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Rethinking the Public Sector: NGOs, Public Action Networks, and the Promotion of Community-Based Health Care in Tanzania

by

Dorcas Robinson

DPP Working Paper No 38

Rethinking the Public Sector: NGOs, Public Action Networks, and the Promotion of Community-Based Health Care in Tanzania[1]

by Dorcas Robinson[2]

1. Introduction: The New Public Management

The term 'New Public Management' (NPM) conjures up a long list of associated words - efficiency, output, performance, contracting, deregulation, professionalism - reflecting the two major influences which have shaped the NPM concept:

> "The first strand is *managerialism*, which refers to hands-on, professional management based on private sector management experience which sets explicit standards and measures of performance and emphasises output controls. The second strand is based on the new institutional economics, also known as rational choice, which argues for 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)

These tenets of the NPM are in the air of international social sector reform , as evidenced by the World Development Report of 1993, 'Investing in Health', which has mobilised multi- and bilateral donor collaboration. That agenda is captured by the core recommendations of the World Development Report:

- Reorienting the state from being regulator, provider and funder, towards the state-as-regulator;
- Increasing the role of the private sector in the provision of services;
- Introducing Community Health Insurance and Cost Recovery Schemes as strategies for financing services; and

1 This paper has been presented at the conference on Public Sector Management for the Next Century, organised by the Institute of Development Policy and Management, University of Manchester, 29 June - 2 July 1997.

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- State provision of 'basic essential health care' packages (the provision of a limited and targeted safety-net, generally focused on immunisation and micronutrient supplement programmes, school health programmes for worm treatment, family planning awareness programmes, and AIDS prevention and STDs).

Emerging as a 'conventional wisdom' (Mackintosh, 1997), the NPM is presented both as a coherent model for re-organising the public sector, and as making unquestionable common sense, because it portrays management as a technical matter. These qualities are important to reformers, as they ostensibly address two key concerns: a) the problem of how to develop social service systems which respond to growing populations and demands without increasing the burden on the state; and b) the problems of probity and efficiency in large, poorly-funded government bureaucracies.

But does the NPM provide an appropriate conceptual basis or an adequately grounded appreciation of management tasks to meet the challenge of shaping and managing viable and relevant public sectors in the 21st century ?

Looking at different aspects of health policy development in Tanzania - the emergence of Community Based Health Care (CBHC) as national policy, and Health Sector Reform as policy change devised at the centre - the paper suggests that there are two significant weaknesses. Firstly, oversights concerning the ways in which 'public' sectors are constructed in real contexts: that what constitutes 'public' emerges through dynamic multiactor processes involving value-based choices. Secondly, failure to address the management implications of multiactor involvement in public services, increasingly important as public sectors decentralize and privatise. Although not unique in this, prevailing international reform agendas tends to reinforce approaches to policy which describe the way the world *should be* or is *assumed to be*, often obscuring what *is*. The study of CBHC reveals the existence of networks of action between government and NGO staff, departments and programmes, which in practice help to shape local and national public values, structure and management. The paper concludes that this reality makes it imperative to rethink what is meant by 'public' sector and 'public' management. It posits that the notion of multiagency public action networks engaged in a constant process of interaction and value redefinition, provides a more realistic conceptual framework for policymakers and managers grappling with the 'public', than market versus state, output-oriented 'efficiency' approaches.

2. Defining and Managing the Public Sector

2.1 Community Based Health Care: Policy Emergence

The CBHC approach

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. CBHC is about individuals and households within the community setting, and beyond the context of health service delivery units. It is concerned with the basic PHC problematic: that the majority of cases[3] presented at village health posts and dispensaries are 'home-preventable'. These cases 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 if the facility is well-resourced and has the capacity to deliver quality health education. Therefore, CBHC seeks to develop health awareness and healthful practice within a framework of empowerment. It focuses on community, on local needs and understanding, on local organisation and resource, and on network linkages.

The community focus is about collective action. This is 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 (in terms of maintenance of livelihoods). 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. CBHC makes a direct link between individual problems and public commitments. Individuals are important, not simply as individual users of health services, but as actors who take on their communal responsibilities, and who are in turn supported by a national system.

Understanding, and working with local needs is about recognition of diversity between and within communities. The provision of standardised packages in health service and education is not appropriate to all[4], justifying a place for community-oriented approaches to health.

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3 The profile of cases seen at this level includes malaria, diarrhoea, respiratory diseases, worms, and malnutrition. The impact of these health problems is most tellingly apparent in high levels of infant and maternal morbidity and mortality.

4 As the case of post-apartheid South Africa shows most starkly, the provision of some technically determined basic health package, along the lines of the WHO comprehensive package, is not appropriate to all communities (Chimere-Dan, 1992), which vary in socio-economic status and in history of public service provision.

Health education messages delivered from health facilities often make few inroads on the practices they are attempting to change, because they are externally derived and not based in local realities and institutions. Using a learner-centred approach to introducing PHC concepts (including disease cause and prevention), CBHC seeks to develop understanding with the community, and local agreement about appropriate changes in practice.

CBHC is also concerned with local organisation and action, and focuses on building management skills at community level. Through a process of facilitated dialogue, research, analysis and planning, community groups identify locally feasible action priorities. A classic example of the use of CBHC dialogue is in communities organising for the rehabilitation or building of a dispensary, which is how many agencies have made original contact with villages. Questions and discussion about whether the dispensary is the real, only or most immediate solution to the key health issues of the community, can lead to decisions to tackle water supply first, or to train community members to support peer health education, or to tackle leadership issues by changing the composition of village health committees. This process is a key element in supporting local organisational capacities, in terms of who is involved in decision-making, and how limited local resources are both mobilised and used. In addition, CBHC focuses on community financing activities, in order to minimise dependence on external support. It is concerned with the development, maintenance and management of resources, and may include start-up support for income generating activities, payment in-kind arrangements for community health workers and health services, and Bamako Initiative-style schemes for managing community-based payment for and distribution of drugs.

Finally, although the focus of CBHC is the community-level, the approach recognises that linkages between communities and other actors in the social service system are important, and must be promoted and made more effective. It is multiactor and intersectoral, encouraging CBHC trained Community Own Resource Persons (CORPS), Village Health Workers, Traditional Birth Attendants, religious and political leaders and government extension staff to work together at the village level. In order to move beyond duplication of work, or single, vertical programmes, CBHC also attempts to build intersectoral and multiactor awareness and committees at other levels from ward to district to region, drawing together government and NGOs.

Implementation of CBHC

CBHC has been developed, and is largely implemented, by NGOs. The approach taken varies according to the history and size of the NGO. For example, local church agency development offices may focus primarily on training parish educators identified through their existing links within village congregations. Other NGOs work across groups of villages, which tend to fall within existing government ward and district boundaries. This approach commonly involves training of trainers at ward or district government level, who are then supported by the NGO in their interaction with village health workers, committees, and CBHC groups. This may be part of integrated development programmes (also concerned with education, water, agriculture, and income), or may be developed around earlier health education programmes with a focus on an issue such as Mother and Child or reproductive health. Many NGOs, particularly the church organisations, have developed CBHC programmes out of old PHC outreach projects working from their own health centres or hospitals. Thus, CBHC is promoted by both service providing organisations in the formal health system, and broad development NGOs.

As indicated, the CBHC concern with networking and linkages means that whilst NGOs may be the main initiators and implementors initially, they generally seek to build the approach into government systems. For example, in 1988 AMREF began a CBHC programme in Rukwa Region, in collaboration with the Ministry of Health and local governments. The agency trained and supported relevant government staff, pulling back its input during the mid-1990s. A similar example is provided by the Community Based Health Care Council (CBHCC). This council grew out of an earlier multi-agency (NGO and government) PHC Coordinating Committee, and registered as an NGO in 1992. Initially supported by Oxfam, the council's first plan of work covered 9 regions and was concerned with the training of key government staff in the hospital and regional/ district structure. Subsequent diversion of Oxfam funding in the wake of the Rwandan refugee crisis has severely limited the council's activities, but has left behind trained personnel, a number of whom are now supported in their work by other NGOs.

NGOs also link their CBHC activities with other health support services they provide. For example, many NGOs are involved in the delivery of government vertical health programmes, such as family planning, HIV/ AIDS, and malaria control. They tend to integrate this with CBHC programmes, developing social marketing schemes for condoms and bednets, community-based care for AIDS patients, information and education prior to vaccination programmes, as well as logistical support (transport, drugs and funds) for these campaigns.

These implementation-related activities reveal a significant level of interdependence between NGOs and government. Not only do NGOs train and support government staff, they often have government staff seconded to them, and in recent years, there has been a growth in the number of NGO staff who are ex-government, which will no doubt continue in the wake of civil service reforms. A history of interaction has also led to localised attempts to build cross-agency collaboration processes. These include both formal committees, and informal networks, which aim to share information, training and approach.

CBHC and national policy

The objective of Tanzanian health policy is to 'improve the health and well-being of all Tanzanians, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people' (Government of Tanzania, 1994). The Health Sector Reform proposal and plans (1994-95) outline the mechanisms for meeting this objective. They build on earlier health policy statements which culminated in the first official health sector policy document in 1990 (Government of Tanzania, 1994), and maintain the government's commitment to Primary Health Care (PHC) as the basis for building a health care system which will be 'cost-effective, efficient and sustainable'(Government of Tanzania, 1994).[5]

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[5] The specific objectives of the health policy are:

- reduction of infant and maternal morbidity and mortality through provision of adequate and equitable maternal and child health services;
- promotion of nutrition;
- control of communicable diseases;
- ensuring availability and accessibility of health services to all in urban and rural areas;
- movement towards self-sufficiency in manpower;
- sensitisation of the community to common preventable health problems through building capabilities and genuine community involvement;
- promotion of awareness in government and the community that health problems can only be adequately solved through multi-sectoral cooperation;
- creation of awareness through family health promotion that the responsibility for ones' health rests squarely with the individual as an integral part of the family.

These:

" ....must be achieved through Primary Health Care (PHC) which is the central element of health promotion aiming at coordinated action by all concerned: health and health related sectors, local authorities, industry, non-government and voluntary agencies, the media and the community at large." (Government of Tanzania, 1994)

The Community Based Health Care (CBHC) Guidelines are cited as one of the tools for implementing this policy commitment to PHC[6], in recognition of the fact that previous government efforts have:

> "...concentrated on improving health institutions for the provision of health services. *This left out communities and other sectors that were providing health care.* It was noted that this approach was not changing the health status of the people of Tanzania.." (Government of Tanzania, 1994, emphasis added)

The reform proposal also notes, with reference to administration, that the existing regional, district, ward, village structure should be maintained:

> "The structure provides an effective decentralisation and coordination of community involvement in the health sector in conformity with other sectors. *The potential of linking Government and health administrative structures is further amplified by the results of the Community Based Health Care study.* The study recommends approaches that will empower communities to organize their health and health services within well defined Government administrative structures. It is recommended that the Government provides more support to CBHC activities since they benefit the majority of the population and represent the actual implementation of Primary Health Care." (Government of Tanzania, 1994, emphasis added)

The study referred to was carried out by AMREF in 1993, and the agency has subsequently been involved with the Ministry in the design of the CBHC national guidelines (1994), and supporting training development at the national PHC Institute in Iringa. That CBHC is now part of government policy reveals that not only are NGOs service-providers and government support organisations, called on by the government to implement its PHC strategy, in recognition of its own limited capacity. They are also innovators, and developers of public policy.

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6 The other 'tools' are: the District Health Planning Guidelines, the Health Management Information System, the Environmental Sanitation Guidelines and the Health Education/ Information, Education and Communication Guidelines.

2.2 Health Sector Reform: Policy Change

The health sector reform package, of which CBHC is part, seeks to address the ideological, financial, managerial and organisational problems identified in the existing policy and its practice (Government of Tanzanian, 1994). In some areas, this has required significant change, not least the reversal of the government's long-standing commitment to free health services for all. This has allowed for the introduction of cost-recovery in health services, and the piloting of Community Health Fund schemes, in addition to the earlier re-legalisation of private health practice. Restructuring of government through civil service reforms also supports a stated commitment to decentralisation in health management.

In addition to addressing these 'ideological' and 'financial' issues in the existing health policy, the reforms also focus attention on managerial and organisational problems. It is noted that there have been significant difficulties in the implementation of PHC, with a tendency for the approach to be misconceived at all levels. In practice, selective PHC (for example, vaccination campaigns, or vertical single-issue programmes) has been adopted, rather than comprehensive PHC, which builds action across sectors. Co-operation between sectors and agencies has been weak, and there is an absence of monitoring tools. This seems to indicate limited capacities and management support. It is into this existing state of play that privatisation, decentralisation and cost-recovery are introducing new management pressures:

> " Private Health Care providers (both for profit and not-for-profit) are now PARTNERS rather than opponents or competitors for the demise of the other." (Government of Tanzania, 1994)

This implies that multiactor relationships have been less than amicable in the past, but does not elaborate on the ways in which this dynamic might be changed.

The health reforms include the relocation of some regional government functions to the district-level, and the establishment of District Health Management Teams. There have also been clarifications of the Ministry of Health's relationship to regional government, and a shifting of the District Medical Officer's dual accountability to both Ministry and Prime Minister's Office, to a single line of communication with the PMO. However, these changes relate to internal government relationships. The reform package (documents and training support) does not address the wider managerial and organisational issues which stem from reorganisation of the public sector in health. Yet there are a whole set of management

capacities (awareness, appreciation, brokering, strategic planning) required when working with and regulating actors outside the government system.

Given the focus on decentralisation, it might be expected that these would be addressed in the District Health Management Guidelines. However, quite apart from their complexity and density, the guidelines are rather technically-oriented, and based on the assumption that managers are organised in a clear hierarchical line within the government system. Whilst the language of policy is decentralised power, existence of private provision, and the importance of collaboration, in the Management Guidelines, reference to working with other actors is limited to statements like:

> " In areas where there are 'special' programs financed partly or in total by external donors or NGOs, these *might* represented in the District Health Planning Team." (Government of Tanzania, 1995, emphasis added)

Relations between local level government managers, NGOs and other health providers still often range from ignorance of each others' activities to wariness to direct attempts at control. Although there are some examples of successful collaboration, as indicated in CBHC programmes, it is difficult to imagine how more successful cases will emerge without conscious support for government managers, which might include not only guidance on how to manage multiagency issues, but also indicate that interagency work is a positive must.

This contradiction between policies (old and new) which both explicitly and implicitly require multiactor interaction, and the practice, was present from the outset of the policy reform process.

The reforms in Tanzania are about the need to reorganise the health sector on a national basis, and to introduce more coherence in planning and management. As such, the process of policy initiation and design has been logically directed from the central office of the Ministry of Health. This has been supported by the multilateral and bilateral donor community in the form of consultation in the Population, Health and Nutrition Groups and the Health Sector Reform Committee. These meetings and a series of workshops enabled the Ministry's Health Sector Reform Working Group to produce the Health Sector Reform Proposal (1994), and the Health Sector Reform Plans of Action (February and May 1996). These, together with the National District Health Planning Guidelines (1995) provide the basic public documentation of health sector reform.

However, although the reform proposals recognise that NGOs are highly involved in health service provision (as illustrated by ownership of hospitals, health centres and dispensaries)[7], the majority have not been aware of the health reform process and content until the debate became public in the media. The same is true for government staff at the local level, whose introduction to reform has largely been subsequent to the completion of plans, and which has generally been focused on training workshops to build capacity to administer new funding arrangements. Policies and guidelines which call for 'partnership' and decentralisation, but do not outline what this means in practice and which do not positively encourage joint consultation, may well find themselves floundering in the same management issues as their predecessors.

3. International Health Sector Reform: Limitations of the New Public Management

Health Sector Reform in Tanzania is concerned with a set of organisational, managerial and financial challenges; in the implementation of CBHC, many of these challenges are already being addressed. CBHC promises to deliver on most of the fronts which the reform identifies as problematic. Focused on the development of community initiative, responsibilities and resources, it offers scope for: developing decentralised, responsive health services based on multiactor provision and intersectoral collaboration; for extending health education and preventive action; and for building community financing for health activities. Yet, the reform process and documentation does not fully recognise this, because at central policy level, NGOs are understood to be private actors[8], not public policy actors.

This is a view perpetuated at the level of international policy. As illustrated by four questions which arise from the World Development Report (1993) there are many implicit assumptions and glossed-over constraints in this view, which left unaddressed, at the very least hinder the process of reform implementation. Those questions are:

- What is meant by the 'private sector' ?
- How do multiple actors interact ?

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7 Ownership of health facilities on the Tanzanian mainland (1994):
Hospitals (Mainland)77 (Government); 85 (Voluntary); 9 (Parastatal); 4 (Other)
Health Centres265 (Government); 8 (Voluntary); 2 (Parastatal); 1 (Other)
Dispensaries 2, 218 (Government); 485 (Voluntary); 175 (Parastatal); 36 (Other).

8 Though they are also distinguished from for-profits in practical terms.

- What do different organisations do in health ?
- What are community health funds, cost-sharing and community management actually about ?

What is meant by the 'private sector' ?

> " In most circumstances, however, the primary objective of public policy should be to promote competition among providers - including between the public and private sectors (where there are public providers), as well as among private providers, whether nonprofit or for-profit." (World Development Report, 1993)

The question 'what is meant by the private sector ?' is equally the question 'what is meant by the public sector ?'. The implications in this statement are that public is state provision and that it may not be the norm; that market competition through private providers should be the organising principle; and that NGOs belong to the private sector. In other places (pp127-8) the Report does distinguish NGOs from for-profits. However, the failure to maintain the distinction throughout reflects a tendency among policymakers to base policy design and implementation on a two-sector model of the world. By grouping NGOs with for-profit actors, the advocates (and often critics) of these reforms are glossing over the differences of norms, behaviour and activity-type between the two types of organisation. Yet these will surely have a major impact on the type of provision which emerges, on cost, on regulatory mechanisms, and on assessment of 'efficiency' and 'effectiveness' ?

The significance of this is that, although the Report does make it clear that NGOs are important actors in health[9] (an important step forward, since in much of the early debate about the public-private split in health systems, many researchers were slow to acknowledge the role of NGOs), it does not explore the question 'important as what ?'. There are contradictory uses made of the concept of 'NGO' in current development discourse of which NGOs themselves are acutely aware, and to which they also contribute. At times, NGOs are 'neither...nor'. They are on the one hand depicted as positively different from the state, perceived to be closer and more responsive to users than government services; and on the other, as more appropriate than for-profits in certain areas because their activities are not determined by motives of profit. Yet on other occasions, NGOs are allocated to the private

[9] The World Development Report (1993) identifies the level of NGO spending on health as $1, 100 million in 1990, at a time when total external assistance to developing country health sectors from donor countries stood at $4, 794 million.

sector. A rather cynical conclusion is that NGOs are being represented as the soft face of privatisation - a way of easing from state to for-profit provision. But is this actually what NGOs are ? Many NGOs, view the core of their work as advocacy, on behalf of poorer groups in society, in the interest of equity of access to development, and usually vis-a-vis the state. Yet, by placing them in the private sector, these reforms are effectively describing NGOs as technical service providing units and as contractors in service systems. Is this a role that NGOs are willing to play ? Are they willing to provide a marketing front and safety net as the state is 'rolled back'?

How do multiple actors interact?

The Report does not address the advocacy activities of NGOs. The place it identifies for NGOs is in implementation of services, not development of public policy. This implementation is at the local level, where local government will be encouraged to 'work with' other actors, perhaps through district health committees, where 'there are important opportunities for governments to form constructive partnerships with NGOs to deliver essential clinical services' (World Development Report, 1993).

This is indisputable, and in many contexts it has been the state of play for a number of years, with, for example, NGOs acting as district-designated hospitals, and receiving inputs such as staff salaries from government[10].

However, one gets the impression from the Report that simply recommending decentralisation and interorganisational cooperation is sufficient for it to occur[11]. Yet despite de facto interaction between governments and NGOs, it is also evident to any agency which works at the local level that there are many barriers to making this real - including limited management capacities and experience on all sides, the dynamic nature of political will and its dependence on powerful individuals, and the lack of trust and understanding between

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10 Again, this reflects the significance of NGOs as health service providers. DeJong (1991) cites a study by Vogel (1989) which indicated that church missions provide 40% of health facilities in Cameroon, a figure similar to Uganda, and a WHO Primary Health Care Review which showed that missions were responsible for health care for 50% of the rural population in Zambia.

11 " Decentralisation of government health services is potentially the most important force for improving efficiency and responding to local health conditions and demands. It will be successful only when local government health agencies and hospitals have a sound financial base, solid administrative capacity, and incentives for improving efficiency - when they are accountable to patients and local citizens." (World Development Report, 1993).

organisations. The Report fails to tackle capacity to implement policy, placing excessive faith in the power of policies to create an 'enabling' environment:

> " In circumstances of severe underpayment of government staff it is unreasonable to expect high motivation and commitment to change, let alone improved managers." (Save the Children, 1993)

Whilst there is again consensus across the political spectrum about the desirability of decentralisation, in terms of its potential for the development of locally relevant social service systems, there is a fundamental question about what it actually means, and how it will be managed. If what is intended is decentralisation within the government system, then far more attention needs to be paid to the wealth of literature which charts a catalogue of failures in decentralising, deconcentrating and devolving. Similarly, the rather chaotic concept of 'decentralisation to the market' (Mackintosh, 1997) which seems to imply no management requirement, must be unpacked. There are quite obviously regulatory issues to do with the development of professional standards and ethical behaviour. What does this mean for government managers at the local level, now expected to regulate a range of health actors ? What could be learnt about this from the history of NGO-state interaction ?

What do different organisations do in health ?

Ambivalence around the distinctiveness of the NGO 'sector', is even more pronounced when it comes to differentiating within the sector. Where the existence of NGOs is recognised, there is a tendency in the public-private split literature, and within Ministries of Health, to refer only to specific sub-divisions of the sector, such as church-funded health clinics (Green and Matthias, 1995). However, as the case of CBHC shows, there are a number of development NGOs who see their programmes as being in support of broader health development. Gilson et al (1994) provide a useful breakdown of health sector functions, of which any one NGO may perform more than one. These are:

- service provision - 'providing comprehensive services from health facilities or addressing a particular problem (e.g. tuberculosis, blindness or AIDS)';
- social welfare activities - 'having particular concern for groups such as the disabled, children, youth and women';
- support activities - whereby NGOs are providing specific services such as training health staff or organising drug supply;

- research and advocacy - whereby NGOs play a role as 'community activists'. This includes 'developing and promoting the primary health care concept, community health workers and community financing approaches' and is often complemented by 'advocacy and lobbying at national and international levels'.

The Health Sector Reform package focuses largely on the service provision role of NGOs, though refers to the social welfare and support activities of NGOs, which can be useful in the provision of safety nets. However, it does not engage with the 'research and advocacy' function, under which Gilson et al mention the Primary Health Care (PHC) concept. This approach to health is totally marginalised within the World Development Report, which proposes a basic health care package which comes nowhere near the philosophy of PHC as outlined in the Alma Ata Declaration in 1978.

This omission is no doubt ideological[12]. PHC is based on recognition that health development, like development more generally, is political. It is about power and access, and is concerned with changing the terms of these. Concerned as it is with health *development* and its politics, not simply with health *care systems*, PHC does not lend itself easily to adoption under an NPM agenda[13]. It is an holistic approach which advocates intersectoral action, making it difficult to manage in linear ways. The range of PHC activities include many which lie outside the confines of the curative, bio-medical system, and it is difficult to quantify many of these in terms of inputs, outputs and results.

What are community health funds, cost-sharing and community management actually about ?

Although the World Development Report does not pay much attention to the issues surrounding cost-sharing and community health funds, it does refer to community-financing schemes, and says:

> " A large number of countries in Africa have had some early success with community financing as part of the Bamako Initiative led by UNICEF and WHO." (World Development Report, 1993)

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12 As Nelson (1995) writes: " The World Bank upholds a central myth of apolitical development, representing itself and the 'development' it promotes as apolitical."

13 " ...Primary Health Care means an approach to the provision of health services which emphasises the *promotion* of health through a partnership between health and other professionals and the community, as well as a system of treatment and curative care based on meeting the health needs of the majority... In most societies, health care provision focuses mainly on curative care based on insitutions and is mainly in the hands of the medical profession." (MacDonald, 1992)

One concern with this type of statement must be the language which tends to surround it. Just as 'decentralisation to the market' remains a dangerously unpacked notion floating in the air of reform, so are other terms which come pre-packed with glowing connotations - participation, empowerment. But what is this empowerment? What is meant by 'patient and citizen accountability' (World Bank, 1993)? Is this about participation as a means to empowering poor communities ? Is this empowerment in terms of consumer power in market-based systems ? Is this 'participation' of people in cost-recovery systems purely as a means for reducing government commitments to social services ?

Answers to these questions have significant implications for practice. Community management of health funds, insurance schemes and of health services requires intensive and ongoing support for organisational and management capacities. Like decentralisation, this is a concept which it cannot be assumed will work simply because it has been advocated. As study of the implementation of CBHC shows, this is an area in which NGOs are heavily involved, working to build collective skills and responsibilities around generating and managing funds within communities. If the role of NGOs is not understood to be more than service provision, then the experience and capacity they have in this area will go overlooked by policymakers.

4. Public Action Networks: Reconceptualising NGOs and the Public Sector

The processes through which CBHC has become a national policy priority; the processes through which it is promoted and implemented in practice, involve relationships which cross organisational and sector boundaries. Many of these are relationships with some history; others are newly emerging. On close inspection, these relationships begin to reveal themselves as networks between individuals, departments and programmes. These networks emerge around shared values, concerns, and histories. They are often efforts to maintain public sector activities in the face of extreme financial and administrative constraints. For example, government and NGO employees who have a common link through education, training and/ or work, developing collective strategies for promoting CBHC through informal discussion and action. This is a process of identifying the spaces within which commitments to the public can be acted upon. Often these are networks built on shared values, which ensure that certain attitudes and practices become institutionalised. These networks are not necessarily definable around individuals and organisations, but fundamentally shape action in the public sphere.

For example, Sivalon (1995) suggests that although shifts in government and church policy over the years have influenced the type of services the Catholic church has provided, the primary factor in the church-government relationship has been effort to cooperate, the commitment to which effort he believes derives from the church-educated background of so many government staff.[14] Similarly, with many government staff employed by, or seconded to, NGOs, these organisations are strongly imbued with the public-oriented culture and ethos which has dominated civil service training and policy in Tanzania. They also remain in constant contact with government preoccupations and plans through these personal relationships. And personal relationships often lead to organisational and programme links. A number of NGOs consciously build on these informal links, initiating shared work. Many have adopted the development of multiactor networks as an organisational goal in recent years - building these around awareness-raising, information-sharing and training in attempts to defend and promote public sector activity.

Often networks are nascent and informal, but others have emerged as steering committees or rolling programmes of activities. They are certainly volatile. This reflects the multiple identities of individuals and agencies, which influence the extent of, and possibilities for, interaction over time. Members of networks move in and out with shifts in personal and organisational politics, resources and priorities. Ultimately though, fluidity and dynamism should not obscure the importance of networks as a mechanism for coping with change in the public sector, and for shaping its values and activities.

However plausible reform proposals may sound, the substantial problem of how these are actually to be implemented and managed in order to meet their overall objectives, remains. Networks around public sector action are real efforts to tackle this problem. By seeing them, policymakers and managers could be in a position to act strategically in order to support the conditions for their development. In order to make these networks more visible, a framework is required which: a) captures the multiactor and dynamic reality of public policy; and b) recognises what this implies in terms of public management activities and capacities.

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[14] It is worth noting an important point about networks. Sivalon looks at the significance of the churches in educating the political elite. Amongst others, he cites the list of the 1957-8 graduates of St Mary's Catholic Secondary School for boys in Tabora, which indicates that 55% were in national ministries, party departments and international agencies, at the time of writing.

Public policy

The notions of public action and of policy as process provide the basis for such a framework. Public action understands 'public' to mean more than government provision of services, or of decisions and actions taken by government employees:

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

Mackintosh advocates a definition which goes further than this, to incorporate action on behalf of sectional interests, which would include for-profit actors Thus, public action is collective, purposeful manipulation of the public environment. This goes hand in hand with the idea that public policy is not a matter of prescription and technical expertise, but it is about process. Public policy and the public sphere are therefore social constructions; constructions which emerge out of a dynamic of multiactor interaction and the constant decision-making from a range of multivalued choices.

Public management

Geoffrey Vickers developed the notions of regulation, appreciation, multivalued choice and interdependence, which drive at the core of the public management task. Vickers (1983) recognised that the world is characterised by an 'increasingly complex net of interdependence' (Rhodes, 1995). The disaggregation of public bureaucracies further increases this, and highlights the insufficiency of the 'target-setting style' of management in dealing with this. Highly critical of the goal-setting approach, Vickers advocated that public management should be understood as regulation, which is about:

> "...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 our relations or in our opportunities for relating: *but the bulk of our activity consists in the 'relating' itself* (Vickers, 1968)" (Rhodes, 1995, emphasis added)

Vickers also identified 'the multi-valued choice [as] a central, inescapable, irreducible fact of life (Vickers, 1970)' (Rhodes, 1995). Yet often the proponents of the NPM seek to avoid the 'inescapable', glossing over fundamental issues by adopting the language of pragmatism:

> " By emulating private sector management, New Public Management plays down the importance of the multivalued choice because it seeks to depoliticize management in the public sector....[but] 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 '3Es' of economy, efficiency, and effectiveness, and it does not encompass broader notions, such as the public interest and public accountability." (Rhodes, 1995, emphasis added)

At the level of the manager, the NPM suggests that the task is clear-cut, in that it is simply a matter of technocratic decision-making. However, in the real-world situation, Vicker's notion of appreciation may ring truer than technocratic views, with managers themselves. In other words, the existence of multi-valued choices involves managers in a constant comparison of the proposed course of action with governing norms, and in turn produces an evolution and modification of these norms. Policy-making involves appreciation of the state of the system (reality judgements) and the significance of these facts (value judgements).

This is an understanding of management shared by the Open University Master's programme in Development Management where it is identified as:

> "The management of *intervention* aimed at *external social goals* in a context of *value-based conflict*' (Thomas, 1996) which is inherently multiactor.

5. Conclusion

Understanding public management to be about management of relationships and values; understanding public sector development to be about dynamic processes in which many different actors are involved, is only to recognise what happens in reality. The example of the ways in which CBHC is implemented in Tanzania, and the ways in which it has arrived on the national policy agenda, reveal that the situation is not one of two sectors with clear demarcations between which 'rightfully' plays. What role in policy or practice. Instead, it indicates processes of constant interactions between people, organisations and the values these seek to promote. These processes can be seen as occurring through overlapping and interacting networks of public action, which allow managers to cope with change, and which

create spaces for continued commitment to forms of collective and public action.[15] The real challenge for public sector development is to use this image of the organisation of the 'public' as a starting point for the building of capacities, on all sides, to manage constantly changing relationships and value choices.

15 Use of the concept of public action networks would also help to make more visible other networks which are promoting very different views of health, public sector development and NGO roles from those which NGOs hold and practice.

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