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In Search of Failure: Guidelines for Ministries of Health

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This article is a sarcasm on why ministries of health in developing countries fail in their responsibility for providing adequate health care.

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Numerous papers and documents have been produced to assist Ministries of Health in developing countries to fill their roles more effectively. The World Health Organization, for example, has developed a number of such documents. Significant efforts include "Information Support to Health System Development and Management" (WHO 1988b), "Strengthening Ministries of Health for Primary Health Care" (WHO 1988c), "National Health Development Networks in Support of Primary Health Care" (WHO 1986a), "Planning and Management for Health" (WHO 1986b), "Planning the Finances of the Health Sector : A Manual for Developing Countries" (Mach and Abel 1983), and "Managerial Process for National Health Development: Guiding Principles" (WHO 1981). The World Bank has also entered the arena with a series of country specific documents including such ones as "Poland: Health System Reform" (IBRD World Bank 1992a), "Zimbabwe : Financing Health Services" (IBRD/World Bank 1992b), or "Brazil : The New Challenges of Adult Health" (IBRD/World Bank 1990), and the "World Development Report 1993: Investing in Health" (IBRD/World Bank 1993).

Despite their internal merit, these excellent efforts to assist ministries of health to improve their management and to achieve a measure of success may be totally off target. In many specific and many more general situations, ministries of health in developing countries *act* as if their goal is not success, but rather that their goal is failure. Without necessarily subscribing to the notion that ministries of health actually seek failure, it still might be interesting to speculate on what activities such ministries should engage in, if they were seeking to fail.

This is not an idle activity. If the goal of ministries of health in developing countries is actually to succeed—despite what appearances often suggest—then a few observations on how to fail might provide countries with useful guidelines as to what they should strive not to do. On the other hand, if the goal of ministries of health is failure (and in

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our observation, this seems to be precisely the goal of ministries of health in many developing countries), it is the contention of the authors that it' is often as difficult to fail successfully as it is to succeed. Consequently, a set of guidelines for failure would seem to be just as important as guidelines for success. So, in the spirit of technical assistance, but at the same time, seeking not to impose upon a developing country the "Western" or "Northern" view that a ministry of health must be in the business of succeeding, the authors offer the following Guidelines. Ministries of health seeking to fail should 1) select high sounding but unattainable goals, 2) assure inadequate funding for the health sector and for individual projects, 3) centralize all decision making, 4) initiate an unwieldy management information system, 5) post untrained personnel and move them often, 6) create an illogical organizational structure, 7) assure the ineffective use of supervision, 8) decentralize the administrative structure, but not authority, 9) delegate as little authority over money and people as possible, 10) limit both internal and external communication, 11) target the relatively well-off for health sector services, and 12) use donors in a creatively inefficient manner.

To be clear as to how these guidelines will move a ministry of health closer to failure, each deserves some further elaboration and discussion.

1. Select High Sounding but Unattainable Goals

The first and most important requisite for failure is a set of high sounding and irreproachable but unattainable goals. "Health for All by the Year 2000" (WHO 1979) is an excellent example. While this seems, on the face of it, to be unassailable as a goal, it has no objectively measurable referents. WHO has said that health for all is a level of health that would permit people to lead socially and economically productive lives (WHO 1984: 9). But what is a socially and economically productive life, and how do we measure it ? Is it the same or different for a person living in Africa as for a person living in Europe ? Is it the same for men as for women ? How can we tell when it has been achieved? We may speak of infant mortality rates, or under-five mortality rates, or life expectancy, or maternal mortality, or disease specific mortality or morbidity, but all, of these are assessments and measures of disease, or of societal malaise, but not of health; surely they are not measures of WHO's socially and economically productive life. In short, then, how will a country know if it is achieving "Health for All"?

Further, many developing countries recognize the ephemeral nature of the goal, "Health for All," and either do not take it seriously, or simply do not have information with which to assess the prevalence of socially and economically productive lives. In 1989 Nigeria attempted to gather information on progress toward the Health for All goal (Lambo 1991). Only 15 of 75 surveyed local government areas (LGA) responded, with the nonresponse attributed to having "nothing to report." Among myriad other weaknesses, lack of information was a primary problem thwarting the assessment of progress toward Health for All. Based on the progress documented in the self-reports, the study concluded that "the evidence available is that HFA by the year 2000 is still illusory and will continue to be so ....the obstacles to be overcome are so great that, even if both visible and invisible hands work together, it is not likely that HFA will be attained by the year 2000" (Lambo 1991: 57).

Less illusive, but just as valuable for assuring failure, are goals such as those promising "to reduce infant mortality from 100 to 50 in seven years," or "to reduce maternal mortality from 800 to 400 in seven years." While those are very clear goals, they are

useful for assuring failure in two important ways first, the goals as stated (these are actual, rather than hypothetical examples) are probably unattainable in the best of circumstances, and second, despite considerable international experience in the reduction of infant and maternal mortality and in other similar changes in health status, there is no clear-cut, widely-agreed-to prescription to be used by a ministry of health to bring these changes about. In consequence, almost any activity, no matter how unproductive, can be claimed to be directed at the stated goals. For example, a country can initiate, an expensive program for training highly specialized pediatricians or ob/gyn physicians, to serve only in the major hospitals of the capital city, and claim that this is the mechanism they will use to reach the mortality reduction targets. The setting of goals for which the mechanisms for attainment are unclear is a highly effective strategy to assure failure.

If a ministry of health truly seeks to fail, it should in no case make the mistake of stating its goals in concrete terms that have, at the same time, a clear mechanism by which they may be realized. For example, to say that a goal of a ministry is to assure that every mother in the country will have access to a trained birth attendant at the time of delivery would be an example of an excellent way to undermine the best efforts at failure. Mechanisms for training, posting, and supervising a person to serve as a birth attendant are relatively straightforward and clear. A ministry that has stated such a goal will run the risk that it will be taken seriously by persons who do not understand the quest for failure, and the goal may actually be realized. Or, for example, a ministry seeking failure should avoid such a mundane but deceptively useful activity as defining a specific set of essential public health functions (monitor water sources, provide immunizations, assure timely-response to infectious disease outbreaks). Defining essential public health functions and providing adequate funding and good management run a definite risk of succeeding in solving local and national health problems.

2. Assure Inadequate Funding for the Health Sector

It may seem so simple as to require no discussion, but it is surprising that the importance of inadequate funding for ministry failure is not always recognized. Some developing countries devote eight to ten percent of their government budget to health. With this level of funding it will be very difficult to assure failure. Chances of failure improve with severely restricted allocations to the health sector.

One clear effect of restricted funding is meager and unreliable salaries for health professionals; this situation not only demoralizes workers, but also tends to drive them out of the clinic to pursue alternative sources of income. Reflecting on the situation in one West African nation, Decosas (1990) writes, "Years of underfunding of the health care sector have resulted in low staff morale as well as complete depletion of medical supplies and pharmaceuticals. The staff has responded to this situation with the spirit of the entrepreneur, and today most employees (from cleaners to medical director) conduct some kind of private enterprise on the hospital premises : selling food, drugs, bed space, or treatment ....A woman in obstructed labor may well find herself discharged without being delivered if the family cannot raise the money for the operating room and the surgeon's fees" (Decosas 1990: 172).

Poor salaries are not the only means of using funding restrictions to assure failure. Major steps can be taken toward assuring failure by arranging inadequate funding for the supplies and equipment required to keep the system running; for example,

by seeing to it that there are no funds for spare parts, for routine maintenance of office equipment, or for expendable supplies. Limiting funds available to assure a clean, dust-free and relatively machine friendly environment can also further the cause of failure in two important ways. First, it means equipment is likely to have a shorter functional life, and second, it will help the ministry use up external funds in non-productive ways. Many ministries receive the bulk of their equipment photocopy machines, typewriters, fax machines, computers and printers, even clinic equipment from external funders. If they can limit the useful life of this equipment by lack of maintenance, lack of replacement supplies, and by a hostile environment, they will be able to replace the broken down equipment with other equipment that can in turn be allowed to become unusable. For the goal of failure, it is curious but highly fortunate that a donor will be much happier spending three to five thousand dollars to replace a photocopy machine or computer that no longer functions than spending a few hundred dollars to keep one running.

While they assist ministries seeking failure at the micro level, by aiding them to use up expendable resources with little apparent payoff, multilateral donors are also providing excellent support for failure at the macro level through economic policy measures. In recent years over 40 African nations have been obliged to implement structural adjustment programs (SAPS) in an attempt to check escalating debt (Loewenson 1993). Loewenson describes the short-term harsh impact of structural adjustment programs: retrenchment, cutbacks in public expenditure and social services, charging fees for social services, rising prices, and shrinking real incomes. These measures have many serious ramifications for the health care system. Workers are not only demoralized by an effective pay cut, but are forced to seek supplemental sources of income to maintain a decent standard of living. Meanwhile, health centers are denied fundamental supplies and equipment needed for basic services. The integrity of care is severely compromised, and the public, in turn, refrains from seeking care from the government facility. The situation churns into a downward spiral that may produce short-term savings but leads to the massive overall costs of a failed primary health care system.

3. Centralize All Decision Making

A third requisite for organizational failure is to assure that as many decisions as possible are made at the highest level possible. This means in practical terms that all decisions with regard to the functioning of the ministry should be made by the Minister of Health himself, or by the top administrative person in the ministry.

There are a number of reasons that decision making at the highest level possible will be likely to assure ministry failure. Most important, perhaps, is that the higher up in the ministry a decision is made, the more likely it is that it will be made on political, grounds. While political decisions may, on rare occasions, run counter to the effort to fail, in the health field they are often likely to lead to failure anyway, because those who have the power to make political decisions (men, the wealthy, those past their productive years) ace likely not to be the persons most benefited by the least costly and most effective health services (women, children, working persons). Wealthy older men are likely to opt for such things as CAT scan equipment, specialist training in urology, and cancer hospitals.

A second value of moving all decisions to the highest level is to assure that decisions are made with as little information as possible. In any health service organization, it is the person at the point of contact with the patient who is likely to have the clearest

view of the difficulties faced by the organization. Persons immediately above service providers, their supervisors for example, may also have a clear view of organization problems. It is best to avoid allowing persons at these levels to make any decisions; recognizing the problems as they do, they may make decisions that will solve them. It is only people at the very top who are likely to have little enough information to assure that decisions will be irrelevant, inappropriate, or wrong.

A third benefit of moving as much decision making as high as possible in the organization is to assure that lower level people have no opportunity to develop the skills to make decisions. By requiring that decisions be made at the top, the organization will not need to fear the possibility that lower level people will learn how to make decisions. Assuring that no one but those at the top have the authority to make decisions is much safer than trusting to the possibility that the ethic of organizational failure can be successfully inculcated in staff at every level.

A further benefit of decision making at the top is the inability of staff at lower levels to act until the decision is made. This will successfully result in staff members at all levels having nothing to do because the appropriate decision has not been taken. Centralized decision making also reinforces workers' sense of powerlessness to make even the smallest changes in work processes to improve service delivery. Such a situation is highly conducive to late arrival at work, reading of the national paper if there is one, and early departures for personal responsibilities and home.

Centralized decision-making is particularly opportune in negotiations with external donors, such as during the process of structural adjustment. Based on experience in East Africa, Loewenson (1993) writes, "Planning has become the prerogative of the very few who sit at the same table and cooperate with the international finance institutions. Even senior national civil servants and professionals with local skills and experience are. reduced to `managers' of policies developed by international consultants, whose exposure to local conditions is a one or two week `mission'. The population is the last to know the program" (Loewenson 1993: 725)

Ministries should not, however, be tempted to accept immediately the reality that decisions will be made at a high level and on political grounds. Significant steps toward failure can be taken merely by creating the appearance of decentralized planning activity. After a planning activity conducted in one Nepal local area under the guidance of WHO technical staff, local health officials admitted that the process had been chiefly a political activity carried out as a necessary step in the quest for foreign aid. The process resulted more in the adherence to .international formats than in insight into national health needs and responsive strategies. Reflecting on this experience, justice writes, "Planning exercises ...have typically produced planning documents that may not be considered useful by the government officers but satisfy the sponsoring agency's needs. All too often the contents of the plans have either been too complex for the ...infrastructure to carry out or simply unrealistic in view of local conditions " (Justice 1989: 67). Sham decentralized decision making contributes greatly in the pursuit of failure, with the added bonus of wasted resources (in this case, time and talent).

In absolutely no circumstance should any initiative be undertaken to involve community persons in decision making, or to seek their input into the shaping of health services systems or health services delivery. Decision making by community persons

might lead to doing something that would be both useful and desired by the people themselves and runs the grave risk of subverting efforts at failure. Perhaps the best means of avoiding community input is to organize national meetings in which planners make a charade of participatory decision making. Health workers from peripheral regions are called to the capital to contribute opinions that are virtually disregarded once the experts get planning underway. Reflecting on such meetings in Nepal, a health inspector is quoted as saying that "we have developed a tradition to get people to give suggestions, but then do nothing about them. Workshops are merely a way of spending money from aid. We have poor working conditions in rural areas, such as lack of supplies and staff, which affect our efficiency, but no one at the Center is interested". (Justice 1989: 129).

4. Establish an Unwieldy Management Information System

A grand scale mechanism for promoting failure is to undertake the development of a management information system (MIS). If properly implemented, development of an MIS can lead to days and days of task force meetings, design and redesign of forms, and large expenditures on computer systems and software. Ultimately, if truly successful, an MIS creates a tremendous volume of paperwork and report preparation for care providers and supervisors. Such paperwork serves to displace service delivery, and is then rendered totally useless at the central level because nothing is done with the reports.

In order to assure that an MIS effort will support failure to the greatest extent possible, however, it is necessary to conceptualize the effort in the proper way. If mishandled it is possible for an MIS effort to backfire and actually produce information that might be relevant to decision making, which then could lead to problem solving, the opposite of what is desired. One long-term staff member of an international organization has suggested that the country should always start with the design of new recording and reporting forms, with an optimal situation being a trial period when both old and new forms are in use, doubling the recording and reporting requirements. Efforts should be made to confuse health status indicators, service performance indicators, and resource indicators, and to assure that the number of indicators in use will be as high as possible and of interest only to donors.

Another important aspect of MIS conceptualization is that the development work must be carried out strictly at the central ministry level, preferably by a group of persons with little service level experience meeting in a closed room. In no case should anyone from the service delivery level be permitted to participate in the development work, and no information should be sought from the service delivery level about the types of decisions that are made or the types of information that are required to make those decisions.

Through observations in Nepal, justice has documented two examples of properly flawed MIS efforts. The first involved the poor quality of statistics. Justice found that administrators and planners in the capital city were aware of the likely inaccuracy of data reported from the periphery, but accuracy did not seem to be of primary importance to them. What was more important was the existence of statistical data that could be exchanged throughout the system to justify the function of the administration and to meet the expectations of the government and donor agencies (Justice 1989: 126). A second major flaw was near exclusive reliance on statistical data, to the discredit of qualitative information presented in situation reports (justice 1989: 127).She attests that

governmental and donor administrators "often described social and cultural information as 'soft' data, saying it was too descriptive, too wordy and confusing, and too difficult to evaluate .... To take this detailed information into account would make their task more complicated. Thus, they tend to disregard information that is potentially confusing" (Justice 1989: 135).

5. Post Untrained Personnel and Move Them Often

The value of untrained personnel for assuring failure has rarely been overestimated. In fact, this tactic may not need explication at all for ministries of health, which accomplish the posting of untrained personnel in a manner that seems almost instinctual. Ministries are particularly adept at placing physicians with substantial clinical experience and absolutely no knowledge of planning, administration, delegation, supervision, monitoring, or budgeting, in positions that require them to plan, administer, delegate, supervise, monitor, and budget. Roemer (1993) writes, "Physicians (as well as the great majority of nurses) are taught to understand, to diagnose, and to treat the sick individual. They learn very little about the prevention of disease and the promotion of health. More important, they learn even less about populations-about how to understand and analyze their social characteristics, about the special ways that disease (both communicable and noncommunicable) strikes populations, about the strategies for control of disease in populations (both its prevention and treatment), about developing relationships with populations, and how to work cooperatively with people. Physicians learn virtually nothing about the effective management of human and physical resources for achieving a goal relevant to the health and well-being of populations." Assigning physicians the role of health service manager serves the cause of failure in two ways : it assures that planning, administration, delegation, supervision, monitoring, and budgeting will be wholly inadequate, and it takes an experienced clinician out of circulation.

But the value of untrained staff is not restricted to the administrative positions. It can be effective at all levels. In addition to, the benefit that an untrained person will not know how to do the job, there is a second and almost equally important benefit from posting untrained persons: the opportunity to send these untrained persons to frequent training courses. Training courses are one of the most effective ways to assure that there will be no one in a particular post. A well organized training course may be able to keep twenty to thirty people out of their posts for periods as long as three months, a great way to promote failure.

Another excellent way to keep people from filling particular posts in an effective manner is to move them often. Before they have an opportunity to learn what they are supposed to do, send them somewhere else. It is also good to hold out constantly the possibility of a transfer, particularly to a more attractive area of the country or to a better position. In such cases, it should be made clear that these transfers can be gained by soliciting them from the right persons at the central level of the ministry. Further, health care personnel assigned to the periphery will be quick to understand the impracticalities of actually moving their families to areas lacking water, power, reasonable schooling, or sufficient staff. Instead, by befriending Ministry officials; such personnel can enjoy the extra salary of a remote posting while using loopholes in the civil service regulations to. justify remaining in the capital city (Somlai 1993: 17). In this way, workers will voluntarily absent themselves from their posts for long periods of time while they lobby with the people at the center for a better position.

Even if a formal transfer is slow in materializing, or is simply not possible for some reason, the benefits for failure of moving people on a frequent basis can often be obtained from a mechanism known as deputation. In deputation, a person who is formally posted to one place (where he or she may have learned the job) is deputed to some other post (hopefully one for which he or she is totally unsuited). Deputation can have the same benefit as assigning a person to a new posting, but it frequently also has the additional benefit of enhancing the system's inability to replace the person who has been deputed. When a person has been deputed, the position that person held before deputation is still, on paper, filled by the deputed person. Thus, it is not possible to fill the position with a new person because the post is not vacant. Anyone who is to. take up the responsibility of the post will have to be deputed from somewhere else. In a ministry optimally organized for failure, nearly everyone can be on deputation from somewhere else and no one need have a real understanding of what he or she is supposed to do or how to do it.

6. Create an Illogical Organizational Structure

The creation of an illogical organizational structure is always an effective addition to efforts to assure failure. One of the most important mechanisms-many ministries of health have used it to assure failure for years-is a vertical structure at the central level and a horizontal structure at the service delivery level. The horizontal structure at the service delivery level (integrated services provided by a single over-worked provider, if one is actually posted or deputed at a particular spot) can be legitimized by the Alma-Ata convention of 1978 that called for primary health care as the panacea for all health problems (WHO 1988a).

The vertical structure at the center needs no justification because it conforms to the power structure at the center and provides each important actor a personal fief. It also conforms to the way in which donor agencies organize themselves and fund programs. The tension between the horizontal program at the periphery and the vertical program at the center will add significant force to the ability of a ministry of health to fail.

Unfortunately for efforts toward failure, many ministries have recently begun organizing themselves along horizontal lines at the central level, integrating all disease control efforts, or all family service efforts, for example. Still, the old turf struggles are likely to remain, and at the present time most donor agencies still wish to fund vertical programs. It is likely, therefore, that the vertical horizontal tension will continue to be an effective disruption to any retrograde counter-failure efforts for some time to come.

Staffing design is an aspect of organizational structure that can assist greatly in the effort to fail. One structure with great potential for failure consists of highly trained personnel working with no support staff. In particular, it is well to assure that a ministry has as many positions as possible for physicians at the service level (specialist physicians are particularly desirable) and as few positions as possible for nurses, nurses assistants, and other lower level service providers.

Another aspect of staffing patterns that can aid in the pursuit of failure is to put men into positions to provide sensitive services to women. Particularly in parts of the world where the education opportunities for women are limited, it is not likely that there will be an adequate supply of women who can become trained family planning counselors, outreach workers, maternal health

service providers, and so forth. Putting men into positions to provide services such as these is a certain means to assure that they will not be used and will significantly further the efforts of ministries of health to fail.

7. Assure the Ineffective Use of Supervision

A ministry that is conscientiously pursuing failure will be certain to use supervision in as ineffective a manner as possible. One obvious option is to provide little or no supervision. In most ministries of health, supervision requires someone in a supervisory position to visit health centers, health posts or other service provider units. To assure failure, these visits should not take place, or should take place as infrequently and sporadically as possible. A valuable mechanism to assure that supervisory visits will not take place is to have an official travel allowance (often referred to as TADA) that is rarely paid, is paid late, or is paid only partially. As long as TADA exists, people will expect it if they are to travel on supervision. If the payment of travel allowances is as idiosyncratic as possible, it will have the maximum effect on limiting supervisory visits.

If supervision cannot be avoided, it must be done in the proper manner. In no instance should supervision be used to provide any type of instruction on the correct performance of a task, to discuss work roles or responsibilities so as to make them clearer or more understandable to the worker, or to help workers conceptualize tasks in ways that might produce better or more effective services. When it is unavoidable, supervision should be used to provide negative feedback about the quality of effort, to inform a worker about sanctions that have been taken against him or her; or to administer punishment.

The decision by a provincial ministry in Papua,

New Guinea to decentralize health services administration provides a useful case study for those seeking methods for maximizing supervisory ineffectiveness. In 1990, the residents of the Western Highlands Province-population 264,000-were divided into 14 administrative districts. After only two years under the new system, health workers were complaining of-among other things-a lack of qualifications of District Assistant Secretaries, a lack of professional oversight of health professionals, and a lack of management training for district officials (Campos-Outcalt, Kewa, and Thomason 1995). Such methods can result in a brilliant failure of the decentralization program even without further effort on the part of provincial officials.

Weaknesses in the supervision of government health services in Nepal have been extensively chronicled. Aitkin (1994) has pointed out that given the absence of job descriptions and specified performance expectations, supervisors have no standard against which to assess performance. No standard supervisory protocol exists, and quality assessment and problem solving are not routine functions of visits. Verifying that the worker is actually at the assigned post becomes a chief function of supervision. One of the chief perceived benefits of supervisory visits was the supplemental income provided to the supervisor through the travel allowance.

8. Decentralize the administrative structure, but not authority

A strategy that can enhance the chances of failure, and at the same time make it appear that failure is not the goal sought, is to develop a decentralized administrative structure with no true responsibility or authority. A structure such as a layer of regional offices between the central and local offices will have several benefits. First, it can add significantly to the number of layers through which a piece of

information must travel before an action can be taken. This in itself leads to the waste of time and resources and enhances efforts at failure. Second, a decentralized structure can assist in furthering confusion about who is making decisions about which subjects. In this regard, it is very important to have unclear lines of authority as well as a decentralized system. The Papua, New Guinea decentralization project mentioned above provides a useful illustration of the benefits of structural confusion in the quest of failure. According to productivity data assembled by outside observers, health workers in the Western Highlands of New Guinea developed a predominantly negative opinion of the results of decentralization. In addition to the complaints about supervision discussed in connection with recommendation 7 above, they complained of a lack of equity in personnel between districts and a lack of role definition for provincial and district administrators (Campos-Outcalt, Kewa, and Thomason 1995).

Third, a decentralized administrative structure, because it leads to extended time in decision making and to lack of clarity about responsibility, will also be highly effective in eroding the morale of people at the periphery and particularly at the regional level, where administrators should be encouraged to think of their offices as no more than mailboxes. Some care should be taken in setting up a decentralized administrative structure, however. If proper steps are not taken to assure that real decision making authority is not decentralized, a decentralized structure runs the risk of violating recommendation numbers three and six above, and bringing decision making closer to the point where the decision issues are understood. Thus, if there is any doubt that decision making authority cannot be restricted to the center in the presence of a putative decentralized administrative structure, it may be better to avoid this strategy entirely.

9. Delegate as little authority over money and people as possible

This is, in essence, a corollary to the recommendation to centralize all decision making and bears on the issue of a decentralized administrative structure with no decentralized authority discussed above. This recommendation should be seen as specific, however, to the expenditure of funds and the hiring and posting of people. These are the two areas where control at peripheral levels can do the most damage to a concerted failure effort, because they are the most critical components of service delivery. Empowering workers to make full use of their skills impedes a health ministry's pursuit of failure. One study involving community health volunteers in rural Nepal found that the delegation of curative responsibilities increased the motivation of volunteers and their acceptance within the community, resulting in a positive return for all primary health care activities (Curtale et al. 1995). Likewise, care should be taken to prevent parents, especially mothers, from becoming empowered with the knowledge and resources to recognize and assist in the management of their children's health problems (Biddulph 1993). Such empowerment might result in the cost-effective utilization of scarce health care resources, thus jeopardizing ministry objectives.

10. Limit communication

Communication can be one of the most damaging factors in the pursuit of failure. Consequently ministries of health seeking to achieve failure will limit communication as much as possible. In particular, communication should be limited in three specific areas.

First, people in one unit of a ministry should not

be encouraged to talk to people in other units of a ministry. An admirable aid to limiting communication between units in a ministry can be to have them physically located in different buildings; ideally they should be scattered about the capital city. Further assisting in the limitation of communication is the presence of an inadequate telephone system. Unfortunately, some countries have developed their telephone systems with external assistance, and because they work quite well, cannot be counted on as an aid to curtailed communication.

On the other hand, an excellent aid to limited communication is the virtual lack of working photocopy machines and the absence of photocopy paper found in most ministries. As long as copies of important documents are not circulated, communication will not reach levels that will lead to coordination. Ministry officials wishing to limit communications should prohibit the installation of any sort of networked computerized health information systems. Even if such systems cannot be prohibited, however, they can at least be rendered ineffective, if not counterproductive, through careful management of the implementation process as described in the recommendation on management information systems above. Since the quality of information produced during a computerization process is only as good as the original data fed into it ("garbage in, garbage out"), communication via computer can be successfully scuttled through the ingenious application of flawed but expensive software coupled with inadequate technical support. According to Woelk and Moyo, officials at the Health Department of Harare, Zimbabwe have apparently allowed such an opportunity for failure to slip through their fingers after- the successful implementation of a health information system in that city (Woelk and Moyo 1995).

Another necessity for assuring poor communication is to keep people at all levels from visiting people at other levels of the system. In particular, personnel at the central level should be discouraged from visiting regional or local establishments of the ministry (this will be assisted by idiosyncratic TADA policies). If people at the central level do go to the regional or local level, they should stay as short a time as possible and talk to As few people as possible. To violate this guideline is again to run the risk that people at various levels will begin to understand the problems faced and to make decisions, even unauthorized decisions, that may lead to an effective act.

Limiting communication also means avoiding intersectoral coordination as much as possible. One of the very real problems faced by a ministry of health seeking to fail is the fact that in large part, the health status of the population (one of the primary areas of failure) is much less determined by what goes on in the health sector (and thus controlled by the ministry of health) than by what goes on in the education sector, the agricultural sector, the water supply and sanitation sector, and the industrial sector.. Ministries of health must avoid' coordinating activities with these sectors as much as they can, so as to assure that anything these sectors may do that is likely to influence health status in a positive way will be purely a chance occurrence. Further, ministries of health should outwardly eschew contact with these sectors, at all times giving the impression that health has nothing to do with anything but the medical care services directed by the ministry of health. In this way the ministry will be able to maintain as much control as possible over its efforts to fail, particularly at the macro-level.

11. Target the relatively well-off

One of the worst strategies that a ministry can adopt

in the pursuit of failure is to concern itself with the health situation of the most needy : the relatively poorer or less well educated members of the society; rural populations; populations living in medically underserved areas; or populations that have a large burden of sickness resulting from malnutrition, vector-borne diseases, or poor water supply and sanitation. The reason for ignoring such populations is that relatively small inputs, if effectively deployed, will have large results in terms of reduction of morbidity and mortality. The World Bank has determined that a minimum package of highly effective public health and clinical interventions could be provided in developing countries for less than US$22 per person per year. Such a package, if properly delivered, could eliminate 21% to 38% of premature mortality and disability in children and 10% to 18% in adults (Bobadilla et al. 1994). Thus, ministries of health aiming to fail must carefully refrain from channeling essential primary care services to segments of the population with the most acute needs.

Ministries of health should concentrate the major part of their efforts on the relatively well-off members of society, which usually means those members of society, who live in the major urban center or centers who can easily get to sophisticated and expensive medical facilities. One method of minimizing access to those financially less well off is to institute hefty user charges for health services. Since econometric models suggest that price elasticity of demand for health services is likely to be higher for lower income groups, such charges present the possibility of not only facilitating the wholesale failure of a national health care delivery system, but also tending to increase existing inequities among social classes (McPake 1993).

This also means that the ministry should find ways to promote advanced medical training to produce physicians to work in sophisticated urban hospitals. It will mean the establishment of additional medical schools or post-graduate programs in the country for the training of these people, and will mean the establishment of several sophisticated specialty hospitals to deal with maladies of the affluent, such as heart disease and cancer. If organized properly, several specialty hospitals could be developed that would require sixty to eighty percent or more of the total budget of the ministry of health just to keep their doors open. At the same time these facilities might serve no more than five or ten percent of the total population of the country. Few mechanisms to assure failure are so effective.

In targeting the relatively well-off, however, ministries need not abandon the less well-off sections of the population. As has already been discussed, the ability to fail on a grand scale means the ability to attract external funds to employ in this failure. Donor agencies are all suckers for the high-sounding phrase and will commit extensive resources to what they consider desirable goals, even if they know that the real benefits of their inputs (including a lot of perks like vehicles for ministry of health elite) are likely to go only to the one or two percent of the people in the country who can speak to them in a European language. Referring to the planners in Sierra Leone, Decosas (1993: 176) writes, "The economic elite (the comprador bourgeoisie) is enjoying excellent health care services without taxation or other state intrusion into their affairs. They are the importers of drugs and co-owners of private hospitals. Any plan that would divert public funds away from tertiary care institutions ...would also undermine their privileged position and economic opportunities.!"

The movement toward decentralization may aid the channeling of resources to the wealthy. "In

situations of elite control over local-level decision-making, public sector decentralization of functions and resources gives greater scope for such groups to further their own privileged interests through the selective channeling of resources and service provisions. Indeed, decentralization can be instrumental in strengthening an elite stranglehold over district-level government through the building up and consolidation of local patronage systems" (Collins and Green 1994: 471).

12. Use donors creatively

It has already been noted that the ability to attract donor resources on a large scale allows failure on a large scale. The more donor money that can be used by a ministry, the more effective it will be in its failure. The first point in assuring that as much donor money as possible can be cornered by the ministry is to deal with donors unilaterally. The most obvious benefit of unilateral deals is that no donor will know what any other donor is doing. In turn, it is often possible to get more than one donor to fund the same activity.

Even if it is not possible to get two donors to fund precisely the same activity, it should be possible to get two or more donors to fund essentially the same activity carried out in two different divisions of the ministry, if donors are discouraged from talking with one another. The real benefit of this, of course, in addition to doubling the cost of whatever is produced, is that both divisions will have the opportunity to reinvent the wheel (and if truly successful, both divisions will invent different wheels, neither of which will roll). Another effective method for discouraging donor cooperation is to court aid and advice from as many different countries as possible. A plethora of foreign experts offering elaborate and contradictory management panaceas should ensure the need for external funding well into the future (Somlai 1993: 15).

It should not be difficult for ministries to deal with donors unilaterally, and in fact to convince them to devote resources to the same activities (although most often in different units). Donors have their own need to develop programs and to spend money, even if the expenditure is not a good one in the classical sense (that is, the view that success is a virtue). Further, every donor believes that only its own agency and staff know what should be done. Thus donors will be quite happy to maintain their ignorance about what other donors are doing and to proceed to fund similar projects. Donors wishing to ensure ignorance should adopt reporting methods lacking in specificity. Such methods will prevent local and international officials from accurately determining levels of external financing for purposes of health services evaluation and planning (Howard 1993).

An important aspect of creative use of donors is never to openly state the true agenda of the ministry. Donors will willingly put money into many doubtful schemes if the ministry writes a preamble to the proposal that invokes infant mortality and poverty, even if the next line says : "and therefore we must have magnetic resonance imaging available at the central hospital." As long as donors can see a suitable rationale, they will continue to provide support. But, even though most donors seek failure just as most, ministries do, they are usually accountable to a higher body that also wants to maintain the fiction that it is doing good. Thus, it is poor policy to state the goal of failure explicitly for donors. In fact, it is not good policy to state it at all.

Conclusion

Experience indicates that though ministries of health espouse values of success and apparently seek improvements in service delivery and the health status of the people, in many cases ministries

seem to act as if they are actually seeking to fail in the sense of providing few and inadequate services and in limiting any improvements in health status, however measured. Without assuming that the actual goal of ministries of health is failure, the authors offer several guidelines that can be adopted by a ministry of health to assure failure. On the one hand, this is done in the spirit of the recognition that knowing what to do to assure failure may assist ministries to avoid these things if they truly wish to succeed; on the other hand-not to judge the goals of ministries-the authors provide guidelines to follow for those that actually wish to fail, as it often appears they do. These guidelines include the selection of unattainable goals, the provision of inadequate funding, the centralization of all decision making, the initiation of a management information system, the posting of untrained personnel, creation of an illogical organizational structure, ineffective use of supervision, development of vague areas of responsibility, nondelegation of authority over money and people, limited communication, targeting of the relatively well-off, and creative use of donors.

Any ministry of health that actually wishes to succeed must acknowledge fundamental system flaws and commit to correcting them. No innovative program, no .influx of resources, will achieve desired results until the ministry creates rational policies and procedures and a sound organizational structure. The truly successful MOH leader will not seek power and influence by protecting the status quo, but will concentrate on assuring that the twelve guidelines for failure laid out above are recognized as exactly what they are-sure mechanisms by which ministries fail-tend will seek in every possible way to eliminate these mechanisms as operating characteristics of the ministry of health.

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