism and protection of catastrophic health costs.

Even though the level of health spending (like total health expenditure or per capitaheath expenditure as percentage of GDP) is important, experiences of some high- and middle-income countries show that more is not always better or always possible. What needs to be kept in mind is how far health expenditure is distributed according to health needs. The effects of good spending and utilization according to health needs are reflected in the level of inequities in health.

Many countries in the world have introduced various financing mechanisms, including community-financing systems, particularly to protect poor families. *Public-private joint venture initiatives for expansion of hospital care have been undertaken in some countries.* Major investments by international and national private corporations in establishing big and medium-scale hospitals and diagnostic facilities have been made in some countries. Various forms of user charges at public health facilities have been introduced to relieve the burden of public expenditure in hospitals and health centres. Considerable evidence in developing countries has been documented on the consequences of imposing user-charges for health care, in the context of equity, efficiency, and consumer satisfaction. This evidence clearly shows that *price alone is insufficient to explain the effects of fee systems. Managerial and organizational factors are central determinants of the impact of this policy reform.* There is also evidence of the danger that direct contribution by users to health financing leads to cuts in the State health budget.

The promotion of competition, either between providers or, more rarely, between financiers of health care, has been used as a strategy to finance reform programmes being carried out in industrialized countries. The strategy to use government funds to buy clinical or non-clinical services from private providers is intended to increase the productivity of public resources by purchasing the gains in efficiency perceived to exist in the private sector. Service contracting is primarily to improve the quality and/or increase the quantity of services that can be made available for a given amount of government expenditure. This kind of a *competitive approach* has been introduced in a few countries.

Many countries *have promoted* or are in the process of *promoting privatization efforts* in the health sector with or without the active participation of health ministries. Some countries have attempted to reduce public involvement in the management and delivery of health services as part of their privatization efforts. They have introduced appropriate policies towards the private sector, and have restricted government activities to policy formulation, monitoring, coordination, and regulation.

This practice of encouraging the *public health sector to abandon health services provision and concentrate on its normative and regulatory role has not always been accompanied by strengthening the normative role of the ministries of health.* More research is required on what capacities, skill, information systems, etc., governments need to develop to play an expanded regulatory role.

While recognizing the advantage of involving the private sector and consumers in future policy-making and regulatory processes, the governments, especially *ministries of health, should be proactive in dealing with issues that might adversely affect the underprivileged segments of the population.*

The greatest health needs are among underprivileged populations. The maximum improvement in the health status of these groups is possible, only when the most cost-effective health actions are targeted to those most at risk or most in need. While an optimal allocation of health resources is required, different mechanisms

and approaches are needed to ensure sharing of both disease and financial risk. Given the complexity of the public-private mix in health care provision or financing, and the complementarities and partnerships between the public and private sectors including the efforts of civil societies, the ministries of health should improve and strengthen their capacities of studying and exploring alternative financing of health care. They should introduce appropriate reform measures and ensure quality of services, and acceptable social responsibility of, and protection for, the consumers, especially the underprivileged.

Reform in Provision of Health Care

After the World Bank in its 1993 World Development Report highlighted the importance of adopting essential clinical and public health packages, many countries, especially those receiving substantial external financial assistance from the Bank and other bilateral and multilateral donors, tried to link their economic investment in health with a core set of essential health care packages.

These essential health packages aimed at improving health care and increasing efficiency by making the best use of contact between health workers and concentrating on the needs of the individual rather than focusing on the single disease. There has been a rapid expansion of selective essential health care interventions in many countries during the past few decades.

These selective primary health care efforts such as disease elimination and eradication are successful due to partnerships among countries as well as with development partners. However, the situation in other public health development areas is quite different. For example, provision of safe water supply and sanitation, provision of essential medical care including essential drugs, provision of essential obstetric care for pregnancy and delivery, leave much to be desired.

The trend for further expansion of coverage of essential health care, especially in the least-developed countries, is not bright due to many uncontrollable factors (political, socioeconomic, and financial). First, the external and internal resource inputs for health infrastructure expansion are scarce. Secondly, nearly 20-30% of the population, who are actually the neediest in terms of health care, is harder to reach for providing any essential health care, mainly due to economic or geographical reasons. The challenge, thus, is how to reach the unreached.

Two decades of implementing the primary health care (PHC) approach revealed a "*new universalism*". It denotes a *renewed PHC approach* that recognizes government's limitations but retains government's responsibility for the leadership and financing of health systems. The *new universalism* recognizes that the most cost-effective health interventions in a given setting are to be provided for all, but not all possible interventions for a whole population. Each country needs to look at what type of essential public health package should be available at various levels of the health system which is universally acceptable and affordable using appropriate technology.

Resource Generation

Despite these reforms, there is still a large gap in people's health status as well as in the development and implementation of policies, financing, organization, management, and delivery of health programmes. The quality, quantity, and balance of human resources for health are the main concerns. The shortage of nursing and midwifery personnel in many countries is one reason for high maternal mortality and low accessibility of essential obstetric care during pregnancy and childbirth.

Another dimension of human resources is the imbalance in deployment between rural and urban areas. A significant emerging factor, which further aggravates this situation, is the increasing competition between the public and private sectors. The people themselves are the most valuable resource for health. The principle adopted in Alma-Ata defined community involvement as a process whereby individuals, families, and communities assume responsibility for their own health and welfare and develop the capacity to contribute to their own and the community's development. Many countries have successfully learned this principle through various innovations. Almost all countries consider community action for health as a political necessity and also an important and effective mechanism for planning, implementation, and evaluation of health development at the local level. *For effective community action, certain prerequisites are necessary, such as local leadership, decentralization, appropriate technology, sustainable mechanisms for partnerships, etc.*

Experiences in many countries show that the conventional approach of extending health care delivery through building more *public* hospitals and health centres has proved inadequate. It is proving economically impossible to bear the cost of full extension and expansion of *public sector health services* to the entire population. It is important to expand and strengthen the role that individuals, families, and communities can play in the promotion and protection of health. This approach has not been encouraged much in many of the national health programmes.

Governance

The reform process starts from the ministries of health, with the aim of reflecting a deliberate change in the policy of the government to improve performance. These reform efforts ensure the strengthening of policy and planning functions, setting of standards for health care provision, and development of appropriate systems for monitoring performance (including quality assurance initiatives), introducing new management policies and practices, defining national and provincial disease priorities, and introducing effective health interventions.

Reorientation and restructuring. During the last few years, as part of health sector reform initiatives, many countries have implemented different forms of reorienting and restructuring their ministries of health.

These can be categorized as follows: (a) making the ministries smaller and less hierarchical; (b) separating the functions of service provision and service financing to enable better performance through competitive measures (allocation of resources and financial management, e.g. expansion of health insurance coverage, service contracting, autonomous hospitals, functional groupings, integrating central health budget, setting up management boards at large public hospitals, joint ventures, etc., (c) shifting the mix of staff and skills from an emphasis on technical and medical training to that of management, finance, and planning of human resources for health in most countries; and (d) legislation and regulations for production and deployment of various categories of health workers including medical profession also.

The usual focus of reform by governments and, more particularly, donors has been on the reduction of the overall size of the civil service, including the health sector. *Reducing the total number of health staff, introducing new pay scales, grading structure and incentive schemes, separating political and executive functions, decentralization, and privatization efforts* are examples of *civil service reforms* introduced in many countries.

Decentralization. As part of political and civil service reforms, *decentralization* is most common. Decentralization usually refers to three different types of processes. The *first* concerns the *devolution of authority and responsibility* from the central government to local government agencies in political and administrative areas. For example, State or Provincial or District Governments are responsible for their local

development including health and other social sectors. The *second* process of decentralization is to *deconcentrate the functions* from higher to lower levels within the administrative apparatus of the countries.

Many countries have introduced this process of delegation of responsibility for managing financial resources, deployment of humanresources, and managing for hospitals and health centres. The *third* way is the *delegation of responsibility and functions* from central government units to other more autonomous and/or specialized types of government agencies or specialized functional agencies or parastatals in almost all countries. The establishment of national health research institutes, national nutrition centres, national and regional research and training institutes, or institute of policy studies are a few examples. In some cases, decentralization also refers to the *transfer of functions* from government (public responsibility) to nongovernmental organizations.

Efforts in decentralization require fulfilling a number of objectives—political, economic, and managerial, which are not always compatible. Although decentralization has been used as a strategy to promote efficiency and public accountability, it is important not to overlook the role of the central authority, particularly the need to establish equitable means for allocating resources and to ensure the existence of effective mechanisms for managing the health market. Experience has shown that in the field of essential drugs, there are various central government functions that should not be decentralized, e.g. selection of drugs that the centre authorizes for circulation in the national territory (drug regulation and registration), quality of standards, and drug pricing policies, etc.

This example illustrates that policies concerning the decentralization of various functions, responsibilities, or authority are *policy tools*, and not merely *policy objectives.* Each country has to consider or identify an appropriate mix of centralized and decentralized functions, responsibility, or authority to best meet policy objectives.

The issue of decentralization cannot, therefore, be viewed by ministries of health in isolation from the overall civil service and political reform.

Reform Related With Other Sectors

There is no denying that many development programmes of other sectors can contribute to health development. There are numerous examples, such as educating people on health promotion and protection; promoting no tobacco or alcohol use; having proper nutrition; empowering women to improve their health and development; initiating poverty reduction; etc. What is more important is how the health sector maintains its leadership role. It may not be enough to indicate what *the others can do for health*, but to indicate what the *health sector can do for others.* The health sector reforms should foster new partnerships and strengthen existing ones in order to place health at the centre of development activities.

With the globalization and liberalization of international trade, there is growing concern on the part of health decision-makers, regarding the impact of international trade on health services. The current international trade negotiations have given importance to opportunities for promotion of international trade in services, including health care.

At the same time, market exploitation of international investment in health care could jeopardize national health systems, including resource allocation. Thus, countries should be aware of the impact of increased international trade in health services.

Strategic Support for Change

Capacity Building

One of the preconditions for successful reform is the national capacity to plan and manage change. Most of the external donor-assisted programmes address this well-known need. Capacity building has many dimensions. It goes beyond training to incorporate many other elements, which may also overlap with institutional development. In the area of human resources development, it is recognized that insufficient attention had been paid to the demand as opposed to the supply. At the same time, trainees were frustrated when the policy and service environment was not conducive to the implementation of research findings.

The major issue of capacity building tends to focus on the general assumption that policy and programme development are the concerns of governments and it is the latter who should be equipped. This assumption is true to some extent considering that many governments have created specific departments, institutes, or units within the ministries of health, whose outputs and advice are sought or used by health policy makers.

In some countries, in order to reduce the degenerative effects of bureaucratic entities leading to little dynamism and creativity, autonomous institutions and centres for policy analysis or research and development, including health, have been established as freestanding entities or as part of academic institutions or even private sector organizations. These institutions have greater flexibility, good compensation, and incentives to attract and retain competent professionals.

One of the challenges was to strengthen national capacity for managing health sector within the framework using sector-wide approaches in health policy and programme development. As decentralization efforts in many countries are being accelerated in recent years, the adoption of sector-wide approaches in health development planning and management will provide many opportunities for channeling the external resources.

This move will make a step forward from development assistance programme to a comprehensive developmental process where donors and nationals agree to work on common goals and priorities. The focus of health development through sector-wide approaches moves from planning and management of individual programmes (for specific health priorities or geographical areas) to the overall policy, institutional and financial framework within which health actions are undertaken. Ultimately, there is a move progressively towards development of a more comprehensive sectoral programme with pooled resources (both internal and external).

Promotion of Research for Health Sector Reform

Health sector reform is itself a researchable issue. The research can be a proactive, a prospective, or a retrospective activity. It contributes to the overall health development within the background of dynamic socioeconomic and political changes. Health policy analysis, both at macro- and micro-levels, also provides invaluable inputs to health sector reform. *The main issue for research covering health sector reform is how to improve the health system performance rather than fact-finding or hypothesis formulation.* The researchable issues are to be identified from the gaps between the desired health situation (equity, efficiency, quality, and responsiveness) and what is actually happening or supposed to be happening. It is more important to *monitor and evaluate the processes of change* rather than looking at the contents of change.

In the process of reform, it is essential that the initiatives include health policy and health systems research as an integral part of the reform agenda. The policy and organizational changes and managerial reorientation of ministries of health and their related sectors (institutional reforms), as mentioned above, are the

means to an end. The development of health policy analysis and health systems research lags far behind the epidemiological, demographic, and economic research studies. Thus, *continuous and simultaneous monitoring, review, and research on health systems are necessary to keep track of changes and to make appropriate improvements*.

The understanding of the consequences of reforms to health sector financing and organization has improved tremendously over the years. But, there is much more to be learned. *There is a need for better systems and mechanisms to enable planners to analyze different approaches to policy and institutional changes in the health sector*. Continuous monitoring and evaluation of health financing reforms must, of necessity, involve analysis and understanding of institutional and organizational changes taking place in the health sector as a whole.

Exchange of Information and Learning-by-Doing

All countries have provided documentary evidence on the steady progress made with various reform initiatives, especially on health care financing. In addition, important insights have emerged with respect to the major content of health sector reform. One such insight was that there are many advantages of a strong linkage of the decision-making processes with those related to health systems research.

Certain core values and operational principles have surfaced, such as equity, efficiency, effectiveness, and quality. Consumers' choice and rights as responsiveness of every health system have to be respected. There are several examples of mechanisms and processes to promote research for health sector reforms at national, regional and global levels.

In each country, the national research promotion and development councils or analogous bodies are responsible for research promotion and strategy coordination.

The same applies to the importance of regional bodies such as the regional health research advisory bodies (ACHR), which provide policy guidance and coordination. However, it is also recognized that there are some gaps between the production of research studies and the use of these products in the policy formulation and decision-making processes.

Some countries have attempted to make use of research results in decision-making by involving the decision-makers at the start of research, and advocating results at various forums including information to consumers. It is also recognized that the resource for research and development of reform is not a major issue. Both internal and external resources could be made available provided that the research agenda fits in with the needs of policy and decision-makers.

It should also be realized that there is a need to document various health sector reform initiatives. There is an attempt by WHO, in collaboration with Member countries and institutions, to conduct a critical comparative review of health systems development in various parts of the world using a common framework. An appropriate country protocol or profile format has been used so that the countries can record health sector reform initiatives systematically. It would also further facilitate the processes of reform as well as help in identification of research agenda, and also enable them to make critical reviews and comparative analysis.

Role of WHO and International Agencies

WHO, through its various collaborative programs, involves itself in capacity building in Member Countries to help take care of the evolving reforms in the health sector. In order to support health sector reform, a series of publications, both at the regional and global levels, have been issued.

WHO continues to provide technical and financial support to the countries for research and development in the area of health sector reform. WHO also works closely with WHO Collaborating Centres (WHO CCs) and other relevant national and international institutions, in order to make the health sector more productive, efficient, and effective in achieving the goals of health for all. WHO is strengthening its role as clearing-house to disseminate information on research and development on health sector reform. Informatics technology is appropriately being exploited for promoting the exchange of information.

Conclusion

Health sector reform is a political and dynamic process. Reforms should take place as sustained processes of fundamental change in the context of health policy and health institutional arrangements. They are not sequential or incremental processes.

In general, improvements in the functioning of the public sector and civil service systems will occur in parallel with, and sometimes in response to, other aspects of institutional reform, such as increasing privatization.

In some cases, the reforms are limited to the public sector. Leaving the private sector entirely to market forces may mean giving up equity considerations. Experiences of many countries, clearly confirm that the success of reforms lies with *how the process is to be applied and bywhom*, rather than on *how the contents are formulated*. There is a need for better understanding of the "process" issues to complement what has been learned about the "contents".

Sustained information and education on health sector reform is needed to generate wider political and public understanding and support. Continuous monitoring and review of health systems development is also required. Research to provide valid scientific evidence for strengthening the processes and mechanisms of health sector reform is also essential.

References

Antezana, F. S., & German, V. (1996). Health economics: Drugs and health sector reform. *Task Force on Health Economics Series (Document WHO/TFHE/96.2)*. Geneva: World Health Organization.

Cassels, A. (1995). Health sector reform: Key issues in less developed countries. *Forum on Health Sector Reform Discussion Paper No. 1 (Document WHO/SHS/NHP/95.4)*. Geneva: World Health Organization.

Cassels, A., & Janovsky, K. (1998). Better health in developing countries: Are sector-wide approaches the way of the future? *The Lancet, 352*, 1777-17779.

Global Forum for Health Research. (2000). *The 10/90 report on health research 2000*. Geneva: Global Forum for Health Research.

Mills, A. (1990). Decentralization concepts and review. In A. Mill, L. P. Vaughan, and D. L. Smith (Eds.), *Health system decentralization concepts, issues and country experience*. Geneva: World Health Organization.

Moore, M. (1996). Public sector reform: Downsizing, restructuring, improving performance. *Forum on Health Sector Reform, Discussion Paper No. 7 (Document WHO/ARA/96.2)*. Geneva: World Health Organization.

Nitayarumphong, S. (Ed.). (1997). *Health care reform—At the frontier of research and policy decisions.* Nonthaburi, Thailand: Office of Health Care Reform, Ministry of Public Health.

Rafei, U. M. (1993). *Primary health care in changing world—South-East Asia regional perspectives.* Background paper presented at *Fifteenth Anniversary Celebration of the Alma-Ata Conference on Primary Health Care*. Almaty, 13-14 December 1993. New Delhi: World Health Organization, Regional Office for South-East Asia.

Roomer, M. I. (1991-1993). *National health systems of the world* (Vol. 1). New York: Oxford University Press.

WHO. (1996a). *Achieving evidenced-based health sector reforms in Sub-Saharan Africa: Report of an intercountry meeting, Arusha, Tanzania, 20-23 November 1995* (Document WHO/SHS/HSR/96.1). Geneva: World Health Organization.

WHO. (1996b). *Health policy and systems development: An agenda for research* (Document WHO/SHS/NHP/96.1). K. Janovsky, (Ed.). Geneva: World Health Organization.

WHO. (1996c). *Health sector reform and health systems research: Can the reform process be evidenced-based?* Background paper for *WHO Conference on Achieving Evidenced-Based Health Sector Reforms in Sub-Saharan Africa: Report of an Intercountry Meeting* (Document WHO/SHS/HSR/96.1). Arusha, Tanzania, 20-23 November 1995. Geneva: World Health Organization.

WHO. (1996d). *Investing in health research and development: Report of the ad hoc committee on health research relating to future intervention options* (Document TDR/GEN/96.1). Geneva: World Health Organization.

WHO. (2000a). *Primary health care 21 "everybody's business": An International Meeting to Celebrate 20 Years After Alma-Ata, Almaty, Kazakhstan, 27-28 November 1998* (Document WHO/EIP/OSD/00.7). Geneva: World Health Organization.

WHO. (2000b). *World health report 2000: Health systems improving performance.* Geneva: World Health Organization.

WHO-EURO. (1998). European health care reforms: Analysis of current strategies-summary. *Proceeding of the WHO Conference on European Health Care Reforms* (Document EUR/ICP/CARE 01 02 01). Ljubljana, Slovenia, June 1996. Copenhagen: WHO Regional Office for Europe.

WHO-PAHO. (1995). *Equitable access to basic health services: Towards a regional agenda for health sector reform: Report of special meeting held at PAHO, August 1995.* Washington DC: Pan American Health Organization, Regional Office for the Americas of the World Health Organization.

WHO-SEARO. (1995a). Alternative financing of health care: Report and documentation of the technical discussions. In *The Forty-Eighth Session of WHO Regional Committee for South-East Asia* (Document SEA/HSD/195). New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1995b). *Privatization of health care: A SEARO kit.* New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1996a). *Health care financing reforms: Report of an intercountry consultation, 2-6 October, Bangkok, Thailand 1995* (Document SEA/Econ./13). New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1996b). Promotion of research on health sector reforms. Working Paper at the *22nd Session of the South-East Asia Advisory Committee on Health Research* (Document SEA/ACHR/22/6). Dharan, Nepal, 22-26 April 1996. New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1997a). Report of technical discussions on health sector reform. In *Fiftieth Session of WHO Regional Committee for South-East Asia, 8-12 September 1997* (p. 16). New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1997b). *Research for health sector reform: Report of a WHO regional consultation, Bangkok, Thailand, 24-26 February 1997* (Document SEA/RES/105). New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1997c). *Tenth Meeting of the Directors of Medical Research Councils or Analogous Bodies and Concerned Research Foci in the Relevant Ministries: Report to the Regional Director* (Document SEA/Res/104). Bandung, Indonesia, 21-25 October 1996. New Delhi: WHO Regional Office for South-East Asia.

WHO-SEARO. (1997d). *Twenty-Third Session of the South-East Asia Advisory Committee on Health Research: Report to the Regional Director* (Document SEA/ACHR/23). Chiang Rai, Thailand, 22-25 April 1997. New Delhi: WHO Regional Office for South-East Asia.