The development management task and reform of 'public' social services

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Introduction: public sector reform and the New Public Management

The 'New Public Management' (NPM), closely associated with public sector reform programmes currently in various stages of design and implementation around the world, emerged as a 'conventional wisdom' (Mackintosh 1997) in the early 1990s. Part of the appeal of the NPM for modern-day reformers lies in its apparent coherence as a model for re-organising public sectors. Drawing on the new institutional economics or rational choice theories, the NPM advocates:

> [the] disaggregation of public bureaucracies; competition in the public sector (for example contracting out, quasi markets); and discipline and parsimony in public spending. (Rhodes 1995)

This approach seems to offer solutions to the problem of developing social service systems that can respond to growing populations and changing demands without increasing the financial burden on the state.

Secondly, the NPM appears to provide a 'common-sense', 'no-nonsense' approach to public management, deemed appropriate to building probity and efficiency in large, poorly-funded government bureaucracies (Mackintosh 1997). It draws on 'managerialism', a body of thinking which extols certain supposed qualities of private-sector management, namely:

> ...hands-on, professional management based on private sector management experience which sets explicit standards and measures of performance and emphasises output controls. (ibid.)

But is the NPM up to the job? Does it, in fact, provide coherency and an adequately grounded appreciation of 'public' sectors and 'public' management to meet the challenges of shaping and managing viable and responsive public sectors in the coming years? This article proposes that three questions require more detailed consideration when talking about public sector reform:

- management of what?
- management by whom?
- how to manage?

These questions are discussed with reference to the philosophy and practice of Community Based Health Care (CBHC) in Tanzania. This discussion highlights aspects of 'public' sector management to which prevailing international and national Health Sector Reform debates and documents, from their inception, have paid only cursory attention. Firstly, the fact that 'public' sectors are geographically and historically context-specific, being constructed through processes of contestation and negotiation, including (and excluding) a range of actors. Secondly, that the fact of multi-actor involvement in public social services requires more than an output-oriented, efficiency approach to public management. It requires management of a wide array of relationships which cut across organisational and sectoral boundaries. Therefore, the questions raised here are relevant to all development managers — whether central government policy-makers, NGO activists, civic leaders, local government planners, for-profit entrepreneurs, or donor agency staff. For it is they collectively — at times inadvertently, at times with intent — who are constantly shaping and misshaping 'public' sectors and their management.

Management of what?

Community Based Health Care: what is it?

Originally developed by the African Medical and Research Foundation (AMREF) in Kenya, CBHC is the complement to the more familiar Institution Based Health Care (IBHC) approach to Primary Health Care (PHC). It is now widely used in Tanzania and Uganda. The focus of CBHC is on individuals and households within the community setting, and beyond the formal health service delivery unit. CBHC seeks to address the basic PHC problematic: that the majority of cases presented at rural village health posts and dispensaries are 'home-preventable'. They are

health problems which tell the tale of poverty — in income, environment (sanitation, water sources, housing quality), education, power, and organisation. The CBHC approach recognises that these are issues that no health service facility can address alone, even where that facility is well-resourced and has the capacity to deliver quality health education and advice. Therefore CBHC seeks to develop people's health awareness and healthful practice within a framework of empowerment and collective action. The motivation behind this can be very simply expressed by the notion that a recurrently sick child is a burden on a mother's time, which is, in turn, an issue for the household. Recurrent and unresolved problems for a household are an issue for the community. And ultimately, what cannot be dealt with by the community is a concern for the nation. Thus, CBHC makes a direct link between individual health problems and public commitments, focusing on community members as key actors. Individuals are important not simply as individual consumers of health services, but as actors who take on their communal responsibilities and who are in turn supported by a national health and development system.

Through a process of facilitated dialogues and learner-centred training, CBHC trainers work within villages to build awareness and understanding of health as inextricably linked with all aspects of people's lives; to explore local needs, priorities and resources; and to develop confidence and capacities to take action. In the Tanzanian context, a common example of the use of such dialogue is with villages or wards which are organising for the rehabilitation of their local, usually government-run, dispensary. *De facto* responsibility for these physical facilities and ancilliary buildings such as staff houses, lies predominantly with the village government. Requests for additional support are usually processed through district government channels, and via these, to NGOs and other actors. This request provides an entry-point for questions and discussions with the villages involved about whether the dispensary is the real, only, or most immediate solution to the key health issues of the user community. Through these discussions, the motivating concern behind the proposed project is often revealed. For example, a high incidence of childhood morbidity or mortality linked to a particular illness such as diarrhoea, malaria, or other environmental health problems. Further dialogue about the cause and effect of the disease can lead communities to review their plans, deciding perhaps to tackle water supply and usage first, or to support the training of peer educators to carry health-related messages to their neighbours, or to reconstitute or revive the leadership of the village health committee so as to ensure they are more active or representative.

CBHC is about health education and awareness. It is also about building organisational and management capacities more generally. These capacities include consulting over the mobilisation and use of village resources. In the interest of better management of these resources, some CBHC interventions may also include start-up support for income generating activities, payment-in-kind for community health workers and services, and exploring schemes for managing community-based payment for, and distribution of, drugs and other material supplies.

CBHC is also about the larger system within which communities are located. For most proponents of CBHC that means the government health and development service system. In order to manage and promote improved health on an ongoing basis, villages have to be well linked to other development actors, in particular government. Most CBHC interventions seek to improve these linkages by working not simply with villages, but also with government departments. The idea is that better understanding on both sides will increase responsiveness and the relevance of support, whether this is the loan of the district truck for transporting building materials, allocation of new staff, or the inclusion of a village project in the next year's district development budget.

CBHC and public sector management

Much of the international health sector reform debate focuses on the formal health service delivery system, government programmes and units, and central policy mechanisms. In all the talk of public/private split, cost-recovery and 'basic essential health care' packages (World Bank 1993), it is easy to forget the history of health debate. Yet deep within this debate lies a fundamental question: what *is* the public sector in health? Is it government regulation of a market-mediated, professionally designed health *care* system, or a system which takes health *development* and the politics of access and equity to heart?

The CBHC emphasis on community involvement in health serves as a reminder of the PHC agenda articulated in the Alma Ata Declaration of 1978. That declaration, and ensuing programmes and publications, captured an international conviction that community participation, inter-sectoral collaboration and affordable technologies 'in the context of equity and social justice' (Monekosso 1992) are key to building better health services and better health in developing countries. With its emphasis on diversity of need between and within communities, CBHC also indicates that the 'public sector' encompasses an arena of action in which priorities,

resources, and activities are various and contested. By advocating, for example, that health education needs to be based on local realities, institutions, and problem analysis — not simply on externally designed standard messages delivered from health facilities — CBHC identifies the need for an appreciation that policy design and implementation cannot just be the preserve of centralised technical experts. Policy design and implementation is about prioritisation, and the allocation of scarce resources. CBHC is one approach which seeks to give communities some space and voice in this arena.

At the same time, there are many limitations on the implementation of PHC. These provide a significant management challenge to those governments, which like the Tanzanian Ministry of Health, maintain their commitment to PHC as the basis for building a health system which will be 'cost-effective, efficient and sustainable' (Ministry of Health 1994a). The Ministry notes that PHC has tended to be misconceived at all levels. This means that in practice it has been reduced to specific programmes and interventions such as vaccination campaigns. In addition, the cooperation between sectors and agencies for which comprehensive PHC strives has been weak. These difficulties are neither uncommon nor surprising given the revolution in professional thinking and practice that comprehensive PHC requires, with its emphasis on 'the *promotion* of health through a partnership between health and other professionals and the community, as well as a system of treatments and curative care based on meeting the health needs of the majority' (MacDonald 1992). As MacDonald notes, however, there is a persistent tendency for health care provision to focus mainly on the curative care provided by medical professionals in formal service centres. This view of health care needs dominates health policy, restricting efforts to open up the debate.

There is also a continual need to reconcile community involvement in health with national frameworks and strategies. An overly macro-level focus on the part of policy makers can limit appreciation of diversity, but so too, a purely micro-level emphasis neglects the importance of potential national public concerns, such as ensuring national service coverage and equitable access. Currently, the proponents of the CBHC approach in Tanzania can be criticised for not grappling as effectively with macro-policy concerns as they could. But in its practice, CBHC is engaging with many of the problems that the Ministry of Health has identified in existing PHC policy and practice. This is because CBHC takes as its starting point a multi-actor, bottom-up, system of action which is based on local needs, existing resources, and improved lobbying for external support where necessary.

Management by whom?

Implementation of CBHC

The main actors involved in developing and implementing CBHC in Tanzania have been NGOs. The approach varies with context, history, and type of NGO. The local development office of a church may focus on training peer educators or CBHC facilitators identified through their parish system. Other NGOs work across groups of villages, describing these as cluster or area programmes. These groups of villages tend to fall within government administrative boundaries, and such programmes commonly involve the training of trainers within the ward and/or district government offices. These trainers may then be supported by the NGO in their interaction with village-level health workers, committees, and CBHC groups. Such an initiative may be part of an integrated development programme which also works on education, water, agriculture, and income issues. Alternatively, it may be health-specific, having emerged from Mother and Child Health (MCH) and other health promotion programmes. Some mission-run health service facilities have developed CBHC programmes from PHC outreach projects operating in the vicinity of their health centre or hospital. But if NGOs are the main implementors of CBHC, how do they fit into public sector management?

NGOs as 'private' service providers

International health policy debate has begun to recognise the significance of NGOs and other actors in the health sector,(1) but there has been inadequate attention paid to what their activities actually involve and how these are developing. While in many countries of Sub-Saharan Africa non-governmental health providers have consistently been responsible for a major percentage of health services (De Jong 1991) managed through fairly cooperative relationships with government (see Sivalon, 1995, on the Catholic Church as a service provider in Tanzania), Green and Matthias (1995) note a 'certain introspection' in health ministries which has produced a tendency to overlook this fact. When NGO activity in health is recognised, ministries tend to focus on particular sub-sections, such as mission-run hospitals. This neglect of NGOs arises in part from confusions about what NGOs actually are. Green (1987) notes a tendency to lump NGOs with the 'private' sector, and this is certainly the picture painted by the World Bank in its 1993 World Development Report, *Investing in Health* (World Bank 1993).

Yet the example of CBHC shows that while mission hospitals are active in community-based approaches to PHC, they are far from being the main actors in this area. Many other non-governmental agencies are not direct health service providers, but are working to build CBHC into existing government systems, with the intention of moving out of this activity in the medium-term. So if NGOs working in CBHC are not adequately described as private service providers, what are they?

NGOs as 'community activists'

Alternative views are provided by Gilson et al. (1994) who identify at least four categories of NGO action in health, more than one of which may be supported by a single organisation. These are: service provision; social welfare; support to the health system through training, supplies and so on; and, research and advocacy. The latter aspect can range from being 'community activists' — developing the PHC concept and training Village Health Workers (VHWs) — to advocacy and lobbying at the national and international level. Given its community-based activities, CBHC implementation puts NGOs in the 'community activist' category. Most CBHC facilitators would see themselves as change agents, not just supporting shifts in people's awareness and understanding of health, but ultimately working with communities to enable them to become more effective managers of their local and collective actions.

NGOs as 'public' actors

However, CBHC activities also highlight another area of NGO work which is rarely discussed. In the same way that NGOs should not be narrowly defined as private service providers, they should also not be lumped simplistically into 'civil society and all that'. A focus on community development is central to the work of most NGOs, but a not uncommon strategy in pursuing this goal is, for many agencies, to provide support to governments. Although this support may be primarily related to the NGOs' operational needs, they are not simply acting as implementors ('gap-fillers', contractors and so on) in government-defined systems, but as change-agents setting out to influence government policies and practices.

In terms of *government practice*, while NGOs may be the main initiators and implementors of CBHC initially, they seek to build the approach into existing systems, and this usually means local government. For example, in 1988 AMREF began a CBHC programme in

Rukwa Region, at the request of, and in collaboration with, the Ministry of Health and district governments. The agency trained and supported government CBHC teams, withdrawing its direct input during the mid-1990s. A similar example is provided by the Community Based Health Care Council (CBHCC). This council emerged from an earlier multi-agency (NGO and government) PHC Coordinating Committee, registering as an NGO in 1992. Initially supported by Oxfam GB, the Council's first work-plan covered nine regions and involved the training of key government staff within the hospital and regional or district structure. This initiative has left CBHC-trained personnel within the government structure, some of whom have successfully lobbied for support for extending CBHC from other NGOs. In some cases this may involve government staff informally liaising with an NGO, or being formally seconded to the agency for a period.

Direct training and support of government staff in CBHC is only one aspect of this NGO-government relationship. Many NGOs also link their CBHC activities with other health support services they provide. For example, NGOs which are involved in the delivery of government vertical health programmes, such as family planning, HIV/AIDS, and malaria control may integrate these with their CBHC programmes, supporting community-based care for AIDS patients, and providing communities with information and education prior to vaccination programmes in addition to providing logistical support (drugs, transport, and funds) for these campaigns.

A history of interaction between NGOs and local governments in these areas has led to localised attempts to build cross-agency collaboration, which range from informal networks that aim to share information, training, and community development approaches, to formal committees with some planning function.

In terms of *government policy* some NGOs have gone further with the promotion of CBHC. The incorporation of CBHC into the Proposals for Health Sector Reform (1994) is in no small way due to the relationship between AMREF's CBHC unit and groups in the Ministry of Health. Having worked with AMREF in Rukwa Region, the Ministry invited AMREF to conduct a study of CBHC in 1993, and the agency subsequently worked with the Ministry on the design of the National CBHC Guidelines (1994b). This example highlights how NGOs can also act as innovators beyond the local level, in some cases as active (though rarely acknowledged) contributors to public policy.

Reforming the system: the public action approach

The piloting, development and implementation of CBHC by NGOs provides just one example of how public policy and public sector management involves complex relationships between a variety of agencies, many of which are not governmental. Yet, whilst most development managers would acknowledge this reality, few are armed with the tools for thinking about its implications for their work. For example, while the Tanzanian Proposals for Health Sector Reform (1994) note that CBHC offers an approach which will 'empower communities to organise their health and health services within well defined Government administrative structures' (Ministry of Health 1994a), the health reform policy process itself has provided few opportunities for effective inputs from groups and organisations outside central government.

The example of CBHC highlights a need for a broader understanding of 'public' if reforms are to reflect what is happening in practice, and if they are to allow for more effective involvement by a range of key actors and stakeholders. The notion of *public policy as a process of public action* offers a way of thinking about the public arena which goes beyond a narrow focus on government systems or on policy as a matter of technical expertise.

> Public action is … not just a question of public service delivery and state initiative. It is also ... a matter of participation by the public in a process of social change (Drèze and Sen 1989, quoted in Mackintosh 1992).

Taking this definition one step further, Mackintosh suggests that public action also incorporates action on behalf of sectional interests, which would include for-profit actors. So what you have in the idea of public action is a recognition that the public arena is open to collective and purposeful manipulation by a whole range of actors. Therefore, public policy, and what is deemed at a point in time to constitute the public interest and the public sector, are social constructions which emerge from a dynamic political process. Having recognised this, what are the implications for the actual task of public management?

How to manage?

What does CBHC suggest about the task of public management?

'I am not a manager... I am a facilitator, an animator' (personal communication 1998).[1]

This government PHC/CBHC coordinator clearly does not see himself as the 'hands-on professional' manager of the NPM (Rhodes 1995). His perception of himself as a facilitator is resonant of the 'soft' aspects of management, which have long taken commercial sector managers far beyond a simplistic focus on goals, performance, and output, to the process and people aspects of management.

In the implementation of CBHC there are at least three groups engaged in the task of managing — communities, NGOs, and government. Not everyone in these groups would call themselves a manager. Few of those outside government employment will think of themselves as 'public' managers. Yet in their practices they are engaged in managing an ongoing process of defining public interests and taking public action. Their activities include lobbying for resources for projects, awareness-raising and discussion, formal meetings to allocate resources, training sessions to build skills, and joint planning activities. The CBHC approach recognises that this is not a set of activities which can be pre-defined and controlled so much as a process of building understanding and cooperation between parties which have diverse perceptions, needs, priorities, relationships, resources, and capacities.

CBHC does not offer a panacea for more effective public management. A study of its implementation simply highlights aspects of current practice, some of which CBHC facilitators set out to change. Many of these have a long history — lack of information-sharing, weak or non-existent consultation mechanisms, poorly defined agendas, externally defined priorities, limited resource control — which reflect limitations in structures and capacities on all sides. Proponents of community involvement in health stress the need for professionals in the health system to adapt their approaches, emphasising their role in 'negotiation, compromise, advocacy, teaching' (Hildebrandt 1994). These skills apply equally to government, NGO, and civic managers.

Unfortunately, in much of the debate surrounding health sector reform, limited attention has been paid to the implications of pluralism in organisation, agendas and action, or to the shifts in philosophy and practice

which are required to manage this. The efforts of the 1980s to operationalise PHC by taking district health management as the logical focal point can be criticised for their over-emphasis on the government system to the exclusion of appreciating the role of, and relationships with, other health actors. A limitation in the current health reform agenda is its excessive faith in the power of policies to create an 'enabling' environment (Save the Children Fund 1993). The 1993 World Development Report talks of decentralisation without reference to the sophisticated debate about the notorious political and practical difficulties of actually implementing this. And despite a lot of current rhetoric about partnerships for health, there are few who have considered and explicated the management implications of privatisation, de-regulation, dis-aggregation and the like, either for government managers or their counterparts in other organisations.

Developing the capacities: public management as management of interdependence

There are significant problems in moving from a state-centred, hierarchically managed view of public policy based on notions of control, to a more decentralised and pluralistic system. In the current health management system in Tanzania, the district government role has not been conceived of as a policy role. There is little emphasis in practice on information analysis, team work, or strategic thinking. The district has been treated as the implementing arm of central government. Similarly, at no level of government are other actors such as NGOs or community groups explicitly thought of in any capacity other than implementation, despite their impact, however localised, on health infrastructure, management, and systems. Finally, non-governmental actors of all kinds often fail to think through their own roles *vis-à-vis* government systems and policy. What is commonly missing is an appreciation and analysis of *interdependence*.

Recognising that public managers are operating in a pluralistic world, caught in an 'increasingly complex net of interdependence', Geoffrey Vickers suggested that goal-setting approaches to public management were insufficient to the task (Vickers 1983, cited in Rhodes 1995). He advocated that public management should be understood as regulation, or the task of:

> ... maintaining through time a complex pattern of relationships in accordance with standards or within limits which have come somehow to be set as governing relations. Its regulative function consists partly in maintaining the actual course of affairs in line with

> these governing relations as they happen to be at the time and partly in modifying these governing relations....
>
> ... the goals we seek are changes in out relations or in our opportunities for relating: *but the bulk of our activity consists in the 'relating' itself.*
>
> (Vickers 1968, quoted in Rhodes 1995, emphasis added)

For Vickers, public managers are engaged in a task of 'appreciation' and of making 'multi-valued choices' through this process of regulating interdependence. All too often, proponents of the NPM gloss over these more qualitative aspects of public management by adopting the language of pragmatism, but as Rhodes (1995) points out:

> ...management in the public domain has distinctive tasks, purposes and conditions. For example, it determines collective values out of the mosaic of conflicting interests. NPM is confined to the values enshrined in the '3 Es' of economy, efficiency and effectiveness, and it does not encompass broader notions, such as the public interest and public accountability.

Conclusion

The NPM would not be the first in a long line of management 'theories' which say more about the way the world *should be* or is *assumed to be*, than about what *is*. The promotion and implementation of CBHC reveal some important aspects of what *is* happening. Firstly that the 'what' of the public sector is not just a set of definable government functions which can simply be privatised and dis-aggregated. It is constantly being redefined in an arena of public action which is home to a range of non-governmental agencies. These are continually initiating action in the name of improved public health, defining new areas for government support, and of public concern. This is the second point: the 'whom' of public sector management includes non-governmental actors, from direct health service providers working within the formal health system to broader development agencies concerned with grassroots empowerment and community development. These agencies are actively involved in relationships with various parts of governments, in the interest not just of implementing CBHC, but of shaping the nature and focus of public management. This fact has implications for the 'how' of public management. These relationships are complex, political, and often fragile. They require management, and of the kind which goes beyond target setting and quantifiable outputs.

The notions of public action and interdependence offer a way of thinking which can be applied by all development managers to the context within which they work. One of the key challenges for the architects of public sector reform is to use these perspectives on public management as a starting point for building the structures, incentives, and capacities on all sides to manage the process of continual re-negotiation of what is being managed, by whom, and in what ways.

Note

1 For example, the World Bank notes that NGO spending on health in developing countries was estimated to be US$1 100 million in 1990 (US$830 million from NGOs' own sources, US$242 million from bilateral donors, US$21 million from the UN system, and US$7 million from foundations), at a time when total external financial assistance to the health sector from donor countries was US$4,794 million (World Bank 1993).

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