

Improving the Government of the Libyan Health Sector: Can Lessons on Decentralisation and Accountability Be Drawn From Health Care Delivery in the UAE?

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature:

Abstract

The study of policy transfer has seen remarkable developments and received considerable attention in developed countries, but it has so far been ignored in the context of Libya. Thus, this research will fill a gap in the literature and further understanding of the topic of policy transfer, not only in relation to Libya but developing countries in general.

This thesis aims at providing a comprehensive and systematic picture of the public health care system in Libya and, at the same time, to learn lessons from the UAE which can be transferred to the Libyan context in order to achieve a more effective health service. At the theoretical level, this research depended on the assumption that lessons can be drawn from the UAE to help build the public health system in Libya. This was achieved through the application of the framework of policy transfer. In order to build a more complete picture in relation to the success or failure of the transfer, the path dependency approach was used to explain the importance of old trajectories or how past legacy can lead to "lock-in" or decrease the ability of the lesson-drawing. Empirically it examined the public health sector in Libya as its main case study, comparing it with the UAE. Qualitative data collection methods were used, including personal interviews and official documents.

With this in mind, the research aims to understand the public health care systems in the two countries and, through comparative analysis, make suggestions as to what lessons can be learned. The findings reveal that many lessons can be learned from the practices of the UAE public health policy. Such experiences would help to remove the problems in public health services in Libya as well as to facilitate improvement of policies and plans. However, there are two factors, namely the legacy of the past regime and state capacity, which may hinder the success of the transfer. Furthermore, political will held by policy makers, including a desire for modernization of the public sector, could facilitate the transfer of the suggested lessons.

Table of Contents

List of Figures.....	7
List of Tables	7
List of Abbreviations	11
Chapter One: Introduction.....	13
1.1 Research Background.....	13
1.2 Statement of the Problem	14
1.3 Aims and Objectives	18
1.4 Research Questions.....	19
1.5 The methodology of the study and research design.....	20
1.6 The Structure of the Thesis.....	36
Chapter Two: A Conceptual Framework	39
2.1 Introduction	39
2.2 Policy Transfer	39
2.2.1 Globalisation.....	41
2.2.2 Policy Transfer Types.....	44
2.2.2.1 Voluntary Policy Transfer.....	45
2.2.2.2 Coercive Policy Transfer.....	45
2.2.3 Pre-Requisites for Policy Transfer	46
2.2.4 Analysing policy transfer.....	48
2.3 Path Dependency.....	56
2.4 The Analytical Framework for this Study.....	59
2.5 Perspectives of the Public Sector, Decentralization and Accountability	61
2.5.1 The Concept of the Public Sector	62
2.5.2 Decentralization.....	69
2.5.2.1 Decentralization and Governance in Health System	75
2.5.3 Accountability	77
2.5.3.1 Traditional and New Accountabilities.....	81
2.5.3.1.1 Accountability in the Traditional Model.....	81

2.5.3.1.2	Accountability in the New Public Management.....	82
2.5.3.2	Dimensions of Accountability	85
2.5.3.2.1	Internal Accountability.....	85
2.5.3.2.2	External Accountability	91
2.5.4	Performance Measurement as Tools for Facilitating Accountability	93
2.6	Conclusion	96
	Chapter Three: The Public Health Sector in the UAE	98
3.1	Introduction	98
3.2	Profile of the UAE.....	99
3.3	Health Care Policy	100
3.4	Organisation and Delivery	106
3.5	Financing Health	109
3.6	Decentralization	111
3.7	Accountability Mechanisms	116
3.7.1	Internal Accountability.....	116
3.7.1.1	Managerial Accountability	116
3.7.1.2	Consumer Accountability.....	118
3.7.1.3	Professional Accountability.....	119
3.7.2	External accountability.....	121
3.8	Performance Measurement.....	126
3.9	Why Should the Libyan Government Learn Lessons from the UAE?	130
3.10	Conclusion	134
	Chapter Four: Socio-Economic, Political Environment Contexts of Libya	137
4.1	Introduction	137
4.2	Background.....	137
4.3	Socio-Economic Context	140
4.4	Politics and Policy Making In Libya	148
4.4.1	Monarchical Regime in Libya.....	148
4.4.2	The Qadhafi Regime	151
4.4.2.1	The Basic People's Congresses (BPCs).....	156
4.4.2.2	The People's Committees (PCs)	157
4.4.2.3	The General People's Congress (GPC).....	159
4.4.2.4	Revolutionary Committees (RCs)	160
4.4.3	The 17 February Revolution	161

4.4.3.1	The Democratic Transition in Libya.....	162
4.5	Conclusion	166
	Chapter Five: The Public Health Care System in Libya	167
5.1	Introduction	167
5.2	The Evolution of Health Policy in Libya.....	168
5.3	Organisations and Delivery of Health Services	176
5.4	Decentralization	185
5.5	Financing the Public's Health.....	188
5.6	Accountability Mechanisms.....	192
5.6.1	External Accountability	192
5.6.2	Internal Accountability.....	197
5.6.2.1	Management Accountability.....	197
5.6.2.2	Professional Accountability.....	199
5.6.2.3	Consumer Accountability.....	200
5.7	Conclusion	201
	Chapter Six : The UAE and Libya: Comparisons, Lesson Drawingand	
Conclusion	203
6.1	Introduction	203
6.2	Comparison of the Health Care Systems	203
6.3	Factors Constraining the Reform of Health Sector in Libya	209
6.3.1	The Qadhafi Regime Legacy	209
6.3.2	State Capacity	212
6.4	Analysis of the Extent to which Lessons from the UAE Might be Transferred to Libya.....	218
6.4.1	Health Care Strategy	219
6.4.2	Decentralization and Institutional Capacity	221
6.4.3	Professional Regulation.....	223
6.4.4	Performance Measurement	226
6.4.5	Managerial Accountability.....	226
6.5	Conclusion	229
6.5.1	Research Contributions	233
6.5.2	Limitations of the Thesis	235
6.5.3	Recommendations for Policy Makers	235
6.5.4	Further Areas of Research	239

Bibliography	241
Appendices	266
Appendix (1)	266
Appendix (2)	267
Appendix (3)	269
Appendix (4)	270
Appendix (5)	271

LIST OF FIGURES

Figure 1.1: Procedure for Case Analyses.....	34
Figure 2.1: A Policy Transfer Continuum.....	54
Figure 3.1: Medical Districts in the UAE.....	112
Figure 3.2: Government Effectiveness in the Middle Eastern and North African.....	115
Figure 3.3: Level of management Accountability Structure.....	117
Figure 3.4: The Political and Legal Accountability Structure	123
Figure 4.1: Map of Libya.....	138
Figure 5.1: Total PHC Facilities per 10,000 Citizens by District.....	180
Figure 5.2: In-Patient Beds per 10,000 Citizens- Pre and Post Conflict.....	187

LIST OF TABLES

Table 1.1: Selective Governance Indicators in Libya.....	15
Table 1.2: Specialized Centres for the Heart, Brain and Neurology.....	17
Table 1.3: Qualitative Research A Process.....	21
Table 1.4: The Use of a Case Study.....	24
Table 1.5: The Relevant Situation for Different Research Strategies.....	25
Table 2.1: A Policy Transfer.....	49
Table 2.2: major punctuations in political and economic change in Libya.....	61
Table 2.3: Strategic Choices in Decentralisation.....	70
Table 2.4: Conceptions of Accountability.....	78
Table 3.1: The UAE Health Profile.....	102
Table 3.2: Values and Strategic Objectives and Benchmarks.....	104
Table 3.3: Indicators of Childhood Mortality in the UAE 1990-2005.....	108
Table 3.4: Development of Healthcare System.....	108
Table 3.5: National Expenditure on Health UAE.....	110
Table 3.6: Health Institutions and Manpower in the 9 Medical Districts.....	114

Table 3.7: Selected Health Services Performance Indicators in the UAE.....	127
Table 3.8: Selected Health Service Performance Indicators in Abu Dhabi.....	129
Table 4.1: Distribution of Investments between the Public and Private Sectors (1970-1990).....	143
Table 4.2: Basic and Intermediate Education; Student/Teacher.....	143
Table 4.3: Trends in the Development of the Libyan Healthcare System (1970-2004).....	144
Table 5.1: Distribution of Actual Spending for the Development of the Health Sector.....	169
Table 5.2: Health Indicators in Libya.....	173
Table 5.3: Instability Administrative in Libya.....	177
Table 5.4: Characteristics of Hospitals According to Type and District.....	181
Table 5.5: Government Effectiveness Indicators in Libya and the UAE.....	183
Table 5.6: Specialized Centres for the Heart,Brain and Neurology.....	184
Table 5.7: The Economic and Social Transformation Plan 1973/1975.....	189
Table 5.8: Expenditure on the Health Sector from 1970 to 2013.....	190
Table 6.1: Comparison of Corruption between the UAE and Libya.....	206
Table 6.2: Accountability Comparison between the UAE and Libya.....	208
Table 6.3: Human and Physical Resources-Rate per 10,000 Population in 2011.....	213

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List of Abbreviations

ADAA	Abu Dhabi Accountability Authority
ASU	Arab Socialist Union
BPCs	Basic People's Congresses
EHA	Emirates Health Authority
FNC	Federal National Council
FSC	Federal Supreme Council
GNC	General National Congress
GPC	General People's Congress
HAAD	Health Authority – Abu Dhabi
IMF	International Monetary Fund
INT	Interviews
MOH	Ministry of Health
MSC	Ministerial Council for Services
MSC	Ministerial Council for Services
NGOs	Non-Governmental organizations
NMC	Nursing and Midwifery Council
NPM	New Public Management
OECD	Organisation for Economic Co-operation and Development
PCs	People's Committees
RCC	Revolutionary Command Council
RCs	Revolutionary Committees
SAI	the UAE State Audit Institution
TNC	Transitional National Council
UNDP	United Nations Development Programme
USAID	United States Agency for International Development

WHO World Health Organization
WTO World Trade Organization

Chapter One: Introduction

1.1 Research Background

The world has witnessed rapid advancements in communication, transportation, international economy, international organisations and the internationalization of politics. As a result interaction between countries has been facilitated. In the last few decades, governments have engaged in the policy learning process in order to learn from other countries' experiences and practices (Rose, 2005). Dolowitz (2003) argues that policy transfer can function as an important tool in the modern policy-making process, and refers to the fact that the British government has used lessons from other countries in its policy-making process.

The concept of policy transfer is highlighted by Evans (2004:10), who argues that policy transfer should be seen as a theory of policy development; in this case, policy transfer analysis is seen as knowledge about institutions, policies or instruments that the government sector applies in the development of institutions, policies or instruments in relevant sectors of the same government. The concept of policy transfer is defined by Dolowitz and Marsh (2000:5) as the process "In which knowledge about policies, administrative arrangements, institutions and ideas in political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting".

The most distinctive features of the development of this field have come from the Western world, which has made significant contributions to this area of study. Evans (2006:480) claims that the literature on policy transfer analysis may be organized into two schools. The first school does not use the concept of policy transfer directly but associates it with concepts of a process of policy-oriented learning and includes the literature on bandwagoning (Ikenberry, 1990); convergence (Bennett 1991a, 1991b; Seeliger 1996); diffusion (Walker, 1969; Mahone, 1991); evidence-based practice (Davies et al., 2000); learning (Greener, 2001; Common, 2004) and lesson-drawing (Rose, 1993, 2005). The second school uses the concept of policy transfer directly, and includes the work of domestic policy scientists (Evans and Davies, 1999; Dolowitz and Marsh, 2000; Page, 2000), comparativists (Wolman, 1992; Peters, 1997; Common, 2001) and international policy scientists (Haas, 1992; Stone, 2000a, 2000b; Evans and Cerny, 2004).

This policy transfer is typically divided into two main areas, namely voluntary policy transfer and coercive policy transfer (Common, 2001). Voluntary policy transfer may happen where dissatisfaction with the status quo is recognized by government, whereas coercive policy transfer happens where a government is forced to adopt programmes by another government or international organizations.

Studying policy learning from abroad is based on the assumption that policy-makers intend to learn from foreign experience to find a solution for the status quo. Thus, they can draw lessons for best practices from across political borders in order to avoid ineffective policies. Learning from foreign experience is possible, but it requires understanding and predicting potential constraints (this issue and the above issues are explained in detail in Chapter 2).

Even though the study of policy transfer has seen remarkable developments and received considerable attention in developed countries, as evidenced by the literature produced, it has not received interest in Libya. As mentioned above, policy transfer analysis is seen as knowledge about development. During the Qadhafi regime, the public administration and public policy were characterised by little modernisation. Now, after overthrowing the Qadhafi regime in 2011, Libya is moving towards a focus on the modernisation of public administration. This task requires a variety of techniques, mechanisms and institutions that come from public management reform movements such as NPM (Massey and Pyper, 2005). Libya urgently needs to modernise and policy learning from foreign experience is one suggested way forward for the country. For this thesis, policy transfer will allow the researcher to look at the health sector in Libya and the many problems it suffers from, and then to recommend a lesson from a different context to develop solutions (more details in Chapter 2).

1.2 Statement of the Problem

The public sector in Libya plays a particularly significant role in providing public services and goods, but has suffered from many problems such as financial and administrative corruption, poor services, lack of responsibility and lack of administrative stability. For example, the Libya Human and Political Development Forum, a non-governmental organization, issued a report in 2010 about “The administrative corruption in Libya”. The report found that public administration in

Libya lacks the essential elements of good governance. The report claimed that many factors are responsible for bad governance in Libyan public administration; these include the absence of popular participation, the absence of the rule of law, a complete absence of transparency in decision-making, and the lack of efficiency and competence in public management (<http://www.libyaforum.org/>).

Public sector management in Libya during the period of the Qadhafi' regime was characterized by fraud, mediation and nepotism, bribery, and the use of positions for special purposes. This was worsened by the presence of many channels for decision-making, implementation and follow-up, as well as a lack of sincerity on the part of staff in the performance of their duties (Qadhafi, 2002:39).

In statistical evidence, Libya has been ranked by the World Bank as weak in terms of government' performance Table 1.1 below indicates the institutional quality in Libya during the period 1998 to 2009.

1-1: Selective Governance Indicators in Libya

	1998	2000	2003	2005	2007	2009
Voice and accountability	-1.4	-1.6	-1.7	-1.8	-1.9	-1.8
Political Stability and absence of violence	-1.0	- 0.43	0.02	0.38	0.31	0.78
Government effectiveness	-2.2	-2.3	-1.1	-1.2	-1.4	-1.4
Regulatory quality	-2.1	-2.1	-1.4	-1.6	0.25	-1.6
Rule of law	-0.9	-0.7	-0.7	-0.8	-0.9	-0.8

Source: <http://info.worldbank.org/governance/wgi/index.asp>

Note: estimate of governance (range from -2.5 (weak) to 2.5 (strong) in terms of performance)

As can be seen, Libya has low scores for accountability, effectiveness, rule of law, and control of corruption. If this is the case, it is clear that accountability is in crisis in Libya.

The National Transitional Council of Libya (NTC) diagnoses the health situation in Libya, as follows:

Although basic healthcare is provided free of charge to all Libyans, it is mostly viewed with distrust. Public health expenditure for 2007 was only 1.9% of GDP, and 5.4% of total government spending, ranking Libya 164 out of 185 in the world. The health system is generally not adequate to cover the population's needs, with many Libyans having to travel abroad for simple procedures. Tunisia and Jordan have been key destinations for the average Libyan due to good quality healthcare available at reasonable prices, while Europe is another destination for those with sufficient means. Infrastructure is another area that has been neglected to a large extent, with recent efforts focusing on building up certain areas of Tripoli through the construction of hotels and business towers, but with no comprehensive infrastructure projects that would address the basic needs of society. Basic government services such as municipality cleaning, maintenance of roads, etc. are managed only sporadically (<http://www.ntc.gov.ly/#>).

A report issued by the National Planning Council of Libya has described the disadvantages associated with the health services (GPC, 2010:96) as follows:

- The lack of confidence on the part of citizens with regard to Libyan doctors, and the fact that many Libyan patients travel to neighbouring countries for treatment.
- The absence of a clear plan for health services.
- Poor accountability and a lack of administrative stability.
- The excessive waste of human and material resources.
- The weakness of the financial allocation to the health sector.
- All levels of health services provide treatment. Services are provided to patients by referral or between different levels of health care ranging from primary care centres to general hospitals and then to a hospital specialist through referral.

It is clear, that the health sector suffers from many problems that have led to poor efficiency and a lack of effectiveness. The report also notes the lack of an even

distribution in the number of hospitals based on population density (see Table 1.2 below).

1-2: Specialized Centres for the Heart, Brain and Neurology

City	Population	No. of Hospitals	No. of beds
Tripoli	1,033,777	2	483
Benghazi	645,892B	1	60

Table prepared by the researcher based on statistics of the MOH
<http://health.gov.ly/web/>

The above discussion, which illustrates both inherited and current problems, clearly indicates the importance of studying and understanding the decentralisation and accountability of the public health sector, both of which are of vital importance to the country, especially at this time of turmoil and change.

As discussed above, the Libyan Health system is an inefficient and underperforming system that has failed to formulate a strategy for optimal use of resources, manpower development and services and thus has become weak in terms of responsiveness and performance. Thus, lesson-drawing is important; Stone (1999) states that an inclination towards lesson-drawing helps decision-makers to respond to crises appropriately because they will examine lessons elsewhere which are linked to the existence of evidence.

Indeed a number of countries, both developed and developing, have improved their public sectors and upgraded the quality of public services by learning from foreign experiences (e.g. UK, Germany, Malaysia, and Estonia). The success of this approach of learning from foreign experiences in these countries suggests that Libya might also benefit from this approach: improving process of decentralisation and accountability in health care system.

The purpose of this study is to provide a comprehensive and systematic representation of the public health service in Libya and its attendant decentralisation and accountability system, and to make recommendations for its improvement. The central focus is on the problems associated with public service, especially in the

public health sector. This study, therefore, could prove invaluable for formulating public administration policies regarding the management of the public health sector in Libya, as the study should aid decision-making not only for improving management efficiency and effectiveness but also for enhancing the decentralisation and accountability of the public health sector. In the light of the recent political transformation in Libya the study will also contribute to the enhancement of good governance.

This thesis will use case study to illustrate the context of the health care system including health care policy, decentralization and accountability in two countries, Libya and the UAE; as Kaarbo and Beasley (1999) explain, researchers may employ the case study method to compare two cases in order to interpret phenomena. More specifically, the case study approach has been chosen to examine the performance of the health care systems in both countries. This comparison will help the researcher to highlight the development in both countries and will provide valuable insights into how governments can provide better services.

1.3 Aims and Objectives

This thesis aims at providing a comprehensive and systematic picture of the public health service and public sector accountability system in Libya and, at the same time, to learn lessons from the UAE which can be transferred to the Libyan context in order to achieve a more effective health service. To this end, the research starts with an investigation of the public health sector, and its decentralization and accountability, thus allowing for a comparison with the system of the UAE. Although there has been no policy transfer or learning between the UAE and Libya, this research will attempt to recommend how the Libyan government can learn from the UAE's example.

The public health sector in Libya is selected for the two reasons. First, it is one of the largest institutional sectors in Libya, with an estimated 90,000 employees, second only to the educational sector. However, because of the numerous problems that have led to inefficiency and a lack of effectiveness (GPC, 2011:96), patients prefer to travel abroad for medical treatment, especially to Tunisia, Malta, or even Germany (Otman and Karlberg, 2007:123-124). What this implies is that the sector is worth examining to investigate the extent to which public health services

are offered as well as to ascertain the degree of failure to deliver them. Secondly, in practical terms, this study will contribute to decision-making: it is hoped that it will lead not only to the formulation of policies that will improve public health services, but also to draw lessons that might be useful in solving problems in other sectors.

The central contribution of this research is to expand the geographical scope of policy learning and policy transfer studies outside of developed countries, as few studies have taken the policy transfer perspective to address the problems in developing countries, thus serving as a response to Evans (2004), who stresses the need to fill this gap. This research will be useful for countries that are embarking on the path to reform public policy, in particular Middle East countries, and will be the first academic study to address policy transfer in Libya.

The specific objectives of the study are as follows:

- to examine the performance of the public health sector in Libya ;
- to link that performance to issues of decentralisation and accountability;
- to identify the factors responsible for the low level of management and professional accountability in the public health sector;
- to assess the factors that facilitate or constrain policy transfer and
- to provide a greater understanding of the mechanisms and effects of policy transfer that will benefit health service delivery in Libya.

1.4 Research Questions

Based on the problem and the research objectives outlined above, the following specific research questions need to be answered:

- To what extent have the political, socio-economic and policy environments in Libya affected the public health sector?
- To what extent can the development experience of the UAE health system be viewed as a model for the Libyan health system?
- What factors have constrained the reform of the health sector in Libya?
- What lessons can be drawn from the UAE in for building public health services in Libya?

1.5 The methodology of the study and research design

This section attempts to link the background material developed in this chapter and following chapters, which are directed towards an in-depth examination of the public health system issues in Libya. It is important when selecting a particular research methodology to take into account the nature of the research objectives and the information needed to answer related questions. This section therefore presents the methodology of the research, providing information on the procedures followed and the techniques adopted to enhance the quality of the data collection tools.

The aim of this study is to understand how Libyan public health services can be improved and how to enhance the decentralisation and accountability mechanism for more effective and efficient management in Libya, to compare this with developments in the health system within the UAE, and to explore how the Libyan government can utilize the lessons learned from the UAE's experience. This research uses a qualitative research design. This research uses a qualitative research design. According to Denzin and Lincoln ,

Qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials- case study; personal experience; introspection; life story; interview; artifacts; cultural texts and productions; observational, historical, interactional, and visual texts- that describe routine and problematic moments and meaning in individuals' lives. (2005:3-4)

Qualitative research provides a detailed description and analysis of the quality, or the substance, of the human experience (Marvasti, 2003:7). It relies on transforming information from observations, reports and recordings into data in the form of written words or visual images rather than numbers (Denscombe, 2010). As explained by Stein and Mankowski, there is a growing trend of scholars using qualitative research as it contributes to providing a better understanding of the social context.

Stein and Mankowski present a framework (see Table 1.3) including activities described as asking, witnessing, interpreting, and knowing, which together suggest offer a more complete set of processes for conducting qualitative research in a

community. Each act in the research process is described at a conceptual and practical level.

Table1-3: Qualitative Research A Process

Name of Act	Process
Act I: The Act Of Asking	Identifying and enlisting the people who will be the focus of qualitative inquiry. Requires reflection about assumptions and goals that motivate selection of qualitative methods. Can choose to enlist disenfranchised groups in qualitative research to support empowerment aims or enlist dominant groups to support power sharing or other transformations designed to end oppression.
Act II: The Act Of Witnessing	Listening to and affirming the experiences of research participants. A witness is an open, totally present, passionate listener, who is affected and responsible for what is heard. The focus of witnessing is on acceptance of what is heard and accountability for acting upon it, not on the personal needs of the researcher or a desire of mutuality between researcher and participant.
Act III: The Act Of Interpreting	Making sense of the collective experience of participants by transforming “participant stories” into “research stories” based on the experiences and knowledge of the researcher. Researcher recognizes his or her interpretive authority in working with qualitative material. A critical point of departure in the experience of researcher and participant.
Act IV: The Act Of Knowing	Creating publicly accessible representations of knowledge gained by conducting qualitative research. Embodies the reflections and understandings of the researcher about the social context and lives of research participants. Knowing can be represented through variety of activities such as writing, teaching, speaking, organizing, depending on research and action goals.

Source: reprinted from Stein and Mankowski (2004: 22).

Public administration researchers undertake qualitative studies for two reasons: to help researchers with knowledge and to help researchers engage personally and meaningfully with practitioners (Luton, 2010:9). Luton justifies the use of qualitative approaches within public administration research as follows (p 9-14):

- Qualitative researchers seek an emic or idiographic knowledge based on an insider's perspective; they seek understanding of a contextualized, specific situation. This emic or idiographic knowledge can be very useful for public administration. Such an insider perspective can be valuable in understanding the world of public administration.

- Public administration research also tends to recognize the importance of context. In this regard qualitative research approaches contribute perspectives and insight on context. This is because qualitative research approaches examine generalization and causal context. Case studies, for example, are particularly effective at presenting contextual factors, the interplay of individuals and collective institutions and of agency and structure. In comparison with quantitative research, it diminishes the importance of differing contexts and attempts to find a generalizable causal model.
- Qualitative research uses thick descriptions and thick analysis instead of generalizable statistical analysis of data to reach conclusions. This involves the reader being presented with sufficient information to be able to interpret details and to understand them as if they were present. Also, qualitative research addresses causation and allows causal explanations to be understood as ideographic and emergent, as an unfolding of interconnected actions.
- Qualitative research approaches help add a valuable perspective to the field of understanding public administration practice. Qualitative research approaches offer distinct advantages to researchers seeking to engage practitioners in order to gain knowledge of and with them and to deepen their understanding of the perspective of those they study. In addition, the participation of public managers in research helps them in taking actions towards improving a situation.
- Qualitative research approaches offer a way to bridge the gap between what practitioners expect and what academic researchers can deliver. This leads to enhancing the possibility that public administration research will address topics of interest to researchers in ways that are relevant to practitioners.

The above discussion serves to justify the use of qualitative research in this study: it provides a detailed description and analysis of the social context, leading to the generation of reliable and valid data for the analysis of the public health system in Libya. As discussed in this chapter, qualitative data from academic journals, books and governmental reports, and in-depth interviews provide thick descriptions, the analysis of which can help the researcher to examine the practice of the public

health sector in Libya and lessons that can be drawn from the UAE by in order to understand what factors led to the low performance of health delivery in Libya.

The case study approach represents a type of qualitative research. Researchers who use case studies hope to gain an in-depth understanding of situations and meaning for those involved (Hancock and Algozzine, 2006:11-12). According to Yin, case studies contribute to our knowledge of individual, group, organizational, social, political and related phenomena. There is a distinctive need in all these situations to understand the complex social phenomena; researchers can retain the holistic and meaningful characteristics of real-life events by using the case study approach (2003:1-2).

Woodside (2010:1) describes the case study approach as ‘An inquiry that focuses on describing, understanding, predicting, and/or controlling the individual (i.e., process, animal, person, household, organization, group, industry, culture, or nationality)’. An important aspect of this definition is its focus on “describing, understanding, predicting, and/or controlling” the context.

Luton argues that it is no simple task to define the case study approach but suggests that:

It is possible to identify certain family resemblances among case studies, things like addressing a contemporary phenomenon, focusing on an integrated system, attention to context, and recognition of complex causal patterns. (2010:125-26)

From the above, it is clear that a case study approach is an inquiry that studies social phenomena in depth to understand all aspects of a situation and its relations with the environment, and then analyses the results in order to reach generalizations which can then be applied to other cases.

Denscombe (2010:55) argues that the case study approach is appropriate for researchers who want to investigate an issue in depth and provide an explanation that can cope with the complexity and subtlety of real life situations; this approach provides a chance to study the processes and relationships within a setting in several different ways as described in Table 1.4.

Table 1-4: The Use of a Case Study

Discovery led Description	Describes what is happening in a case study setting (e.g. events, processes and relationships)
Exploration	Explores the key issues affecting those in a case study setting (e.g. problems or opportunities)
Comparison	Compares settings to learn from the similarities and differences between them
Theory led Explanation Illustration	Explains the causes of events, processes or relationships within a setting Uses a case study as an illustration of how a particular theory applies in a real-life setting
Experiment	Uses a case study as a test-bed for experimenting with changes to specific factors (or variables)

Source: reprinted from Denscombe (2010:55)

According to Luton (2010:129), the case study approach is used by researchers for the following reasons:

- to study a phenomenon in its natural, real-life context;
- to focus on the special characteristics of the phenomenon being studied;
- to report on a noteworthy success (or failure);
- to recognize the importance of the context surrounding the phenomenon being studied;
- to explore the relationships among personal, collective, organizational, and structural dynamics; and
- to assist in theory development

Yin (2003:4-5) compares the case study approach with other research strategies (experiment, survey, history, and archival analysis). Each approach uses a different method to collect and analysis empirical evidence and each approach exhibits

different advantages and disadvantages, but they can all be used for exploratory, descriptive, or explanatory investigations. In order to choose which approach is appropriate for a study, it is necessary to know the conditions of these strategies. According to Yin there are three conditions, these being the type of research question, a required control of behavioural events, and a focus on contemporary events. Table (1.5) shows how each condition relates to the research strategies.

Table 1-5: The Relevant Situation for Different Research Strategies

Strategy	Form Of Research Question?	Requires Control Of Behavioural Events?	Focuses on Contemporary Events?
Experiment	how, why?	Yes	Yes
Survey	who, what, where, how many, how much	No	Yes
Archival analysis	who, what, where, how many, how much?	No	Yes/No
History	how, why?	No	No
Case study	how, why	No	Yes

Source: reprinted from Yin (2003: 5)

In this research, the case study approach was chosen to examine the performance of the public health sector in Libya and lessons that can be drawn from the UAE. Both contexts share a range of factors such as Arab and Islamic culture, the provision of universal health care free of charge, the financing of the health systems in both countries largely through general revenues, and reliance on oil to achieve development.

As mentioned in Table 1.4, case study is appropriate for research which aims to compare settings to learn from the similarities and differences. In this thesis, the aim of comparison is to suggest lessons for Libya from the UAE especially with regard to decentralisation and accountability. The comparison is important for the study as suggested by Fitzpatrick et al., (2011:821):

It can help scholars and practitioners recognize how differences in governance contexts—institutions, administrative processes, and culture—can present opportunities and challenges for effectively adopting uniform “best practice” solutions.

Case study was seen as particularly relevant to this study for the following reasons:

- it helped the researcher investigate the public health sector in Libya, leading to a comprehensive and systematic picture of the service. This sector is second to the educational sector in terms of employees but is plagued by a myriad of problems that have led to inefficiency and a lack of effectiveness (GPC, 2011:96);
- it helped the researcher understand the political and economic context, both of which have had a significant impact on the public health system;
- an investigation of the policy and performance of the health sector helped the researcher to focus on the weaknesses in the health sector in particular and the public sector in general;
- it helped the researcher analyse the extent to which lessons from the UAE might be drawn in Libya; and
- in order to set the boundaries for the case study, this research does not compare the whole of the public health sectors in Libya and the UAE but focuses on decentralisation and accountability.

While this research benefitted from the case study approach, the researcher was also aware of its inherent limitations. It has been argued that the results generated from one case can be used for other populations to a certain extent (Yin 2003; Flyvbjerg, 2006). The challenge of generalizing to other conditions arises not only with qualitative case studies but also for laboratory experiments when generalizing the results taken from a single experiment involving a specific group of experimental subjects in a given place and time (Yin 2010:99). Yin argues that case studies, like experiments, can be generalized for theoretical assumptions and not for populations or universes. In this sense, the case study does not represent a sample but a case study, so the researcher’s goal is to generalize theories rather than to enumerate frequencies (2003:10). Flyvbjerg (2006:228) writes, “One can often generalize on the basis of a single case, and the case study may be central to scientific development via generalization as supplement or alternative to other methods”.

With this shortcoming identified, this research cannot claim that its findings can be generalised to other countries. As Stake (1994) comments, the purpose of the case study approach is not to imagine a representation of the world, but to represent a specific case. This study aims to investigate the Libyan health system within its environment, and how to reform it by learning from other countries. However, it is possible that this study can benefit other developing countries which experience similar conditions.

Research design is defined by Nachmias and Nachmias (1992 cited in Yin, 2003:21) as guiding the investigator “In the process of collecting, analysing, and interpreting observations. It is a logical model of proof that allows the researcher to draw inferences concerning causal relations among the variables under investigation”. According to this definition, Yin’s (2003:21) design for case studies comprises five important components: a study’s questions; its propositions; Study’s units of analysis; Logic linking the data to the propositions; and the criteria for interpreting the findings.

The researcher has implemented the above components in this study as follows. Regarding to the first component, the research questions were formulated based on the existing literature on the Libyan and the UAE public health service. Questions raised concerned the health sector and the relationships between variables. With regard to the second component, as Yin states,

These “how” and “why” questions, capturing what you are really interested in answering, led you to the case study as the appropriate strategy in the first place. Nevertheless, these “how” and “why” questions do not point to what you should study. (Ibid.,22)

To this end, the research questions were aimed towards providing a comprehensive and systematic picture of the public health service, decentralisation, and the accountability system of such in Libya and the UAE. This is undertaken by examining how the UAE deals with these issues and how it can pertain to the Libyan government. This study investigates how to strengthen the accountability and decentralisation of the public health service in Libya in order to find methods of enhancing performance, as demonstrated in Chapters 5 and 6. In terms of units of analysis, the main unit of analysis focuses on national-level of the health system in

terms of decentralisation and accountability in Libya and the UAE, and the activities and actors involved in the health policy process appeared as subunits within the main unit of analysis. Regarding components 4 and 5, Yin states that “these components foreshadow the data analysis in case study research, and a research design should lay a solid foundation for this analysis” (Ibid., 26); this will be discussed in Chapters 5 and 6.

In this thesis, the case of the public health sector is analysed as a single case study, in that the study seeks an in-depth investigation into the health sector in order to produce sufficient information about the decentralisation policies and accountability. The public health sector also is a unique case among other public sectors in Libya and this sector has proved to be of significant importance in the socio-economic life of the nation:

The health care system in Libya has suffered long periods of neglect, poor funding, and lack of development and modernisation programmes. The matter was further complicated by corruption, outdated ideology, and alienation of even the simplest management concepts. (El Oakley et al., 2013:1-2)

It was decided to focus only on the public health sector because of time, finance and human resource constraints on the study, and the fact that the researcher has experience of working as a civil servant, and is able therefore to provide general background knowledge concerning the legislation and performance of the Libyan health sector at all levels. The thesis is an exploratory study of the public health sector of Libya. As Gabrielian et al. (2008) and McNabb (2013) note, exploratory studies are used in order to gain insights and ideas about research problems and the variables and issues associated with those problems. Exploratory studies also help the researcher gain greater understanding of the problem for which more information is needed. This is true of this study, as the research investigates the problems of the public health system and explores how to improve the public health services and enhance the accountability mechanisms towards effective and efficient management.

In terms of sampling in case study, the goal of quantitative research is to obtain a large sample and to generalize findings to populations, whereas qualitative research works with a small sample. The goal of qualitative research is typically to obtain insights; qualitative researchers usually strive to extract meaning from their data

(Onwuegbuzie and Leech, 2007:106). Miles and Huberman (1994) emphasise that sampling in qualitative research involves two actions: the first is to set boundaries for the subject of the study, and the second is to create a frame to help discover, confirm or qualify the processes underlying the study. In terms of selecting samples, they state that while both random and non-random samples are useful in quantitative research, in qualitative research, sampling must be consistent with the purposes and research questions of the study. In addition, Faugier and Sargeant show state that snowball sampling is considered as a type of purposive sampling in order to overcome problems of data sampling in studying hidden populations. This can be used both as an informal way of reaching a population and as a more formal method intended to make inferences with regard to a population of individuals; in other words, participants have informed the researcher of other potential study participants (1997:792).

It is against this backdrop that the researcher has chosen the purposive sampling technique and, specifically, snowball sampling for the study. This helps to ensure that institutions and people included within the sample are closely involved or affiliated to the health system in Libya.

As outlined in this Chapter, this research presents a method of understanding the workings of the public health service in Libya, and the case of the public health sector is analysed as a single case study. The sampling frame focused on the Ministry of Health within the case; the decision was made to focus on executive personnel, experts and scholars. The sampling frame also focused on other sectors that are related to the health sector, namely the Ministry of Finance, Ministry of Labour, Audit Bureau, hospitals, central hospitals and the District Health Office.

The literature on the case study approach mentions the utilisation of multiple sources of evidence (Yin 2003, Luton 2010, and McNabb 2013), which serves to distinguish this approach from other approaches. For example, survey research, qualitative interviewing and narrative inquiry are focused upon a single method of gathering information, whereas the case study approach collects information from a variety of resources such as interviews, field research and document analysis (Luton, 2010:134-35). Yin (2003) provides six major sources of evidence used in case studies, these being documentation, archival records, interviews, direction

observation, participant-observation, and physical artifacts. In terms of choosing a source of evidence, Yin (2003) states that not all sources will be relevant to all case studies, but that the use of any source must be developed and mastered independently in order to ensure that each source is properly used. Therefore, two methods were used when collecting data for this study: semi-structured in-depth interviews and document analysis. These two methods were systematically employed. Using multiple sources of collected data is important because this enhances the validity and reliability of findings (NOOR, 2008).

In-depth interviews are one of the most common methods used in qualitative research. One reason for their popularity is that they are very effective in providing research problems with a human face. In-depth interviews are an effective qualitative method for prompting people to talk about personal feelings, opinions and experiences and they are useful for learning about the perspectives of individuals. They are also an opportunity for the researcher to gain insight into how people interpret and order the world. This approach provides the researcher with a chance to provide causal explanation, and investigate particular events, phenomena, and beliefs. People might be reluctant to discuss issues in a group setting, so interviews are particularly appropriate for addressing sensitive topics (Mack et al., 2005:28-29). In addition Luton defines semi-structured interviews as “Intended to purposefully pursue understanding (information and meaning), using predetermined questions, improvisational probes, and responsive follow-up questions” (2010:23). Daymon and Holloway (2002) suggest that semi-structured interviews prove more advantageous than other types of interviews because the interview guide ensures that data of similar type is collected from all informants. This can save time and the ‘drop rate’ is lower than for unstructured interviews. The interview guide allows the researcher to develop questions prior to interviewing and then allows for deciding which issues to pursue. The importance of semi-structured interviews in public administration research is justified by Luton “because public administrators need to learn from the people they serve and from the people with whom they work in order to be effective” (2010:23). In his view the interview is not only an approach to collecting data, but also the creation of understanding. It is also a more personal and interactive method of data collection than a quantitative survey and standard conversation. Stake also justifies the use of semi-structured interviews as follows:

The purpose for the most part is not to get simple yes and no answers but description of an episode, a linkage, an explanation. Formulating the questions and anticipating probes that evoke good responses is a special art. (1995:65)

Semi-structured interviews provide the researcher with more freedom to direct the interview in the way that they want and to focus on issues and information that were unclear and closely related to the public health sector in Libya. It also allows the respondents to have freedom and flexibility because they are able to talk about issues and information in detail and depth.

Semi-structured interviews were employed in this research in order to obtain an in-depth understanding of the Libyan public health system issues being studied and to collect accurate information. Interviewees included those involved with the Ministry of Health as well as the Ministry of Finance, the Ministry of Labour, the Audit Bureau, hospitals, central hospitals, the District Health Office, experts and scholars. The grades or status of officers (doctors or civil servants) vary, ranging from senior managers to middle managers; the details of the interviewees are shown in Appendix (3).

According to Luton (2010), interview procedures can be divided into three main stages, each with its own preparation requirements. Firstly, preparing an interview guide; this stage requires the researcher to prepare the questions that are going to be asked by developing an interview guide including topics to cover and questions to ask. The researcher at this stage needs to be aware of how to use probes and when and how to follow up. For this present study, questions were set and passed to the researcher's supervisor for feedback. After the questions were revised an interview guide was developed in both English and Arabic languages. This guide included open-ended questions that covered issues exploring aspects of the research (see Appendix 2).

Secondly, preparing for the interview; this stage requires preparation of a consent form (Appendix 4). Two copies are needed when meeting with interviewees. Prior to the actual interview, the investigator and the interviewee should each sign a copy. This procedure is significant because it helps the researcher to make interviewees comfortable. For the present study, the researcher prepared a consent form as well

as a Research Participants Information Sheet that includes the purpose of the study, what participants will be asked to do, consent for participation and withdrawal, benefits and information about the confidentiality and security of data. Both documents are an important part of recruiting research participants.

Thirdly, conducting the Interviews: Luton outlines ten commandments of interviewing, as suggested by Berg, which should be followed during the interview itself.

The interviews were carried out in Libya in November 2012 and January 2013. At the beginning of each interview, the researcher gave a brief introduction on the research aims and the purpose of the interview. All interviews were conducted face to face. During the interviews, the researcher used the interview guidelines to extract information from the respondents (see Appendix 5), who were given the opportunity to elaborate on any issues they believed to be relevant. Arabic is the native language of all interviewees, so the interview questions and the responses were each originally written in Arabic and then translated into English. All the interviewees requested not to have the interview recorded, so the answers were gathered by note-taking. The interview questions were typically asked in a systematic and consistent order and the answers given were very informative and valuable.

The researcher was unable to conduct a primary research in the UAE. This is because my scholarship does not include expenses to conduct a field study outside Libya. So the method to be employed for the UAE case is documentary analysis such as policy documents, reports, and web sites in both Arabic and English produced by various government organisations in the UAE, and the publications of international organisations.

As mentioned in above, documents were also used in collecting data. According to Yin, documentary sources are important to the case study approach because documents are helpful in verifying the correct spellings and titles of organizations and can provide specific details to corroborate information from other sources. Documents play an explicit role in data collection when undertaking case study research (2003:87). Documents used can include letters, emails, web sites, memoranda, newsletters, announcements, meeting agendas, meeting minutes, reports, proposals and press releases. Documents play an important role in

collecting data in public administration because they are considered the official versions of events and are the heart of bureaucratic organizational activity (Yin, 2010). Documentary evidence is seen as a method to cross-validate information gathered from interviews when considering that actions might not always correspond with the interviewees' answers. Additionally, documents provide guidelines to assist the researcher with the inquiry during interviews (NOOR, 2008).

The researcher was interested in relevant official documents such as meeting minutes, policy documents, reports, and web sites in both Arabic and English produced by various government organisations in Libya and the UAE, and the publications of international organisations such as WHO were also examined to further identify various important aspects. It is worthwhile using documentary sources for this study because these sources provide information about public administration, public policy and public health system issues, and the documents were complemented by the primary data collected through interviews specifically for the purpose of this study. Furthermore, in this study, the researcher found the literature available in the library of Exeter University, in conjunction with the library's on-line system, particularly useful when conducting secondary research.

To enhance the validity and reliability of the study, the researcher first conducted a pilot study. Yin emphasizes the importance of this as it helps "to refine your data collection plans with respect to both the content of the data and the procedures to be followed" (2003: 79). A number of issues in this research benefited from the piloting process as indicated below.

Initially, the researcher intended to select the Libyan water sector as the case to be studied, the reason being the desire to investigate how it could be improved through examining the UK's experience of the privatization of the public sector. During discussions with the study supervisor, particularly following the Libyan revolution, it became apparent that it was important to examine both the education and health sector in Libya because these sectors are related to social life. It was also difficult to compare situations between developed and developing countries. As a result the idea was abandoned and it was decided that the best candidate for this research would be the public health sector for two reasons: firstly it suffers from serious

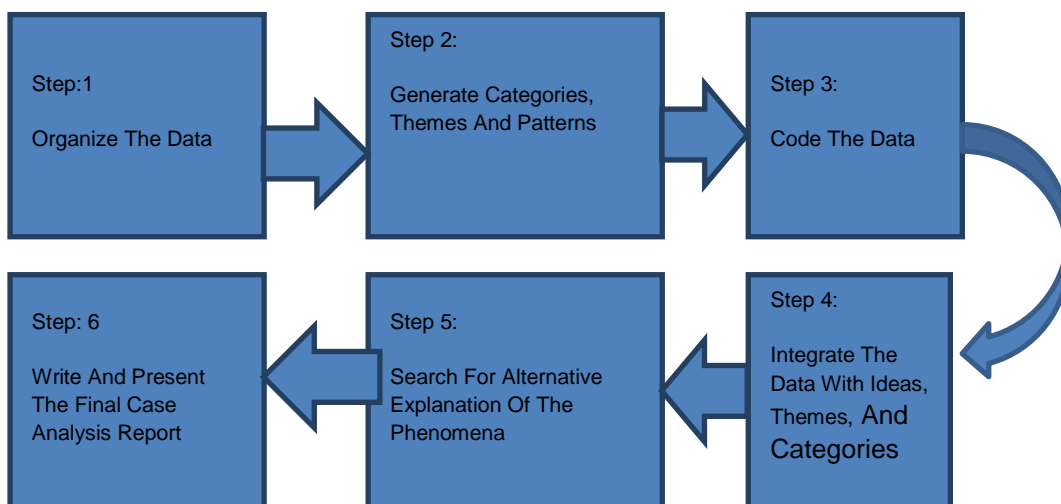
problems of corruption, low performance, and mismanagement, and, secondly, it is the main provider of health services in Libya (WHO, 2007).

The interview questions, once established with the help of the supervisor, were translated into Arabic. To ensure validity, they were sent to Libyan academics who provided the researcher with feedback about the questions themselves and the translation. This feedback was useful in developing the final format for the interview guide.

For the purposes of this study, a review of relevant literature, analysis of documents and data from interviews were employed. Together they provide useful details and explanations of the public health sector in Libya and the UAE, and add to the reliability of the findings.

In order to arrive at conclusions, there must be a clear strategy for analysis. McNabb (2013) proposes that the analysis of all qualitative data takes place in a progression of six separate phases, as shown in Figure 1-1.

Figure 1-1: Procedure for Case Analyses



Source: reprinted from McNabb (2013:325)

Figure 1.1 shows various stages of the analysis. This analysis is based on the important requirement that the volume of data is reduced at each stage because the research might include irrelevant information for which it is impossible to find a logical explanation. Reduction of the volume of data involves organizing the data into sets of mutually exclusive categories. In the case study approach, the researcher must concentrate on information (all of the collected information) which sheds light on the study question. McNabb states that “Analysis of case data involves looking at and weighing the collected data from a number of different viewpoints before writing the final case narrative” (Ibid.,325).

According to McNabb, data analysis does not always occur in the logical sequence shown in Figure 1.1. In addition, analysis can be broken down into five separate steps as follows:

1. Grouping the data according to key constructs
2. Identifying bases for interpretation
3. Developing generalization from the data
4. Testing alternative interpretations
5. Forming and /or refining generalizable theory from the case study (p.325).

McNabb believes that the process of data analysis does not end with the first set of conclusions, but is a circular process. This can mean that sections of the analysis might be used in the next step, while other parts, even entire sections, might prove to be dead ends. When this happens, the researcher must look for alternative explanations and test these against the themes that evolved during the operationalization phase, and they must then either reach new and different conclusions or adjust the themes and categories to reflect the reality of the data.

For the purpose of this study, the analysis involved categorizing themes and patterns of the issues of the public health sector according to the data extracted. Using this approach was beneficial for coding the data and integrating the data with ideas and helped to reduce the amount of data collected in the study without removing the data from their context. This was carried out by organizing the data into sets of mutually

exclusive categories, and integrating the data with ideas and themes which helped in reaching conclusions.

Regarding to ethical considerations, the researcher was committed to the ethical requirements for conducting research (see Appendix 1), which, in this case, included an information sheet describing the purpose of the study and a consent form for interviewees. Interviews were held in confidentiality and for the purpose of the study only, and anonymity of the interviewees and removal of any potential identification traits were guaranteed in order to insure confidentiality. All responses to questions and information provided were anonymised i.e. no personal details relating to the interviewee. All data collection, storage and processing complied with the principles of the Data Protection Act. At no point has anyone other than the researcher had direct access to the information provided by the interviewee.

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1.6 The Structure of the Thesis

This thesis is divided into six chapters, organised as follows. Chapter 1 provides an overview of the whole thesis, including general background about the research problem, and aim and objectives. Chapter 1 also presents the methods used in conducting the research, including exploratory, secondary and primary research methods. The qualitative paradigm defined and reasons for choosing a qualitative model put forward. The chapter also discussed and justified the interview as the main primary data collection tool.

Chapter 2 introduces the policy transfer and path dependency approaches. This chapter will firstly highlight the concept of globalisation, as this is relevant to the development of the policy transfers approach. Subsequently this chapter outlines the conceptual framework, presenting first the policy transfer approach, followed by the path dependency approach. This Chapter presents detailed information about key issues and themes pertaining to the study, namely public sector, decentralisation and accountability. These issues will inform the empirical part of the thesis, and will provide background knowledge to enable a greater understanding of the public health sector.

Chapter 3 focuses on the public health sector in the UAE and outlines the health system from 1971, the time of the creation of the United Arab Emirates as a federation, and the foundation of the UAE Ministry of Health. The chapter includes a number of sections focusing on the development and growth of the public health sector, the structure of and processes within the health services, and its accountability structures and operational procedures. Secondary data/information will be used in the discussion, analysis and assessment undertaken in the chapter. The information about the UAE is expected to be useful for comparison with the problems in Libya, and as a benchmark to make recommendations for Libya.

Chapter 4 The aim of this chapter is to explain the nature of the Libyan environment. To this end the history of Libya, its physical features, population, religion, language, and customs are discussed in detail. The economic environment is also discussed, with particular reference to economic conditions, before and after the discovery of oil in 1959, social and economic development plans, and the economic resources of the country. This chapter also presents the development of the Libyan political structures from the independence of state in 1951 until the 17 February Revolution.

Chapter 5 outlines the development of the public health sector, and assesses its performance by analyzing both secondary and primary data. This chapter will study all institutions related to providing public health as well as a delivery system for public health, in particular, the structural elements that provide public health services in Libya. A number of elements will be considered, including national policy for public health, health resource allocation, administrative instruments for public health, human resources, and hospitals and health care centres.

Chapter 6 systematically compares all the findings in previous three chapters. The comparison between the two countries help this research develop lessons for health care in Libya. Also, this chapter will discuss factors that have facilitated or constrained the implementation of health sector reforms in Libya. This Chapter also presents an overview of the study, and introduces recommendations for public management reform in order to suggest possible means of resolving the lack of efficiency in the public sector in Libya in general and the public health sector in particular, as well as the lessons that Libya can learn from the UAE. The conclusion

also seeks to propose a framework for enhancing the accountability of the public health sector.

Chapter Two: A Conceptual Framework

2.1 Introduction

This chapter presents a conceptual framework which is relevant to understanding how Libya reformed the public sector. Two possible approaches can be applied: policy transfer and path dependency, both of which facilitate the analysis of the extent to which lessons from UAE might be of relevance in Libya. This chapter will firstly highlight the concepts of policy transfer, together with a consideration of the concept of globalisation, because of its relevance in the development of a policy transfer approach (Dolowitz and Marsh, 2000; Common, 2001; Evans, 2004). This chapter then outlines the conceptual framework used in this study with policy transfer presented first, followed by the path dependency approach.

This chapter will also discuss in detail the concept of public sector, followed by an examination of its characteristics and the differences between the public and private health sectors. It then examines the concepts of decentralization and accountability and diverse issues related to them. The researcher introduces these concepts because they are the focus of the empirical part of the thesis, and they are important to contextualise the study because they are to be subjected to analysis in order to draw a transfer lesson from the UAE for Libya.

These issues will make two major contributions to the study. Firstly, they provide background knowledge and understanding that can facilitate a specific analysis of public health sector improvements in Libya. Secondly, these issues provide an awareness of previous work in this area, which may lead to suggestions which can be used to further improve Libya's public sector.

2.2 Policy Transfer

The world has witnessed rapid advancements in communication, transportation, international economy, and the internationalization of politics. These developments have led academics to focus on policy transfer. The importance of policy transfer in political science can be appreciated in the light of Martínez' (2006:99) claim that

Policy transfer has received growing attention in political science literature. The frequencies of development policies' transfers, as well as the intense

policy cooperation between industrialized countries indicate that there is great interest in the concept of transfer, its mechanisms and the conditions for its success.

While attempting to justify policy transfer, Dolowitz and Marsh (1996) and Dolowitz (2000), have all argued that there are two main reasons for its growth. The first reason relates to globalisation, which they argue has made all nations (both developed and developing) interdependent. This makes it difficult for nations to insulate themselves from the global economic system. The second reason they give is that the development of communications makes the spread of ideas and knowledge easier. In this respect, international organizations such as the United Nations (UN) and the International Monetary Fund (IMF) provide practical guidance and training on how to upgrade institutions and structural policies. From the perspective of globalisation and communications, policy makers look to other countries for the improvement of their institutions and policies. Rose (2005) believes that governments should search for solutions from foreign experience in order to learn how to make their own policies better.

Hill (2009:180) argues that policy transfer provides a distinct contribution to the study of the policy process: national policy makers look elsewhere in order to design their own policy. He also argues that policy transfer should be seen as a driver of policy change. The concept of policy transfer is further highlighted by Evans (2004:10), who argues that policy transfer should be seen as a theory of policy development: in this case, policy transfer analysis is seen as knowledge about institutions, policies or instruments that the government sector applies in the development of institutions, policies or instruments in relevant sectors of the same government. The concept of policy transfer is defined by Dolowitz and Marsh (2000:5) as the process

In which knowledge about policies, administrative arrangements, institutions and ideas in political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting.

This definition includes the borrowing of policies that can be used in improving public policy such as administrative arrangements, institutional reform and ideas. In the

following section, the concept of globalisation will be discussed because of its role in leading to a convergence in public policy in the world (Common,2001).

2.2.1 Globalisation

Soederberg at al. (2005:5-6) provide definitions of globalisation focusing on three basic categories: essentialist or teleological definitions; narrow economic definitions; and additive or interactive definitions of globalization as a political process. Teleological definition refers to the tendency of national states to move to a borderless world. It follows that national governments adapt themselves to global conditions, and, in this way, lose their capacity to take decisions according to national or local conditions. The second category defines globalisation as the growth of international trade, and of technologies and multinational firms. The third category, additive or interactive definitions, sees globalisation as a political process involving the growth of new multidimensional and multi-layered forms of politics. In other words, the nation- state becomes a part of global political webs. They attach two meanings to the term 'globalisation'. The first meaning sees it as internationalization: cooperation among countries leads to the establishment of treaties, international government organizations, common norms, and culture. The second meaning gives a transnationalization dimension to globalization, indicating that the world has witnessed the rapid development of formal and informal structures and processes outside the known traditional border actors.

Skogsta (2000:808) observes that the concept of globalization should be classified according to four processes. The first is economic: globalization rooted in structural developments, technological changes, and the movement of capital. The second process is political: the emergence of international institutions, and citizens being subject to multiple layers of political authority. The third is the cultural diffusion of values: the development of technology plays a significant role in diffusing the values, tastes and norms worldwide. Skogsta's final dimension of globalisation associates it with an ideological process, which depends on market liberalism, deregulation and privatization.

From the above discussion, it is clear that globalization leads to the creation of new situations in the world such as the rapid growth of formal and informal organizations at both national and international levels. Also, globalization is embedded in the

liberalisation of the market, its deregulation and privatization. The concept of liberalism as discussed by Soederberg et al. as

Liberalism is itself a complex mixture of meanings. It reflects the ambiguity of its central referent and contemporary usage. The concept places value on the notion of liberty and makes the individual central to this instead of a more holistic conception of society.(2005:11)

The authors offer an interpretation of the meaning of liberalism in different societies: in Europe, they see it as “A political philosophy of the capitalist right”; in America, “The moderate centre life”; and in Australia, “Social liberalism”. Further discussion of liberalism is highlighted by Jessop (2002:455), who claims that liberalism can be seen as a philosophy within capitalist societies. This philosophy includes four features: private property, free choice, free markets, and the separation between civil society and the state. Liberalism can thus be seen as a philosophy which leads an individual to advocate a specific kind of government, public policy and society.

With the rapid globalization of the capitalist economy and its many accompanying ills, such as inflation and the rigors of fighting the same, economic policies have tended to tilt towards neo-liberalism in the global context. Jessop (2002:457) observes that the establishment of neoliberalism was a reactionary move against liberalism: “The initial rise of neoliberalism as a wide-ranging economic and political strategy was associated with the neoliberal regime shift in Britain and the US in the late 1970s”. Soederberg et al. (2005:15-17) provide three dimensions for the concept of neoliberalism; these include reducing barriers to trade and capital flows, reforming the national finances and the state ministries and agencies in order to reduce waste and make them operate according to the same sort of efficiency standards used in private management styles, and supplying public services according to a working framework of rules and performance indicators for market actors to follow. Cerny and Evans (2004) argue that neoliberalism should be embedded in “financial orthodoxy” in order to find solutions for economic problems like inflation.

Neoliberalism has had a considerable impact on government and public administration especially in relation to the power of the state (Lee and McBride 2007:10). Tanzi and Schuknecht (1997) claim that ideology has created pressure that has led in turn to changes in the role of government in the public sector.

Privatisation is the main concept of the "new liberalisation", which has led to changes in the public sector and reduced public spending.

Skogsta (2000:805) argues that the developments of multilateralism and international regulatory frameworks (as phenomena of globalization) such as the World Trade Organization (WTO) pose new challenges to domestic governance and policy making. This is because, with globalisation, as Cerny (1994:321) points out,

States also subsequently lose much of their general hierarchical and holistic character in this process. The central paradox or dilemma facing states in public policy terms in today's world therefore, is not that states simply lose power to other structures; rather, they undermine and legislate away their own power, confronted by the imperatives of international competitiveness. In this way, state policies have tended to converge on more liberal, deregulatory approach because of the changing structural character of the international system.

Global governance is a result of the globalization process and the concept has been discussed by many scholars. Massey defines global governance as a

Democratic system of multilateral governance that should be located within the global system of international law and administration, ensuring governments make effective use of existing governmental machinery for addressing pressing issues of resource allocation and global goods. (2009:394)

He also argues that concepts such as the UN's Millennium Goals and the Bretton Woods institutions' drive for modernization through NPM can be seen as a policy mimesis between states . Global policy process leads to isomorphic tendencies in many states. Non-Governmental organizations (NGOs) can play a role in local, national, regional and international contexts by implementing effective systems of public administration (transparency and accountability), which may, in turn, serve to address problems of health, education, poverty and environment that may only with difficulty be resolved by the state (Massey, 2005b).

From the above discussion it can be seen that globalisation does not necessarily weaken the capacity of the nation state, but that the nation state can benefit from

globalization. Clearly, NGOs influence public policy across national boundaries including humanitarian aid and developmental efforts.

Furthermore, Common (2001) argues that globalization is the leading cause of change in the nature of the state and international systems. This also affects how public administration responds to the global environment. He notes that “The role of state as a primary actor in the international arena is diminished by globalisation”. The logical consequence of the processes of globalisation is that the increasing number of inputs into the policy process weakens the state. Policy elites in individual states are more open to suggestion in an increasingly globalised world and are therefore more amenable to policy transfer (ibid.,6). The application of new public management (NPM) in many developed and developing countries is a result of globalization. As Hood (1991:3) notes, “The rise of NPM is one of the major international trends in public administration”. Cope et al. (1997) point out that states have restructured from traditional models of public administration to NPM as a result of increasing globalization that leads to a decline in state autonomy and sovereignty.

It is clear that globalisation has made policy transfer a key feature in the contemporary state (Savi, and Randma-Liiv, 2013). With the effect of globalisation, as Common states, “The administration of a particular country engages in reform strategies as a result of global socio-economic pressures impacting on administrative elites” (1998:444). Generally, there is an argument that policy transfer is facilitated by globalisation, international organizations, and best practice of different countries. With regard to the specific case of Libya, these arguments are used to demonstrate the role of the influence of globalization in creating the necessary conditions for the consolidation of Libya's public administration reform agenda. The next section will therefore discuss policy transfer as an important tool of the analysis globalisation.

2.2.2 Policy Transfer Types

According to Common (2001:15), understanding policy transfer requires the consideration of two types of policy transfer (voluntary and coercive) that can help to explain why a country would want to transfer policy. Both types will be explained below.

2.2.2.1 Voluntary Policy Transfer

According to Dolowitz and Marsh (2000:14), voluntary policy transfer can be defined as a rational response chosen by actors. Thus, problems will drive actors voluntarily to seek out new ideas in order to reform the status quo. Voluntary policy transfer is seen as “A rational, action oriented approach to dealing with public policy problems” (Evans, 2004:11). In spite of the fact that voluntary policy transfer is a rational action, Dolowitz and Marsh (2000:14) argue that it is rare that actors are perfectly rational. Policy makers may make mistakes in their decision because of incomplete or mistaken information. Thus, policy makers should evaluate the real situation and gather enough information in order to reduce the risk of transfer.

A voluntary policy transfer is an aspiration that aims to reform the status quo - in the absence of internal/external pressure (Dolowitz, 2009:319). Common (2001:15-18) argues that voluntary policy transfer may take two forms, namely “emulation”, “learning”, and “copying”. Emulation of policy transfer occurs as a result of globalisation that has allowed government elites to observe policy innovations worldwide. Governments also may tend to learn policy from other countries, but learning policy is unsystematic because of globalisation. The globalisation spree has put governments under pressures that encourage them to transfer policy. In other words, globalisation has stressed competition in the economic realm, thus necessitating the transfer of policy in order to bring about internal reform. The results of best practice in other countries motivate policymakers to copy policy or programmes from another jurisdiction.

2.2.2.2 Coercive Policy Transfer

Common (2001:18) refers to coercive policy transfer as “The imposition of policy on a country by either another country or a powerful transnational actor”; he contrasts this with what occurs in voluntary policy transfer, where one assumes that the state is an autonomous actor. Coercive policy transfer occurs when an outside actor imposes policy solution on another country (Dolowitz, 2009:319).

Evans (2004:11) divides coercive policy transfer into two types: indirect and direct. Indirect policy transfer refers to a negotiation in which governments are compelled by outside actors to introduce new policy in order to secure grants or loans. Direct

coercive policy transfer refers to a process in which governments are forced by another government to introduce political changes against its will.

In a related development, Common (2001:19-20) observes that coercive policy transfer may lead to globalization of certain practices and policies. He points out that “International intervention or 'external inducement' occurs when one state (or its agents) provides incentives or inducements that lead other states to adopt the preferred policy”. External inducements can range widely in their severity, from overt coercion to the loose structuring of incentives and sanctions.

According to Dolowitz and Marsh (2000:14), policy transfer, in some cases, involves both voluntary and coercive elements of transfer. They provide examples. In the mid-1980s the Thatcher government began facing a rise in the level of unemployment which compelled the government to find solutions. The first response was to develop ‘make-work’ programs which failed to work.

So the government embraced policy transfer from the USA at this point, which was a mix of voluntary and coercive forces. During the Thatcher, Major and Blair governments the policy continued, as the American-style workfare policies and programs remained the preferred policies of the governments. Over this period, unemployment fell. This led to a decrease in the coercive pressures and voluntary factors became much more apparent (p15-16).

2.2.3 Pre-Requisites for Policy Transfer

As Common (2001:20-22) has argued, the conditions that can facilitate or constrain the transfer of policy vary. This entails analysis of how similar the problems are between borrower and lender, how successful the policy was, and how the policy setting in the originating country compares to their own. He also stresses that similarity is an insufficient basis for transfer because ‘comparative difference’ remains an important consideration in order to predict what facilitates or constrains the transfer of policy. Rose (1993, cited in Dolowitz and Marsh 1996: 353) suggests six hypotheses that facilitate transfer:

- Programmes with single goals are more transferable than programmes with multiple goals;
- The simpler the problem, the more likely transfer will occur;

- The more direct the relationship between the problem and the ‘solution’ is perceived to be, the more likely it is to be transferred;
- The fewer the perceived side-effects of a policy, the greater the possibility of transfer;
- The more information agents have about how a programme operates in another location, the easier it is to transfer and
- The more easily outcomes can be predicted, the simpler a programme is to transfer.

Dolowitz and Marsh argue that these hypotheses offer a basis for future research but attention should also be on the other factors that interact with policy transfer. They pay attention to past policy, as they observe that “Past policies constrain agents as to both what can be transferred and what agents look for when engaging in policy transfer” (p 353). In addition, policy transfer relies on whether the political system possesses the political, bureaucratic and economic resources to implement the policy.

Another argument provided by Dolowitz and Marsh can be found in their themes of policy transfer and policy failure. They put forward an explanation for why policies may be successful in one country but not in another, as well as why some transfer is unsuccessful. They suggest three factors that have a significant effect on policy failure:

First, the borrowing country may have insufficient information about the policy/institution and how it operates in the country from which it is transferred: a process we call uninformed transfer. Second, although transfer has occurred, crucial elements of what made the policy or institutional structure a success in the originating country may not be transferred, leading to failure: we call this incomplete transfer. Third, insufficient attention may be paid to the differences between the economic, social, political and ideological contexts in the transferring and the borrowing country: we call this inappropriate transfer. (2000: 17-18)

These factors were used by Dolowitz and Marsh to examine the transfer structure of the British Child Support Agency (CSA) from the United States to the British government.

2.2.4 Analysing policy transfer

Different models for analysing policy transfer have been developed, including one developed by Dolowitz and Marsh (2000, pp.5-24) that is widely used (Evans 2009: 254). Dolowitz and Marsh combine policy transfer, policy learning and lesson-drawing into a framework of broader concept. As they explain,

Policy transfer, emulation and lesson drawing all refer to a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place. (Dolowitz and Marsh, 1996: 344)

This framework is organized around six questions: Why do actors engage in policy transfer? Who are the key actors involved in the policy transfer process? What is transferred? From where are lessons drawn? What are the different degrees of transfer? What restricts or facilitates the policy transfer process? How is the process of policy transfer related to policy “success” or policy “failure”? (2000:8). They further argue that generating a series of questions provides a way of organizing research but these questions are of limited use in providing explanatory power. In this case, they use policy transfer as an explanatory variable to understand and explain the process of transfer focusing on these questions: why a lesson is drawn, where a lesson is drawn from, and who is involved in the transferring process all affect both whether transfer occurs and whether that transfer is successful. This argument, according to Dolowitz and Marsh, helps to explain policy outcomes and what causes transfer.

Table 2-1: A Policy Transfer

Why Transfer? Continuum			Who Is Involved in Transfer?	What Is Transferred?	From Where			Degrees of Transfer	Constraints on Transfer	How To Demonstrate Policy Transfer	How Transfer leads to Policy Failure
Want To.....Have To				Past	Within-a Nation	Cross- National				
Lesson Drawing (Perfect Rationality)	Lesson Drawing (Bounded Rationality)	Direct Imposition	Elected Officials	Policies (Goals) (content) (instruments)	Internal	State Governments	International Organizations	Copying	Policy Complexity (Newspaper) (Magazine) (TV) (Radio)	Media	Uniformed Transfer
	International Pressures		Bureaucrats Civil Servants	Programs	Global	City Governments	Regional State Local Governments	Emulation	Past Policies	Reports	Incomplete Transfer
	(Image) (Consensus) (Perceptions)									(Commissioned) (uncommissioned)	
	Externalities	Pressure Groups	Institutions			Local Authorities		Mixtures	Structural Institutional	Conferences	Inappropriate Transfer
	Conditionality	Political Parties	Ideologies					Inspiration	Feasibility	Meetings/ Visits	
	(Loans) (Conditions Attached to Business Activity)								(Ideology) (cultural proximity) (technology) (economic) (bureaucratic)		
	Obligations	Policy Entrepreneurs/ Experts	Attitudes/ Cultural Values						Language	Statements (written) (verbal)	
			Consultants Think Tanks Transnational Corporations Supranational Institutions	Negative Lessons			Past Relations				

Source: reprinted from Dolowitz and Marsh (2000)

Why policy transfer occurs is the first question that appears in Dolowitz and Marsh' (2000) policy transfer framework (Table 2.1). This question identifies the motivations for actors to engage in policy learning. As discussed earlier in this chapter, policy learning and transfer may be either voluntary or coercive. Dolowitz has provided new insights into the learning processes. In his opinion a problem is the main motive for transfer and learning to search for a solution. He draws attention to the concept "Hard learning and knowledge updating", and how this information can be used in finding a solution and development (2009). According to Bennett, there are five different political motives that drive policy makers to utilize the policy experiences of other states: "To put an issue on an institutional agenda; to mollify political pressure; to emulate the actions of an exemplar; to optimize the search for the best policy; and to legitimate conclusions already reached" (1991: 33).

Political motives can be seen as a significant justification to learn from abroad. Rose argues that lesson can be interpreted as satisfaction for home environment that motivates policy-makers solving the dissatisfaction (2005). Determining the best practice could help policy makers to find new ideas in order to reform the status quo.

Dolowitz and Marsh point out that the policy transfer should not involve a distinction between borrower countries and lender countries and this distinction should not be over-exaggerated. They identify nine main categories of political actors engaged in the policy transfer process: elected officials, political parties, bureaucrats/civil servants, pressure groups, policy entrepreneurs and experts, transnational corporations, think-tanks, supra-national governmental and nongovernmental institutions and consultants (2000: 10). With regard to identifying the actors of policy transfer, there is little difference between Dolowitz and Marsh's categories and those of other scholars. For instance, Evans (2009:244) provides the same categories, namely politicians, bureaucrats, policy entrepreneurs including think-tanks, knowledge institutions (KIs), academicians and other experts, pressure groups, global financial institutions, international organizations and supra-national institutions.

Dolowitz and Marsh (p 12) argue that anything can be transferred from one political system to another. They identify eight different categories, namely policy goals, policy content, policy instruments, policy programs, institutions, ideologies, ideas and

attitudes as well as negative lessons. In particular, they argue that policy transfer distinguishes between policies and programmes as follows: "Policies, which are seen as broader statements of intention and which generally, denote the direction policy-makers wish to take, and programs, which are the specific means of the course of action used to implement policies". Rose (2005:7-18) argues that there is a fundamental difference between the programmes of different countries. This difference leads countries to look to other nations for lessons to address the same problems. He provides as an example the programmes to supply clean water to cities in different OECD countries. Furthermore, policy makers should look at programmes in counterpart countries because governments have common problems. This way, policy makers help constitute useful knowledge. In addition, Stone argues that the 'soft' transfer of norms and knowledge is important for completing the 'hard' transfer of policy tools, structures and practices. The transfer of soft and hard complement each other and help to promote learning (2004:246).

Bennett (1991:32) points out that policymakers learn from the export of knowledge through various channels of transnational communication, and this leads to policy transfer. He distinguishes between "knowledge of a foreign program, utilization of that knowledge, and the adoption of the same program" (p32): Knowledge of a foreign program is not enough for adoption in a country, but utilising the knowledge of a foreign program requires evidence and that evidence should involve written documentation and fact-finding (P37).

Dolowitz and Marsh (2000) classify policy transfer according to three levels: the international, the national and the local. Within a country, policy-makers can draw lessons from another country or units within their own country. Furthermore, a political system can draw lessons not only from national governments but also from other sub-national levels and units of government. Lastly, government can draw lessons from international organizations or nongovernment organizations. In addition, think tanks, NGOs, advocacy coalitions and intergovernmental bodies such as the OECD play a vital role in transferring lessons (ideas and norms) between many different venues (Stone, 2004).

There are different views about how to describe the degrees of transfer. Evans and Davies (1999) define five degrees of transfer: copying, emulation, hybridization,

synthesis and inspiration. Dolowitz and Marsh (2000:13) note four different gradations of policy transfer:

Copying, which involves direct and complete transfer; emulation, which involves transfer of the ideas behind the policy or program; combinations, which involve mixtures of several different policies; and inspiration, where policy in another jurisdiction may inspire a policy change.

In addition, Dolowitz and Marsh mention that the type of transfer depends upon factors such as who is involved in the process and where within the policy-making process transfer occurs. Thus, if politicians tend to look for 'quick-fix' solutions, they rely upon copying or emulation, bureaucrats. Furthermore, a combination of the type of transfer is possible so that, while emulation is crucial at the agenda-setting stage, copying may be more applicable at the policy formulation or implementation stage of the policy-making process. Evans (2009:246) identifies four different processes of policy-oriented learning which emerge from the process of transfer: (1) copying without modification; (2) emulation, which provides the best standard for designing; (3) hybridization, refers to the combining of elements of programmes; and (4) inspiration, which occurs when an idea inspires policy makers to change policy.

Benson and Jordan argue that the degree of transfer can link types and specific transfer processes. For example, emulation or copying appears to result from 'hard' coercive transfer, whereas imitation and inspiration appear to result from softer forms of transfer. In addition, they believe that the analysis of policy transfer should focus on what drives transfer, what transfers and how, and what the impacts are 'on the ground' (2011:371).

Dolowitz and Marsh (1996:353-354) argue that the complexity of a program affects its transferability, and may depend on a number of factors, including past policies, institutional and structural impediments, the lack of ideological similarities between countries, bureaucratic size and efficiency, technological abilities, and monetary resources. These factors have been analysed by many scholars.

With regard to variables which can constrain the implementation of ideas collected in the framework of policy transfer, Evans (2009:246-247) identifies three, namely cognitive obstacles, environmental obstacles and public opinion. Regarding cognitive

obstacles, before making a decision to transfer, policy makers should define the problems, ideas, and the receptivity of existing policy actors; environmental obstacles refer to the absence of effective cognitive and elite mobilization strategies deployed by agents of policy transfer; and public opinion includes elite opinion (political, bureaucratic and economic), media opinion, and the attitudes and resources of constituency groups.

Dolowitz and Marsh (2000) also emphasise themes of policy transfer and policy failure, and offer views on why policies which have been successful in one country will be successful in another as well as why some transfer is unsuccessful. They suggest three factors that have a significant effect on policy failure:

First, the borrowing country may have insufficient information about the policy/institution and how it operates in the country from which it is transferred: a process we call uninformed transfer. Second, although transfer has occurred, crucial elements of what made the policy or institutional Structure a success in the originating country may not be transferred, leading to failure: we call this incomplete transfer. Third, insufficient attention may be paid to the differences between the economic, social, political and ideological contexts in the transferring and the borrowing country: we call this inappropriate transfer.(2000:17-18)

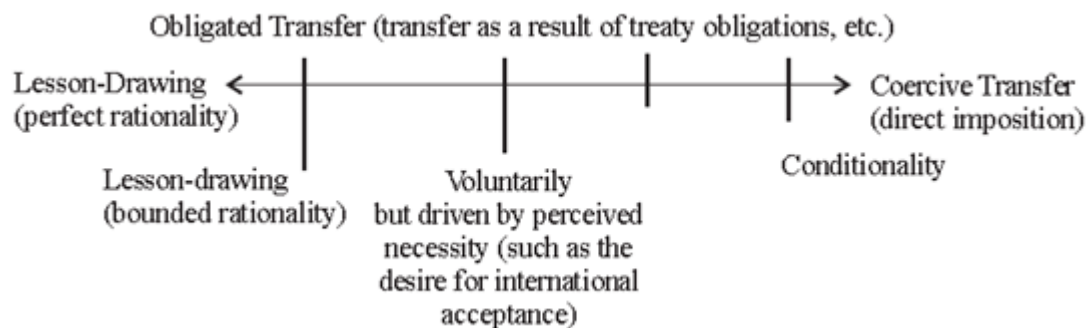
These factors were used by Dolowitz and Marsh to examine the transfer structure of the British Child Support Agency (CSA) from the United States to the British government.

In developing countries, the literature of policy transfer has concentrated on the bureaucrats and administrative capacity. Tambulasi argues that NPM decentralization reform has been constrained by bureaucrats in developing countries, because top managers, through self-interest, do not like to pass managerial activities down to lower levels (2013). In addition, Randme-Liliv and Savi, in their study of the factors that influenced the process of policy transfer between Estonia and Latvia, state that “The administrative capacity of a newly democratic country in the Central and Eastern Europe (CEE) plays a critical role in the process of policy transfer” (2013:67), their finding is that limited administrative capacity is a

risk in policy transfer, as policy outcome may be determined by the preference of civil servants instead of by examining the merits of the policy model.

Dolowitz and Marsh (2000:13) suggest that policy transfer can be conceptualized as lying along a continuum that runs from lesson-drawing to the direct imposition of a program, policy or institutional arrangement on one political system by another. This is illustrated in the diagram below.

Figure 2-1: A Policy Transfer Continuum



Source: reprinted from Dolowitz and Marsh (2000)

The diagram shows how reference to the continuum can help researchers understand the processes involved in the transfer process in order to capture the shifting motivations inherent in it. As can be seen, voluntary transfer entails willingly agreeing to adopt a policy while coercive transfer entails imposition of such policy. In all this, the role of actors becomes an important analytical point which deserves closer attention. In the case of lesson-drawing the emergence of a problem or dissatisfaction with the status quo will drive actors voluntarily to find solutions. In coercive transfer, international aid agencies have been able to compel governments to adopt programs and policies against their will, and governments can be forced to adopt programs and policies as part of their obligations as members of international regimes and structures (p14-15). The policy transfer from the USA during the Thatcher, Major and Blair governments to provide a solution to the unemployment crisis is a good example of this.

The policy transfer approach has been criticized for a number of shortcomings. James and Lodge refer to the difficulty of disentangling policy transfer from a wide range of other concepts of policy-making (2003:181) and argue that policy transfer does not develop an explanation of failure of the process of policy transfer (p88). They suggest:

Alternative accounts exploring the consequences of policy-making processes for policy outcomes focus more directly on how processes influence outcomes. Institutional accounts based on 'path dependence' suggest that policy changes in general face substantial difficulties because of fixed costs, resource dependent constituencies and established standard operating procedures.(p188)

In addition, they add,

The effect of more 'lesson drawing' seems to be that policy-making works more like the systems conventionally described in rational accounts. The production of 'how to' guides specifying mechanisms for improving 'learning', including sources and ways to analyse evidence, would appear to be a way researchers contribute to its fulfilment. However, the use of 'policy transfer' to explain 'policy change' and policy 'success' or 'failure' does not adequately separate the policy 'success' or 'failure' being explained from processes of 'policy transfer. Instead, Dolowitz and Marsh redescribe aspects of 'failure' as some form of 'transfer'. At other points, they evoke explanations that go beyond features of the process of 'transfer' to include the aims of policy-makers. Researchers may be better off using alternative theories focusing more directly on the effects of learning processes or styles of policy-making on policy outcomes. (p190)

Evens criticize policy transfer for absence tool of evaluating and failing to make their research relevant to the world of practice (2010:85). Consequently, the application of policy transfer alone is not sufficient for analyzing the problems of the public health sector and drawing lessons, but when combined with path dependency, it can help build a more complete picture, especially in relation to the success or failure of the transfer.

2.3 Path Dependency

Path dependency plays a crucial role in understanding social and political processes. It aims to explain the operation of systems of institutions and their interaction with the wider socio-economic and political environment (Kay, 2005:555-558). Furthermore, he argues that sequencing matters, since events occurring at an initial point in time will affect events occurring at a later point in time as well as encourage future developments in that same direction. Thus, the effects of initial decisions will often reinforce those decisions; there are positive feedback loops.

Pollitt explains that path dependency can be applied to specific organizations, as well as to study the evolution of the welfare state. He lists the essential features of the path dependency framework as follows:

- It provides some broad concepts (positive feedback, punctuations, etc.) which can be applied in many circumstances, including organization level analysis;
- these concepts prompt some very useful questions about both continuity and change; and
- these questions set us on the track of mechanisms, each of which may have its own particular time profile .(2008: 103-104)

According to Mahoney (2000: 510), path-dependent analysis focuses on the study of causal processes that lead to events that take place in the early stages. As Pierson (2000) notes, the reason we study the causal processes is to understand how variations in current variables affect present social outcomes. Furthermore, we cannot understand social reality without understanding 'how it got here'. Outcomes and trajectories are influenced by previous events; previous steps in a particular direction induce other movements in the same direction: this is the concept of increasing returns. Pierson (1996) argues that increasing returns can also be described as self-reinforcing or positive feedback. He notes the impact of the junctures of society in the shaping of social life; the main factors in the shaping of social life are the critical moments or junctures, specific patterns of timing and the sequence of matter.

Mahoney (2000) also observes that the path-dependent approach examines sequences that have self-reinforcing properties. In these sequences, first steps will

induce movement in the same direction such that, over time, it will be impossible to reverse direction. Economists characterize the self-reinforcing as increasing returns “to highlight how the probability of further steps along a given path increases with each move down that path until an equilibrium point is reached”. Increasing returns processes play a crucial role as they drive actors to impose their preferences instead of other preferences (Pierson: 2000).

Furthermore, on the path, the early decision-making may lead to ‘lock-in’, and each decision-making has a powerful focusing device for subsequent decision-making. As time unfolds, the likelihood of continuing along the path will be increased, while the ability to deviate from it or to establish a new path will decrease (Wilsford, 1994:253-254).

In addition to the issue of change within path dependency, Pierson (2000:264) mentions that providing important hypotheses about the sources of change requires an investigation through path dependence in order to explore the prevalence of resistant change; this is a useful way of developing new propositions about the conditions that facilitate or impede various types of political change.

Additionally, Pantazis and Pemberton (2009:366) point out that the notion of path dependence plays a pivotal role in understanding policy transfer dynamics. They write:

This would enable a discussion of the role of policy transfer vis-à-vis potentially competing explanations such as path dependency. It is important that policy transfer analyses are contextualised through accounts of path dependency in order to understand the historical trajectories of policy development alongside the conjunctural conditions that serve to incorporate external policy solutions into local contexts.

Furthermore, in his analysis of health policy reform in the U.K, Greener (2002:162-163) points out that the focus on path dependency has attempted to explain how policy goes through periods. It is therefore a possible complement of policy-transfer, in that it can demonstrate how policy paradigms become institutionalized and the remarkable difficulties of securing radical change. The path dependency approach is

therefore useful in identifying the considerable constraints that exist on policy makers.

Tuohy's (1999:113) study of the dynamics of change in the health care arena in the United States, Britain, and Canada in 1999, where he focused on policy legacy to explain why some legacies are followed and others not, helps us to understand the path dependency of policy development, and what the circumstances and constraints of policy legacies are. One of the implications of path dependency is that the efficient policies and good practice which have appeared in different countries may be unsuccessful because 'causal processes' and 'increasing returns' may constrain the application of new policy or reform. As Rose (2005:105) points out, path-dependency restricts current choices for government because of past commitments, as well as locking in the government by limiting its decisions.

The concept of the legacy of the past is seen as part of path dependency, because of the focus on the results of long-term institutions and policy developments. In Central and Eastern European countries, scholars have focused on the communist heritage as a legacy explanation of the public administration reform. Meyer-Sahling (2009) discusses the effect of the communist legacy on post-communist administrative developments. He mentions the concept as "legacy explanations", which are important in providing an explanation for the causal mechanism, "Connect the past and the outcomes of the present". He found that the impact of the legacy of the past on post-communist administrative development is not only description of the legacy of the past on post-communist administrative development but also is a specification of the causal mechanisms that link the legacy of the past to post-communist administrative outcomes (p523-525).

Nellis's study (1983) of the Magreb States of North Africa (Morocco, Algeria, Tunisia, and Libya) indicate that the socio-economic and political environment in these states plays a crucial role in initiating policies. Thus, an understanding of the environment and political setting is important to situate the constraints and opportunities in order to implement and translate policies into action (Cheema and Rondinelli , 1983:27).

2.4 The Analytical Framework for this Study

In Chapter 1, I argued that the aim of the thesis is to draw transferable lessons from the UAE for Libya to achieve more effective health services. As discussed earlier in this chapter, a policy transfer perspective will be applied in the study, basing my approach on Dolowitz and Marsh's framework. This approach is adopted because, as Common (2001:29) mentions, it is a "Heuristic map to inform policy transfer research". Evens (2010:79) argues that Dolowitz and Marsh's framework can be seen as more inclusive than that used in previous studies, as it includes policy transfer, policy learning and lesson-drawing. He further claims that the framework seeks to explain causal processes that lead to the transfer as well as outcomes of processes of policy transfer. In this study, Dolowitz and Marsh's framework and ideas put forward by other authors in relation to developments on the subject of policy transfer/learning seem most applicable, in that they provide a realistic picture of how to perform an in-depth public policy analysis in order to tackle the problems of such policy. Furthermore, a policy transfer perspective, as noted, can help provide a better understanding of how learning across political borders may influence domestic policy formation and implementation.

The main questions then are: Why policy transfer? What is transferred? From where are lessons drawn? What factors enable or constrain transfer? (See section 2.2.4). These questions highlight the key factors which can be learnt from the UAE, which can be applied to reform the Libyan public health services to ensure accountability and decentralization. In other words, the analysis of the public health systems in the UAE and Libya, with respect to accountability and decentralization, through the lens of a policy transfer perspective, will reveal the development experience of the UAE health system, and a comparison between the two systems will shed light on lessons which can be learnt by Libya. Emphasis will be placed on analysis of contextual factors that facilitate or constrain the implementation of policy learning in Libya. In this thesis, an examination of what is transferred is limited to accountability and decentralization, as introduced in this chapter.

The use of the additional approach of path dependency will facilitate the study, in that the circumstances necessary for transferring a lesson can also be analysed: path dependency concerns help to understand how time and long-term patterns

affect present social out-comes (Pierson, 2000), which is also of interest to this research. Libya has experienced many changes, historical legacies and punctuations that have affected the country's public administration and this inevitably has influenced the policy reform of its health sector.

Against this backdrop, this study intends to analyse the extent to which path dependency will lead to a better understanding of the constraints on and opportunities in the transfer of health sector reforms in Libya. According to the table 2.2, during the Qadhafi regime 1969-2011 Libya experienced many changes and events in the political and economic sphere which influenced public administration. This period was characterized by the weakness and backwardness of the administration. Although the regime collapsed in 2011 and Libya started on a new path, the legacy of Qadhafi, in the form of ideas, values and practices, remains in the public sector, and this will constrain any future reform. This study will demonstrate the usefulness of the concept of path dependency in researching the legacy of the past and how the old trajectory (the legacy of Qadhafi) will affect and constrain the reform and policy transfer/learning in Libya. One of the benefits of path dependency is its emphasis on the importance of old trajectories that are broken when a new path is begun (Pollitt, 2008:46).

Table 2-2 : major punctuations in political and economic change in libya

Year	Change
1969	A small group of military officers led by a 27-year-old army officer, Muammar Qadhafi, staged a coup d'état against King Idris.
1973	Qadhafi declared a 'Popular Revolution' and announced a five-point programme to reform public administration structures by turning the masses against the inefficient, corrupt bureaucracy, and abolishing outdated laws.
1977	The transformation of Libya into a socialist state. This period saw two plans for economic and social transformation which aimed to establish a socialist society based on the public sector and public ownership of state. These changes led to the new role of the state in society.
2011	The revolution of 17th February overthrew Qadhafi and his regime. Libya embarked on a new stage which has adopted new policies and practices.

This table was prepared by the researcher, using the work of Fathaly (1980) and Otman (2007).

2.5 Perspectives of the Public Sector, Decentralization and

Accountability

A reform of the public sector has focused on how to improve decentralization policies and accountability, so these two areas have become the main issues in developing countries in order to make the public sector more responsive and more effective in service delivery (Bangura et al., 2006; Jreisat, 2009).

This section will focus on the concept of the public sector, followed by an examination of its characteristics and the differences between the public and private health sectors. It then examines the concepts of decentralization and accountability and diverse issues related to them. These issues will make two major contributions to the study. Firstly, they provide background knowledge and understanding that can facilitate a specific analysis of public health sector improvements in Libya. Secondly,

these issues provide an awareness of previous work in this area, which may lead to suggestions which can be used to further improve Libya's public sector.

2.5.1 The Concept of the Public Sector

Before discussing the public health sector, it is important to explain the public sector and related concepts: what is the role of the public sector in providing public goods and services, and achieving the economic and social welfare of the state. The public sector is defined as government agencies that are funded by taxes, charges and fees or from the sale of state-owned assets. It includes departments, bureaus, the judiciary, funded state bodies, publicly-owned corporations, and fully or partly subsidised organisations such as social welfare agencies, schools, and universities (Scott, 2010:1). Flynn (2007) defines the public sector as consisting of all parts of the economy that are either in state ownership or under contract to the state, and parts that are regulated in the public interest. The concept of the public sector, according to Lane (2000), is a tool for government to drive the market, intervening in several ways with operations and outcomes of market allocation mechanisms. Lane also refers to several interpretations of the public sector, namely bureaucracy, planned economy, authority, public resource allocation, public distribution of income, public ownership, and public employment (2000:47), and the size of a state's public sector depends upon the vision of state and the benefits offered by the institutions (Jackson, 2003).

Differences between the public and private sectors are suggested by Hughes. He states that there are some major differences that affect the way the public sector can be managed (Hughes, 1998: 257-60):

- Citizens comply with the decisions of public institutions and apply sanctions on them in case of non-compliance, but not all public activities are coercive, while coercion is not present in the private sector. Hughes argues that the private sector has freedom in dealing with customers and administrative measures while the coercive power of the public sector restricts management.
- Mechanisms of accountability in the public sector are different from the private sector. Private companies are accountable to shareholders, while the public sector is subject to political accountability in many additional ways.

- The presence of political authority is a key difference between the public sector and private sector. Therefore, public service managers are dealing with an outside agenda set by the political leadership.
- Performance measurement in the public sector is more difficult than the private sector. NPM has made changes to improve performance measurement, but it is difficult to measure output because the public sector lacks bottom-line criteria analogous to profit in the private sector.
- The public sector is characterized by being large in size and having to carry out a variety of activities, which makes co-ordination and accountability difficult.

According to Lawton and Rose (1991), it is difficult to distinguish between the public and private sectors because of the co-operation between them, and both are influenced by the political environment. Flynn (2007) also notes the lack of a clear distinction, suggesting there are similarities between them. For example, services in both sectors need to be managed in a similar way and public and private services are created by organizations similarities between the two sectors are suggested by Lawton and Rose:

- Increasingly the public sector charges for some of its services; for example through increased prescription charges or charges for leisure facilities.
- The private sector also operates within a political environment as decisions made by politicians to, for example, keep interest rates high will have a profound effect upon the very existence of some firms faced with borrowing costs and reduced sales.
- The activities of the private sector are also constrained by statute as firms are regulated over unfair trading practices, health and safety at work or environmental pollution.
- Public and private partnerships have developed over urban redevelopment where groups such as Business in the Community have promoted private sector involvement at local levels. (1991:7)

For the purpose of this research the researcher has defined the public sector as the total of the various regulatory institutions that provide public goods and services and achieve economic and social welfare of the community.

In the case of health services, health care delivery is an essential service with huge financial requirements usually provided by the government of any country. The organization of governmental public health evolves in response to public needs and demands as well as political will. The public health organizations provide public services to society because those services are beneficial to society at large, and public health services are likely to be under-produced by the private sector (Mays, 2008:69), mainly because of the huge costs required to provide such services efficiently.

It is important to distinguish between the health system and related concepts, including public policy, health policy and health systems. According to Howlett and Ramesh, public policy is a choice that is made by a government in order to develop some course of action and deal with a problem or concern (2003:5-7). Among the many definitions of health policy, Buse et al. offer the following: health policy “Covers courses of action (and inaction) that affect the set of institutions, organizations, services and funding arrangements of the health care system (both public and private)” (2005:6). This definition includes all activities, whether undertaken by government or private sector that influence health organizations that provide health services. Blank and Burau distinguish between three relevant concepts: health policy, health care policy and health care politics. Health policy refers to all actions taken by government which affect the society: it overlaps with education, the economy, housing policy and other areas. On the other hand, health care policy refers to all actions taken by the government dealing with the financing, provision, and governance of health services. Finally, health care politics refers to the interaction between political actors and institutions in the health care arena (2007:2-3). The focus of this thesis is health policies adopted by government which deal with the provision and governance of health services.

In this regard, health system involves delivery, finance and regulation. These elements might be described as the function or process of the health sector. Delivery of health involves doctors and other people who are qualified to practise medicine, managers, and patients. Health care finance refers to the way in which health services are financed. In some countries, health services are financed by the government (e.g. UK, New Zealand, and most developing countries), while other countries depend on private insurance in providing health services and the role of

government is one of less intervention in health finance (e.g. the USA). Health regulation is related to markets, hierarchies and networks (Freeman, 2000:1-3). In addition, delivery of health includes equity of access to health care. The Declaration of Alma-Ata in 1978 stated that:

The existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.(Hixon and Maskarinec, 2008:587)

As highlighted by Son (2009:1), equity of health care may be viewed from three broad perspectives: (i) equity in health, (ii) equity in health service delivery, and (iii) equity in health financing.

The WHO defines a health system as including “All the activities whose primary purpose is to promote, restore or maintain health” (2000:5). In developing countries, a health system consists of government activities and non-government activities, including services provided by both modern and traditional practitioners. Governments typically provide free or low-cost health services directly within ministry of health institutions.

In developing countries, the public sector plays a vital role in providing health services, especially in ‘distributive states’ which derive their income from the sale of a commodity, and do not depend on taxation of its citizens (Vandewalle, 1998). In distributive states, the state is responsible for education, health, housing, and creating jobs. In this sense, governments fund, regulate, and deliver health services. In other words, states provide universal coverage of health care, free of charge.

As a result of the marginal role of the private health sector in developing countries, the public health sector becomes the main actor in providing health services (Drechsler and Jütting, 2007). According to Schieber and Maeda (1999), governments in developed and developing countries play an important role in the health sector, but the governments in developing countries have a more significant role in providing health services, managing the health facilities, financing, and employing the health workforce than developed countries. According to Freeman, one way of analyzing the health system is to consider the role of the state. The

health system may be more or less efficient. This is not only dependent on the model of health system but also the degree of state intervention. The health sector may be understood as being embedded in political processes of the state (2000:8).

For this thesis, the public health sector refers to the various institutions that are fully administered by the government and provide free health services. This study is concerned with the public health sectors in Libya and the UAE and the role of the state in the mechanisms of delivery, regulation and finance.

Hughes (2003:81-83) argues that governments have different roles in society. The public sector plays a crucial role in determining the services that are provided by the government, and most people depend on government services such as education, health, security and environment. He discusses the tools used by governments to intervene in society: government provision (such as in education, health, defence, and roads); subsidy; production (such as in electricity supplies and rail services); and regulation.

Massey and Pyper (2005: 17-18) explain that governments use the public sector to deliver services and goods to the public. The delivery of service and goods is either direct, as with defence, education, and welfare payments, or indirect as with doctor services and the provision of roads and refuse collection. They also discuss the important function of the public sector in relation to the citizen and the government, suggesting that, if the public sector fails, then the government has failed to fulfil its obligations. If the public sector is corrupt or inefficient then society will suffer from a lack of quality and efficiency in public services; citizens with low incomes suffer from the inefficiency of the public sector because they depend on the government for their livelihood.

The main debate among scholars concerning the role of government in the public sector is related to what the government should pay. There is an ideological debate about the role of government in the public sector. In the 1980s the UK saw extensive discussions about the privatization of public institutions in order to reform the public sector, control public spending and achieve efficiency and effectiveness. This debate has spread to all countries in the world, especially socialist countries, in order to conduct reforms and changes in the role of government. However, the management of the public sector in developed countries has transformed from the traditional

model of public administration to that of new public management. This shift is not just a programme of economic reform, but it reflects the changes in the role of government for society and the relationship between the government and citizens (Hughes, 2003).

According to Tanzi and Schuknecht (1997), ideology has created pressure to change the government's role in the public sector. Privatisation is the main concept of the "new liberalisation" which has led to changes in the public sector and reduced public spending through the privatisation of many public institutions.

Pollitt (2003) claims that the change in the philosophy of management and operations of the privatisation of the public sector in developed societies reflects the ideological motives of the neoconservatives. In the UK, which experienced privatisation after 1980 by the Thatcher government (Conservative Party) in order to introduce economic reforms and reduce the role of government, this policy has been adopted by successive governments. This suggests that there is no desire to return to traditional administration.

The public sector can be seen as the ideological strategy of the government. Therefore, the government plays a vital role in determining the general framework of public sector activities. This situation is to be expected in both developed and developing countries, but the size of government differs between countries. The size and scope of a government has to do with the ideological considerations of the state. Scott (2010: 1-3) explains that the relationship between the public sector and the government has become more complex. He mentions two factors that have contributed to this complexity. The first factor is that many governments have given the public sector organisations a high degree of autonomy. The second factor is that the provision of public goods and services has become a partnership between the government and the private sector and the voluntary social organisations. Under the influence of new public management doctrines, core government is divided into centralised functions such as finance, security, and overall policy-making, and decentralised government or public sector, which are concerned with social policies such as education and health. Decentralisation includes the notion that, if public sector organisations get a high degree of autonomy from central control, they are able to provide services efficiently and effectively. However, Scott assumes that

power has been divested to decentralised public sector organisations. A public sector institution's degree of autonomy from the central government depends on its function, public finance, public perception of its need for independence and political circumstances. In many cases, autonomy is limited to performance. For example, regulatory agencies entirely funded by the government could be formed to control and protect consumers from dangerous goods. These agencies have autonomy to administer legislation but they do not take the final decision on what the legislation should be.

In addition, governments have taken different steps to increase the efficiency and effectiveness of services, such as privatisation, restructuring the economy, and reforming public administration. Perhaps the concept of governance fits with these transformations and changes in the policies and methods. Bekkers et al. (2010:11) state that the concept of governance includes three elements of reform. First, the concept of governance assumes that all public and private institutions have taken various actions which have had an effect on social problems such as crime, and, therefore, successful intervention in these problems requires co-operation between all actors in society. Secondly, networks, whether internal or external, play an important role in the regulation of relations between relatively autonomous actors. The government may participate, but as an actor among many others. Networks, however, work to arrange the action needed to solve political problems. Thirdly, the focus is on the processes of governing instead of the structures of government. These processes concern negotiation, concentration and cooperation rather than the traditional processes of coercion, command and control.

From the above ideas it is clear that governments of the world take different policies in order to provide services efficiently and effectively. These policies are privatization, decentralization, governance, and autonomy. This section has concluded that development in the public sector reflects the changes in the role of government, and the role of government is important to understand why and how public sector develops. In this thesis, discussion of the role of government in the public sector will be used to explore the public sector existing in the Libyan public health service, and to help to illuminate some of the problems faced.

To conclude, the concepts of the public sector and the health care system are useful for the analysis of practical issues such as health care policies, institutional organisation and delivery, and financing health in the UAE and Libya.

2.5.2 Decentralization

Decentralization is the transfer of power and functions from the centre to lower levels of state institutions; there are three areas of decentralization, namely administrative decentralization, fiscal decentralization, and devolution or democratic decentralization (Manor, 1999:4-6). The most commonly used framework to distinguish between forms of decentralisation is that developed by Rondinelli et al., (1989:72-78), who identified four categories:

- **Privatization and Deregulation:** some governments transfer responsibility for functions to voluntary organizations or private businesses in order to improve public services. Local governments also privatize by contracting out some government administrative functions. This privatization leads to the great potential for lowering the current operating expenditures of local governments since personnel costs tend to be the largest expenditures in operating budgets.
- **Delegation:** in some cases, government tends to shift responsibility for producing goods and supplying services that were previously offered by central government agencies and ministries to public corporations or to publicly regulated private
- **Devolution:** improving services can be done by devolving responsibilities to local governments or administrative units. Devolution is achieved by giving autonomy and independence to the local government. In this view, central government has little or no direct control over local government.
- **Deconcentration:** some types of public goods can only be provided effectively by the central level or by some agent of the central government at local level. This type of decentralization does not include the transfer of power of decision-making but it involves the shifting of workload from the central state to government offices situated outside the capital city or the head offices. Government tends to apply this type of decentralization in order to help to make service delivery more responsive to users' needs and the delivery process more efficient and effective.

According to Pollitt and Bouckaert (2011:102), there has been a global rush towards decentralization but decentralization is applied in different forms. Decentralization

can be seen as a process that contains three strategic choices, as described in the table below. The first choice is between political decentralization, where the central government transfers power to local government by electing political representatives, and administrative decentralization, where authority is passed to an appointed body. The second choice is between transferring authority to another body which is selected by competitive means, and transferring authority by non-competitive means. A third choice is between internal decentralization, where the transfer takes place within an existing organization, and external decentralization, where authority is transferred from an existing organization to an outside organization. NPM countries such as France, the UK, and the Netherlands, have probably undertaken more external decentralization, creating new, autonomous, and specialized bodies, and then devolving powers to them.

Table 2.3: Strategic Choices in Decentralisation

Either	Or
Political decentralization	Administrative decentralization
Competitive decentralization	Non-competitive decentralization
Internal decentralization	External decentralization (devolution)

Source: reprinted from Pollitt and Bouckaert (2011).

The literature shows that decentralization can have positive effects. In terms of the benefits, characteristics of decentralization have been discussed by scholars to clarify how decentralization leads to increased government responsiveness to local needs. Pollitt provides arguments in favour of administrative decentralization as follows:

- Decentralization (both vertical and horizontal) speeds decision making by reducing the overload of information which otherwise clogs the upper reaches of a centralized hierarchy. Faster decision making is more efficient.
- Decentralization means that decisions are taken closer to the users/consumers of an organization's products and services, and

this, in turn means that decisions are likely to be more responsive to those users.

- Decentralization improves the ability of an organization to take account of differences between one local context and another. Services can be better “tuned” to local conditions.
- Decentralization may be used as one way to reduce political intervention in matters that are best managed without political interference in details (e.g. case work with individual citizens; regulatory functions, etc.).
- Decentralization encourages innovation (because new ideas no longer have to find their way all the way up the hierarchy to the centre to be approved and authorized).
- Decentralization improves staff motivation and identification. They feel they can “belong” to a smaller, more comprehensible organization, rather than just being a cog in a gigantic bureaucratic machine. (2005:281)

With regard to political decentralization he provides the following arguments in favour:

- Devolution of political power puts it closer to the citizen.
- Devolution of political power makes politicians less remote, more visible and more accountable.
- Devolution of power encourages more citizens to play some active part in the democratic process—by voting, attending meetings or even standing for office.
- Devolution of political power allows for greater expression of legitimate local and regional differences. (Ibid., 281)

Despite these benefits, there are problems that occur in developing countries when they apply decentralization policies. The six most important obstacles to decentralization are the following: lack of coordination between central and local government; central-local government conflict; poor incentives at local level; weaknesses in municipal management capacity; lack of accountability; and central

government restrictions on municipal financial management (Smoke and Lewis, 1996:1290; Rondinelli, 1990:49-50).

Following on from a discussion of the concept of decentralization and its forms, it is important to consider how decentralization can be measured. Vrangbaek (2007:52-53) explains five variables that can help in assessing the degree of decentralization as follows:

- The level of potential autonomy varies between units. So larger decentralized units will have more potential for autonomous administration.
- Political decision structure refers to the possibilities of citizens' participation for decision-making. This factor reflects the extent to which autonomy of organization will lead to the involvement of citizens and organized interests in decision-making.
- The number and importance of functions/tasks. This refers to the degree of autonomy and the level of decentralization.
- How central level steers the local level. It is useful to distinguish between two kinds of steering: direct and indirect. Direct steering means that central level decides the goals for the local level. This places the local level under constraints that lead to loss of autonomy. Indirect steering, on the other hand, focuses on the conditions for achieving particular purposes in terms of organizational, budgetary and informational resources.
- There is extensive or limited control between central levels and local levels.

The above five variables can guide this thesis in measuring the degree of decentralization in this case study. Drawing on the above discussion, this study defines decentralization as the transfer of decision-making, functions and resources from the central government to local governments (municipalities) in order to bring higher levels of responsibility and accountability to local communities and to improve public services. In other words, decentralization can be seen as an important way to promote a more efficient allocation of public resources and to provide public services at the local level through participation in decision-making and the people should be the focal point of development through decentralized and improved governance.

In recent development literature considerable attention has been paid to the relationship between good governance and decentralization. Before discussing the relationship, it is necessary to define the concept of good governance. The term 'governance' refers to a new process of governing. Governance represents changes that occur within government, and these changes lead to self-organizing and inter-organizational networks that are characterized as being interdependence, resource exchange, rule of law, and autonomy (Rhodes, 1997:15). According to Kooimam, the process of governance encompasses individual citizens, public and private sectors and civil society. He refers to the process as 'governing' which considers all interactions between actors that aim to solve societal problems or create societal opportunities (2003:4-5). Governance recognises the capacity to get things done that is not based on the power of governmental hierarchy in commanding and using its authority, but is based on networks and partnerships (Newman, 2001:11-12). Massey (2010) suggests a difference between good governance and bad governance: the former begins with transparency and democratic accountability, which includes not only government institutions but also civil society institutions and NGOs; the latter, on the other hand, is characterised by the absence of accountability, transparency and the redress of grievance.

Good governance, according to some observers, should aspire to the following:

- be transparent;
- be accountable for its actions;
- be accountable not just for its actions, but also in terms of its management, project implementation, financial management, and information disclosure;
- operate ethically;
- operate regardless, or rather beyond the boundaries of, race, ethnicity, religion, culture and politics;
- respect and support individual human rights. (Omelicheva, 2004, cited in Massey 2005:9)

The World Bank defines good governance as

Epitomized by predictable, open, and enlightened policymaking (that is, transparent processes); a bureaucracy imbued with a professional ethos; an

executive arm of government accountable for its actions; and a strong civil society participating in public affairs; and all behaving under the rule of law. (World Bank 1994, p. vii)

According to Smith, the essential point of good governance is decentralization and decentralization is a key aspect of political and administrative reform. He provides evidence that some donors such as the United States Agency for International Development (USAID) emphasize the contribution of decentralization to the strengthening of democracy and social development and poverty reduction (2007:101). The USAID issued a report in 2000 that showed the importance of decentralization in achieving the elements of good governance especially with regard to human rights, political openness, participation, accountability and administrative capacity (2000:1). In addition, Lister and Betley see decentralization as a benefit that goes along with democracy, good governance, a market economy, poverty alleviation and efficiency in public expenditure (1999: 3-4). They provide arguments to support the idea that decentralisation can contribute to good governance, reduce bureaucracy in decision making, facilitate experimentation and innovation, leading to the dissemination of better practices, and promote the values of democracy and participation in local communities.

Decentralization thus contributes to the basic elements of good governance such as increased opportunities for people to participate in political decisions and economic and social development. Furthermore it helps to develop the capacity of the people, and to improve the response of governments to citizens as well as strengthening transparency and accountability. As noted by Mitchell and Bossert,

Decentralisation can be used to improve any aspect of governance, one of its principal objectives is to enhance the accountability of public policy to the immediate beneficiaries; in this sense it is an organisational reform aimed at reducing the scale at which institutions operate and making them more accountable to the population served. (2010:671)

2.5.2.1 Decentralization and Governance in Health System

This section will investigate how decentralization contributes to the achievement of general health sector goals. This thesis will discuss the perspectives of health systems on the appropriateness of using decentralisation to improve service delivery.

According to the World Bank report, health systems in some developing countries face three problems: insufficient spending on cost-effective health activities, internal inefficiency of public programs and inequity in the distribution of benefits from health services. This report recommended that decentralization constitutes an agenda for reforming health systems: decentralization is the best way to improve health systems in developing countries in that it will help local units to achieve greater financial and management autonomy and greater responsibility for planning and budgeting. Improving decentralization should lead to greater decision-making in local units and greater responsiveness to views of the local population (1987:6-10).

The importance of decentralization in health systems has been discussed by many scholars (Bossert, 1998; Peckham et al., 2005; Bossert and Mitchell, 2011). Vrangbaek (2006:46) defines decentralization in health system as,

The transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services, usually from a smaller to a larger number of geographically or organizationally separate actors.

Vrangbaek (ibid.,48-51) provides a framework for describing all types of decentralization within health care systems. Political devolution may relate to all functional areas of health care in terms of financing, arranging and delivery. This is characterised by a high degree of autonomy in decision-making. In practice, in public health care systems, there is shared responsibility between central and local authorities and decision-making will be subject to negotiation. In deconcentration decentralization, there is transfer of power from central authorities to local representatives of the central level, for instance Health Authorities in the UK. On the other hand, delegation and autonomization, which refer to the transfer of some functions to more or less autonomous public organizational management, can be

found, for example, in Norway, where public enterprises arrange and deliver hospital care, and rely on medical societies for elaboration of standards and guidelines. Privatization and deregulation exist in health systems when responsibility for particular functions is transferred from public to private actors .

Bossert stresses the need to apply decentralisation in health systems in developing countries by expanding the decision-making power that is held by local officials (1998, 2002, and 2011). He uses the concept “decision space”, (1998:1518), a view which “principal-agent” theory: decision space sees decentralization as the way in which relates to the central authority (principal) transfers choice to the local authorities (agents), and the agents decide preferences according to the principals’ objectives. This approach serves to improve decentralization policies through the participation of local decision makers in formulating health programs and policies that will lead to the achievement of general national objectives of equity, efficiency, quality, and financial soundness. From this view, decentralization in health systems is seen as the degree to which various functions (financing, service organization, human resources, targeting, and governance) are transferred to local authorities (1998; 2002).

Bossert and Mitchell argue that public health sector decentralisation relates to the transfer not only of authority but also of capacities and accountability. Decentralization will improve the delivery of health services when the local institutions have the capacities to make choices and the accountability of those choices to local health needs and priorities (2011:39).

Institutional capacities which are administrative, technical, organizational, financial, and human are very important for decision space. When the local levels take on the capacities of institutions, this will lead to the better performance in the health sector. The empirical evidence from Bossert and Mitchell in the case of Pakistan found that the health system suffered from problems of its authoritarian political system and bureaucratic civil service system. For health sector decentralization to bring about improvements in service delivery and achieve health system objectives, health policy reform in Pakistan needs to adopt decentralization policy that encourages decision space, institutional capacity, and encourages greater accountability to local elected officials (p 48).

2.5.3 Accountability

Accountability is seen as the heart of public administration and the core characteristic of good governance. There are various definitions of accountability given by scholars. According to Kim (2009) accountability basically means obligation to a task as expected or taking responsibility for failure. For Lawton and Rose (1994:19), accountability is when a person or group of people are asked to provide an account of their activities and to offer this account to an agency or person, according to rules, which may be written or unwritten but are advanced. This definition provides a general perspective of accountability.

The World Bank has sought to develop a working definition of accountability to promote good governance and the rule of law, and to prevent illegal or corrupt activity by public officials. To this end, in a report published in 2003 they define accountability as “Holding individuals and organizations responsible for performance measured as objectively as possible” (p7). This report refers to the elements of accountability that bureaucrats should be responsible for in the fulfilment of predetermined policy goals and for responsiveness of policies to the specific needs of public, and particularly to the needs of those who most depend on government services. Answerability and enforcement should add capacity of officials to take into account the knowledge and opinions of citizens (p7-8).

The view of the performance of the government and the improvement of public services as an element in the definition of accountability is reflected in the definition of Guy Peters (2007:18) which emphasises the importance of accountability for efficiency and effectiveness. He argues that mechanisms of accountability should not be limited to identifying violations and punishing people or institutions that do not perform adequately but should provide comments about the performance of the government and the means of improving the delivery of public services to ensure the provision of high quality. Accountability has a central place in determining the efficiency and effectiveness of service delivery through cost-benefit analysis and financial accountability.

Koppell (2005:96) provides five conceptions of accountability: transparency, liability, controllability, responsibility, and responsiveness. In his view, these conceptions suggest questions which can help remove the current state of conceptual fuzziness

of accountability, since they provide a vocabulary for discussion of the disparate views, as shown in table 2.4.

Table 2.4: Conceptions of Accountability

Concept of accountability	Key determination
Transparency	Did the organization reveal the facts of its performance?
Liability	Did the organization face consequences for its performance?
Controllability	Did the organization do what the principal (e.g., Congress, the President) desired?
Responsibility	Did the organization follow the rules?
Responsiveness	Did the organization fulfil the substantive expectation (demand/need)?

Source: Koppell, J. G. S. (2005:96)

Koppell's definition has been criticized by scholars. For example, Bovens (2007) argues that these concepts are broad conceptualisations and that it is very hard to establish empirically whether an official or organisation is subject to accountability. These concepts cannot be measured along the same scale: some dimensions, for example transparency, are instrumental for accountability not constitutive of accountability; and responsiveness is more evaluative than analytical. Furthermore, accountability is a part of control, but not all forms of control are accountability, because control is a power and it applies by laws and regulations, whereas accountability operates through procedures in which officials are to explain and justify their actions.

According to Bovens, accountability is not a broad or evaluative sense concept but is a practice of account giving. Thus he defines accountability as "A relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences" (2007:450).

From the perspective of accountability as a relationship between parties, Pollitt (2003) sees accountability as a relationship between an actor, the accountant, and a

forum, the account holder, or accountee. The accountant renders an account to someone/something that is, for the purposes of this particular relationship at least, their superior and it is for the accountee to pass judgement (p 89). Explanations and justifications are not made in a void, but involve the provision of information about performance and the debate of questions by accountee and answers by accountant. Eventually, there is the judgement, which will take the form of sanctions or rewards in case of adequate performance.

Bovens' and Pollitt's definitions outlined above stress the relationship between the accountee and the accountant and the need for explanations and justifications of the relationship to make accountability effective, thus suggesting an interdependent relationship between actors. Additionally, accountability can be regarded as closely associated with five critical criteria: responsibility, answerability, amendatory, redress of grievances and sanctions (Massey and Pyper, 2005:152). Responsibility refers to matters for which politicians and officials are to be held accountable. In terms of answerability, accountability includes a commitment to provide answers to questions and debates. Amendatory means that the accountability system should be able to amend the policy or processes that have caused problems. Accountability involves a redress of grievances of proven error and exposure to sanctions (p.152). Massey and Pyper claim that accountability will be weak if it includes only answerability, or explanatory accountability. The full version of accountability could involve the layers of amendatory accountability, redress of grievances and sanctions. This renders accountability stronger. Massey and Pyper put forward three questions/criteria for analysing accountability mechanisms. Firstly, for which action is the account to be given? This will yield a series of both role and personal responsibilities. Secondly, to which institution/person is the account to be given? This produces a list of institutions or groups of people who are to be given information. Finally, through which mechanism is the account to be given? This can take a wide array of forms, such as parliamentary questions, debates, select committees, standing committees, ombudsmen, external auditors, the courts, inquiries of various types, and party bodies of different descriptions (p.154).

As discussed above, the concept of accountability is seen as a social relation between actors (accountant and accountee or superiors and subordinates), and the three questions/criteria are explained to present the relationship between the actors.

In this thesis, the above criteria are used to represent who is accountable, accountable to whom and what the mechanisms for achieving accountability are.

After studying the concept of accountability through a variety of different definitions of the concept, it is important to clarify the concept of good governance and its relationship to accountability. The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) states that

Accountability is a key requirement of good governance. Not only governmental institutions but also the private sector and civil society organizations must be accountable to the public and to their institutional stakeholders. Who is accountable to whom varies depending on whether decisions or actions taken are internal or external to an organization or institution. In general an organization or an institution is accountable to those who will be affected by its decisions or actions. Accountability cannot be enforced without transparency and the rule of law.

(<http://www.unescap.org/sites/default/files/good-governance.pdf>)

It would be possible to conclude from this definition that the concept of good governance for accountability is based on the adoption of mechanisms for accountability and transparency in decision-making institutions, and commitment to the rule of law and combating corruption. Many scholars have also pointed out the importance of accountability for good governance. Massy and Pyper show that openness, transparency and an effectively functioning system of accountability are the positive qualities of a system of good governance, while a system of government that suffers from a lack of accountability leads to the failure of its citizens in important aspects (2005: 151). In addition, Ackerman suggests that the fundamental element of good governance includes the commitment of public officials to inform and explain their actions, and the agency's ability to impose sanctions on those who have violated their public duties. He also advocates that the only method to ensure good governance is institutionalising powerful accountability in which each employee is responsible for his actions as a public servant (2004:448).

In terms of the public health sector, accountability is essential. This, according to Brinkerhoff (2007:371), is for the following reasons. First is the need to check

corruption in the health system. This is manifest in many health systems, especially among developing countries. Some developing and developed countries express dissatisfaction with health system performance with regard to costs, quality assurance, service availability/access, the equitable distribution of services, abuses of power, financial mismanagement and corruption, and lack of responsiveness. Stamping out corruption is the only answer to such malaise. Secondly, accountability becomes a core element in a health system because health actors in both the public and private sectors play a significant role in affecting people's lives and well-being. A third reason relates to the need to take stock of expenditures: government expenditure in health constitutes the major part of budgetary expenditure and proper accounting for the use of these funds is essential.

2.5.3.1 Traditional and New Accountabilities

There are two theories of the development of accountability: the first theory is the traditional model of public administration, whereas the second emerged from the NPM. It is very important to study both theories of accountability in order to explore different scholarly perspectives, their applicability to the concerns of the thesis, and the various mechanisms available for achieving accountability.

2.5.3.1.1 Accountability in the Traditional Model

The traditional model of public administration depends to a large extent on Max Weber's definition of the nature of bureaucracy. This model emphasizes control from top to bottom in the form of monocratic hierarchy. The control system depends on which policy is set at the top and carried out through a series of offices, with each manager and worker reporting to one superior and held to account by that person. The rules and regulations come from public law (Pfiffner, 2004: 443).

According to Hughes, traditional public administration relies on bureaucratic accountability, wherein bureaucrats provide advice to the political leadership on policy and manage its resources. Public officials in the framework of the hierarchical construction of the department are accountable to the political leadership. Providing just advice is the role of bureaucrats in the management of resources, which means that public administration is not free from political interference regarding the department's mechanism of work. Hughes explains that the interference between the

two parties is a source of problems because each party is different from the other in terms of both culture and the type of accountability. Public employees are part of the hierarchy construction and have a role in the administration, with the result that the public employee is accountable to a superior. At the top of the hierarchical construction of the institution there is a person who is president of the institution, and he is accountable to the Minister. In parliament, the relationship is that between the minister and the departmental head. However, the link between the bureaucrats and politicians is problematic because of the absence of a clear role for each of them (1998: 232-233).

In practice, over the past decades, the traditional model of accountability has been under serious pressure in a number of national states. This is because it has failed to set ways that give a more diversified and pluralistic set of accountability relationships (Bovens, 2007:100). This argument has been discussed by many scholars. Barberis (1998:452-53) argues that traditional accountability is ineffective, because of the legal relationship between the parties (parliament, ministers, civil service). According to the hierarchical model, accountability lies with the person who occupies the highest position in the hierarchy. Public officials are not accountable, because they work according to the orders and instructions of the president (Thompson, 1980:905-6). Furthermore, Hughes claims there are three problems with traditional accountability. First, accountability in the traditional model is political accountability. Administration leaders are not responsible because they carry out the policy diligently. Second, interaction between politicians and administrators is likely to be a source of problems because of the differences in cultural forms of accountability. Third, political leaders have insufficient knowledge of lower level functions, and the weakness of the administrative measures of performance can lead to difficulties in accountability (2003:245-46).

2.5.3.1.2 Accountability in the New Public Management

During the 1980s, there was a move towards NPM in a number of OECD countries. The main change of public management was a shift towards accountingization. NPM has been involved with a different conception of accountability: it shifts the emphasis from process accountability towards a greater element of accountability in terms of results (Hood, 1995:93-94). As discussed, the traditional accountability in public

administration is responsible for operations, with the legislative authority establishing general guidelines for the various processes to be followed by the organizational units. On the other hand, NPM focuses more on results than processes: thus, the management is responsible for its results (Behn, 1998:151-153).

Hughes states that the emergence of NPM is a result of the failure of the accountability system in the traditional public administration. He describes a range of changes involved in what might be called the NPM model of accountability (2003: 246), which can be summarized as follows:

- i. Accountability in traditional public administration has relied on the formal links provided through the hierarchical structure, but the model of accountability in NPM is more fluid and more political. NPM has added direct accountability to the public (Hughes, 2003:248). Furthermore, Massey and Pyper comment that NPM has strengthened the internal lines of accountability, especially in the field of finance. The internal line of accountability has led to the growth of resource accounting and budget. This has created clear and open lines of accountability between middle managers, senior officials and ministers (2005:161). In addition, NPM has led to improved accountability, as Pereira argues:

Making agencies and social organizations accountable through control of contracted outcomes, managed competition, and social accountability, that involve high transparency, rather than through classic bureaucratic controls (procedural rules, auditing, and parliamentary review). (2004:191)

- ii. NPM has led to another change in accountability: an improved relationship with clients. Hughes argues that in the old model, the one way of being accountable was through political leadership, but now the agency assesses the direct relationships with clients to improve public service. The aim of the accountability system is to focus on the customers and to improve the interaction between departments and customers (2003:248).
- iii. Another change is a system of accountable management, which means that public employees are personally responsible for achieving or not achieving results, rather than compliance with rules and procedures, as well as for the effective use of available resources and technical means to achieve management objectives (Hughes, 2003:249).

Hughes identifies four parts to the adoption of management accountability. Firstly, management should be transparent with respect to results achieved or not achieved, and to providing incentives for institutions to achieve goals. In the traditional model, there was never any real way to determine the performance and achievement of results. The second part is the personal side of accountability. All senior managers are personally responsible for achieving results in accordance with the targets set for the managers. Conversely, accountability in the traditional model only occurs at the top. Thirdly, public management rules should be trusted. Public Management allows managers to achieve the goals, but for reasons of accountability, all programs are subject to evaluation and verification. Public Managers will be trusted to achieve goals and to hold personal responsibility, but their results must be verified (Hughes, 2003:251). Fourthly, formal accountability to parliament is enhanced. In the United Kingdom, there has been a range of changes, which effectively led to the creation of ministerial responsibility.

In terms of problems of NPM accountability, scholars argue that the NPM pays more attention to money and efficiency, and this has led to weak political accountability. Massey and Pyper claim that the general weakness of the accountability system in the NPM is the multiplicity of accountability (political, managerial, consumer), which, they note, leads to problems in executive agencies. This problem is a clear distinction in the area of accountability as a result of a clear division between the policies and issues that are the preserve of ministers and the issues of administration, which are located in the civil service. Also, political, managerial, consumer accountability can become devalued simply because NPM has given great importance to the value of money and efficiency rather than accountability (2005:166-69).

As Christensen and Laegreid explain, NPM has contributed to a change in the concept of participation by focusing on people as consumers rather than on their role as citizens, thus leading to confusion about the allocation of roles between the political leaders and administrative leaders. Traditionally, politicians and civil servants were responsible for fulfilling the mandate, but NPM has changed this by providing the dual accountability of civil servants to politicians and consumers (2002:286). They add that the role of political leadership under the NPM is ambiguous, distant and indirect. The political leaders have limited control over the

public sector because the bureaucracy responds to the demands of customers and not to political decisions, so that the NPM focuses on trade efficiency and accountability for performance, without paying much attention to political accountability (Ibid., 287-88).

2.5.3.2 Dimensions of Accountability

It is important to understand what kinds of mechanisms are available for achieving accountability. The different types of accountability can be distinguished according to the source of the accountability relationship, whether internal or external to the one being held accountable (Lindberg, 2013:212). According to Radin and Romzek, accountability can be organized depending on the source of control, whether it is internal or external to the agency (1996:61). Massey and Pyper (2005:154) argue that accountability is analysed by dual lines of accountability, external and internal, attached to each of which are specific mechanisms.

In 2003, the World Bank carried out a study with the aim of improving public sector performance and governance in the Middle East and North Africa (MENA). This study involved both internal and external accountability. Internal accountability refers to that of the government to the citizens, and involves the participation of citizens in public decision-making and their influence in providing public services. External accountability refers to the government serving to protect public interest through establishing institutions and procedures in order to control the behaviour of institutions.

2.5.3.2.1 Internal Accountability

Internal accountability refers to the public officials remain answerable to supervisors for their work (Sidiquee, 2005). Internal accountability operates within organizations. A civil servant is accountable to managers, an agency, and his/her department. A very wide range of devices and mechanisms are designed to achieve internal accountability, for example, performance appraisal and performance indicators to judge the efficiency and effectiveness of work. Furthermore, delegated budgets and the allocation of resources impose internal financial accountability to ensure control procedures (Massey and Pyper, 2005:155). The pattern of internal accountability has resulted in four different types of accountability relationships as outlined below.

Hierarchical accountability:

Hierarchical accountability relationships are defined internally and exhibit a high degree of control. They are manifested in organizational roles, supervisory relationships, rules, standard operating procedures, and close, detailed scrutiny of employee or agency performance (Radin and Romzek, 1996:61). Kim argues the role of public officials and politicians in developing countries as

Those who have power, wealth, or knowledge exercise a substantial degree of influence in society. They enjoy great privileges in various dimensions. As elites in their society, they should contribute to its interests with greater responsibility. Unfortunately, the reality in many Asian countries is disappointing, as elites often use their influence for their own interests. This tradition needs to be changed. Thus, a culture of noblesse oblige should be broadly enhanced. (2008: 594)

Managerial Accountability:

The central change prescribed by NPM doctrine is a move from process-oriented accountability to results-oriented accountability. As Schwartz states,

Supervision of subordinates within organizations moves away from hierarchical accountability based on detailed standards and guidelines about how to operate and toward professional accountability, in which professional managers are left free to manage processes while being held to account for the achievement of output and outcome objectives. (2002:64)

As suggested above, input, output, and outcome are the main keys of managerial accountability. Information and financial reports are important tools for showing how organizations use resources and how effective they are (Behn 2001). It is clear that this type of accountability can confirm that public institutions are using the value of money and guidelines about how to operate goals. In terms of the merit of managerial accountability, Cendon (2000:55-58) explains the factors of managerial accountability that can contribute to improve public administration accountability as follows:

- i. Compliance with rules and administrative procedures cannot be more than one principle for the evaluation. Performance according to the objectives and targets set for each administrative unit within the general framework of the government's program brings the public administration closer to the complete satisfaction of the needs of citizens and their interests. It should be emphasized that economic criteria are integrated heavily into the concept of new public management, with full respect of fundamental rights enshrined in the Constitution, and of the principles of neutrality, justice and equality of all citizens before the law;
- ii. The vertical accountability for oversight and control should be reduced to achieve goals and objectives, and special importance should be given to horizontal accountability to citizens to meet their needs and to consider them as customers; and
- iii. To ensure effective accountability in public administration, all administrative units should have managerial autonomy to achieve the goals of society, but also in full compliance with the principle of the legal system of the legitimacy of administrative activity.

In the public health sector, managerial accountability involves objectives and performance. It is concerned with quality in health care and this ensures that health providers seek to take responsibility for all their undertakings. The focus is on the services, outputs and results of public agencies and programs, not on individual service encounters between patients and providers. The health system is linked to financial accountability in that the financial resources to be accounted for are intended to produce goods, services and benefits for citizens, but it is distinct in that the emphasis of financial accountability is largely on procedural compliance whereas performance accountability concentrates on results.

Professional Accountability:

This kind of accountability derives from internal sources but involves low degrees of control and high degrees of discretion to the individual or agency being held to answer for its performance (Radin and Romzek, 1996:62); this may be formal, such as in academic and professional contexts, or informal, for example among peers and cohorts of professionals. Professional accountability acts as an audit on safeguarding the organizational or occupational reputation (Lindberg, 2013:214).

The existence of difficult problems facing governments has led them to depend increasingly on professionals and experts to provide appropriate solutions. These professionals and experts are expected to be fully responsible for their actions and to have the skills necessary to achieve the goals (Romzek and Dubnick, 1987:228).

The main idea of professional accountability is that professions are to be accountable to society, politicians, institutions, and clients. The role of professionals in areas such as law, medicine, teaching and social work plays an important part in achieving government objectives in order to provide public goods and services on behalf of governments. Professionals must be loyal to their employer, but at the same time they must also serve according to the ethical code of their professional body. However, there is often tension between these allegiances as public sector reforms lead to changes in the status of professionals. In general, conflicts between managers and professionals are of a moral nature. For example, senior managers are working to achieve the goals of the institution, causing problems for the professionals, who need to achieve a balance between quality and quantity measures (Hutton and Massey, 2006: 23-26). On the other hand, Wilding (1982:29) states that the role of professionals in policy-making and management is important, but at the same time it leads to problems in that professionals appear to act in their own interests rather than the public interest, which leads to the development of services according to their interests rather than the client's needs because they have the power to influence public policy and administration. Wilding (1982) claims that professionals have a high degree of autonomy which gives them power. However, society dislikes the autonomy enjoyed by professionals because professionals often fail to achieve the interests of clients through political activity and professionals tend to use their autonomy to create conditions. He also refers to the relationship between professions and society: professionals are supported by the community and at the same time professionals use community resources. Therefore, participation should be extended among professionals and the community because the professionals are accountable to society. In addition, professionals should work according to the ethics of their profession and their sense of professional responsibility.

Observers and practitioners of public sector management are looking at how to develop basic skills and professional values in government and how to aid the

development of individuals with these skills and values. This requires the use of effective professional codes of ethics. This is a strong weapon for those looking for good governance. In addition, public accountability and the professional accountability in the community are achieved through an increased focus on the proper implementation of professional codes of ethics. In other words, ethical and professional accountability of public sector management depends on the commitment and enthusiastic compliance of professionals employed to structure and deliver services (Hutton and Massey, 2006: 23-30).

In the public health sector, doctors and nurses should be responsible to professional codes of ethics and to professional bodies, which lay down codes with standards for acceptable practice that are binding for all members. These standards are monitored and enforced on the basis of peer review (Bovens, 2007). Disciplinary tribunals can also sign sanctions for doctors and nurses, who should be fully responsible to professional codes of ethics.

Consumer Accountability:

In order for public administration to be more accountable, there have been developments in the mechanisms through which individuals who feel aggrieved can obtain compensation. The NPM contributed to the focus on the channels of influence and participation of the people in the direction of the public authority. By highlighting the importance of citizens as consumers or clients, NPM has helped to expand the choices of citizens through market mechanisms, the participation of citizens in public decision-making and their influence in public services (Christensen, 2002:286, 289).

According to Behn, this type of accountability is seen as a key element of democracy because the government must be accountable to all citizens to achieve equality in society. This kind of accountability is based on citizens' perceptions of the services that they receive to ensure the interest and improve the efficiency, competitiveness and accountability of government institutions (2001:5).

The UK could be seen as a model of development with regard to the mechanism of consumer accountability. During the 1980s, the public sector in the UK suffered from a lack of responsibility to the needs of citizens. The view of many critics was that the growth of public sector institutions and their focus on serving their own interests

rather than focusing on financial control and meeting the needs of citizens led to the crisis of public sector institutions. This problem has led many institutions to reconsider the mechanism to make the public sector more accountable to citizens (Lawton and Rose, 1994:25).

The Citizen's Charter was an initiative, launched by Prime Minister Major, that was used in public sector institutions in England to provide a link between the administration and the rights and requirements of the citizen. The Charter focused on several principles, including consultation with customers about service standards, the provision of information on the achievements of performance, openness in decision-making and accountability and the provision of mechanisms for dealing with customers. Thus, the use of the Citizen's Charter in the public sector institutions added a dimension of accountability and attention to citizens (Colin, 1994:9). In addition, the development of the NPM and modernisation in the UK resulted in an increase in channels for public participation in the accountability mechanisms (Massey & Paper, 2005:162).

Gilson (2003) emphasises that the patient/provider interaction is at the heart of health care provision. The patient/provider relationship relies on the quality services available to the patient. The institutions embedded within the health system also play a vital role in shaping the relationship between patient and provider. He mentions factors that are vital in building trust in health services, these being participation, outcome, and professional and ethical codes. He argues that in order for the health system to be trustworthy, patients should be given the opportunity to participate in decision-making, better health outcomes, and ethical codes.

Consumer accountability in the public health sector is associated with citizen expectations of how public officials fulfill the public trust. In this case, institutions, procedures, and mechanisms should seek to ensure government fulfills that trust (Brinkerhoff, 2004), by ensuring that the interest of consumers is served and efficiency in service delivery is improved. When this is achieved, competitiveness and accountability of government institutions can then be guaranteed. For example, in OECD countries, governments seek to inform, consult and engage citizens in order to enhance the quality of services, to improve the quality of service delivery and increase the level of consumer satisfaction with health services (Ringold, 2012).

2.5.3.2.2 External Accountability

External accountability is when officials are responsible for actions and performance to relevant authorities outside their organizations (Siddiquee 2005; Massey and Pyper 2005). An example of external accountability can be seen when ministers are held accountable for their department to parliament through a series of mechanisms (questions - discussions - committees). External financial accountability is achieved through the mechanism of scrutiny by audit commissions. Furthermore, external accountability focuses on scrutiny which could be brought to bear on the roles of officials. This can be seen through the work of ombudsmen, agencies of the external financial audit, and regulatory agencies that examine the functioning of public services (Ibid., 155). The pattern of external accountability has resulted in two different types of accountability relationships, namely legal accountability and political accountability, as outlined below.

Legal Accountability:

Legal accountability derives from external sources of control and exercises a high degree of control and scrutiny (Radin and Romzek, 1996:61). It is based on the relationship between the controlling party (outside agency) and members of the agency. The outside party of accountability is an individual or group in a position to impose sanctions or legal or official confirmation of the contractual obligations. Legal accountability is the relationship between controllers and the controlled (Romzek and Dubnick, 1987).

Legal accountability mechanisms are very important to ensure the rights of the citizen in obtaining benefits and services. To achieve this, there are legal procedures such as appeal, which is a procedure to provide information from citizens to members of the bureaucracy. The appeal procedure leads to increases in the compliance of street level bureaucrats (Hudson, 2001).

Political Accountability:

Political accountability relationships derive from external sources but involve low degrees of direct control (Radin and Romzek, 1996:61). This type of accountability involves three key elements: responsibility to voters, responsibility to public opinions and responsibility for actions. On a practical level, there are five types of action for

which ministers are held politically accountable: ministers redirect questions from members of parliament, ministers give reports to parliament, ministers explain their actions, ministers amend policies and departments, and ministers resign for personal or administrative errors (Lam, 2009:574-75). The main benefit of political accountability is the exposure of the violations and shortcomings of political officials rather than the identification of problems in order to rectify them. In other words, political accountability focuses on results and outputs because it is very important to evaluate public programs (Peters, 2007:20). According to Bovens (2007:455), the essence of political accountability includes the media. This is because the media are fast gaining power as informal forums for political accountability.

In authoritarian regimes, political accountability is hard to achieve. This leads to the question: what causes the problems of political accountability in non-democratic states? One reason is that these regimes are characterized by the lack of role of civil society, and the absence of the role of watchdog organizations (Kim: 2008). More specifically, Kim (2009:593), using the concept of “the government’s authoritarian culture”, argues that authoritarianism leads to serious reform failure and irresponsibility, with the president failing to listen to citizens and making serious errors; governmental decision-making too often takes place without viable discussion, in closed or non-participatory settings.

In the public health sector, the health services are an important issue in political campaigns, because of their attractiveness for politicians in generating electoral support. Thus, elected officials and legislatures play a vital role in political accountability, by overseeing ministers and other agency heads linked to the health bureaucracy (Brinkerhoff, 2004:374). Political accountability also means that political processes should support the development of a health system and enable the poorest people to access health services (Gilson 2003). In some developing countries that are not democratic, the state is the main provider of health services. This raises an important issue in that the ministry of health is not only responsible for providing health services but also for putting mechanisms in place to increase accountability and to enhance the rule of law in order to achieve equality in health services (Siddiqi et al., 2009).

To sum up, external accountability includes legal accountability and political accountability, whereas internal accountability involves hierarchical accountability, managerial accountability, professional accountability, and consumer accountability. In this study of accountability in the Libyan public health sector and the UAE, all these types of accountability will be studied. With regard to external accountability, the relationship between the MOH and outside agencies (institutions and citizens) is discussed; in respect of internal accountability, the emphasis is on the operations within organizations.

The framework for the analysis of accountability is presented above, and is capable of generating typologies. Under each of the two typologies, dimensions of external and internal accountability can be examined. These add to its breadth as well as its comprehensiveness. This categorization is used to explore the accountability mechanisms existing in the Libyan public health service, and to help to illuminate some of the problems faced.

2.5.4 Performance Measurement as Tools for Facilitating Accountability

Performance measurement plays a major role in public sector organisation. It helps to improve government performance and service delivery. Poister defines performance measurement as follows:

The process of defining, monitoring, and using objective indicators of the performance of organisations and programmes on a regular basis is of vital concern to managers in government and the non-profit sector. (2003:1)

Pollitt defines performance measurement as a series of processes relating to:

- setting performance objectives and targets for programmes (and in many cases made public);
- giving managers responsible for each programme the freedom to implement processes to achieve these objectives and targets;
- measuring and reporting the actual level of performance against these objectives and targets;
- feeding information about performance level into decisions about future programme funding, changes to programme content or design and the provision of organisational or individual rewards or penalties; and

- providing information ex post review bodies such as legislative committees and the external auditor (depending on the latter's performance audit mandate), whose views may also feed into the decisions referred to above (2001:10-11).

Performance measurement helps the public sector achieve two tasks. The first is to provide better services because managers have access to comprehensive information on performance within the organisation. The second is greater accountability through better reporting and the indicators which encourage stakeholders to pay greater attention and get a better understanding of the performance (Bolton, 2003). In addition, Robert Behn (2003) lists purposes for performance measurement in the public sector: evaluation, control, budget allocations, motivated employees, promotion, celebrate, and learn. Furthermore, performance measurement is way of gathering and reporting information in order to alert managers to any potential problems or benefits from possible changes. It is also a way of ensuring accountability in the use of public funds by both public and voluntary organisations (Osborne et al., 1995).

In the United Kingdom, Massey (2005: 49-50) points out that performance measurement plays a role in promoting accountability. He states that the Comprehensive Spending Review 1998 imposed Public Service Agreements (PSAs) as a mechanism to improve efficiency and effectiveness. The PSAs have been supported by Service Delivery Agreements (SDAs). With SDAs, each department and agency must use a common structure. This begins with an accountability statement that makes clear who is responsible for delivering targets. SDAs explain:

- How high level targets will be achieved;
- How performance will be improved;
- How stakeholders and consumers' needs will be met;and
- How human and IT resources will be managed to achieve change.

On the whole, the increase in services provided by the public sector in all countries throughout the world, particularly in areas such as educational and health services, has led governments to become more concerned with performance measurement in

public institutions. Therefore, performance measurement is useful for the public sector as a tool to guide the organisation so that it can achieve its goals as well as efficiency and effectiveness. On the other hand, issues related to accountability need to be addressed with specific consideration for performance measurement in the public sector.

In the public health sector, health systems include different stakeholders: patients, various types of health-care providers, payers, purchaser organizations, regulators, government and the broader citizenry. The fundamental goal of health systems is to improve the health of the general public. Performance measurement concentrates on and evaluates the services, outputs, and results of public agencies and programs of the health sector (Brinkerhoff, 2004), and as such it can serve to guide the organisation and to promote accountability.

In the case of Libya, performance measurement is essential to promote accountability in the public health sector and to reduce corruption: as Scott (2007) states, according to the World Bank, performance measurement could emerge as an anti-corruption control in developing countries.

2.6 Conclusion

This chapter has set out a conceptual framework within which to discuss policy transfer and path dependency, and offered an explanation of the main concepts, explaining how they are used and the context within which they are defined and used in this study. Based on a wide review of the relevant literature, Dolowitz and Marsh's framework of the macro level context of policy transfer will be used in this study, as it permits the analysis of contextual factors that facilitate or constrain the implementation of policy transfer and will therefore serve as a useful tool to recommend a policy transfer between the UAE and Libya. However, the adoption of a single approach as the policy transfer perspective would not be sufficient to capture the whole picture, especially in relation to the success or failure of policy transfer. The path dependency approach demonstrates that several concepts need to be taken into account in order to appropriately analyse social and political processes: punctuations, causal processes, increasing returns and the legacy of the past. This approach can therefore help address the legacy of the Qadhafi regime. To this end, policy transfer and path dependency approaches provide a full range of powerful analytical tools that can integrate both the managerial and political dimensions of the reform health care sector in Libya.

As mentioned in section 2.1, the purpose of this chapter is to discuss various aspects of the public sector, decentralization, and accountability, in order to develop a practical and analytical framework, which will be used in the empirical part of the thesis, to analyse the findings and answer the specific research questions. In other words, this framework will serve to facilitate the analysis of how the public sector of the UAE and Libya apply decentralization and accountability, and this may lead to lessons which can be learned by Libya.

This chapter discussed the meaning of the public sector, difference between the public and private sector, the public health sector, and the role of government in the public sector. Through the review of the literature, it showed how governments deal with the problems of the public sector in order to address or overcome dysfunction in public services delivery. This chapter also showed the importance of decentralization and the relationship between decentralization and good governance, and how to assess the degree of decentralization. It can be inferred from the literature that

decentralization plays a vital role in improving public services. The positive impact of decentralisation on the health services depends not only on the transfer of authority, but also on institutional capacity and decision space. Given the focus of the thesis, the concept of decentralization, institutional capacity and decision space will be used to explore the application of decentralization in the case study.

This chapter also covered the concepts and aims of accountability in the public sector, traditional and new accountability with a focus on the effect of NPM on accountability, and the importance of performance measurement for facilitating accountability. The external and internal accountability outlined in this chapter offer more analysis of accountability relationships, and can serve as a systematic framework for the analysis of how accountability mechanisms of Libya and the UAE work.

The insights derived from this chapter provide a basis for the analysis in Chapters 3,4,5, and 6. and the task of Chapters 3-6 will be to deepen the analysis of public health care sector, decentralisation, and accountability carried out in this chapter.

With the explanation of the conceptual framework, literature review, and research methodology in the first two chapters, it makes sense, before starting the in-depth analysis of the Libyan case, to consider that of the UAE, in order to learn lessons which can be transferred to the Libyan context to achieve a more effective health service. Thus, in line with the research methodology adopted in this study, Chapter three will be devoted to a study of public health services in the UAE, exploring both the literature and relevant documents. This will be followed in Chapters Four and Five by a similar investigation of the literature and documents relating to public health in Libya, together with analysis of the interview data. Chapter Six will focus on a comparative analysis of the two sets of data.

Chapter Three: The Public Health Sector in the UAE

3.1 Introduction

As discussed in Chapter Two, the field of public policy includes literature which examines the ways in which countries can learn from each other's experiences with regard to what constitutes effective practices or in order to avoid ineffective policies and tackle problems of public policies. Lesson drawing which refers to voluntary policy transfer and is the process by which 'political actors or decision makers in one country draw lessons from one or more other countries, which they then apply to their own political system (Dolowitz and Marsh 1996). As such it is an appropriate concept for considering the context of Libya and for suggesting solutions as to how Libya can tackle the problems facing the delivery health services.

Based on the theoretical framework discussed in Chapter 2, this chapter will discuss in detail the reform initiatives and the trajectories that took place in the UAE's health services delivery, especially in relation to health care strategies, decentralization, accountability, and performance measurement. It will show the experience in public health reforms in the UAE, which will be used as a benchmark to suggest useful ideas for improvements in Libya. This chapter aims to address the question: to what extent can the development experience of the UAE health system be viewed as a model for the Libyan health system?

The following section offers a profile of the UAE, and this is followed by a number of sections offering an analysis of various aspects of public health policy in the UAE, including public health organization, health finance, decentralisation, and accountability and performance measurement. The chapter will also explore the elements forces that encourage Libya to voluntarily learn best practice policies from the UAE. The final section will consider what lessons the Libyan government could usefully learn from the UAE context. As discussed in Chapter 1, the data used in this discussion is from documentary analysis.

3.2 Profile of the UAE

The UAE emerged as an independent country in December 1971, and is presently a federation of seven emirates: Abu Dhabi, Dubai, Sharjah, Ajman, Umm al-Qaiwain, Ra's al-Khaimah and Fujairah. Within the federation, central authority rests in Abu Dhabi, but each emirate is governed by the head of its local ruling family. The highest central authority in the UAE is the Federal Supreme Council (FSC) and the federal government is afforded jurisdiction over foreign relations, defence, security, immigration, communications, health, labor affairs, and education (Gonzalez et al., 2008:92). The FSC consists of rulers of the seven emirates constituting the federation or their deputies in their emirates in case of rulers' absence or unavailability. Each emirate has one single vote in the council resolutions and deliberations. The Federal National Council (FNC), which is an advisory body to the FSC, is the highest legislative authority because it reserves the right to discuss laws and financial bills. Members of the FNC are not directly elected, as is made clear in the constitution: "Each Emirate shall be free to determine the method of selection of the citizens representing it in the Federal National Council". Since December 2006, however, the citizens have the right to elect half the members of the FNC, and the first-ever partial elections of the FNC were held in the UAE (<http://www.undp.org.ae/undpuae/governance.html>). The federal cabinet is the executive authority for the federation. Under the FSC, it manages all internal and foreign affairs of the federation under its constitution and federal laws.

With regard to the economy, it is important to understand the economic dynamics which have aided the development of the UAE. The economy thrives based on oil, which together with gas, has been the most important source of income for the UAE since its establishment in 1971 (The UAE Yearbook, 2006). The country is renowned as the world's eighth largest oil producer. The revenue from the production of its vast oil reserves has been used to finance the country's economic and social development. This is reflected in investment in education, health facilities, and infrastructure, thus bringing the services in these sectors from near non-existence to world-class (Ibid.).

The non-oil sector also contributes to the economy of the UAE. According to Almezaini (2012), since the 1970s the government has focused on economic diversification, particularly the expansion of the manufacturing sector. The UAE's

power is concentrated in its economy, with oil a vital commodity for its economic survival. The UAE's relatively diverse economy is beginning to have significant impact on its GDP. By classical definition, the UAE is a small state that has been trying to use its economic resources as an influential tool on the international level. The stability and security of the UAE has enhanced economic growth and strengthened the government's position internationally (Ibid. :25).

The economy of the UAE is regulated by the government. This is reflected in steps taken to develop the private sector through adoption of market driven economic policies, encouragement of foreign investment and privatization of public concerns to attract private investors. The privatization policies have helped to create government partnerships with the private sector to finance and manage the public sector with a view to achieving improved and efficient operation of government business. As Micheal (1998) notes, the essence is to reduce government expenditure.

In an attempt to diversify and enhance its economy, the UAE government established free trade zones. This was accompanied by a no-tax policy and relaxed trade rules for foreign ownership within these zones. This, combined with the strategic location of the UAE, has attracted investors and enabled the country to become a business hub for trade and export (Grant et al., 2007:512).

3.3 Health Care Policy

After the foundation of the UAE as an independent, sovereign state in 1971, the late founder and President of the UAE, Zayed bin Sultan Al Nahyan, consistently expressed his vision of access to high quality healthcare for the entire community. Over the past four decades, realizing this vision has been one of the key drivers of reform in the provision of healthcare (Koornneef et al., 2012:115).

This announcement can be seen as a critical juncture that referred to state responsibility and the existence of a political will to ensure the effective and efficient delivery of health services. To this end, since 1971, central governments have created a new role and policies for the state regarding public health in order to enhance the role of the MOH in improving policies, regulations, governance guidance, and fostering a culture of accountability. As Shihab observes, the UAE

government has played a key role in the protection and promotion of the economic and social well-being of its citizens:

Since its formation in 1971 the UAE has enjoyed a political stability. The existing political structures appear to suit the tribal society of the UAE, and the distribution of huge oil revenues in the form of social and economic infrastructure, high salaries, a high standard of social services, such as health and education, has raised the standard of living for UAE citizens and considerably reduced the likelihood of internal political and social unrest. (2001:250)

Tenbensen et al., (2012) succinctly summarise the most fundamental objectives of any health system and see them as health outcomes, access/equity, efficiency/cost containment, quality, and the relative attention given to different types of health services such as primary, secondary and tertiary health care. In addition, these objectives should occupy a substantial share of health policy agendas of government. In the case of the UAE, the health policy agendas and practice came to be associated with these objectives, and, as is clear, appear to work well. The standards of healthcare are generally high in the UAE; better health provision has been reflected in rapidly improving figures for key indicators such as life expectancy and infant mortality rates, which are now at Western levels. Table 3.1 shows the progress that the UAE has made with figures for the UAE comparable with global averages. This overall improvement has resulted from the greater efficiency of the MOH and its strategy to improve the performance of the public health sector and to distribute health services to all. In the World Health Organization (WHO) evaluation of public health, the UAE compared well with other countries in the world. Furthermore, comprehensive health programs have been adopted to meet the needs of UAE society, with the MOH taking the responsibility for establishing national standards to provide and control the quality services (WHO, 2006).

3-1: The UAE Health Profile

Selected indicators (2010)					
		Country	Regional average	Global average	
General	Total population (thousands)	7 512	
	Population living in urban areas (%)	84	50	50	
Mortality and burden of disease	Life expectancy at birth* (years)	Male	77	64	66
		Female	79	67	71
		Both sexes	78	66	68
	Under-five mortality rate (per 1000 live births)	Both sexes	7	68	57
	Adult mortality rate* (probability of dying between 15 and 60 years per 1000 population)	Both sexes	79	188	176
	Maternal mortality ratio (per 100 000 live births)		12	250	210
	Prevalence of tuberculosis (per 100 000 population)		6	173	178

Source: WHO <http://www.who.int/countries/are/en/index.html>

The establishment of the Ministry and the policies that guide and direct its activities are found in the Federal Law no. (1) of 1972 and the subsequent organisational changes of the Ministry are specified under the Federal laws No. (8) of 1973; No. (7) of 1975; No. (4) of 1983; No. (1) of 1986; No. (11) of 1989 .The Constitution established the Public Health Authority and specified that it is a public organisation responsible for the provision of health services including preventive services, curative services and control of diseases and epidemics (Ali, 2000:301). This shows the central role the Supreme Council plays in making health policy through establishment of laws and policies with which public health services administered.

In 1977 the WHO issued guiding principles for formulating strategies for health for all by the year 2000. The strategy for health for all can be summarised as:

The political commitment of the State as a whole to improve the health of the population; coordinated efforts of social and economic sectors, including the health sector, concerned with national and community development; a more equitable distribution of health resources both within and among countries; involvement of the community in shaping its health and socioeconomic future; and technical and economic cooperation among countries in the field of health. (Mahler, 1988:76)

The FSC, the ministerial council and the MOH are the main actors to formulate and implement a national health policy agenda and to allocate health resources. These actors have taken a number of steps in order to meet the WHO's needs for improving the health of the population. The National Health Plan was issued in 1986 and approved by Cabinet Decree No. 139, which was consistent with the WHO's aims of providing "Health for all by the year 2000", and re-stated the commitment of the government to achieving the following health objectives:

- Provision of comprehensive health care to all residents of the UAE;
- Adoption of regulation for prevention and control of communicable diseases mainly among infants and school children;
- Early detection and treatment of chronic diseases especially cancer, diabetes and cardiovascular problems;
- Ensure the provision of occupational health safety;
- Support and improve health care for the elderly and the disabled; and
- Prevention and treatment of victims of accidents and injuries. (Ali, 2000:302)

Healthcare policy in the UAE has impacted on the entire spectrum of stakeholders: patients, providers and those responsible for planning, assuring the quality of services and financing the health system. The MOH adopts a set of values and strategic objectives and benchmarks in dealing with its various partners and constituents (see Table 3.2).

Table 3.2: Values and Strategic Objectives and Benchmarks

Values	Strategic Objectives & Benchmarks
Compliance & Loyalty: The MOH places high esteem on staff loyalty and exerts great efforts to create a friendly work environment where staff members are interested to remain and excel in compliance with the ministry's vision and values and in line with applied policies and regulations.	First Objective: To enhance and strengthen the MOH role in setting and applying policies, regulations and governance guidance on federal level.
Professionalism & Competence: The MOH encourages staff members to comply with professional ethics and competence standards.	Second Objective: To develop and improve the MOH infrastructural facilities.
Creativity & excellence: The MOH encourages staff members to invent and present creative solutions towards achieving high performance standards.	Third Objective: To enhance and develop the healthcare safety system to counter health hazards.
Motivation & Support: The MOH motivates staff members to excel and feel satisfied with their jobs.	Fourth Objective: Promote public healthcare standards and raise public healthcare awareness among the community up to international standards.
Equity of Services: The MOH aims at achieving a fair distribution of healthcare services to cater for all individual community needs all over the UAE.	Fifth Objective: Ensure and guarantee provision of comprehensive healthcare services up to international standards.
Credibility & Accountability: The MOH adopts a credible approach in dealing with its staff members and the community, where the accountability principle applies at all managerial and staff levels alike.	Sixth Objective: Support, enhance and apply scientific researches and healthcare studies.
Client's Priority: The MOH adopts a policy that places the needs of its clients as top priority.	Seventh Objective: Ensure and guarantee the provision of central administrative services according to applied quality, efficiency and credibility standards.
Teamwork: The MOH adopts a policy that encourages teamwork spirit and joint responsibility principle.	Eighth Objective: Ensure and guarantee the provision of decentralized administrative services according to applied quality, efficiency and credibility standards.

Source: <http://www.moh.gov.ae/en/About/Pages/Strategy.aspx>

In terms of the reform of the health care sector, the UAE government has sought to redirect health care policy toward new objectives. To this end, the leadership of the UAE launched new strategies in 2007 and 2011, with the aim of continuing the path of development established by the founder of the UAE in providing high quality healthcare for the entire community (Ministry of Cabinet Affairs [MCA] 2011-2013). Al-Khouri points out that the strategies aimed to improve government services and bring them in line with international standards, with special emphasis on education, healthcare, judicial and government services (2011:25). The principles of the UAE health care strategy are summarized as follows:

- Ensure universal access to healthcare services by ensuring availability of healthcare services in all regions, and developing health insurance and implementing scheme
- Provide world-class healthcare services by improving governance in the healthcare system, enhancing healthcare services, medical diagnosis and operations while leveraging partnerships, pursuing the accreditation of hospitals and other healthcare providers in the UAE, and upgrading the standards for healthcare professionals
- Reduce epidemic and health risks by promoting a healthy way of life that reduces the prevalence of diseases, strengthening preventive medicine, and developing readiness to deal with health epidemics. (MCA 2011-2013)

This health care plan provides comprehensive coverage of all levels of care, including prevention, ambulatory care and in-patient services. It also contributes to improving the governance in the UEA health system and offers a good example of the role of the state in formulating a programme for health. This opened a window of opportunity for good governance in health services in terms of decentralization and accountability.

This health reform should be understood as the result of the preferences of political actors such as the FSC, FNC, the Council of Ministers, and the MOH. According to the constitution of the UAE, the government assumed a systematic consideration of public health and medical service. In accordance with this, public health policy is the exclusive legislative and executive jurisdiction of the union authorities. This research found that the government realized early on that ensuring the effective and efficient

delivery of health services is a main role of the state, with the result that the trajectory of health care policy has continued towards achieving this. This is an example of path dependency, or what Pierson (1997) refers to as "increasing returns" (see Chapter 2).

On the whole, consequently, policy-making in the UAE can be said to be a success in that it has helped fashion clear policies and strategies that meet residents' needs and international standards. In addition, there is a political will that has played a significant role in reforming the public health sector.

3.4 Organisation and Delivery

Public healthcare services are administered by different regulatory authorities in the UAE. The MOH is responsible for healthcare across the UAE, and it receives its regulatory power from the FSC, which is the highest authority in the union and is a main tool that formulates public policies. The MOH serves federal agencies, which use the strategy as policy instrument to achieve individual expectations of a highly standardized and efficient healthcare system. The core duty of the MOH is to enhance and develop the health system in compliance with international standards. In 1973, the MOH assumed full responsibility for overseeing the provision of health care and preventive measures and therapeutic services. Its responsibility also included the establishment of hospitals and health centres, management and technical control facilities to the private sector related to this field. In addition to the health services provided at the national, state and local level, each Emirate was expected to maintain law and order, ensure that there is security within its territories, provide public utilities for its inhabitants and raise the social and economic standards within the Emirate. This has resulted in the provision of health related service by more than one sub-governmental body in the UAE (<http://www.uaecabinet.ae>) .

The importance of federal agencies as the main actor in the public health arena cannot be overemphasized. Federal agencies have the ability to formulate and implement a national health policy agenda and to allocate health resources. In fact, both legislative and executive authorities engage in federal health policy resource allocation. Moreover, federal health agencies play a significant role in providing information and technical assistance to state and local authorities. These enable

federal agencies to undertake public health activities and to use a variety of policy and administrative instruments (Mays, 2008: 71).

In 2009, the FSC established the Emirates Health Authority (EHA), the aim of which is to encourage cooperation between the federal and local health authorities. The EHA is responsible for following up how health facilities apply international best practices and criteria, and it aims to improve the capabilities of healthcare employees in close cooperation with local agencies (National Bureau Of Statistics, 2009). Besides the EHA, there is the Ministerial Council for Services (MSC). Formed in 2006, it consists of ministers of the service ministries (health, education, housing, roads and means of transportation, water and electricity) and was established to be the executive council for the cabinet. The MSC is responsible for following up the implementation of government general policy, to make the necessary contacts with official authorities across the UAE and to have mutual consultations with them in the area of implementation of their responsibilities (<http://www.uaecabinet.ae>).

The MSC plays a significant part in enhancing the role of the service ministries in devising effective regulations and integrated policies by successful planning and enforcement. This leads to enhanced and effective coordination as well as cooperation between the service ministries and local governments, which, in turn, helps the government to provide high-quality and integrated government services.

The UAE has seen remarkable progress in its health care organizations, as can be seen through a number of indicators as illustrated in Table 3.3 below. These indicators suggest that the health services in the UAE are efficient and effective, as they are on a par with the global average. The advance of health services in the UAE can be said to have resulted from the greater efficiency of the MOH, which has a clear strategy to improve the performance of the public health sector and to distribute health services to all. The United Nations Development Programme's 2009 report (UNDP) estimated that since the formation of the federal state, UAE has witnessed spectacular growth in the sector of health services. The government has succeeded in building a wide network of hospitals, health care centres and diagnostic clinics. It provides all aspects, stages and specializations of health care all over the country.

Table 3-3: Indicators of Childhood Mortality in the UAE 1990-2005

Indicators	1990	2005
Under-five Mortality rate (per 1,000 children)	14.0	9.4
Infant mortality Rate (per 1,000 live births)	11.40	8.70
Proportion of one-year-old children immunized against measles	% 66	% 40

Source: UNDP, 2009.

Table 3.4 shows the development of the healthcare system in the country in its aim to achieve comprehensive health care for all residents and to meet the WHO's strategy. The table indicates that the development of the health care infrastructure and human resources has kept pace with other health care developments to ensure that adequate services are provided in the UAE.

Table 3-4: Development of Healthcare System

Years		1970	1980	1990	2000
Population		580,000	1,040,000	1,844,000	3,108,000
Hospitals		7	20	29	30
Hospital Beds	Total	700	3000	4300	4473
	Pop./Bed	1/1500	1/3500	1/4200	1/6900
Health Centers		21	65	90	115
Physicians	Total	200	1000	1500	2350
	Pop./phys	1/2900	1/932	1/1230	1/1322
Nurses	Total	1000	3300	4600	6300
	Pop./Nurse	1/580	1/315	1/400	1/490

Source: http://www.moh.gov.ae/moh_site/others/health_services.htm

On the whole, the UAE government has brought benefits to the public health organizations, in particular in relation to the role of the state, which has been significant in enhancing the role of the MOH in devising effective regulations and integrated policies by successful planning and enforcement. Efforts made to achieve administrative stability and decentralization have enhanced the effective coordination and cooperation among services ministries and with local governments (Biygautane and Al-Yahya, 2011:5).

3.5 Financing Health

As discussed in Chapter 2, a health care system may be more or less efficient, depending on the degree of state intervention in the health sector. Paying attention to financial factors helps in understanding the role of the state in influencing health building and outcomes (Blank and Bura, 2010).

A discussion of the finance health system in the UAE allows an insight into the role of government in the health system and the size of the health system. In the UAE, there are two kinds of funding for healthcare, namely public and private. Public funding is a central resource and comes from federal government. In fact, the MOH has assumed the responsibility for determining the funds allocated to medical districts in order to ensure quality services. For example, the budget of the MOH was 2.785 billion dirhams in 2011 and constituted approximately 6.4% of the general budget of the Union, in order to complete the implementation of the Strategic Plan of the Ministry to follow best international practices in the field of health care and ensure access to comprehensive health care services and raise health awareness within the community. Private sources of funding have also played an important role in the UAE. In 2001 the government introduced charges for expatriates; a move that partly sought to reduce the draw of healthcare on public funds. (WHO, 2006).

Table 3.5 shows healthcare expenditure as a percentage of GDP: as can be seen, total expenditure on health ranges between about 2.5 and 4.4 per cent. It is also clear from the table that the government spends between 59 and 79 per cent of its total expenditure on health. In the case of the UAE's health services, over 65 per cent of funding comes from government. On the other hand, healthcare in the country also relies on private insurance. Expatriates (non-UAE nationals), who comprise 80% (2006) of the population, are required to obtain a health card which

entitles the holder to access medical services at all MOH facilities for minimal fees (Ibid.,:27-28). According to the table, the general government expenditure on health ranged from 79.0%in 1995 to 74.4% in 2010. As is clear, the UAE health system is an example of a publicly funded health system, with health care funded by the state. The main purpose of the private sector is to provide health services to non-UAE nationals. According to the National Bureau of Statistics, in 2010 the non-national population was 8,264,070, whereas the national population was 947,997. (<http://www.uaestatistics.gov.ae/EnglishHome/tabid/96/Default.aspx>).

Table 3.5: National Expenditure on Health UAE

	1995	2003	2004	2005	2006	2007	2008	2009	2010
Total expenditure on health (THE) as % of GDP	2.6	2.6	2.5	2.3	2.3	2.5	3.0	4.4	3.7
General government expenditure on health (GGHE) as % of THE	79.0	63.2	59.1	59.0	59.4	59.6	66.0	76.9	74.4
Private expenditure on health (PvtHE) as % of THE	21.0	36.8	40.9	41.0	40.6	40.4	34.0	23.1	25.6

Sours: <http://apps.who.int/nha/database/DataExplorer.aspx?ws=0&d=1>,

The funding of healthcare consists not only of raising and allocating financial resources but also controlling funding. The types of funding (public or private) lead to types of control, and the type of control leads to pressures for reform (Blank and Bura, 2010). As mentioned above, the health service in the UAE is publicly funded, with funds coming from the federal budget .The process of setting the health budget in the UAE is developed initially by the MOH who submits it to the Ministry of Finance. When the two branch ministries achieve a consensus, a final draft of the budget passes to the FNC in order to be discussed and issued (<http://www.mof.gov.ae/Ar/Publication/Pages/BudgetGuidelines.aspx>).

To summarise, in the UAE the control of resources and the allocation of health services derive from the federal government; government is the main source of

funding and this has led to the government reflecting its own interests in raising and allocating health services.

3.6 Decentralization

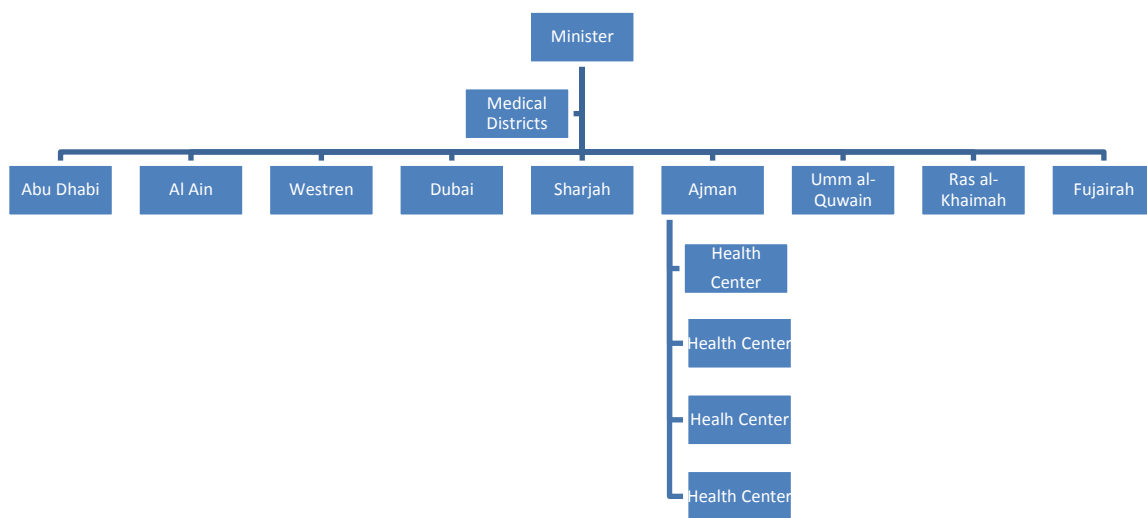
As noted earlier in this chapter, the UAE is a constitutional federation with authority shared between the national government and its seven emirates. To illustrate the decentralization in general in the UAE, Simmons states the following:

The development of local governmental institutions has affected the balance the federation. Local governments vary in size, structure and degree of autonomy from central institutions according to a number of factors including population and the level of economic and social development of each emirate. Mature local government systems were not in place in 1971 when the constitutional arrangements were made which means that the relationship between federal institutions and local governments has evolved, taking different forms according to the capacity of the local government institutions. In some cases this has led to integrated arrangements, with some emirates merging some of their departments with their federal counterparts. However, regardless of these arrangements, as a member of the Supreme Council, the ruler of each emirate has a significant role in determining the nature and extent of local government activities. (2002:362)

Statutory backing for the decentralization of the health care system in the UAE can be found in Article 36 of the Council of Ministers Order No 11 of 1989 concerning the organizational structure of the Ministry. The essence is to ensure more effective delivery of health related services in the UAE. The article stipulated that the 9 (see Figure 3.1) medical districts be established so that each district has administrative and technical capacity to plan, organize, supervise and develop its own health care services. The administrative set-up at the district level represents all sectors of the Ministry in the form of corresponding departments and sections (UAE, Health Directory 2002-2003). This reform resulted from a number of factors, outlined below, which led to rapid changes in the health services and the subsequent reforms through decentralization:

- Difficulty in establishing health programs appropriate to the circumstances of Emirati society due to increase in population;
- Lack of coordination between federal authorities and local health services and
- Low efficiency in the level of the health services (Economic and Social Report, 1989).

Figure 3-1: Medical Districts in the UAE



Source: UAE, 1986, the MOH, Primary health care (1986-1990).

Decentralization is the distinguishing characteristic of the healthcare system in the UAE. This was achieved through the establishment of the 9 medical districts. While the federal authorities make and provide policies, the medical districts manage the details including field operations through health centres and hospitals in order to distribute the health services to all the population in the UAE. The MOH also gave each district administrative and technical capacity to be able to provide efficiency of services in order to be responsible for health services. This can be seen as a decentralisation of the UAE health system which has transferred the resources and power to lower level authorities (medical districts).

As noted above (see Figure 3.1), each medical district includes health centres, the number of which depends on the population of the district. At this level, citizens have the right to participate in the management of the health centre to discuss their expectations (MOH, 1986). This participation between health centre and citizens means that the MOH is accountable for ensuring and improving the efficiency and accountability of government institutions.

From the foregoing, it is clear that the health care system in the UAE is decentralized because the government needs to distribute health services to all the population. In terms of decision space (see chapter 2), the MOH equally gave each district all administrative and technical capacity to be able to provide efficient services. The MOH has the responsibility to formulate national health policies which regulate all health and medical practices in the country. At the same time the MOH created medical districts as separate and autonomous and delegated to them health care management.

Table 3.6 below shows the distribution of health institutions that provide health service at all levels through division of the country into 9 medical districts in order to ensure access for health services for all residents. According to Smoke

There are many potential, sometimes conflicting goals of decentralization. The majority of the initially expected benefits can be broadly characterized as improvements in efficiency, governance, and/or equity in public service delivery processes and outcomes. (2004:64)

In addition, health service users in general do not face barriers to accessing health services in the UAE both on the demand and on the supply side because the health policy agenda gave government agencies (MOH, medical districts, and hospitals) power to ensure that there is direct access to health services by all residents .The UAE system placed a premium on ready access to the health care delivery system, high numbers of providers and technological equipment.

Table 3-6: Health Institutions and Manpower in the 9 Medical Districts

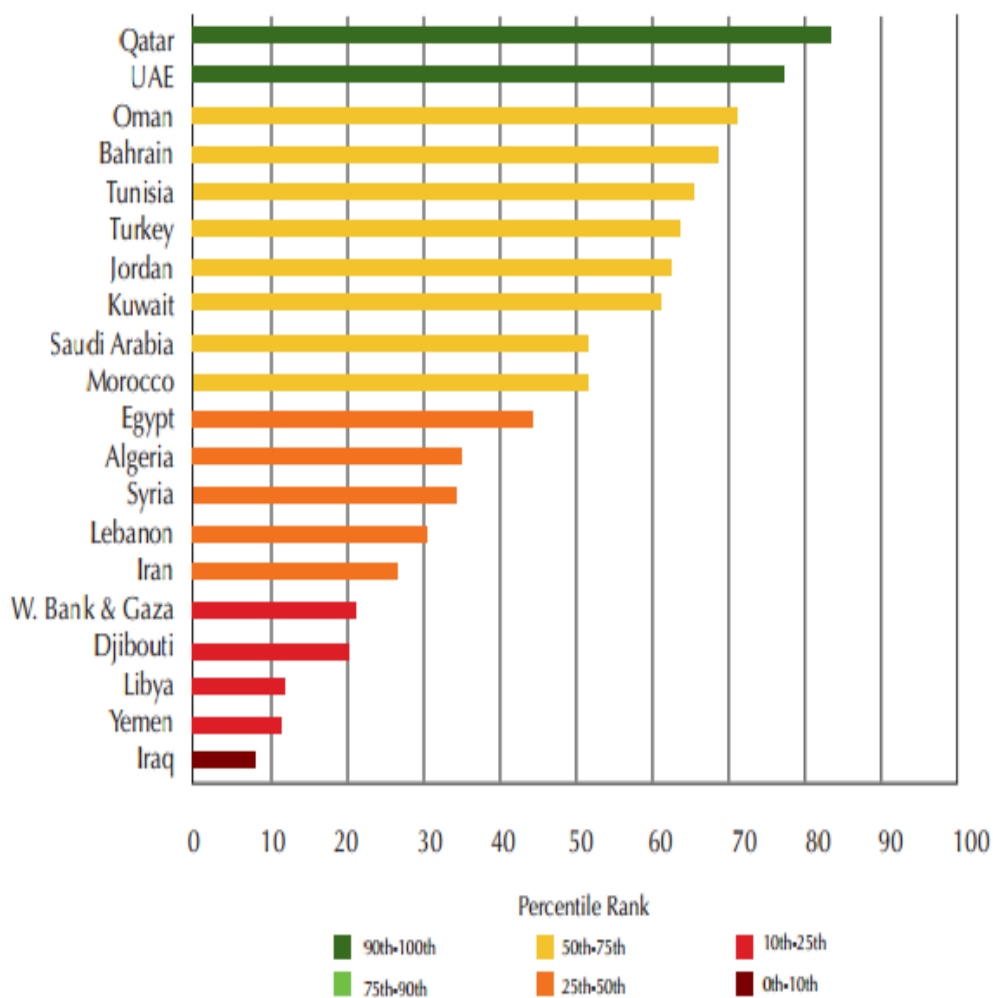
District	Hospitals	Health Centres	Other Institution	Man-power	
				Physicians	Nurses
Abu Dhabi	6	21	5	763	1697
Al Ain	3	20	5	434	1415
Western	5	8	3	109	201
Dubai	2	9	6	173	268
Sharjah	5	14	5	266	754
Ajman	1	6	4	89	255
Umm al-Quwain	1	5	4	79	146
Ras al-Khaimah	3	16	4	185	384
Fujairah	2	7	5	119	260

Source: The MOH, UAE Health Directory (2002-2003)

In Chapter 2, the relationship between decentralization and good governance was discussed. In the case of the health care sector in the UAE, the decentralisation policies contribute to greater financial and management autonomy and greater responsibility for planning and budgeting. The UAE did indeed launch impressive programs of administrative change that brought an update in the quality of governance such as the Council of Ministers Order No 11 of 1989, Government Strategy 2007, and Government Strategy 2011-2013. These have all had a beneficial effect on good governance. For example, decentralisation is not only successful in providing health access to all citizens but also gives power to the medical districts to make decisions regarding the management and financing of health services. In this sense, the autonomy of the medical districts is taken seriously and medical districts respond to local societies.

According to a report published by the World Bank the UAE has a high score for government effectiveness (Figure 3.2). This indicator reflects the quality of the public sector bureaucracy in formulating and implementing policies and delivering services. Treisman argues that decentralization plays an important role in affecting the quality of government, because “decentralization improves the quality of government by bringing officials ‘closer to the people’, encouraging competition between governments for mobile resources, and facilitating the satisfaction of diverse local tastes” (2002:1). If this is the case, it is clear that decentralisation has enhanced the quality of government in the UAE.

Figure 3-2: Government Effectiveness in the Middle Eastern and North African



Source: Kaufmann and Mastruzzi (2010)

3.7 Accountability Mechanisms

A framework to assess accountability can be derived from the source of control: whether it is internal or external to the agency. As seen in Chapter 2, external accountability includes legal accountability and political accountability, whereas internal accountability involves hierarchical accountability, managerial accountability, professional accountability, and consumer accountability.

In this section on accountability in the UAE public health sector, all these types of accountability will be studied. With regard to external accountability, the relationship between the MOH and outside agencies (institutions and citizens) is discussed; in respect of internal accountability, the emphasis is on the operations within organizations.

3.7.1 Internal Accountability

The first line of accountability is internal accountability. The pattern of internal accountability has resulted in four different types of accountability relationships as outlined in the following sections.

3.7.1.1 Managerial Accountability

As earlier discussed, the most striking component of the decentralized health care system is the delegation of state power to medical districts and local organization. Each medical district has several health organizations such as health centres and hospitals which provide health services, and each medical district has administrative and technical capacity to plan, organize, supervise and develop its own health services. In this section, the system of management accountability will be discussed from the perspectives of the relationship between the MOH and medical districts.

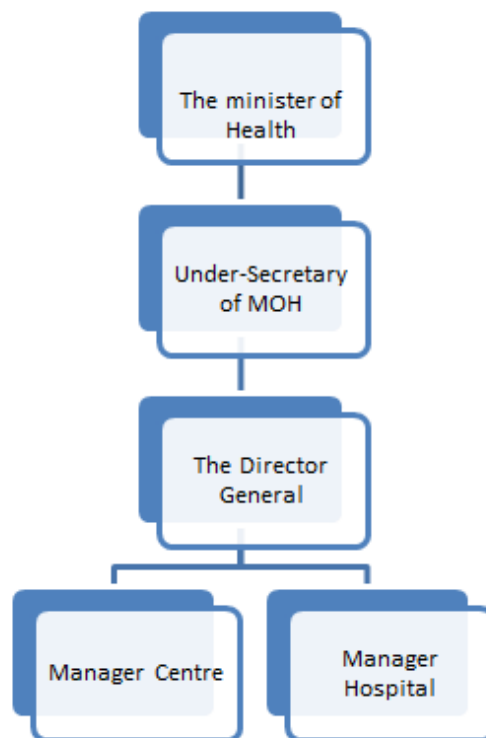
The MOH is represented mainly by the 9 medical districts, so that the administrative set-up at the district level represents all sectors of the ministry in the form of corresponding departments and sections. The MOH is accountable and legislative for achieving and attaining the UAE Government's strategic vision. In other words, the MOH ensures and guarantees the provision of de-centralized administrative services according to applied quality, efficiency and credibility standards (WHO, 2006). A hierarchical structure of the UAE health system (Figure 3.3) is administered from top down by the MOH, with the Minister at the top of the hierarchy followed by an Under-Secretary who is directly responsible to the Minister. The MOH is

responsible for formulation of the annual budget, providing the operational strategy and tactics, controlling the budget expenditures and advising on financial affairs, and granting licenses for private hospitals and medicine and nursing practicing (Law No 3, 1973).

Medical districts are responsible for providing primary and curative health services to meet the population needs in these Emirates. Each of the medical districts is supervised and controlled by a Director General who is responsible for health services in its medical districts. The Director General is directly responsible to the Under-Secretary of the MOH (WHO, 2006).

As discussed above, medical districts have administrative and technical capacity which means that civil servants are able to provide efficient services. They are responsible to the Under-Secretary of the MOH to manage the strategy formulated by the MOH. Such efficiency emanates from the decentralized approach followed in the establishment of medical districts and operations in the UAE.

Figure 3-3: Level of management Accountability Structure



Source: Ali (2001)

With regard to managerial accountability, for this research, input, output, and outcome are the main key factors (Behn, 2001). All health districts are accountable to the MOH, through audit and reports. In order to improve effective accountability, health districts are given higher autonomy to achieve the goals of health and to be responsible for health services. In addition, the government and MOH issue national plans and strategies to provide directions and guidance to health districts to promote high quality in health service delivery (see section 3.3); furthermore, the MOH has paid attention to reducing vertical accountability by concentrating on citizen satisfaction and performance measurement, these will be discussed in the following sections.

3.7.1.2 Consumer Accountability

A framework to assess client accountability can be derived from the characteristics or conditions of citizen participation in the public sector. As seen in Chapter 2, client accountability is associated with citizens' perceptions and expectations of the services that they receive (Behn, 2011), and administrators have wide latitude about choosing what form citizen participation will take (Handley and Howell-Moroney, 2010).

In the UAE, although political participation is almost insignificant, the government placed system in the health authorities as a part of the reform of public services have aimed to involve citizens in the mechanism of accountability. As mentioned by Christensen and Lægreid, P.(2002) and Brinkerhoff (2003), these structures will facilitate strong relationships between administrators and citizens. The mechanism of citizen accountability in the UAE is an important way of developing public relations and customer service initiatives in order to positively promote the health strategy and performance amongst stakeholders in government and the community (WHO, 2006). For example, in Abu Dhabi medical district, the Customer Services Centre (CSC) was established to ensure that customers are provided with the right services and information, and to promote patient satisfaction. The CSC is the primary way of interacting with customers and aims to create a culture built to meet the priorities of the clients, prepare and develop a comprehensive plan for customer service, and respond to customer complaints . This centre can be seen as a mechanism for citizen input into the health institutions and assessment of citizen satisfaction can

contribute to strengthen managerial accountability by citizen participation in decision-making(<http://www.haad.ae/haad/>).

It is clear from the above that the UAE government has a number of initiatives to strengthen accountability through the creation of departments that focus on the involvement of citizens in evaluating the government's performance and improving public services. As Massey and Pyper (2005:161-62) discuss, the importance of client accountability is the emphasising direct official accountability to service users. This kind of accountability establishes a mechanism through which public service managers can be called to answer for the performance of their organizations and for the use they have made of public resources to service clients.

3.7.1.3 Professional Accountability

As discussed in Chapter 2, professional accountability is a strong weapon for those looking for good governance. Professional accountability in the community is achieved through an increased focus on the proper implementation of professional codes of ethics. In other words, ethical and professional accountability of public sector management depends on the commitment and enthusiastic compliance of professionals employed to structure with a view to delivering services.

In 2010 in the UAE, the government issued its Code of Ethics and Professional Conduct Document Service, with the following aim:

Finding and developing institutional culture for the Public Servant and to support professional values and develop responsibility spirit and adhering to the supreme ethics in dealing with his Superiors and colleagues in work as per the basic values of Human Resources and to render the best services to enhance trust and incredibility in Government Sector. (FAHR,2010)

Furthermore, according to the code,

All public servants should exercise the highest ethical standards and adhere to the code of professional conduct ... Uphold the highest principles of ethical conduct in all government transactions. Full compliance with professional ethics> policies and procedures. (Ibid.)

This reform should also be seen as part of the measures to enhance accountability and to improve the quality of services available to citizens. In practice this has been

implemented throughout the UAE's health sector, and in 2009 the Nursing and Midwifery Council (NMC) was established to regulate the nursing and midwifery professions, and to promote and advance nursing and midwifery services. It was also saddled with the responsibility of protecting, promoting and ensuring the health safety of the public based on the highest standards (NMC, Annual Report 2011).

The NMC has established professional codes of ethics and mandatory registration for all nursing and midwifery professionals in order to enhance their responsibility and public accountability.

This professional code of ethics includes the following:

- Respect for self and others
- Honesty
- Safe and competent care
- Confidentiality and Privacy
- Quality nursing care for all people
- Team work
- Risk Management . (Ibid.)

The NMC has paid attention to enhancing the responsibility of nursing and midwifery through the mechanism of accountability. In addition, the UAE government issued Federal Law No. (10) Of 2008 concerning medical liability. According to the law, doctors shall take care to comply with the rules, regulations and procedures of practicing the profession, depending on their grade and specialization.

In order to ensure that doctors, nurses and midwives take full responsibility for their actions, in 2009 the Cabinet established the Medical Liability Supreme Committee. This committee protects patients from medical errors and must submit its opinion at the request of the public prosecution or competent court.

In addition, the Abu Dhabi Health Authority published its Patients' Charter, which reflects both the relevant healthcare laws and professional responsibilities to patients in receipt of health care. Such a charter enhances citizen accountability in that patients can make a complaint about health services, as stated within the charter:

If you are unhappy with any medical examination or treatment you have received, the behaviour of the professional staff or the safety standards of any healthcare facility, you have the right to make a complaint to the healthcare facility management or the Health Authority – Abu Dhabi.

(<http://www.haad.ae/haad/tabid/1141/Default.aspx>)

It is clear from the above that the UAE has given attention to enhancing professional accountability through a code of ethics, professional conduct and regulation in order to achieve government objectives. This has been achieved by making doctors as well as all other health professionals accountable for quality service provision, and for maintaining the highest standards.

To conclude this discussion of the internal accountability mechanisms, it can be claimed that the UAE government has been able to establish a responsible public health system, with accountability ensured by making health institutions answerable to other governing institutions and to the public as well as making civil servants accountable to the client; all of this has been developed within the last decades. This is achieved by harmonizing individual goals and objectives with those of the organization. From this finding we can conclude that the UAE has been successful in applying the NPM in terms of management accountability that depends on a move from process-oriented accountability to results-oriented accountability.

3.7.2 External accountability

In Chapter 2 it was suggested that one of the fundamental principles for external accountability is that government and ministers must have accountability towards parliament, voters, public opinion and actions (Massey and Pyper, 2005; Lam, 2009), so political accountability can be assessed through the role played by the legislative institution.

In the UAE, understanding political accountability requires an understanding of the wider political context and the ways in which power is exercised in the country. Power in the UAE is exercised through several institutions. The FSC is the highest political authority in the country: it formulates and oversees the execution of public policy, and appoints the Council of Ministers. The FSC consists of rulers of the seven emirates constituting the federation. Also the FNC can which is advice body to the FSC and it is the highest legislative authority, because it reserves the right to discuss laws and financial bills, and Members of the FNC are not directly elected. As Herb (2009) points out, the power of the FNC is almost insignificant. This reflects the powers allotted to the parliament in the UAE's constitution which makes the FNC an entirely advisory body.

Many observers argue that the role of the FNC is weak, as stated by Almezaini, the FNC as parliament, though ensures accountability because of its role in parliament,

but cannot be said to be as active as what we have in the developed countries. The FNC exercises political control through specific mechanisms which are the general topics for discussion, make recommendations, this is because its actual role is consultation because the FNC can only be brought before it by the FSC and the council of ministers (2011:34). The United Nations Arab Human Development Report 2009 shows that the mechanisms of political and legal accountability in the country are more similar to a traditional model of accountability with an administration under the formal control of the political leadership.

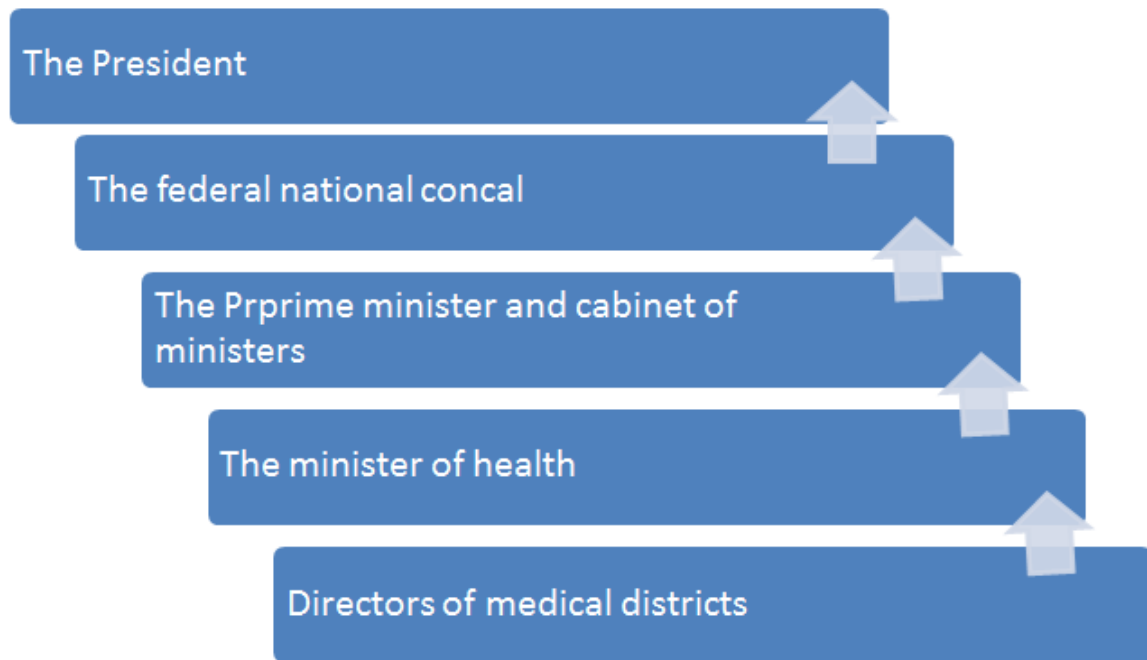
According to the political accountability analysis outlined in Chapter 2, the mechanism of political accountability in the UAE is weak because of the lack of clear relationship between the citizens and the FNC. The lack of interaction between the stakeholders and the legislative branch results in the FSC being the main source of control and power in political life. In fact, the regime of the UAE is authoritarian in nature but uses its authoritarianism to satisfy its tiny citizen population with welfare benefits. Although the UAE has taken positive steps to provide economic and political stability for its society, political participation is still very small.

Consequently, political accountability is not effective because of the role of the FSC in the country's political life. In addition, there are no political parties and no electoral democracy in the country, with all decisions resting with the dynastic rulers of the seven emirates. The UAE's ruling families play a controlling role in political life and public policy reflects their interests with the result that they have made themselves leading capitalists in their emirates. Members of the FNC are not given full freedom to debate and discuss current issues in the interest of the people and the country. Furthermore, the FNC has limited power to amend and repeal laws and to question the prime minister and ministers.

In terms of legal accountability, the most fundamental distinction in accountability mechanisms is that the president, the prime minister and his ministers (cabinet) perform the role of the legislature. Clearly, the MOH is responsible for healthcare across the UAE; the MOH serves as a central actor in ensuring accountability in relationships that exist in the health sector, by holding health care providers accountable and by ensuring that medical districts are directly accountable to the MOH. The MOH has exercised its accountability functions effectively through procedures which have achieved service delivery equity and service user trust. Figure 3.4 presents the political and legal accountability structure in the health

system in the country. The Minister of Health is responsible for the activities of the Ministry and is accountable to the Prime Minister, the FNC and the President as well as to his Cabinet colleagues collectively(<http://www.uaecabinet.ae/Arabic/The%20Cabinet/Pages/default.aspx>).

Figure 3-4: The Political and Legal Accountability Structure



Medical liability in the UAE is organised by Federal Law No. (10) of 2008. This law states that practitioners should discharge their duties with accuracy and honesty as dictated by the profession and according to the established scientific and technical principles while affording patients due care. This law also aims to protect medical practitioners and patients in order to improve health services and have a positive effect on health services. To this end, the law established a committee, the Medical Liability Supreme Committee, which plays a significant role in determining medical error and, accordingly, requesting public prosecution in a competent court or medical body of any found wanting.

The law holds medical practitioners responsible and compliant with legal obligations. It also serves as protection for all cadres of health. Such medical liability enhances legal accountability, by imposing legal sanctions or asserting formal

contractual obligations. It is important to understand that all medical practitioners and health institutions in the country are subject to the federal medical liability.

Another kind of external accountability is financial accountability. As earlier noted, the power of the FNC is almost insignificant. This reflects the powers allotted to the parliament in the UAE's constitution which makes the FNC an entirely advisory body. However, the FNC exercises financial accountability of health through a number of committees such as the Committee on Finance and Economic Affairs (<http://www.almajles.gov.ae/AboutTheFNC/UndertheFNC/Pages/AboutFNC.aspx>).

The framework of financial accountability flows from the alignment of budget with government strategy. This is done through program budgeting, performance monitoring, accounting process and reportage of expenditure that conforms to set standards. The system of financial accountability can thus be seen as a form of administrative control because political parties and pressure groups are not found in the UAE (MOH).

The health budget in the country is determined by the objectives of the government and performance, and thus encourages improvements in the efficiency and effectiveness of the use of public money. As discussed, the UAE government launched a strategy for the years 2011-2012, which is dedicated to ensuring the highest standards of living for UAE citizens, by raising the standards of healthcare, education, and other areas. Therefore, the budget of 2011 was calculated to be in line with government strategy (MCA), which seeks to build a world-class healthcare system. The procedures adopted in the health budget (input and output) are important tools in improving financial accountability of the country, because setting performance objectives and targets for programmes gives managers financial accountability for each programme to achieve these objectives and targets (see chapter 2).

The second mechanism of financial accountability is the UAE State Audit Institution (SAI) which is an independent authority that reports to the FNC. The SAI aims at improving accountability and standards of governance across the UAE. It is also dedicated to ensuring that the Federal Government properly collects monies, and that public funds are spent wisely. In addition, it ensures that federal organisations deliver on their stated objectives (SAI, online). It should be clear from the above that the SAI is a central element that can help to achieve financial accountability and to support the FNC in what federal organizations should do.

As earlier mentioned, the UAE's health budget is strongly linked to performance, paying attention to derivable results. The role of the SAI in auditing performance objectives of the MOH and reporting on whether they are providing services and achieving specified programs, for which they are funded, is simply to ensure that there is accountability. In addition, if the SAI discovers fraud, mismanagement and waste of federal assets and resources, it has power to punish individuals for their action. Both Federal Law No. (7) of 1976 on the Establishment of State Audit Institution, and Federal Law No. (8) of 2011 on the Reorganization of the State Audit Institution gave the SAI power of control over federal government funds and performance.

Another process of financial accountability is local audit. The UAE provides for local audit in each Emirate. The aim is to enhance and promote transparency and accountability across local government. In Abu Dhabi, for example, the Abu Dhabi Accountability Authority (ADAA) is primarily responsible for enhancing and promoting transparency and accountability across the health authority within that Emirate. The ADAA reviews performance and provides advice and recommendations as well as performing other procedures and services in order to help improve performance. The essence is to promote accountability and transparency across the Abu Dhabi Government, by assuring that governmental organizations are operating in accordance with the government's objectives and providing procedures for improving performance(<http://www.adaa.abudhabi.ae/Ar/Publications/Pages/Publications.aspx>) Law No (14) of 2008 of the ADAA gives it the right to apply disciplinary action, and to refer the case to the relevant public prosecutor's office to take the necessary action, if the report or investigation of the ADAA shows that there has been a violation (<http://www.adaa.abudhabi.ae/En/Publications/Pages/publications.aspx>).

As Meraj (2009) points out:

The establishment of the ADAA is an important step towards strengthening public sector accountability and transparency. At the federal level, the UAE already has the SAI, which is an independent body that reports directly to the FNC and is responsible for the auditing and oversight of state funds and those of other specified public entities. But the establishment of the ADAA will complement and enhance that role at the local level in the Emirate of Abu Dhabi. This is a measure worth emulating by the other Emirates.

It is clear that the local audit plays a significant role in ensuring that health services are provided as well as the finance to meet it. The local audit also ensures that sanctions are incurred if the account is unsatisfactory.

3.8 Performance Measurement

As mentioned in Chapter 2, performance measurement helps the public sector achieve two tasks: better services and accountability (Bolton, 2003). In the public health sector, performance measurement concentrates on and evaluates the services, outputs, and results of public agencies and programs of the health sector (Brinkerhoff, 2004), and as such it can serve to guide the organisation and to promote accountability.

The MOH and the SAI depend on different types of performance measurement including performance audit, performance information, and best practice guides. These performance measurements can be seen as mechanisms for control and accountability. In fact, these benchmarks ensure a high level of financial accountability in the UAE. As the Transparency International Organization's report 2010 confirms, the UAE has good scores for accountability, effectiveness, rule of law, and control of corruption.

The MOH focused on performance standards in order to achieve accountability. It has established standards of performance as a benchmark to guide the evaluation of program outcomes. For instance, the MOH has drafted a Strategic Plan (2011 – 2013) - Health System for High Communal Health - that is both comprehensive and effective. The aim is to achieve individual expectation of a highly standardized and efficient healthcare system. This system is capable of rationalizing the contribution of all institutions providing health services in the country and directing such input to making quality health care comparable to that of the most developed countries available and accessible by the people of the UAE (WHO, 2007).

Performance indicators have been presented as an instrument of MOH control and as a way of reinforcing the accountability of institutions. Furthermore, the MOH determines the following objectives of the programme: professionalism and competence; motivation and support; and credibility and accountability (Table 3.7).

Performance indicators in the UAE health sector can provide more information for senior managers and citizens; as Carter et al. (1995) suggest, performance indicators offer a tool of self-evaluation and a way of seeing the performance of their own district within a national framework.

The Health Information System represents the assertion of performance measurement in the UAE. This made possible the use of comparative data in decision-making, whether in the MOH or in medical districts. According to WHO (2007), the country has a strong national health information system capable of providing benchmarks to be used to improve health care institutions.

Table 3-7: Selected Health Services Performance Indicators in the UAE

Dental Services by Medical District
Rates of Health Services Performance in U.A.E.
Actual Rates of Frequencies at P.H.C. By Medical District
Rates of Availability at P.H.C by Medical District
Rates of S.H.C. Services by Medical District
Supporting Services by District
Important Rates of Hospital Services by Hospital & Medical District
Accident Injuries by Type of Injury District, Age Group & Nationality
Accident Injuries by External Cause Of Injury & District
Hospital Services to Outpatients by Nationality & District
Hospital Services to Inpatients by Speciality

Source: Ministry of Health, UAE. <http://www.moh.gov.ae/en/Statistics/Pages/2008.aspx>.

The MOH has applied performance measurement to improve the health services through the implementation of an automated Health Information System across all health institutions. With the system, health administrators can look forward to a streamlined management process that increases administrative efficiency and reduces operational costs. It also gives physicians and medical professionals faster

access to a patient's medical history and data and increased collaboration and interface amongst specialists (<http://www.wareed.ae/ar/advantages.html>).

The UAE's health budget is usually given attention because it focuses on the performance of objectives through the government strategy. This budget links spending and the performance of results: in order to demonstrate efficiency in the implementation of activities, programs and objectives are expected to provide quality and efficient services with optimum use of funds and with priorities of spending. Budgets are introduced in the UAE to measurable standards and to enhance performance as expenditures are scrutinized (<http://www.mof.gov.ae/Ar/Publication/Pages/BudgetGuidelines.aspx>).

The concept of program budgeting is applied in the UAE and this has contributed considerably to maximizing the social impact of public spending, making better use of resources and increasing budgetary process transparency. It has moved the country into the group of internationally acknowledged best practice countries in budgeting and financial management of resources. Program budgeting is widely implemented in other leading OECD countries, e.g., the UK, Singapore, New Zealand as well as in several US states and private companies around the world (MOF). The OECD countries have been working on introducing performance information into budgeting in order to control and improve allocative efficiency and productive efficiency, and improve public sector service delivery, efficiency, and performance, and enhance accountability to politicians and the public (OECD, 2007). In local government, performance measurement has been used by the health authority in Abu Dhabi to measure a number of indicators, as shown in Table 3.8 below. The performance measurements produced by the health authority have sought to monitor and analyse the health status of the population and the performance of the system (HAAD Annual Report 2011).

Table 3-8: Selected Health Service Performance Indicators in Abu Dhabi

Performance indicators	Performance indicators Definition
Satisfied customers	-This KPI requires Entities to collect customer satisfaction data -By increasing the frequency, Entities will collect satisfaction data at least twice a year
Initiative expenditure variance	-This is a new KPI to replace Opex/Capex Variance Since major portion of spending is derived from the strategic initiatives (both capital and operating), this KPI will help each entity to monitor the overall financial performance of their strategic initiatives
Operating budget variance	-Monitoring the variance between planned and actual expenditures to improve the overall financial planning and forecasting
Average employee satisfaction	-This KPI measures an important element of human resource management
Employees who received at least 24 training hours per year	-Training is a key element of developing human resources -This % encourage Entities to spread the activities of training across all employees
Leadership Development Tracking Index (LDTI)	-To drive Government's priority of training leadership

Source: The Health Authority Abu Dhabi <http://www.haad.ae/HAAD>

In conclusion, the model of performance measurements as used in the country makes improvement in health services possible. Managers, physicians, and other medical professionals in all medical districts are, by extension, made accountable solely to achieve the singular goal of an efficient health service delivery. At local government level, performance measurements lead to increased accountability. In particular, they ensure customer participation in evaluating performance and formulating goals. In Abu Dhabi, for example, the health authority has asked a sample of the public about their views and feelings towards the health institutions

and health care issues in general in order to evaluate performance and improve management.

3.9 Why Should the Libyan Government Learn Lessons from the UAE?

In Chapter 2, this research offered reasons for why a lesson could be drawn and from where. The arguments put forward, according to Dolowitz and Marsh (2000) and Evans (2004:11), call for an explanation of policy outcomes and for the reasons for transfer. It is important to focus on lesson-drawing as a part of voluntary policy transfer in order to propose a transfer to reform the public health system in Libya. The UAE experience as explained above can be used as a benchmark to suggest some useful ideas for improvements in Libya. The reasons why the Libyan government should learn from the UAE are outlined below.

First, Libya and the UAE share a range of common factors such as language and Islamic culture, provision of universal coverage of health care free of charge, and the financing of the health systems in both countries largely through general revenues. Both countries depend on oil to achieve development and provide services in what Vandewalle calls a distributive state (1998). Both countries also experience the same socio-political problem of tribes playing a significant role in the political processes. Strang and Meyer claim that common cultural values between societies facilitate the process of transfer policy because the transfer policy depends on 'perceptions of similarity' between prior and potential adopters, and thus policy transfer can be predicted between the most similar systems (1993 cited in Common, 2004:44).

According to the scholars of policy transfer, culture can be seen as an important factor in facilitating policy transfer. Culture is defined as "a way of life of a group of people or a society through which it views the world around it, attributes meanings, attaches significance to it, and organizes itself to accomplish, preserve, and eventually pass on its legacy to future generations" (Dwivedi & Gow, 1999:21-22). Understanding culture is significant in analysing public management reform because culture and public management reforms are closely linked, and management reform should closely reflect cultural features in society (Bouckaert, 2007:29). Common argues that political and societal culture can be seen as an important factor between countries. He provides empirical evidence that Georgia and Saudi Arabia each has

their own political culture that acts to severely limit policy transfer from a Western direction (2013:26-27). It is clear that a similarity between cultural features is an important factor in facilitating policy learning between countries.

The mainstream cultures of Libya and the UAE are founded on Islam. The vast majority of Libyans and Emiratis are Muslims who follow the Maliki tradition of the Sunni sect of Islam. Islamism is important as it constitutes a template for culture, and it has played a significant role in impacting on the structure, values and attitudes of society. In terms of public administration, both countries have been affected by an Islamic perspective on its public administration. An Islamic approach to public administration is similar to other models and, according to Mir (2010), it can be identified by four principles. The first principle is ideological orientation, which refers to the belief that public administration can be run only by Muslim managers. This means that administrative skill is not only a standard of appointment but also that ideological consideration is extremely important in matters of appointment. The non-Muslim citizens of an Islamic state have the same civil rights as Muslims and they can be appointed as an expert or advisor. The second principle is primacy of humanistic ends, which refers to the view that the organization must provide reasonable wages and salaries, and an appropriate working atmosphere for its administrators and employees. The third principle is moral accountability: the Islamic perspective of accountability depends on administrative measures, social accountability, through popular opinion and pressure, and moral accountability. The final principle is supremacy of law: according to this principle, persons in authority must be obeyed, although compliance may be refused if the order is morally unjustifiable, evidently wrong, and involves disobedience to God.

In practice, the Islamic administrative tradition stresses the role of a hierarchical, centralized state, with the bureaucracy often central to political rule. However, in addition, the bureaucracies in many modern Arab states suffer from bloated staffing budgets, a proliferation of agencies with duplicated functions and little coordination, and rampant corruption (Painter & Peters, 2010:29-30). Thus, Islamic culture dominates organizational behaviour in both countries, and this factor can be seen as a real incentive for Libyan policy-makers to learn from the UAE.

Second, Libya is now witnessing a transitional phase that requires the transfer of policies and programs to deal with public policy problems. As Ivanova and Evans

(2004) suggest, policy transfer has an important impact on the performance of government in transition societies. In terms of the public health sector in Libya, official evidence was issued before the revolution admitting the poor performance of the health system. After the overthrow of the former regime, the country desires to correct the problems in the health sector (see Chapter 4).

Third, according to Lana and Evans, international organizations use the concept of best practice by referring to those countries that are successful in terms of outcomes and costs, and these countries open channels for lesson-drawing and policy transfer (2004:208). According to the WHO(2007), the health service sector in the UAE is a modern system with facilities and professionals which are able to provide excellent healthcare and advanced performance. The most important feature in the field of healthcare in the UAE is that they have developed a comprehensive system capable of rationalizing the contribution of all institutions that provide health services in the country. In addition, this system provides the UAE with a quality of health services comparable to the quality of health services in developed countries. It is important to understand that the main reason for successful public health services in the UAE is the responsibility taken by the Government in developing national standards for the quality control of health services (<http://gis.emro.who.int/HealthSystemObservatory>).

Fourth, following the Libyan revolution in 2011, the Libyan government signed an agreement with the Dubai School of Government to develop an educational leadership program. This agreement aims to train 300 administrative leaders in the public sector who work in the Ministries of Labour, Health, and Education as well as the Electricity and Water Authority to increase their skills in strategic planning, quality and organizational excellence, as well as project management and financial priorities. As part of the program, all participants have attended field work in government departments such as the Dubai Government Excellence Programme and the Department of Economic Development to gain an understanding of the workflow of these departments, These field visits help participants identify best practices within the government institutions (<http://www.dsg.ae/en/home/index.aspx?&PriMenuID=2&mnu=Pri>).

In this way, the leadership program has responded to a range of challenges which are faced by the Libyan public sector. By learning such skills from the UAE this program will provide ways forward in public management in Libya by using skills learned from the UAE. At the same time it will contribute to transfer mechanisms and

procedures that remedy the problems of public management and allow it to become effective in providing goods and services. As discussed by Common, organisational learning indicates the propensity for governments to transfer from the international environment and desire to improve performance in the public sector (2004:43).

Fifth, when asked interviewees if they recommend the transfer mechanisms and programs providing health services from the UAE to Libya in order to improve the level of health services, all interviewees participating in the present study responded positively to the idea that Libya should take lessons from the UAE, and they believe that the UAE's experiences are important in finding a solution to the problems facing health in Libya.

For example, the president of the Libyan international medical university expressed the view that the level of health services in the UAE is characterized by providing a high level of quality in the field of patient care and is concerned with training doctors and nurses to a high degree of efficiency and quality. He also added that the UAE's experience of the health system is useful to the reform of the health system in Libya because the UAE can be seen as a good model which has been successful in modernising its health system (INT).

From the above discussion it is clear that the change of political system in Libya in 2011 was combined with a strong desire by senior officers to draw lessons from abroad in order to overcome problems in the public health system. As Rose suggests,

In searching for an effective programme, policymakers are not engaged in research as that term is understood in universities. Policymakers are driven by the need to dissipate dissatisfaction. Instead of new knowledge, policymakers prefer the assurance of doing what has worked before, or been effective elsewhere. Searching is instrumentally directed. (1991:10)

3.10 Conclusion

One of the key issues in the process of policy transfer/learning is the selection of the role model or best practice that can help to tackle the problems of the home country. In this chapter the UAE was selected as a model that may offer useful lessons for Libya.

The UAE offers useful lessons for developing countries, particularly those countries which are facing a crisis of confidence in their healthcare systems. This chapter found that there is a great deal to be learnt from studying the experience of the UAE health sector, which has been successful for several reasons. These include the commitment of political leadership and institutions to undertake actions to achieve a reform of the sector.

The first is that the growth of health policy and strategy has come from the perspectives of the developing state. Policy makers made effective decisions for health policy in pursuit of a world-class healthcare system that ensures universal access to healthcare services, world-class healthcare services and a reduction in epidemic and health risks. The health policy was set by meeting the health needs of the citizens and the international standards of healthcare. These policies and strategies included processes and procedures for improving governance in the healthcare system and enhancing healthcare services.

The second lesson to be learnt from the experience of the UAE is the importance of decentralisation in the public health organizations. In the country, decentralization has had a positive impact on the structural development of health organizations and delivery. The structure of health delivery has seen remarkable progress in health care organizations, which have met the needs of UAE society. This chapter has investigated whether decentralization has created autonomy in health districts and discovered that the decentralisation policies of health care services contribute to greater financial and management autonomy and greater responsibility for planning and budgeting. Each district has the administrative and technical capacity to plan, organize, supervise and develop its own health care services. Decentralisation has also been successful because of the launch of programs of administrative change that improved the quality of governance. These initiatives have served as an important instrument in reinforcing good governance. Such initiatives reinforced the decentralisation to be as not for providing health access to all citizens, but also to

give power to medical districts to make decisions regarding the management and financing of health services.

The third important lesson is that was done by establishing two authorities in order to achieve cooperation and coordination between ministries. The Ministerial Council for Services consists of ministers from the various service ministries (Health, Education, Housing, Roads, Transportation, Water and Electricity) in order to follow up performance of the federal government authorities when implementing the general policy of the UAE government and to achieve cooperation between service ministries for implementing goals and progress. Besides the Ministerial Council for Services, there is the EHA, which encourages cooperation between the federal and local health authorities. These agencies seek coordination between the MOH and the service ministries, and between the MOH and local authorities, to help the ministries and local authorities work together to achieve successful performance and health goals.

Another important lesson is that the UAE has focused on managerial accountability and performance measurement and the important role they play in fighting corruption and providing a clear line of accountability and efficiency. In particular, the UAE government has paid attention to enhancing professional accountability through a code of ethics, professional conduct and regulation in order to achieve government objectives. This has been accomplished by holding doctors as well as all other health professionals accountable for the quality of service provision, and by maintaining the highest standards of health care. Regarding consumer accountability, it was discovered that the UAE government has established a number of initiatives to strengthen accountability. These focus on the involvement of citizens in the oversight of government health performance. This has opened a window of opportunity for citizens to participate in evaluating the government's performance in the health care sector and improving public health services. With regard to finance, there has been a financial accountability improvement programme for the public sector. The UAE government has paid attention at federal and local levels to ensure the safety of public funds. This has been achieved by information audits, performance audits, investigations, and best practice guides. These procedures served as significant instruments to enhance a high level of financial accountability in the country. The government also understood the importance of fighting corruption by setting up the

Fraud Control Framework, which is a system of coordinated measures put in place by organisations to prevent, detect and respond to any instances of fraud. This chapter has found that the UAE applies program budgeting which makes strong links between spending and performance. This type of budget has contributed to strengthening the transparency of the budgetary process, making better use of the resources of the UAE, improving allocative efficiency and productive efficiency as well as public sector service delivery, and enhancing accountability.

The findings of this chapter will lead to recommendations as to how the Libyan public health sector (Chapters 5 and 6) can learn from the experiences in the UAE.

Chapter Four: Socio-Economic, Political Environment Contexts of Libya

4.1 Introduction

The political, economic and social environments of a country can be seen as systemic factors which may have an effect on health policy (Buse et al., 2005). The Libyan public health sector is no exception. The public health sector is expected to be developed in response to changes in the socio-economic and political environment in Libya and an examination of this environment should precede the study of any aspect of its public health sector. The purpose of this chapter is to examine the historical context of socioeconomic development and politics and policy making in Libya.

4.2 Background

Libya is located in North Africa and has borders with Algeria, Chad, Egypt, Niger, Tunisia and Sudan, with a Mediterranean coastline of 1,800 kilometres (see Figure 4.1). The country has an area of 1,774,440 square kilometres, making it the fourth largest African country in terms of size. Its climate is pleasant along the coast but dry and extreme in the desert interior. More than 90% of the country is desert or semi-desert terrain. According to Trading Economics, the estimated population in 2013 was approximately 6,200,000 (<http://ar.tradingeconomics.com/>).

Figure 4-1: Map of Libya



Source: <http://www.infoplease.com/atlas/country/libya.html>

Regarding its recent history, Libya has been subjected to foreign control of various types: Ottoman rule (1551–1911), Italian occupation (1911-1943) and a British-French administration (1943-1951) (St. John, 2006). During the period 1551-1911, Libya became followed the Ottoman Empire. The weakness of the Ottoman Empire in the early years of the 20th century led to a decline in its hold on Libya. This encouraged Italians to invade Libya in 1911. Under the Italian occupation the country suffered from deprivation of education, health, housing and other essential aspects of the infrastructure; this, together with the colonial master-servant relationship and hostility with locals was the reason for the countries underdevelopment problems. The extent of the Libyan problem was widespread, and affected more than one generation (Farley, 1971:79). With the advent of World War

II, Italy was thoroughly trounced by the British and French in 1942 and Libya came under British (Tripolitania and Cyrenaica) and French (Fezzan) control (Simon, 1987). In 1951, the UK brought independence to Libya, achieved by King Idris Senussi's alliance with the British government, and the UK and USA signed an agreement that prevented the Soviet Union from any influence in the country (Ahmida, 2012).

Islamism, Arabism, and tribes are important components because they constitute a template for Libyan culture. Since Islam came to Libya in 642 AD it has played a significant role in impacting on the structure, values and attitudes of Libyan society: it is the main unit of loyalty and identity, and has contributed greatly to the formation of political, social and economic life (El Fathaly et al., 1977:11). In terms of Arabism, the majority of the population is Arab: there are other ethnic groups, e.g. Berber, Tibu, and Tuareq, but these form only about 10% of the total population of Libya. As Golino writes:

Despite the particularism represented by the Berber, Tuareq and Tibu, however, Arabic represents the dominant cultural linguistic element in the pattern of Libyan national identity formation. Libya is in this sense more closely identified with the eastern Arab world dominated by the Arab cultural renaissance emanating from Cairo. (1970:345)

Thus, Libya shares common cultural values, language, religion and other social values with the Arab countries. This Arab culture has a significant role in shaping Libyan cultural values (Vandewalle, 2008).

As mentioned above, tribal society in Libya consists of Arab, Berber, Tibu and Tuareq tribes. Tribe has played a considerable role in the history of Libya and anti-colonial movements as well as in the process of formation of the state and its institutions. Since independence in 1951, tribe has been a major component in the relationship between state and society. Gelvin observes the following:

Tribal units that exist in the Arab world today are as much a part of modern political and social life as parties and trade unions. As a matter of fact, it is because of the weakness or absence of other institutions in Yemen and Libya - from government ministries to parties and trade unions - that the state turned to tribes to perform functions it could not otherwise carry out. (2012:78)

EL-Katiri argues that, during the period of monarchical regime (1951-69), the alliance between King Idris and the tribes was the power base for his rule, with the tribal

nobility constituting a significant part of the King's cabinet, serving as advisors and confidants. With regard to the Qadhafi regime (1969-2011), the tribes were used politically in order to strengthen and stabilize his regime. For example, Qadhafi sought to create problems between tribes that had experienced conflict between each other in the past. Thus he strengthened his power by effectively playing the tribes against each other. Qadhafi also appointed several blood relatives and members of tribes loyal to him to key security and military positions in order to strengthen his security control in the state. In 1990, he established the People's Social Leadership Committees: tribal and regional notables became the main members of these new committees, which took over a number of social and bureaucratic functions from the central state. This committee served a variety of purposes which included settling local conflict and directing the society to support the regime. During the February revolution period, tribes played a vital role in discussing the security and political situation, prompting issuance of a number of loyal statements in support of either Gadhafi's regime or that of the rebels (2012:9-14).

4.3 Socio-Economic Context

For approximately 10 years after political independence in 1951, Libya was one of the poorest countries in the world with over 70 percent of the labour force working in agricultural and animal husbandry (El Fathaly et al., 1977:16). In the late fifties the World Bank sent a team to assess the socio-economic situation of the country and the people. The team published its report in early 1960, concluding that Libyans live a very simple life, their food is simple, their necessities are limited, and their knowledge of the twentieth century technology very limited. The majority are farmers who consume most of their production. Their living quarters are very poor, and the majority live in shacks, hamlets and in caves. They use donkeys, camels and horses for transportation (The Economic Development of Libya 1960 cited in Kilani,1988).

Since September 1961, when Libya began exporting oil, the country's socio-economic and political developments have been linked to its oil sector. By means of its oil wealth, the Libyan economy moved from the third poorest country in the world to an economy that has the ability to make development and great changes in social structure. As Fathaly and Palmer (1980) write, the outstanding characteristics of the Libyan economy in this period were the transformation from a stagnant to a rapidly growing economy and the predominance of the oil sector. Within eight years of the

first oil shipment, Libya became the world's fourth largest exporter of crude oil: "eventually; this dramatic change was reflected in the government budget and national economy" (Ibid., 21). Consequently, the entire way of life of Libyans changed within a very brief period of time. For example, Libya's 1962 income of \$86.698 million rose to \$1,080.912 billion and became \$6,999.290 billion by 1975 (Ibid., 22).

With the rapid growth of the oil industry, old societal values that held sway before oil exploration began to give way to new ones. Libyans had improved living conditions as they had access to more money. As Sanger (1975:414-15) noted when he attempted to describe how oil revenues developed the Libyan society:

The oilfields were pouring out undreamed-of wealth and most of it was being wisely used. The people were better clothed than ever before, and there was a vast boom in middle and lower income housing. Millions of dinars were going into paved roads and better streets, new parks were being opened, new sports areas built for boys and girls alike. Educational opportunity had become universal, with thousands of young men and women attending advanced schools...The position of women had changed greatly, largely for the better. Medicine was nationwide and free, with hospitals and medical centres in every town and clinics in most villages. Libya was short of doctors and female nurses, but the population now saw hospitals as a hope for recovery, not a place to die.

Through a large-scale redistribution of its oil revenues, Libya was able to use its oil wealth to develop the country through a series of five-year development plans aimed at maximising the economic and social welfare of the Libyan people. The first five-year development plan was launched in 1963. This focused on building the foundation of economy for development as well as giving infrastructure a facelift. The objective of the first plan was to develop needed human resources and economic infrastructure. Both plans were to be achieved through investing in education, transportation, housing, education, and health. The plan was estimated to gulp \$ 1,234,000,000 broken down as follows: 43% for public works, transportation and communication, 11% for housing, 10% for agriculture, 9% for education, and 5% for industry, and 4% for health (El fathaly et al., 1977:18-19).

On 1st September, 1969, the Libyan army announced an end to the monarchical system in Libya and established the Libyan Arab Republic. The new Libyan regime

adopted socialism as the prevailing ideological framework. The first full development plan after the coup was a three-year plan between 1973 and 1975. It was estimated to cost 2.6 billion Libyan dinars. The plan's top priority was provision of education and health to all citizens. Consequently, 18.4% of the total was for home ownership, and 13% for educational and health services (Ministry of Planning, 1975: 34-35).

Under the new political regime, the Libyan government nationalized some sectors of the economy, including the country's banking system, petroleum companies, and the pharmaceutical trade. The government also retained ownership of hospitals and trading companies (El Fathaly et al., 1977:20). Thus, the Qadhafi regime started what many believed was his first step on the road towards achieving socialism in Libya (St John, 2008:129).

The second development plan, for the period 1976 to 1980, was entitled "the economic and social transformation plan", and focused mainly on the development of the industry and agriculture sectors as both sectors were important to increase national production, and to achieve successful economic diversification. The total budget for this plan was 7,870 billion Libyan dinars, with 1,506 billion Libyan dinars for industry and 1,030 billion Libyan dinars for agriculture (Ministry of Planning, 1976:22-23).

The third 'five-year development plan', between 1981 and 1985, had a total amount of 10,9 billion Libyan dinars budgeted for it. The main characteristic of this transformation plan (1981-1985) was that it was to be implemented as a part of the socialism approach identified by the Green Book (Ministry of Planning 1981-1985:282). Consequently, the economic system in Libya made the country a socialist economy, with all economic activity such as production, banks, trading and contracting now under direct control of the state.

Table 4.1 below shows how the state tilted towards socialism by relying on the public sector in the development process in the late seventies. The public sector became a mechanism that provided goods and services instead of the private sector. Furthermore, the public sector became the main user of the labour force in the community (GPC,2011).

Table 4-1: Distribution of Investments Between the Public and Private Sectors (1970-1990)

Period	Public sector %	Private sector %
1970-1972	69.1	30.9
1973-1975	79.1	20.9
1976-1980	87.2	12.8
1981-1985	91.7	8.3
1986-1990	90.2	9.8

Source: Libya revolution in 30 years: 225

The tables below summarise the changes and pattern of development which resulted from the commitment of resources under successive plans.

Table 4-2: Basic and Intermediate Education; Student/Teacher

Period	Basic education			Intermediate education		
	No of pupils	No of teachers	Pupil/teacher ratio	No of pupils	No of teachers	Pupil/teacher ratio
1969/70	347100	13884	25	15300	1663	9.2
1975/76	679500	32357	21	43300	4330	10.0
1979/80	875000	54688	16	89500	7458	12.0
1985/86	1045200	69680	15	148700	9294	16.0
1994/95	1364900	74995	18.2	441300	35589	12.4
2000/2001	1202900	117931	10.2	380200	64441	5.9

Source: Libyan national authority of information and development, 2005 cited in Otman and Karlberg 2007:103.

Table 4-3: Trends in the Development of the Libyan Healthcare System (1970-2004)

indicators	1970	2004
No. of beds	7589	19499
No. of clinic complexes	1	39
No. of basic health care centres	12	306
No. of basic health units	439	886
No. of tubercular centres	9	22
No. of physicians	783	9234
No. of population per physicians	2507	800
No. of staff nurses	3037	30085
No. of population per nurses	639	207
No. of technicians	358	13387
No. of population per technicians	5098	443
No. of administrative staff	-	24071

Source: Libyan national authority of information and development, 2005 cited in Otman and Karlberg 2007:120

As can be seen from Tables 4.2 and 4.3, Libya used some of its oil wealth to develop the country through a series of development plans executed through annual transformation strategies with the sole aim of achieving maximum economic and social welfare for the Libyan people.

Libya's oil is instrumental in creating jobs, economic institutions, and development. Oil revenues strengthen the government's ability to promote and implement policies of economic and social transformation (Vandewalle, 1988). According to the role of the state, the Libyan government adopted economy policies that emphasized social welfare programs such as increased housing and improved healthcare (St. John, 2007: 77). The state's role in all stages (monarchy, Qaddafi regime, and Republic) is reflected in its commitment to the provision of basic services of health, education and housing.

In terms of the public sector, Vandewalle (1998:169-173) argues that Libya is a 'distributive state' with the state deriving its income from the sale of a commodity; so Libya does not depend on taxation of its citizens. In other words, national and local institutions emerged not to extract wealth (through tax-gathering mechanisms) but to spend it. Vandewalle provides evidence for his argument. He explains that before discovering oil Libya depended on external revenues, accrued from the rent for military bases: Libya had signed with the United Kingdom (1953) and the United States (1954) agreements setting up military bases in exchange for economic aid to balance its budget. After discovering oil, Libya became dependent on revenues that accrued from oil exports. These external revenues led to the creation of large bureaucratic structures, and the state became responsible for creating jobs. This is because Libya does not rely on mechanisms, markets, or effective economic statecraft.

In spite of the country's oil wealth, the socio-economic situation in Libya during the Qadhafi regime was characterized by a low level of social justice, and failure to combat the phenomenon of corruption. There was at the same time a lack of suitable jobs for graduates as well as failure to adopt a rewarding salary scale commensurate with the living conditions of the Libyan citizens. As El-Katirir states:

The limited market economy reforms introduced by Gadhafi in the late-1990s and during the 2000s were not sufficient to relieve poverty for a large number of ordinary Libyans, and instead were perceived as benefiting a small number of Gadhafi's family members and his inner circle of loyal friends. This bred pessimism with regard to any likelihood of positive economic change in Libya under the former regime. (2012:7)

In the same way, economic policy under the Qadhafi regime aimed at ensuring control over the population rather than economic development. Qadhafi put restrictions on foreign investment, foreign trade and the private sector, and he used state-owned enterprises and supported fuel and foodstuffs to prevent the emergence of other forces in society. As a result, the private sector remained underdeveloped and this paved the way for mismanagement which consequently induced greater corruption (Christopher et al., 2012:11). The International Advisory Board Co-Chairs issued a report in 2006 which described the human resources and skills in the country as weak:

Although the Libyan workforce has a good basic level of education and high literacy rates, there is a shortage of more advanced skills required in the job market. This is a major constraint to Libya's development which needs to be addressed urgently. (Porter and Yergin, 2006: 62)

During the last century, decreasing oil prices, corruption, loss of accountability, and low quality in the public sector prompted the state to move towards economic reform by adopting a policy of privatization in 2003 (St John, 2008). Qadhafi realised that the path of socialism had failed; in September 1988 he called for an end to government control over trade in order to increase the role of the private sector (St John, 2008). Between 1987 and 1989, the government passed a new selection of laws and, for the first time since 1977, allowed limited private sector investment in Libya. In 2003 Qaddafi called for privatization as a part of economic reform, stating that the nation's public sector had failed and should be abolished (Ibid). The privatisation of what was perceived as strategic companies and the establishment of the Libyan stock market clearly reflected the shift of the country's ideology towards liberalization (Alafi and Bruijn, 2009). As a result of the reduced state control of economic activity, the private sector began to take part in economic activities, and the country witnessed private companies that provided health and education services. However, the policies reform failed for a number of reasons such as the lack of political will in support of reform, Libya's failure to bring in foreign investment because of financial and administrative corruption, and a lack of legislation that defined the role of the private sector (Mogherbi, 2005). The government also failed to take action to address the greatest obstacles facing the economic reform, namely corruption, mismanagement, and centralization (Alafi and Bruijn, 2009). As mentioned in the report issued in 2005 by the IMF, the long legacy of centralization and past shortcomings in policy formulation and implementation created a huge challenge that constrains reform in Libya. To overcome these problems, as recommended in the World Bank report in 2009, Libya needs to pay attention to the improvement of accountability channels involving three players - policymakers, service providers, and clients - with solid institutions and enhanced transparency.

According to Porter and Yergin (2006), the public sector in Libya is inefficient as they lack standards and good management. This report offered an evaluation of three public sectors as follows:

Education: Despite high literacy levels and enrolment ratios, the Libyan education system is not providing the skills required to drive the economy forward. The system suffers from poor quality curricula, teachers and infrastructure; and from structural problems such as the lack of objective standards and inefficient allocation of public resources. Healthcare: The healthcare system faces serious challenges: poor service quality in the public health system, particularly in primary healthcare; inefficient allocation and use of public resources, both in the employment of health workers and the purchase of medical supplies. Behavioural risk factors are also increasing, such as the incidence of non-communicable diseases, poor road safety and water contamination. Housing: Poor urban planning has reduced the supply of land available for urban development. The uncertain legal position on property ownership also deters private individuals and companies from investing in residential property construction. (p4)

In general, the public sector plays an important role in the delivery of public services; this is because of the nature and role of the distributive state which depends on a monopoly of economic activity and restricts activities that allow the emergence of private companies.

During the period of revolution that lasted approximately eight months, the revolution had an unprecedented impact on the Libyan economy. As noted by the World Bank, “Oil production fell from 1.49 million barrels per day (bpd) in January 2011 to as low as 22 thousand bpd by July 2011 as a result of the conflict”. Consequently, Gross Domestic Product and growth declined by 60 percent as oil production declined to an average of 500 thousand bpd by the end of 2011. Non-oil output growth also declined by 50 percent as economic activities were interrupted. Approximately 600 thousand migrant workers fled Libya during the 2011 civil war, making it the largest migration crisis since the first Gulf War of 1991. In addition, food and cash shortages were reported in different parts of the country (<http://www.worldbank.org/en/country/libya/overview>).

After the victory of the revolution in Libya that preceded the first democratic electoral process, there was a new parliament and government in place. This led to a situation where the Libyan economy experienced an impressive recovery as oil production and exports rebounded faster than originally predicted. The National Oil Company subsequently announced that total oil production for the first seven months of 2012 reached 302 million barrels, equivalent to an average of 1.42 million bpd.

As discussed earlier, the Libyan economy depends on oil as a single commodity, and as a source of income with which it provides public services. This led to the dominance of the public sector over the economic activities. Most of the government organizations/enterprises were established by the state directly. Due to the role of government as distributive state, the state assumed the sole responsibility for providing all services including health, education and the provision of law and order. By undertaking to carry out all the country's needs for modern services, the government extended its role and involvement in the socio-economic activities of the nation.

4.4 Politics and Policy Making In Libya

Libya has experienced three political regimes, namely a monarchical regime (1951-1969), the Qadhafi regime (1969-2011), and a democratic regime (2011 to the present). Below is a discussion of politics and policy making in these regimes.

4.4.1 Monarchical Regime in Libya

Libya became an independent state under the auspices of the United Nations on December 24, 1951. The country was divided into three provinces, namely Cyrenaica in the east, Tripolitania in the west, and Fezzan in the south. Mohammed Idris El Sensei headed the first kingdom of Libya. He is seen by many to have emerged with the active support of tribal and religious elements (El fathaly et al., 1977:21-23). Although the king had wide powers, he rarely expressed support for any specific programs or took a clear-cut position on public issues. This was attributed to the king devoting himself full-time to religious and tribal matters (El Fathaly and Palmer, 1980:16-17).

Following this was a period between 1951-1963, when Libya witnessed a federal system that resulted in the presence of local authorities along with federal authorities. Federal authorities represented by Articles 41-42-43 of the constitution of

1951 comprised three branches: legislative, executive and judicial. The Federal Legislative Authority included the king and parliament, which consisted of two chambers: the Senate and House of Representatives. The Senate was made up of 24 members representing the provinces, half of which were nominated by the king while the other half were elected by the provinces. The House of Representatives consisted of members that were elected through universal suffrage. In terms of policy making, the Senate was entitled to put forward any draft of law with the exception of financial issues, which required the approval of the king. All laws and financial issues required joint approval by the king, the Senate and the House of Representatives. In addition, the members of the Senate and House of Representatives had right of oversight over the prime minister and ministers. Achieving this, takes any of the following processes of questioning/interrogation, investigation and ministerial responsibility (Mirza, 1969).

The Federal Executive branch consisted of the king as the Supreme Head of State and the Council of Ministers. The Council of Ministers was made up of the Prime Minister and Ministers. According to Article 72 of the Constitution, the king chose the prime minister and ministers. He also accepted his resignation, should this happen. The role of the prime minister and ministers was to realize public policy of the state and to achieve co-ordination between federal government and local government. In addition, the prime minister also served as the Supreme Head of Civil Service with the function of oversight, coordination and guidance of state employees (Mirza, 1969). Consequently, executive power in Libya was vested in the Council of Ministers headed by the prime minister. As noted earlier, the prime minister was appointed by the king through decree. Some ministers of the Cabinet were appointed by the king and parliament on the recommendation of the prime minister. Furthermore, the Cabinet controlled the state institutions as it was responsible for the general policy of the government and execution of the same. Each minister in the Cabinet held one or more portfolios. The prime minister and his ministers were accountable to the king and the parliament. In terms of the health policies of the state, health policy was enacted to develop health infrastructure. This was to shore up the government's responsibility in the provision of health services and the establishment of hospitals and health care centres.

However, in practice, during the period of federal formula (1951-1963), all governments attempted to execute effective economic policies, but local

governments and the king's entourage obstructed the work of the central government (Vandewalle, 2012:49). This was due to the failure of what the to determine the precise political relations between the central government and local governments (Vandewalle, 1998:46). The federal regime contributed to the creation of political conflict between federal authorities and the provinces, because the provinces considered themselves as independent entities. Consequently, they arrogated to themselves the right to formulate public policy in isolation from the federal government. As a result of this, and the high cost of maintaining the system, the federal system came under criticism (Ben-Halim, 1992).

In 1963, the political system in Libya saw changes following the constitutional amendment adopted in April 1963. This change transformed the country from a federal to a unitary form of government. The legislative authority was made up of the Senate and House of Representatives to the exclusion of the local government system. The country was thus divided into districts with a single executive authority (Mirza, 1969).

The establishment of the unitary form of government was one thing the monarchical system became known for because it forced the national government to concentrate on planning, administrative and economic issues. Transformation of the federal system to a unitary system was not as a result of political willingness or of the provinces' administrative capacity but rather because national groups wanted to achieve economic development and integration in the state. In reality, the abolition of the federal regime and the adoption of a unitary system led to the creation of efficient institutions, bureaucracy and effective cooperation between the king and the Council of Ministers (Vandewalle, 1998:51-53).

Under the constitution, legislative powers were given to the Senate, House of Representatives, and central government to make laws and execute the same. This they did in addition to playing an active role in guiding the government and ensuring accountability. With regard to political parties, they were not permitted in Libya as the king saw political parties as antithetical to Libyan interests since they received guidance and funding from outside its borders. At the same time, the King was keen on the rights and interests of citizens and gave them the maximum amount of freedom (Ben-Halim, 1992).

On the whole, the monarchical regime sought to bring about a comprehensive transformation in Libya's socioeconomic and political life. In terms of the

modernization processes, the monarchy established constitutional and political institutions for the formulation of public policy in the state and monitored their implementation. However, these institutions were controlled by the ruling elites. This appeared to contradict the desire of the Libyan governments to invest oil wealth in enhancing the efficiency and effectiveness of the economic development as well as to meet the needs of its population in terms of education, health and job opportunities.

4.4.2 The Qadhafi Regime

On 1 September 1969 a coup led by Mu'ammarr Qadhafi ended the monarchical regime. He became the chairman of a Revolutionary Command Council (RCC) (Vandewalle, 2012). After 1969 Libya witnessed significant shifts, both in the ideological framework and structures of the political system. The historical evolution of the political system can be tracked by considering it under the following time frame: the first period from 1969 until 1976; and the second period from 1977 to 2011.

In the first period (1969-1976), the military was an essential tool in governance, after the RCC cancelled the monarchical regime and all institutions such as the Legislative Council and the Council of Ministers. In order to control the political and administrative institutions, the RCC also destroyed the political and economic elites of the monarchy. On September 8, 1969, the RCC appointed civilians to the Council of Ministers but reserved complete authority in all areas to itself. The RCC thus became the supreme authority in the state, issuing proclamations, laws, and resolutions. It ensured the support of the armed forces oversees and the activities of the government and created new institutions to promote the objectives of the revolution (Ronald B, 1987 cited in Obeidi, 2001:137-138).

In December 1969, the RCC issued the constitutional proclamation which outlined the structures of the political system with the RCC as the highest political authority in the country. It formulated and oversaw the execution of public policy, the appointment of the Council of Ministers, the establishment of public institutions, and the appointment of senior civil servants and military personnel. Under this regime, the Council of Ministers consisted of the prime minister and the ministers: the executive and administrative authority. They were responsible for the implementation of the public policy of the state as laid down by the RCC.

From the above discussion, the RCC can be seen as the highest political authority, since it exercised power of legislation, formulated public policy and appointed the Council of Ministers as well as senior staff in the public service. As Vandewalle (1998:96) states: "The real power remained with the RCC". Although the RCC was the highest authority in the country, Colonel Qadhafi succeeded in singling out for himself full power after the exclusion of his comrades from the RCC (Almagariaf, 2001).

In order to mobilize the population toward the regime, the RCC established the Arab Socialist Union (ASU) on June 11, 1971, with the aim of reducing the power of traditional identities and institutions. Furthermore, the RCC issued a law to criminalize partisan action and any political activity outside the ASU; a crime punishable by death (Vandewalle, 2012:88). According to Obeidi (2001:138), this organisation was one of a series of experiments made by the RCC in order to establish a structure for political participation, but the experiment failed, especially with regards to mobilisation and participation. El-Fathaly et al (1977:95) offer the following reasons which, in their opinion, were responsible for the failure of the AUS to achieve the goal of political participation: (1) negative preconceptions based on the Egyptian counterpart, (2) a complex organisational structure which confused the public, (3) a failure to understand the traditionalism of the public and the central role of traditional leaders in the development of public perceptions, and (4) a failure to coordinate with the new modernising local officials.

El-Kikhia (1997:45-46) argues that the RCC during the first four years succeeded in formulating public policies that played a major role in building houses, factories, roads, hospitals, and other infrastructure, but the ASU failed as a political structure to encourage participation and lost its popularity. El-Kikhia also notes that the failure of the ASU confronted the political leadership with two choices:

The choice facing the Libyan leadership was whether to continue duplicating the Egyptian experiment or to develop an alternative set of principles that would make the Libyans more amenable to change by first encouraging their involvement in the decision-making process and then by handing them the difficult task of helping themselves. What was adopted was a combination of the two: a solution that reflected the unsettled divisions within the RCC. (P46)

On 15 April 1973 in Zwara, Qadhafi announced a five-point program (cultural revolution) to revolutionise the administrative structures of the government by turning the masses against the inefficient, corrupt bureaucracy, and abolishing outdated laws (Obeidi, 2001:139). He imposed a five-point program as follows:

- the annulment of all laws in effect, and the continuation of the revolutionary work with the establishment of new procedures and penalties;
- purging the country of deviationists was to be tolerated. They conspired against the revolution. This applied to people who "preach communism and capitalism as well as Muslim Brethren if they engage in clandestine activities";
- freedom belongs to the people and not to its enemies: arms would be distributed to the people for whom the revolution was started as an experiment;
- to launch an administrative revolution; and
- to launch the cultural revolution. (Ministry of Information and Culture, cited in Obeidi, 2001:139)

El-Fathaly and Palmer claim that this five-point program "Became a first step toward popular involvement... the Libyan cultural revolution was far closer to Yugoslavian and Algerian experiments in worker self-management than to its Chinese namesake". El-Fathaly et al., note that the popular revolution provided an opportunity for citizens to participate in decision-making processes:

The popular committees, in addition to their administrative responsibility, were given full legislative authority in what might be called, broadly, service functions. Decision about health clinics, minor roads, schools, sewage, water, parks, and so on, were within the policy domain of these municipal level committees .the provincial committees were given responsibility in many of the same functions, but tended to have determinative roles where the scope of the function crossed municipal boundaries.(1977:96)

The aim of the Cultural Revolution was to increase Qadhafi's control over political life by destroying traditional power centers; as El Kikhia points out, "To destroy the traditional centres of power in the state and replace them with popular rule as manifested by the people's committee" (1997:48). Vandewalle (2012:85) argues that the popular revolution was meant to create a locally based youthful leadership drawn from the lower-middle and lower classes in order to destroy the country's traditional

elites. This led to a situation where the country's new bureaucratic cadres were highly inexperienced. The popular revolution produced a large amount of administrative and bureaucratic chaos in the country. In practice, Qadhafi invited the public to implement this revolution. During April and August 1973, some 2,400 popular committees were formed to undertake the revolutionary tasks. This led to situations where executive managers were forced to step down in public sectors, which created administrative chaos in the country (Nellis, 1983).

Qadhafi's declared motivation for a popular revolution was mobilisation of new political resources. But in reality, the aim was destruction of the traditional centres of power in the state. El Kikhia has analysed that first period and writes the following:

With all dissent quelled and the country firmly under his control, Qaddafi had free hand to shape the country's future. Before 1975, the newly created institutions were still too weak to be used to impose radical political and economic change. The new environment provided Qaddafi with all the power he needed to impose change. (1997:51)

In 1976, Qadhafi published the "Green Book" and was ready to launch the new era of a restructured political system in Libya. The Green Book consists of three parts: Part 1, the solution of the problem of democracy; Part 2, the solution of the economic problem; and Part 3, the social basis of the third universal theory. Qadhafi named the Green Book the "Third Universal Theory" because he believed that his theory came after the two theories of capitalism and communism.

Qadhafi's ideology was based on a criticism of the political theories and economic models in the world today; he argued that neither liberal democracy nor communism had dealt effectively with the many problems plaguing contemporary societies. This is because they failed to put power and wealth in the hands of the people. Furthermore, Qadhafi claimed that capitalism had failed because it focused interest on the individual, while communism emphasized the collective and ignored the individual. Qadhafi's theory aimed at correcting the shortcomings of communism and capitalism. Its application was direct democracy which was the ideal based on popular congresses and popular committees, and he did not see political parties as democratic instruments, because the sovereignty of the people was indivisible. Parties govern on behalf of the people but his principle is that there should be no representation in lieu of the people (El-Khawas, 1986:15-20).

It is important to understand that Qadhafi's theory was the main pillar of the Libyan political system in the orientations, public institutions and public policies during the period 1977-2011. As Vandewalle states:

The Green Book clearly represented a turning point for the Libyan revolution: it was simultaneously the culmination and codification of Qadhafi's earlier thoughts and the guideline to a new political and economic system for the country. (1998:91)

This stage is characterized by the disappearance of the military tool in governance (RCC), and the application of direct democracy, as expressed by the Green Book. On 2 March 1977 Qadhafi announced that the "Era of the Masses" had arrived, and he renamed Libya "Al- Jamahiriya al-arabiyya al-libiyya al-sh'abiyya al-ishtirakiyya" (Vandewalle, 2012:105), and the transformation of the political system from a republican system to a Jamahiriya system that would build on the Green Book (popular conferences decide and the popular committees implement).

The Green Book was drawn from the path of socialism in Libya. Socialism was seen by Qadhafi as a redistribution of wealth, resources, and self-management. This approach was translated into law, tightening controls over private enterprise and shaping a new stage. The management of the economy became increasingly socialist in intent and effect, with wealth in housing, capital and land being significantly redistributed. The government controlled trade, and private enterprise was virtually eliminated and largely replaced by a centrally controlled economy (St John, 2008). All social and economic policies had objectives in line with the ideology of socialism as described by Qadhafi.

The declaration provided the definition of the political system in Libya. This was based on direct democracy as defined by the Green Book. The political system, according to the declaration, established people power which gave people the right to participate politically, economically and socially. This Qadhafi achieved through the Basic People's Congresses. The structure of people power or 'direct democracy', according to the Green Book, comprised four key elements. These are covered below:

4.4.2.1 The Basic People's Congresses (BPCs)

In accordance with Article 3 in the Declaration on the Establishment of the Authority of the People,

- (1) people are divided into basic People's Congresses; (2) all citizens register themselves as members of the basic People's Congresses in their areas; and
- (3) every basic People's Congresses shall choose from its members a committee to lead the congress. (El-Khawas, 1986:192)

Each BPC had an administrative secretariat that was appointed by the members of the BPCs. The BPCs met once every four months in order to discuss local issues, laws and public policy of the state, then the administrative secretariat transferred its decisions and recommendations to the General People's Congresses. In addition, the People's Committees were held accountable for their decisions to the BPCs, because the People's Committees were elected by congresses (Otman and Karlberg, 2007).

In practice, people took a passive role in the BPCs. Obeidi suggests a number of reasons for the passivity and the lack of motivation:

- (1) First, some people stayed away because they were not familiar with such an experiment. Others attended the BPC sessions but did not take an active role in the discussions; and (2) some of the Revolutionary Committee misused their duties and functions and became dominant in the BPCs. The Revolutionary Committees are regarded by the Libyan system as an instrument of the People's Revolution, as a means to guide the masses... But among the population there was a feeling that decision-making in the BPCs was dominated by particular groups. Theory proved to be very different from practice. In theory the BPCs were the main decision-making institution through which people were involved in the political process at the grass-roots level. The people and the people alone were supposed to have the prerogative and indeed the authority to make-decisions, with no veto over the people's power. (2001:142-143)

The imposition of the agenda of BPCs from the top meant that the members of congresses did not have the capacity to formulate and amend public policies or bills. Consequently, the BPCs became incapable of solving the problems of society that

included poor public services, lack of planning, the collapse of infrastructure, and the disruption of development as well as lack of control over the corruption caused by the lack of transparency and accountability in the country.

The researcher believes that the unwillingness of large segments of the Libyan society to attend the BPCs is in itself a true indicator of the failure of the entire experiment. This can be attributed to the inability to achieve any degree of political participation or any degree of efficiency in the administration of Libya (Obeidi, 2001; Vandewalle, 2012).

4.4.2.2 The People's Committees (PCs)

As discussed above, In 1973 Qadhafi announced the popular revolution that led to the abolition of bureaucratic management and replacement of this with People's Committees in the municipalities and provinces as well as public institutions. The Green Book rejected the hierarchical bureaucratic structures inherent in modern states. Qadhafi saw bureaucracy as an instrument used by the ruling class to control the community, and these bureaucratic institutions prevented individuals from directly managing their own lives (Vandewalle, 2008). The solution of the problem, as provided by Qaddafi, was self-management, which gave people the opportunity to take part in political structuralisation and broke the monopoly of power. In reality, the self-management as applied led to administrative chaos because public managers were appointed to key positions in economic, financial, and social institutions; they were loyal to Qadhafi and were members of revolutionary committees. The self-management or popular management paid little attention to efficiency standards that should be applied when appointing managers. In the case of the health system, popular management led to poor management and administration and a poor healthcare service because of the absence of clear policies and lack of smooth procedures to assure a fair and just delivery of healthcare (Bakoush et al., 2007).

The PCs were administrative tools chosen by the BPCs. According to the Green Book, they were management committees taking the place of the government administration, with the aim of managing all local and national institutions. They were accountable to the BPCs, an executive instrument for formulating public policy by the BPCs, and could be divided into the following levels:

- i. General People's Committee: This represented the highest level of the People's Committees system: it was chosen by the General People's

Congress and was responsible to that congress. The Committee consisted of the Secretary General (the Prime Minister) and a group of Secretaries (Ministers) for the different sectors (education, health, economy, etc.). Each Secretary headed the popular quality (specialized) public in its sector.

- ii. People's Committee of the Municipality: chosen for the municipality by the members of the Municipal People's Congress. This consisted of the Secretary General, and a group of trustees responsible for different sectors (education, health, economy, etc.).
- iii. People's Committee for Municipal Branch: chosen for the branch by the Municipal People's Congress of the municipal branch. This consisted of the Secretary General and a group of trustees responsible for different sectors (education, health, economy, etc.).
- iv. People's Committee of the Basic People's Congress (Mahalla): chosen for the locality by the Basic People's Congress, which consisted of all adult citizens. The committee consisted of the Secretary, and a group of trustees responsible for different sectors (education, health, economy, etc.).

Theoretically, the structure of the PCs as an administrative system was based on decentralization. It provided an opportunity for political participation and speed in completing tasks as well as achieving efficiency in administrative work. The PCs also contributed to formulating development plans and participated in decision-making processes. It encouraged the people to participate, thus promoting the involvement of citizens in the decision-making process, and created transparent, decision-making institutions. As a result, the process became accessible to and understandable for the general public (Wimmer, 2009:425).

In reality, this popular management was characterized by a centralized system with a strong power structure which resulted in a lack of independence in decision-making at all levels. In addition, policy formulation and execution in Libya under Qadhafi was tied to one man, thus denying Libyans the opportunity to have a stake in the process. Vandewalle provides an analysis of the weakness of political institutions in Libya and observes that it had no real authority to make decisions:

The regime had managed to destroy, reshape, or reorganize many of the institutions of the state in the name of popular rule. Simultaneously, it had created a carefully controlled system of patronage managed by the remaining

RCC members, the top military elite, and the cluster of Qadhafi loyalists at Bab al-Aziziyya who, in contradiction to the official policies of popular rule and popular management, controlled access to the country's main spending institutions-its ministries... but reality was starting to him in the revolutionary rhetoric: the pursuit and implementation of statelessness could not disguise that the Popular Congress and Committee system, as well as the General People's Congress, possessed no real power.(2011:136)

4.4.2.3 The General People's Congress (GPC)

The General People's Congress (GPC) was the highest political authority in the country and the instrument of government with legislative and executive powers. It consisted of Trustees of the BPCs - Trustees of the PCs of the municipalities – and Trustees of professional conferences. The GPC had the power to pass laws and public policy of the state. This was expected to be discussed by citizens and approved in their Basic People's Congresses (BPCs).

As previously noted, the above institutions were applied with the “Masses” as embodied in the BPCs, the PCs, and the General People's Congress , but these institutions were merely theoretical. Although the political system provided an opportunity to participate in the political process, the political institutions suffered from structural problems that led to the lack of confidence of citizens in their political effectiveness. A study conducted by Amal Obeidi in 2001 in order to investigate the attitudes of citizens towards political participation in Libya confirms this. Amal Obeidi argues that the lack of political efficacy indicated that the political regime in Libya showed “deep-seated structural problems”. The system of people's congresses and people's committees did not have any real power in the formulation and execution of public policy (Vandewalle, 2012).

According to El Kikhia, the system of BPCs and PCs in Libya exhibited problems and Qadhafi announced that the aim of the People's Committees was to weed out those who were opposed to the ideas of the Green Book. This resulted in those people being excluded from participation, and an increase in the number of Libyans who became dissidents outside Libya for failing to conform to Qadhafi's ideology. The political system did not allow any compromise because it saw compromise between government and opposition as a threat to its validity and its ability to function. Libyans dissidents were forbidden from receiving any benefits from government.

Another problem was the inability of leadership to keep in touch with local governance because of the absence of a political party (1997:54-56). In fact, the Qadhafi regime was prepared to do anything to remain in power. For example, on 29 June 1996, 1200 prisoners in Abu Salim prison were executed by the regime because they demanded fair trial and good health services (Human Rights Watch, 2009).

4.4.2.4 Revolutionary Committees (RCs)

In formal terms, Qadhafi did not have an official place in the system, because he described himself as a revolutionary leader and thinker. In reality, he was the main actor who affected the policy-making process. To this end, Qadhafi created the RCs in 1979 in order to maintain his regime and create elites that were loyal to him. The RCs were not formal structures of the political authority, and these committees did not form part of the Third Universal Theory. The duties of the RCs were as follows:

- inciting the masses to exercise authority;
- firmly establishing the people's authority;
- practicing revolutionary supervision;
- agitating the Popular Congresses;
- directing the Popular Committees and the secretariats of the congresses to the right path; and
- protecting, defending and propagating the revolution. (Mattes, 1995 cited in Obeidi, 2001)

Although the Third Universal Theory rejected the party system, the RCs were similar to a political party, in that they became extremely powerful, and had a control function over all the state in terms of formulating and implementing policies. These RCs also played a significant role in selecting ministers, public managers, and the heads of universities, colleges and departments. In addition, they established the revolutionary courts, which brought anti- Third Universal Theory to trial (Naur, 1986). In this sense, the RCs became an undeclared political party during the Qadhafi regime and the main authority for controlling the state. According to Mattes (2004:13-14), the RCs were created to safeguard the Qadhafi regime and two factors contributed to this task. Firstly, the RCs were spread throughout the country and were mostly made up of dedicated followers of the ideology developed by Qadhafi. Secondly, they were well armed and well equipped, for example in

telecommunications. With regard to the role of the RCs in the policy-making process, Vandewalle writes that “In reality the revolutionary committees increasingly set and enforced agendas at local congress meetings, often through intimidation. They became the only institution allowed to engage in revolutionary activities” (1991: 223). From the above discussion, it is clear that the political system in Libya during the period 1969-2011 should not be seen as expressed by its official structure (Popular Conferences and People's Committees), since the formal structures of the political institutions lacked political effectiveness and competence. In reality, the centre of power was Qadhafi who played the main role in decision-making, formulation of policy and execution of the same. Moreover, his sons and the revolutionary committees had the power to influence decision-making. The prohibition of political organizations such as political parties, together with the inability to create effective institutions, to achieve development and to fight corruption, were the main reasons for the loss of legitimacy, effectiveness, and efficiency.

4.4.3 The 17 February Revolution

The precedent set by the successful removal from power of the Tunisian and Egyptian presidents, Zine El Abidine Ben Ali and Hosni Mubarak, added desire and motivation to a wide range of other factors (economic grievances and deep resentment of the Qadhafi regime) that pushed Libyans to begin mass protests in Benghazi and other eastern cities in February 2011 (EL-Katiri, 2012:3). The revolution was initially a peaceful demonstration and protest but Qadhafi's use of heavy weapons to suppress demonstrators turned the revolution into armed-conflict that sought to overthrow Qadhafi and his regime. In this context, Gelvin (2012:84) writes that the revolutions in Tunisia and Egypt did not witness the use of violence, while the revolution in Libya and Yemen experienced an armed conflict; in both Tunisia and Egypt the army announced its commitment to protect demonstrators, while in Libya and Yemen, the military and other armed groups were divided between loyalists and opposition.

When the people of Libya rose up in February 2011, Qadhafi retaliated by launching a brutal crackdown. This situation led the Arab League and the UN Security Council to place sanctions on Libya, referring to Qadhafi's actions as crimes against humanity. On March 19, following UN authorization, NATO launched air missile strikes against Qadhafi forces focusing on the large concentration of armoured

vehicles approaching Benghazi. Benghazi was the headquarters of the revolutionary forces and home to some 750,000 people whom Qadhafi had labelled as “rats.” In order to protect civilians, a NATO-assisted assault on the Qaddafi regime led to its demise and helped protect hundreds of thousands of citizens. The result was the overthrow by rebels of one of the world’s longest-ruling dictators (Daalder and James, 2012:2-3).

During the civil war, the rebels established the Libyan Transitional National Council (TNC) in the city of Benghazi on 27 February 2011. During the combat phase of the uprising, the TNC with an Executive Team charged with the responsibility of managing the crisis as well as providing public services to citizens in liberated cities, gained international support, and claimed Qadhafi’s overseas assets (Gelvin, 2012:85). On 3 August 2011, the TNC issued the provisional constitutional proclamation which outlined the structures of the political system. During the combat phase of the uprising, the head of the TNC and its members were not elected but were selected according to their role in the revolution.

After ruling Libya for more than 40 years, Muammar Qadhafi was killed by the rebels on 20 October 2011. They eventually toppled his regime to mark the end of 8 months of civil war. Thus, Libya witnessed the establishment of a new phase of its political system. On 23 October 2011, the TNC declared the country fully liberated from Muammar Gadhafi's regime, paving the way for the formation of a transitional government to be the first step on the road to democratization and to restore stability.

According to the provisional constitutional proclamation, the aim of the TNC is to serve as the highest political authority in the country, to formulate public policy as well as overseeing the execution of the same, to appoint a government, to establish public institutions, and to appoint senior civil servants and military personnel. Furthermore, the interim government, which consisted of the prime minister and ministers with executive and administrative authority, had the responsibility of implementing public policy of the state as laid down by the TNC.

4.4.3.1 The Democratic Transition in Libya

As a result of the revolution, Libya underwent a dramatic transition from one of the world’s longest-running dictatorships with skewed political participation to one of democratic regime which gives citizens the right to participate in political activity.

After the revolution, the political community in Libya became dynamic at both the society and elite level as interaction in the project to establish the new state has developed. The direction in Libya at this time showed a tendency towards institutionalizing democracy with the introduction of both local and general elections. The local election for local councils was seen as a strong factor that can contribute to the democratic transition in Libya. In the local elections in Benghazi, Misrata and other cities, candidates who were either independent, rebels or activists won contested positions, thus indicating that the tribal factor did not contribute to choice of candidates. Local elections contributed to speeding up the process for national elections, as well as strengthening confidence in the transition and electoral process in the new Libya (ACRPS, 2012).

As mentioned above, the TNC issued a provisional constitutional proclamation that drew up a roadmap for democratic transition in Libya. This includes the establishment of the “High National Election Commission”, which undertakes the following task:

Preparation, implementation, supervision, monitoring of the election of the General National Congress and announcing its results in accordance with the principles and rules adopted for the electoral process in the Electorals Law. (<http://www.hnec.ly/>)

On July 2012, the High National Election Commission made it possible for Libyans to vote in a national ballot for the first time in almost six decades. The proportion of citizens who participated in the election was 62% (<http://www.hnec.ly/>). This election was adjudged as free, fair and transparent according to the reports of international institutions such as The European Union Election Assessment Team on Libya 2012, The Carter Center, the Arab League, and the African Union.

From the above discussion, it is evident that previous steps paved the way for enhanced democratization in Libya as well as achieving core democratic elections. Furthermore, Libya became politically plural, thus overcoming the legacy of authoritarianism and unilateralism that hitherto had undermined her quest for democracy. Consequently, the country’s political life was strengthened and this in turn enhanced its capacity to develop economic and social options and the cross-cultural interaction of free and informed participation of political actors.

According to the constitutional proclamation and the results of the first democratic elections, the structures of the political system were the following:

General National Congress: in a ceremony on 8 August 2012, the NTC formally transferred power to the General National Congress (GNC). The GNC is composed of 200 members with 80 elected through a party list system of proportional representation, and 120 elected as independent candidates in multiple-member districts. The GNC thus becomes the highest political authority in the country, formulating and implementing public policy as well as overseeing the execution of the same. Other functions were the appointment of the Council of Ministers and establishment of public institutions.

According to Article (30) of the provisional constitutional proclamation, the National Congress has the following constitutional responsibilities:

- The GNC appoints the prime minister, who in turn shall propose the ministers of his government.
- The GNC appoints the heads of sovereign functions
- The GNC will oversee the election of a constituent body to draft a constitution for the country.
- The GNC put the draft constitution to a referendum by the people.

The GNC became the first democratically elected institution, thus opening the window for citizens to have the opportunity to make public policy, conduct public affairs, choose political leaders at both local and national levels, and discuss national budget. This led to outputs that meet the demands of society.

On 1 October 2012, the GNC named Ali Zeidan as prime minister. Two weeks later, he proposed the members of his Executive from the 30 people that took part in government.

Libyan Interim Government: according to Article (30) of the provisional constitutional proclamation, the GNC appointed an interim government. This interim government consisted of twenty-seven ministries as follows: Justice, Care for the Families of Martyrs and Missing, Higher Education, Local Government, Social Affairs, Telecommunications, Defense, Youth and Sports, Interior Affairs, Education, Agriculture, Foreign Affairs, Finance, Industry, Tourism, Work and Rehabilitation, Transport, Economy, Oil, Health, Electricity, Water Resources, Islamic Affairs, Housing and Utilities, Planning and Culture.

The importance of political change in Libya is political development. In practice, the members of the GNC were given the power to formulate public policies that meet the

expectations of the society, and the GNC has the power to secure transparency of the work of the executive by discussing the policies and actions of the government, as well as auditing and making them visible to public view. Furthermore, after toppling Gadhafi's regime, Libya has witnessed the establishment of several political parties and civil society organizations, which actively participate in the democratic process. These institutions are the closest to the grassroots community and the most able to express their views.

Libya has faced challenges that have constrained state-building in an effort to move from a dictatorial system to a democratic system. The revolution was initially a peaceful demonstration but Qadhafi used heavy weapons to suppress the demonstrators, thus turning it into an armed-conflict. The local militias (Twwawr) fought the war instead of a national military and, after the war ended, security remained in the hands of these local militias, because the government was unable to take action to curb their power or to integrate them into a single national force (Christopher et al., 2012:2). The report of the Minister of Health to the GNC issued in September 2012 points out that the main challenge that faces the Ministry is the security situation, which has had a negative impact on medical elements committed to providing better services. In addition, the killing of the U.S. ambassador and the attack on the English and Italian Embassies indicate that there is security chaos in Libya. Security is the biggest challenge: without it, programs for promoting the democratization transition and projects for development and modernization will fail.

The ousting of the Qadhafi regime, apart from liberating Libya from four decades of authoritarian rule, has also left a legacy of weak institutional capacity that will remain for several years. Gelvin argues that Libya is a weak state and cites four characteristics that demonstrate this. Government institutions are not strong but they have survived more than four decades because the Qadhafi regime adopted strategies that ensured their survival, including the support of the elite, who have power and wealth and work to suppress opponents in order to maintain a regime without any group and institutions. The second factor is that during the Qadhafi regime, the state functioned as a centre for redistributing revenues rather than for planning and development. The third factor contributing to state weakness in Libya relates to the choices made by Qadhafi that resulted in a country without a constitution, with no stable administration, and with high levels of corruption (Ibid, 73-76).

4.5 Conclusion

This chapter reviewed the development of political institutions in Libya from 1951 to the present, in order to understand the goals of public policies and the manner of their formulation. Since Libya's independence in 1951 a range of changes have occurred in the country's political and administrative structures, including the monarchy regime (1951-1969), the Qadhafi regime (1969-2011), and the democratic regime (2011 to present).

This chapter has shown that before the discovery of oil Libya was one of the poorest countries in the world. After its discovery, Libya had access to more money and this led to improved living conditions and clearly defined economic and social development plans. These plans included improving education, transportation, housing, education, and health. Libya is a distributive or rentier state, in which the state derives its income from the sale of oil and Libya does not depend on extraction of financial resources from its citizens through tax-gathering mechanisms. Thus the public sector is the main instrument in providing services. The socialist ideology that was adopted in the 1977, led to the introduction of a centrally directed economy in Libya.

In addition, this chapter has outlined the governance structures and mechanisms that have been in place over the past six decades. This study concentrated on the Qadhafi period and how the regime influenced political, economic, and social life in Libya, and how Muammar Qadhafi took on the main role in decision-making, formulation of policy and execution of the same. The study also highlighted the relevance of the post-uprising situation, as an effective policy process will be essential as the country rebuilds politically, economically, and socially. The purpose of this chapter was to provide information about the Libyan environment, while the influence of this environment upon the public health sector system will be dealt with in the following two chapters.

Chapter Five: The Public Health Care System in Libya

5.1 Introduction

This chapter will describe and analyze the Libyan health care system based on the socio-economic and political environment in Libya as presented in the previous chapter. Path dependency theory is used to explain the development and change in the health care system. The concept of path dependency emphasizes the continuities in the organizational life of the public sector, critical junctures and the significance of 'legacy effects. Therefore, this gives us a lens through which it is possible to explore inherited ideas and structures in the Libyan public administration that might act as factors which inhibit or accelerate reform. This is because path dependency might be one of the factors that explain why a policy transfer process is not successful; it also suggests that policy transfer may be successful when policy makers in Libya become aware of the conditions that may constrain policy transfer.

This chapter presents the findings related to the following research questions of the study:

- To what extent have the political, socio-economic and policy environments in Libya affected the public health sector?
- What factors have constrained the reform of the health sector in Libya?

The chapter focuses on the assessment of health care policy and good governance in terms of decentralisation and accountability in Libya from the military coup in 1969 up to 2013. A brief review of Libyan political structures from the independence of the state in 1952 until the establishment of the military regime has also been included in this study.

The chapter is based on a critical review of official documents and published and unpublished literature. This chapter therefore deals with the opinions and perceptions of civil servants and doctors, collected in interviews. It comprises seven sections. Section 5.2 presents the evolution of health policy in Libya. Section 5.3 looks at organisations and the delivery of health services. Section 5.4 discusses centralization. Sections 5.5 and 5.6 examine the financing of the public's health and accountability mechanisms, while 5.7 is devoted to concluding remarks.

5.2 The Evolution of Health Policy in Libya

The evolution of health policy in Libya is examined through the use of approach path dependency. As discussed in Chapter two, path dependency facilitates an understanding of the constraints on and opportunities in the reform of the health sector in Libya. The health policy can be understood through critical junctures that shape institutions and public policies. Since its independence in 1951, Libya has provided universal coverage of health care free of charge. The federal authority was responsible for formulating health policies, while the provinces were responsible for implementing these policies. In practice, the federal government attempted to formulate effective policies, but local governments obstructed its work (Vandewalle, 2012), with the result that the federal government, within a specific context such as health, was considered less powerful in formulating policy and setting priorities. During this period, the country had a number of health units and hospitals, but these were only to be found in Benghazi, Tripoli and Sebhe. In fact, the federal government funded health services from aid provided by the United Nations, the United States and Britain; the USA and Britain established hospitals in Benghazi and Tripoli (International Bank For Reconstruction and Development, 1963:297). From 1951 to 1961, as discussed in the previous chapter, before the discovery of oil, Libya suffered from economic and social problems and deficits in its budgets, and this situation had a negative effect on public policies, with Libya partly depending on foreign financing, grants-in-aid and rent for the use of military bases by the UK and the USA.

After the discovery of oil and the abolition of the federal system in 1963, the national government was forced to concentrate on planning, administrative and economic issues. The MOH had the capacity to improve health services: this led to an increase in the number of hospitals and the establishment of several small health centres (Otman and Karlberg, 2007:119). With regard to the contribution of the oil industry, the government was able to use its oil wealth to develop the country through a series of five-year development plans aimed at maximising the economic and social welfare of the Libyan people. The state was responsible for providing health services and for fighting disease in cooperation with international institutions. It was the view of the King that it was the role of the state to ensure that all citizens received free health services.

The health policy was based on the improvement of health care services provided to citizens of the Kingdom, and the state provided universal health coverage free of charge, as well as health services in the fields of preventive, curative and rehabilitative medicine through a network of health facilities under the MOH. This aim was confirmed by the 1963-1968 development plan: the health sector represented 17.5% of the nation's total expenditure. Table 5.1 shows the actual expenditure on health development from 1962 to 1969.

Table 5-1: Distribution of Actual Spending for the Development of the Health Sector

	1962	1963	1964	1965	1966	1967	1968	1969
Percentage %	0.9	0.8	0.9	1.5	2.6	3.4	3.5	2.6

Source: Ministry of Planning (1975).

The above table indicates that budgetary spending on health between 1962 and 1967 increased, from 0.9 per cent in 1962 to 4.3 per cent in 1967. This increase was due mainly to the government's willingness to improve health services and establish a health infrastructure. The monarchical regime adopted the first five-year development plan from 1963 to 1968, which aimed to ensure the early improvement of the standards of living of the people, permitting the public sector to continue its investments in such services as education and health. However, there was a decrease in expenditure in the health sector between 1968 and 1969, as this marked the end of the first development plan.

As discussed in Chapter 4, the 1 September 1969 coup in Libya, led by Mu'ammar Qadhafi, ended the monarchical regime, creating a critical juncture which started a path dependent process which shaped the health care policy. The new political system initiated a process which dissolved or changed all existing political and administrative structures in order to replace them with organizations conforming to a fresh approach. According to the constitutional proclamation promulgated in 1969, health services and medical care are the rights of all citizens, and the state is responsible for establishing institutions and curative health care.

The establishment of the new republic in 1969 implied a fundamental change in public administration and in the ideological framework, which influenced the formulation and implementation of the health system in Libya. Thus, the change in the political system in 1969 was a new event that brought about rapid changes in the health system in Libya. The new administration of the country adopted "Freedom, socialism and unity" as the basic principles of the military coup, and this punctuation played a significant role in shaping the health system. The RCC succeeded in formulating public policies that initiated the building of houses, factories, roads, hospitals, and other infrastructure (El-Kikhia, 1997). In addition, the rapid growth of oil wealth gave the country the ability to undertake development and make great changes in its social structure, including its health care.

With the five-point program (Cultural Revolution) announced by Qadhafi on April 15 1973 the country saw major changes in policies and structures. This is an example of 'path dependency', and it confirms what was explained in Chapter 2 about the way in which trajectories are influenced by previous events and causal processes. The Cultural Revolution was intended to seize power through the election of PCs throughout the country, and to attack members of the bureaucracy and the opposition (see Chapter 4). The main effect of the Cultural Revolution was that the PCs became a part of the policy process framework in the country instead of offering administrative expertise.

During the period from 1969 to 1976, the RCC, as the key element in governance and administration, issued law No 106 of 1973, which occupies an important place in the development of the health system as it led to re-organisation of the health and medical activities in the country. This law states that health care and medical treatment are free and the right of all citizens and the state is responsible for providing health services. Throughout the period from 1973 to 1976, the national health policies were an integral part of the comprehensive socio-economic development policy, which emphasized social welfare programs such as increased housing and improved health care, which enjoyed widespread popular support (St John, 2008:77).

In 1977, Qadhafi announced the "Era of the Masses" and the transformation of the political system from a republican system to a Jamahiriya system, built on his "Green Book Theory", drawn from the path of socialism. This approach was translated into policies and procedures (see Chapter 4), and should be seen as a critical juncture

that had a profound effect in political, administrative and economic areas. The path of development of health policies can be traced from this announcement by Qadhafi. In effect, socialism deeply affected the public health sector: all health organizations were under the direct control of the state and the private sector was no longer allowed to provide services.

National health policies were an integral part of the transition to the socialist system. Two development plans, for the periods from 1976 to 1980 and from 1981 to 1985, were closely related to a socialist approach. The first plan (1976-1980) was based on the support and development of the public sector and the transition to the socialist system. The plan aimed not only at the nationalization of manufacturing and agricultural assets and a change in the structure of the economy but also at increasing the importance of the public sector, with greater reliance upon the public rather than the private sector for the delivery of services and goods. The public sector also became the main user of the labour force in the community.

The second plan was a socio-economic-transformation plan for 1981 to 1985. The main strategies of the plan for the health sector may be summarised as follows:

- Improving, upgrading and development of health services, giving attention to quality in parallel with quantity;
- Implementation of the Primary Health Care (PHC) approach;
- Total manpower to be increased to 61.3 thousand health workers in 1985 from 45.8 thousand in 1980;
- Libyanization (empowering the Libyan employee instead of foreign labour) sought to empower 40% of Libyan medical personnel and 90% of Libyan nurses, paramedics and technicians;
- Completion of projects that had not been executed in the 1976-80 Health Development Plan;
- Start of high specialized services so as to decrease the number of patients sent for treatment abroad;
- Emphasis to be given to applied medical research (WHO, 1986).

According to the official report issued in 2011, the evaluation of development plans indicated that the period from 1970 to 1985 was one of the best periods of health delivery in Libya; the country adopted a health policy that focused on health for all members of society as well as the efficiency and stability of the administration

(National Planning Council of Libya, 2011). Two factors contributed to the improved public health sector and the path of the state's commitment towards health delivery during this time. One was political: the government had a positive attitude towards improving the health sector and changing the socio-economic situation of the country. The second factor was economic: revenues accrued from oil contributed to investment in the health care sector with emphasis on the construction and provision of community health centres, hospitals, services and associated facilities. In 1994, the Libyan MOH issued a Cabinet Decree No. 24 that stated the commitment of the government to achieving the following health objectives:

- 1) Strengthening health administration by training the managerial staff and improving the health information and documentation systems;
- 2) To develop the national health manpower resources, through the program of continuous education, with the aim of nationalizing all the workers in the health sector;
- 3) Fostering the concepts of primary health care in medical schools, and involving local doctors from all specialties in the delivery of PHC services;
- 4) Maintaining the existing health facilities and improving the quality of care they provide by improving their diagnostic and therapeutic capabilities. The services and distribution of these facilities should be continuously re-evaluated;
- 5) Improving the methods of medical supplies and updating its regulation, promoting rational use of drugs, and promoting the local pharmaceutical industry;
- 6) Advocating cooperation with the international regional and Arab organizations to make maximum use of their capabilities in the implementation and evaluation of this strategy; and
- 7) Increasing financial resources by creating new sources of funding, and promoting rational use of the available resources by using quality control manuals for the different health activities and by introducing measures of auditing and continuous evaluation. (WHO, 2007:36)

This period clearly shows the provision of health services to all people and the development of medical services and quality improvement. For example, the national

health system was successful in combating infectious diseases and reducing the rate of infant mortality, as shown in Table 5.2.

Table 5-2: Health Indicators in Libya

	1980	1990	2000	2005	2010
Mortality rate, neonatal (per 1,000 live births)	49.5	21.4	14.8	12.3	9.6
Immunization, DPT (% of children aged 12-23 months)	60	84	94	98	98
Mortality rate, under-5 (per 1,000 live births)	72	44	27	22	17

Source: the World Bank <http://data.worldbank.org/topic/health>

After 1985, the Libyan regime faced different pressures. This can be seen as a critical juncture, created by three main factors. Firstly, the fall in oil prices in the first half of the 1980s constrained the regime's ability to support extravagant socialist policies (St John, 2008). The second factor was the effect of economic mismanagement and inefficiency of the public sector, with inflation remaining high throughout this period (42 per cent in 1993 and 50 per cent in 1994). Thirdly, in 1992 the UN Security Council imposed sanctions on Libya. Although the sanctions did not include oil exports, the technology and the equipment for extracting and transporting oil were banned (Pargeter, 2006: 221-222). Consequently, the role of the state in the health services declined; an opinion that was reinforced by the majority of the twenty interviewees who participated in the present study. As one interviewee stated:

The state did not take any serious steps to increase the financial resources and rationalize expenditures, improve the quality of health care activities and services, and face the constant increase in the demand for these services.
(INT)

According to a scholar in public policy field:

In the health care policies in Libya during the Qadhafi regime, clearly defined and enforceable plans and strategies were neglected, particularly after 1985. All reforms in health sector came under pressure from certain circumstances but were not a part from comprehensive reform. So the state failed to formulate a strategy for optimal use of resources, manpower development, the services to be delivered, and especially for the health professional

manpower for the services. All these happened in the absence of a clear policy framework. (INT)

As Tim Niblock (2001:80) has noted, the regime suffered from a weak legislative framework, With regard to the health sector, he wrote,

Medical equipment in hospitals broke down and was not replaced; medicines, apart from the most basic, became difficult to obtain within the public health sector; and hospitals were left without proper upkeep.

As discussed in Chapter 2, governments take different policies in order to provide services efficiently and effectively. Privatisation is adopted by many governments in order to introduce economic reforms and reduce the role of government. In the case of Libya, the former regime took steps to deal with the problems outlined above. After the mid-1990s, Qaddafi called for privatization and a free economy as a part of economic reform, stating that the nation's public sector had failed and should be abolished (see Chapter 4). This point can be seen as a "lock in" of the path to socialism in Libya that initiated new policies. In the health sector, the government decided to encourage the expansion of private clinics and hospitals. According to the WHO (2007), the private sector failed to provide good services, because of the absence of a clear and consistent government policy, the granting of licenses to operate without clear criteria or inspection policies and the absence of health insurance.

Although this was the situation under former regime, Libya is a welfare country where health is free and provides universal coverage. In practice the health services are poor. This is because of the absence of real reform As Pargeter has noted,

Ultimately the reform process in Libya has been hindered by an absence of political will at the highest level. This absence stems from the regime's obsession with its own security that far outweighs any perceived need for change. The discourse of reform is largely aimed at creating the impression that real change is occurring, whilst in fact the underlying structures remain the same. (2006:233)

From above discussion, strong political commitment is an important tool to develop and reform the health sector. Libya is a middle-income country, which means that it has sufficient resources to provide good health services.

In 2011, with the fall of Qadhafi after forty-two years in power "path-breaking" (Yu, 2008), a new political scene began to emerge. The health system faced changes as

a result of the armed conflict that had already influenced health delivery as well as the infrastructure of health organizations. The new events led to the opening of new windows for policy-makers and this in turn led the government to take new action. Responding to this situation, the Ministry of Health set up a plan for the post-conflict period. The policy document identified the following main objectives (Ministry of Health, Libya, 2012):

- ensure integrated health care for the war-wounded and rehabilitation for them psychologically and physically;
- rehabilitate health services in primary health care centres and hospitals;
- prepare a comprehensive strategic plan for the development of the health system;
- develop a health information system and build a management system to ensure the quality and efficiency of the health services;
- adopt a plan to reduce maternal, neonatal and infant mortality in line with the Millennium Development Goals;
- regulate the private sector in order to achieve benefit from its services in the provision of health services to citizens; and
- restore citizens' trust in the public health sector by ensuring the provision of health services in line with global standards.

The government took a series of steps to develop the health services. Benefiting from international organizations, an assessment survey of health facilities services was conducted by the MOH Libya with the collaboration of the WHO Regional Office for the Eastern Mediterranean. This collaboration began the planning process of re-engineering the health sector and identifying problems. To this end, a team from the WHO visited Libya in 2012 and conducted an assessment of accessibility of services and the readiness of the facilities to provide an adequate level of service both for general health and for specific key health interventions. The Libyan MOH, in collaboration with the WHO and other international experts in the field, sponsored the National Health Systems Conference in Tripoli between the 26th and the 30th of August 2012. This conference led to the identification of the main issues and challenges to be considered in reforming the Libyan health system, these being governance, financing, services delivery, human resources, technology and

information. These findings are discussed in the following sections of this and the following chapter. As suggested by Dolowitz and Marsh, policymakers here, as in many developing countries, relied on advice from international organizations in relation to what they regard as the “best practice” (200:10).

5.3 Organisations and Delivery of Health Services

The public health sector is the main health services provider in Libya. Health care, including preventive, curative and rehabilitation services are provided to all citizens free of charge by the public sector (WHO, 2007:29). Since 1951, the right to health of Libyan citizens has been provided for through development plans and health policies, as mentioned in the previous section. There are three levels of the health system that operate as follows:

- The first level consists of the primary health care units (which provide curative and preventive services for 5,000 to 10,000 citizens); primary health care centers (serving from 10,000 to 26,000 citizens); and polyclinics, staffed by specialized physicians and containing laboratories as well as radiological services and a pharmacy. These polyclinics serve approximately 50,000 to 60,000 citizens;
- At the second level, there are general hospitals in rural and urban areas where care is provided to those referred from the first level; and
- The third level comprises tertiary care specialized hospitals. (WHO, 2007:30).

All three levels of the health system are operated by the MOH. The MOH is the main state executive body responsible for health care and health protection in Libya. In addition, it has the ability to formulate and implement a national health policy agenda and to allocate health resources, as well as supervising all health services delivery, and monitoring and controlling all health facilities. The hierarchical structure of the Libyan health system is administered from the top down by the MOH; this has been the case both before the revolution and after. The Minister is at the top of the hierarchy, followed by an Under-Secretary who is directly responsible to the Minister. The MOH is responsible for formulation of the annual budget, providing operational strategy and tactics, controlling budget expenditures and advising on financial affairs, and granting licenses for private hospitals and medicine and nursing practicing.

Since the centralization of the health system, municipal health departments implement health policies and plans without playing any role in health agenda building, policy making and planning, as described by the politicians and professionals at Ministry of Health level (WHO, 2007; GPC, 2011). The administrative structure of the state has witnessed several changes (see Table 5.3) with the result that it is characterized by instability. This in turn is reflected in the instability of health sector governance.

Table 5-3: Instability Administrative in Libya

ITEM	Local Government	Central Government for Health
1969-1978	Ten provinces	Ministry of Health
1979-1980	41 Municipalities and 161 branch of Municipalities	Ministry of Health
1980-1995	25 Municipalities 173 branch of Municipalities	Ministry of Health
1992-1997	1455 People's Congresses	Abolition of the Ministry of Health
1998-2011	Shabeya People's Congress	Ministry of Health
2012-present	Fifty-two Local Councils	Ministry of Health

Source: GPC, 2011

As discussed above, the popular revolution in 1973 rejected the hierarchical bureaucratic structures. This led to a reshaping of the administrative structures and created the PCs in all public institutions. In 1977, Qadhafi launched his new political system: the most significant change in the Libyan political system, transforming the administrative system from bureaucratic management to popular management in the municipalities and public institutions. After 1980, the instability of public policies can be seen as a main cause of the frequent merger of or complete abolition of public institutions. According to many scholars, popular management produced widespread administrative and bureaucratic chaos in the country, because of financial and administrative corruption, poor services, lack of responsibility and lack of administrative stability (El Kikhia, 1997; Vandewalle, 2012).

These changes in the administrative structure of the state have had a clear impact on the performance of the administrative apparatus's executive and administrative instability. The instability in central and local government led to deficiencies in the performance of tasks and low efficiency, duplication and overlap in the terms of reference (AL Mogherbi, 2005). In other view, like other third world leaders, Qadhafi refused to share power with other institutions (El-Kikhia, 1997:2). To this end, Qadhafi established a new theory based on 'Direct Democracy' (see chapter 4). This ideology rejected the party system, constitution and parliament and was supposed to give the Libyan people total control over all issues of political power and wealth. Officially, the Libyan people were at the centre of power, but in reality the centre of power was Muammar Qadhafi, his sons, Rijal al-Khaimah (the Men of the Tent) and revolutionary committees (Pargeter, 2006) and they played a vital role in formulating public policies, the structure of public administration and the role of formal institutions which served the desires of the elite. During the four decades of this situation, Qadhafi created chaos because the survival of his regime hinged on continued turbulence. Continuous rapid change ensured instability (El-Kikhia, 1997:5) and the instability of the structure of public administration was created in order to maintain his regime. Another point was the absence of a constitution that creates standards in changing public policy and administrative structure. In the case of the health sector, this administrative instability and the different visions of those in charge of the executive led to the government's inability to enforce the implementation of its health policies efficiently and effectively (GPC, 2011). A number of interviewees were of the opinion that the instability of public administration created serious problems for health services. According to the Director of Legal Affairs in the Benghazi health region

The change of political ideas and the lack of political will for reform led to the instability of the health sector. This is because of weakness and backwardness of the administrative and functional legislations to keep pace with developments in the field of public administration; the continuous change in the administrative framework and the cancellation or merging of administrative units, resulting in the absence of clear lines of management. Also the levels of motivation of staff and departmental performance in the health sector were influenced by cancellation or merging of the health sector

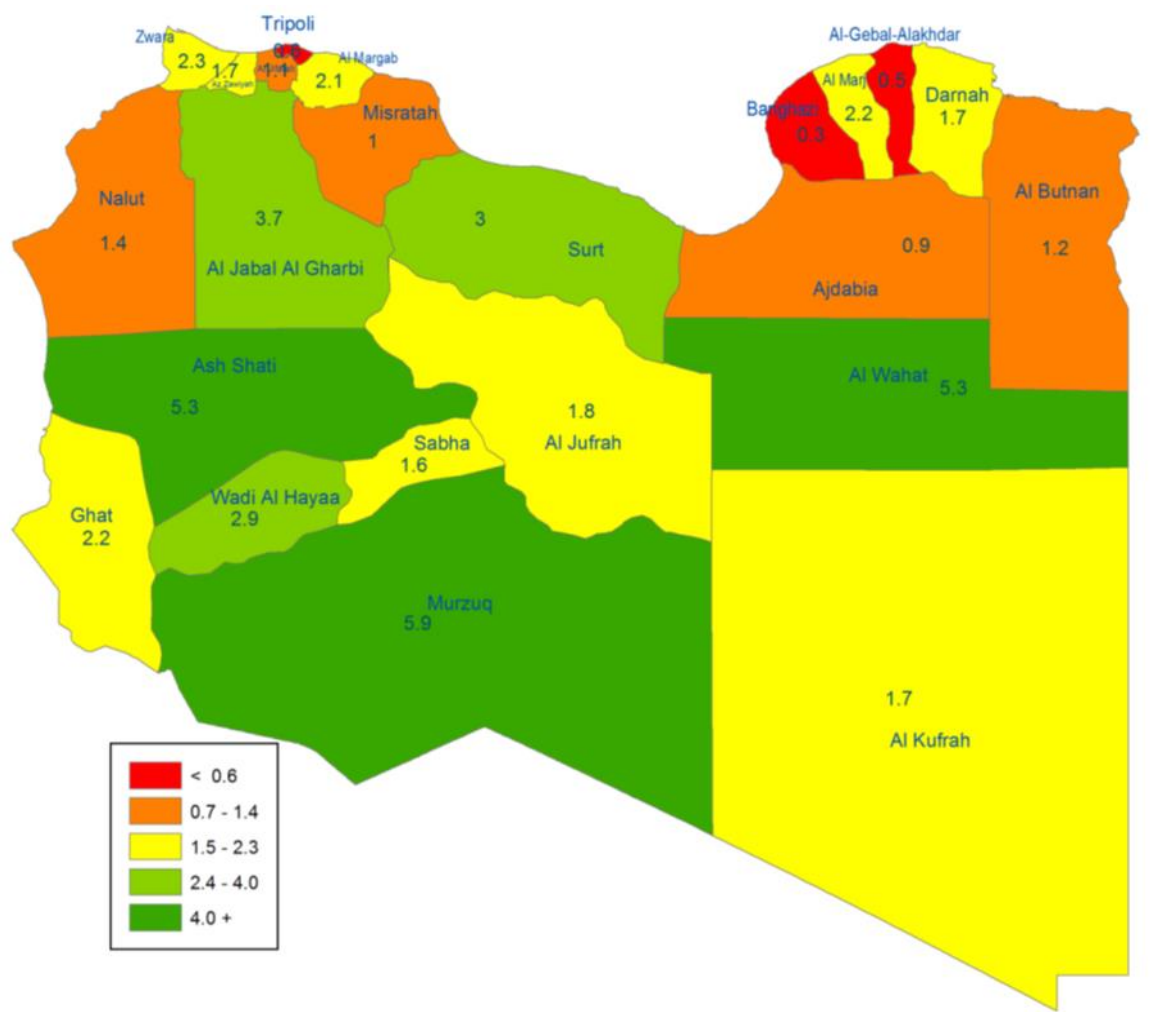
and inadequate communication channels between central and local government. (INT)

There was administrative instability in the structure of the state, both at the central level, which saw the abolition of the MOH during the period 1996-2006, leading to the lack of a national policy to deal with health problems, and the local level, which witnessed more changes from centralization to decentralization than in the move from decentralization to centralization. This has led to a lack of government support for health programs and a waste of resources. As one administrative expert of the public civil service in the Ministry of Labour, commented:

Instability in the structure and organization of the administrative apparatus of health can be seen as an obstacle to the achievement of good performance. The merger of or complete abolition of public health institutions at local and national was very common practice during the former regime, and this caused lack of continuity and a waste of time and resources without achieving targets; also this was further compounded by the lack of proper cooperation and coordination channels between different government agencies .(INT)

In terms of distribution of health facilities, the MOH controls primary health centres, dispensaries, hospitals, and tuberculosis control branches. According to the WHO, the facility density is primarily an indicator of outpatient service access. Figure 5.1 presents the density of facilities per 10,000 citizens. Based on the 2010 population, there are 1.5 primary facilities available per 10,000 citizens, with 0.74 Primary Health Care (PHC) units and 0.62 PHC centres. The numbers of facilities available per 10,000 citizens differ greatly by District (WHO, 2012: 7).

Figure 5-1: Total PHC Facilities per 10,000 Citizens by District



Source: WHO, 2012. Post Conflict Health Facility Assessment/Libya.

It is important to consider how the hospitals are distributed, because this has a considerable impact on the provision of health services. In Libya, there are three types of hospitals: teaching tertiary hospitals, secondary hospitals and rural hospitals. Table 5.4 below presents the characteristics of hospitals according to type of hospital and district (WHO, 2012b:7). According to this table, a large number of hospitals are not in a position to provide services, not just because of the direct effects of armed conflict but also because they were not completed by the Qadhafi regime, especially in terms of medical devices and equipment (WHO, 2012b).

Table 5-4: Characteristics of Hospitals According to Type and District

Background characteristic	Number of beds	Renovated	Under Renovated	Population year 2010	Number of hospitals per 10,000 population	Number of beds per 10,000 population	Number of hospitals
Type of hospital							
Teaching tertiary	6782	13	8				33
Secondary	3884	5	9				20
Rural hospital	1746	11	3				31
Other	120	0	0				2
District							
Albetnan	570	1	0	163000	.18	34.97	3
Derna	60	2	0	167000	.18	3.59	3
Al-Gebal-Alakhdar	120	3	0	208000	.14	5.77	3
Almarege	500	1	1	188000	.21	26.60	4
Benghazi	2541	3	3	667000	.22	38.10	15
Al-Wahat	80	1	0	30000	.33	26.67	1
Ajdabia	410	0	0	148000	.14	27.70	2
Al-Kufra	122	1	0	46000	.43	26.52	2
Sirte	360	1	0	143000	.14	25.17	2
Joufara	240	0	1	458000	.04	5.24	2
Morzig	194	1	1	79000	.25	24.56	2
Sebha	60	1	0	129000	.08	4.65	1
Wadi-Alshati	400	1	2	79000	.51	50.63	4
Misurata	810	0	3	552000	.07	14.67	4
Al-Merghip	657	2	1	441000	.14	14.90	6
Tripoli	2649	6	4	1067000	.11	24.83	12
Al-Jufra	200	1	0	51000	.39	39.22	2
Alzawea	650	1	1	292000	.07	22.26	2
Zwara	713	3	2	290000	.17	24.59	5
Al-Gebal-Elgharbi	840	0	1	310000	.23	27.10	7
Naloot	356	0	0	94000	.43	37.87	4
Total	12532	29	20	5702000	0.15	21.99	86

Source: WHO, Post-conflict Assessment of Hospitals/Libya, 2012b.

Coulter and Jenkinson (2005) mention that responsiveness to patients is now seen as a key characteristic of effective health systems. The achievement of responsiveness depends on the role of policy-makers in narrowing the gap between public expectations and patients' experience. As Siddiqi et al. observe, "Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users" (2009:18). Responsiveness in the health system refers to how the government should respond to the population's health needs and to regional local health needs. Patients always expect a speedy response from health facilities; also, patients expect doctors, nurses and medical equipment to be readily available to achieve a rapid diagnosis. Increasing responsiveness of health care providers leads to greater patient satisfaction.

In Libya, the performance of health facilities is weak because of the poor quality of services and corruption (Otman and Karlberg, 2007: 124). In this context the Medical Manager in the kidney unit of the Hospital of Benghazi stated:

Lack of effective professional regulation has caused the poor performance of professionals, and significant proportions of the workforce are not skilled to cope with allocated tasks and responsibilities. Information technologies are not available in the majority of health institutions; information technologies now play an important role in booking appointments, patient's information, and supporting physicians to seek a second opinion. The absence of information technologies has influenced providing good services to patients. (INT)

According to the national report issued by the Libyan Information Foundation in 1999, the health sector has suffered from a lack of clarity about the goals of health policy, low public spending, and lack of efficiency and effectiveness. This was echoed by most of the interviewees in the present study, who argued that health policies and planning in Libya are set without clear targets and with little concern for how targets will be translated into practice. This was confirmed by two participants, the Dean of the Faculty of Pharmacy and the Head of the Libyan Medical Supplies Organisation, who blamed the absence of a clear strategy which determines priorities and implementation mechanisms (INT).

Another problem relates to referral: in theory doctors refer patients to specialists, but in practice, the referral system fails to function and service users largely ignore it and

go directly to the level of the system that they want (GPC, 2011), with patients going directly to regional and national referral hospitals.

In order to understand the weaknesses in responsiveness and performance in the Libyan health system, it is necessary to bear in mind that public health sector institutions have a limited institutional capacity, in part because of the inefficiency of the Libyan government. The World Bank (2009) defines government effectiveness as

Capturing perceptions of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies.

Table 5.5 below presents indicators of government effectiveness that reflect perceptions of the quality of public services, civil services, and the quality of policy formulation and implementation. This table shows that, for all years, Libya has scored less than 1, indicating weak government effectiveness. In contrast, the UAE has scored better than Libya indicating that the UAE has successfully improved the quality of public services. The absence of performance measurements in the Libyan public sector has led to these problems (GPC, 2011:35). In particular, the WHO's 2007 report stated that Libya needs to introduce various efficiency measures to make physicians and teams accountable to patients and health services (p43).

Table 5-5: Government Effectiveness Indicators in Libya and the UAE

Year	1996	2000	2002	2006	2008
Libya	-0.72	-0.91	-0.94	-0.71	-0.84
UAE	0.34	0.74	0.77	0.86	0.82

Source: Kaufmann, Kraay & Mastruzzi (2009). Governance Matters VIII: Aggregate and individual governance indicators, 1996-2008. World Bank policy research working paper.

Chapter 2 covered the topic of equity of access to health care; equity means ensuring that all people have access to a minimum standard of health services. Health Law no (106) of 1973, which is still valid today, gave citizens the right to free health services from the public sector. However, the health law did not explicitly mention achieving equity between people in the health system. As Table 5.6 indicates, it is clear that hospitals and beds are not distributed evenly between cities in accordance with population density.

Table 5-6: Specialized Centres for the Heart,Brain and Neurology

City	Population	No. of Hospitals	No. of beds
Tripoli	1,033,777	2	384
Benghazi	645,892	1	60

Table prepared by the researcher based on statistics from the Ministry of Health: <http://health.gov.ly/web/>.

Data in the above table suggests that the health system under the Qadhafi regime did not run on the principles of equity and justice in the provision of health services for all citizens. This lack of equity was mentioned by most of the interviewees in the present study, especially by managers at local administrative level, indicating that this principle has not really been addressed within the Libyan health system. This was confirmed by the Former Public Manager of Benghazi Municipality:

The health system suffered from a lack of equity regarding the distribution of hospitals, health centres and beds. There is no equitable distribution of medical equipment, medical supplies or surgical equipment between health facilities. This has an adverse effect on health services, so many patients find it difficult to get services, especially in surgeries. (INT)

Additionally, the WHO's report in 2007 mentions that the Libyan health system has inadequate capacity and coordination between the MOH and municipalities to properly provide better health services (WHO, 2007).

5.4 Decentralization

As discussed in Chapter 2, path dependency is very relevant for explaining the operation of systems of institutions and their interaction with the wider socio-economic and political environment, and, as seen in Chapter 2, a decentralisation policy has been introduced to enhance the performance of local government, improve local public services and finally ensure its accountability. This section will look at the decentralisation policy in health care system based on path dependency. Decision-making within government structures was highly centralised during the Qadhafi regime (see Chapter 4), as a result of the nature of a political system that was characterized by a centralized system with a strong power structure which resulted in a lack of independence in decision-making at all levels. The health care system was no exception.

Moreover, the centralised policy in the health care system was a result of historical paths and political choices based on opinion of Qadhafi. The political factor is important to explain path dependency centralisation since Qadhafi coup. Qadhafi regime created centralised system that controlled by the RCC members, the top military elite during the period 1969-1976. In 1977, Qadhafi announced that the “Era of the Masses”, this stage is characterized by the disappearance of the military tool in governance (RCC), and the application of direct democracy, as expressed by the Green Book (see chapter 4) but reality direct democracy possessed no real power (Vandewalle, 2012) the centre of power was Qadhafi and the cluster of Qadhafi loyalists.

The MOH formulated and approved health policies and programs and ignored any role in policy making and planning by the civil servants, professionals and citizens at local level. The BPCs constituted local government and were responsible only for the implementation of plans and programmes formulated by the MOH (MOH, 2012).

The issue of centralization is most often mentioned by respondents at local level. The Director of Administration in the General Directorate of Health Affairs Benghazi Region, made the following comment:

The concentration of power in the capital has led the central government to be a main actor in formulating public policies and decision making. The highly centralized system also did not allow local societies to participate in policy formulation and decision-making, and the central authorities did not give the

local authorities of health and hospitals a space for decision-making. This situation has caused many problems such as inequities in the distribution of investments between the municipalities and hospitals and its concentration in the capital, the lack of coordination and cooperation between the Ministry of Health and municipalities. This has created the phenomenon of the state being unable to raise interest in a fair and proportionate manner towards the actual needs of differing segments of society to achieve social cohesion and social justice. (INT)

The same concern was expressed at the National Health System Conference (2012) which recommended improvements to the health system in Libya with the suggestion that the country should “Restructure the organizational Chart of the Ministry of Health and decentralize the service in harmony with developing a patient-oriented quality health service.” (El Oakley et al., 2013:3)

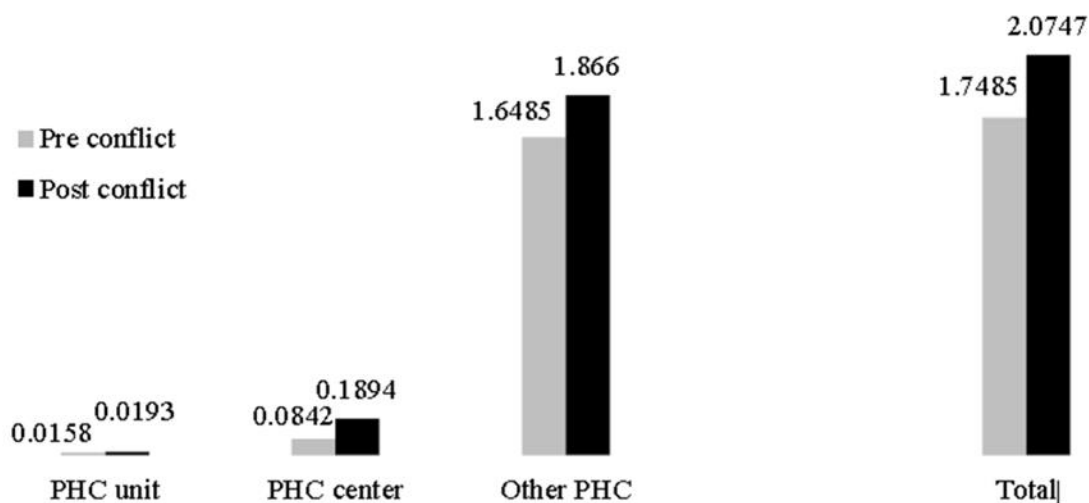
The overthrow of the Qadhafi regime in 2011 provided a window for breaking the path of centralisation. Libya’s health care system has faced restructuring in order to improve its responsiveness and performance and this critical juncture opens the door for new policies. The action taken by the new regime is to apply decentralization in order to improve health services. The move from centralization to decentralization can be found in Article 1 of the MOH Order No 284 of 2012 concerning the organizational structure of the MOH. The article stipulates that the medical districts have administrative and technical capacity to plan, organize, supervise and develop their own health care services. According to this reform, local administrations will have the opportunity to formulate their own health policies and budgets.

During the interviews for this study, actors working at the MOH and at municipal level (doctors and civil servants) acknowledged that general managers of health in the municipalities participate more in decision-making through the development of operational plans at the county level, along with their participation in the implementation of the plans and the development of the financial allocations. The interviewees also added that decentralization will solve the problem of citizens’ lack of confidence in the health system, because all health districts will have the opportunity to respond to regional and local health needs. With regard to decentralization, the government issued law no 525 of 2012, which gives health service managers in the health regions and hospitals jurisdictions and powers, thus enabling them to make decisions according to their priorities. The new system opens

a window for the health system to apply decentralization, which was lacking during the Qadhafi regime. The majority of scholars interviewed for the present study expressed the view that decentralization in the health system during the Qadhafi regime was very difficult under a political system characterised by non-participation, ineffective accountability and corruption (INT). Furthermore, a report issued by the Minister of Health in 2012 referred to the role of decentralisation in enhancing autonomy in order to improve the efficiency with which health services operate, by increasing public participation and prompting internal management reform (2012, p.54-55).

The MOH has continued to improve the health system situation in Libya. As can be seen in figure 5.2, it would appear that there has been an increase in the number of units and health care centres in Libya since the war. In addition, the number of in-patient beds increased from 6.99 per 100 pre-conflict, to 8.30 per 100 post-conflict (WHO, 2012:15).

Figure 5-2: In-Patient Beds per 10,000 Citizens- Pre and Post Conflict



Source: WHO, 2012. Post Conflict Health Facility Assessment/Libya

5.5 Financing the Public's Health

This section will focus on health financing as a key to effective interaction between providers and citizens. As discussed in the previous chapter, Libya is a 'distributive state' which derives its income from the sale of a commodity, so Libya does not depend on extraction of funds from its citizens. In fact, the Libyan economy depends on oil as a single commodity, and as a source of income with which it provides public services. The delivery of health services in Libya is financed from public funds. The total expenditure on public health services comes from the government and the services are free of charge, while the private sector is totally financed by out of pocket payments. There is no private insurance: the fee for the service is the main source. There are no mechanisms in place to provide services to the disadvantaged segments of society. The fee in the private sector is market-driven, with no regulatory mechanism on setting the level of fees (WHO, 2007: 50).

The general state budget is the major source of public financing of the health sector, funding all health services in the country. Blank and Burau classify the sources of funding according to two kinds of health system. The first is public funding, which includes two sources: the government and social security. The second source is private funding, which includes three types of sources: out-of-pocket payments, private insurance and non-profit institutions. They mention that the source of funding provides an indicator of the size of the health system and the role of the government in the health system (Blank and Burau, 2010:71-73). According to the WHO, financing of the health system in Libya has been mainly from the state, with funds flowing through regional administrations and hospitals (2012:12).

During the period from 1962 to 1967, as shown in Table 5.1 above, the budgetary spending on health increased from 0.9 per cent of the total public expenditure in 1962 to 4.3 per cent in 1967. This increasing expenditure in the health sector was due mainly to the government's willingness to improve health services and establish a health infrastructure. In addition, with the new regime in 1969 national health policies became an integral part of the comprehensive socioeconomic development policy, while the public health sector became the main provider of the health services in the country. The first full development plan after the Qadhafi coup was a three-year plan, for the period from 1973 to 1975, which called for expenditure of 2.6 billion Libyan dinars, allocated between economic activities as shown in Table 5.7.

Table 5-7: The Economic and Social Transformation Plan 1973/1975

Economic Activity	Total	Allocation Rate
Agriculture, Forestry and Fisheries	327.8	16.5
Mining of Oil & Natural Gas	48.9	2.5
Other Mining & Quarrying	2.9	0.2
Manufacturing Industries	231.6	11.8
Electricity and Water	257.4	13.1
Construction	6.2	0.3
Wholesale & Retail Trade, Restaurants & Hotels	1.0	0.1
Transport, Storage and Communications	253.8	12.9
Finance, Insurance, Real Estate (Excluding Houses) and Business Services	0.4	0.0
Ownership of Houses	361.3	18.4
Public Services (Excluding Education and Health)	186.7	9.5
Educational Services	192.1	9.8
Health Services	71.5	3.6
Other Services	0.0	0.0
Reserve	23.9	1.2

Source: Ministry of Planning, three-year economic and social development plan 1973 – 1975, cited in Kilani, 1988: 54.

As shown in the above table, policy-makers paid more attention to social development. In fact, the total expenditure of the plan contributed only about 54% of total budget outlay on public services including electricity, water, houses, education and health. This planned budget contributed only about 3.6% of total budget outlay on health care. This plan was to be implemented as a part of the socialism approach that was identified by announcing the military coup, with the Libyan government focusing attention on the financing of social development including health services. This was continued through the second and third development plans from 1975 to 1985. As discussed in the first section, this ideology had an effect on all states, and led to the announcement that all retail activities would be controlled by state-

administered and state-owned supermarkets. The whole private sector was abolished (Kilani, 1988:55).

Table 5-8: Expenditure on the Health Sector from 1970 to 2013

year	Expenditure (Million L.D)	Health expenditure, total (% of GDP)	Year	Expenditure (Million L.D)	Health expenditure, total (% of GDP)
1970	4.9	3.5	1992	58.5	2.8
1971	3.7	2.0	1993	4.6	2.5
1972	15.4	4.0	1994	20.6	1.0
1973	9.8	4.0	1995	22.3	3.5
1974	15.9	4.0	1996	66.0	3.3
1975	20.9	3.6	1997	52.8	3.1
1976	28.3	3.9	1998	27.3	4.1
1977	36.3	3.8	1999	69.2	3.9
1978	53.5	4.2	2000	107.4	3.7
1979	69.8	5.0	2001	135.7	4.5
1980	69.1	4.0	2002	397.1	4.7
1981	115.6	4.6	2003	326.0	3.5
1982	84.0	4.0	2004	249.0	3.0
1983	68.7	4.0	2005	343.2	2.4
1984	63.2	4.0	2006	274.2	2.2
1985	48.4	4.0	2007	343.2	2.2
1986	47.7	4.0	2008	274.2	2.0
1987	49.2	3.8	2009	484.9	3.1
1988	32.4	3.9	2010	363.2	3.0
1989	31.9	4.0	2011	-	4.4
1990	22.3	4.2	2012	210.0**	-
1991	37.1	4.0	2013	19.300,000,000***	-

Source: Ministry of Health (2010)

*<http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

**The annual report of the Audit Bureau (2012)

***Total development programs and reconstruction

The above table provides a comprehensive picture of two key indicators for health for the period 1970-2013: first, the expenditure (in million L.D), and, secondly, the health total expenditure (% of GDP). During the period from 1970 to 1985, the economic and social transformation plans tended to increase the expenditure on the health sector, as the state was responsible for strengthening health infrastructure and improving health services. In addition, this period was characterized by the implementation of socialism. So the public health sector was the only provider of

health services to citizens. It is important to note that these expenditures for the period from 1970 to 1985 include only the building of various health facilities, medical equipment and drugs, and not salaries or administrative expenses.

After 1985, the economic and social transformation plans were abolished and the financing of the health sector was by annual budget (GPC, 2011). In fact, the government spending on health was characterised by instability. For example, for the seven years from 1987 to 1993, government spending on health dropped from 79.2 million Libyan dinars to 4.6 million Libyan dinars, although for the three years from 1994 to 1996 the spending increased from 20.6 million Libyan dinars to 66.0 million Libyan dinars. During the period from 1997 to 2000, there was fluctuation in health spending (52.8, 27.9, 69.2 and 107.4 million Libyan dinars respectively). In the period from 2001 to 2010, the government expenditure on health increased dramatically, peaking at 484.9 million Libyan dinars in 2009 before falling to 363.2 in 2010.

With regard to equity in health financing, this system did not bring opportunities for municipalities and hospitals to be able to decide their budget. As the Director of the Inspection Department of Benghazi Health Authority remarked:

During the Qadhafi regime, the MOH assigned responsibilities and budgets to municipalities and hospitals for all services health delivery. The government of Libya did not give autonomy to local governments. Municipality and hospital officials considered themselves employees of central government. There was also strong central government oversight of local governments. (INT)

As shown in Table 5.3 above, Libya experienced frequent change of government that affected health care system policies. The fluctuation in government spending was a consequence of the change of the role of the state and administrative instability. During the period from 1973 to 1985, the health system was successful (GPC, 2011) because of the economic and social transformation plans that reflected the state's attitude towards improving the health system, and also because there was administrative stability. After 1986, the state tended to retreat in spending on the health sector for a number of reasons: the lack of a health strategy, administrative instability and the lack of political will to ensure a better public sector because of a change in ideology from socialism to liberalism. The state's attitude towards public health spending however changed after 2002 because of reform efforts adopted by the government to improve the performance of the health system. The WHO's report

in 2007 states that, in 2002, the government announced that it was substantially increasing the development budget for health services (2007, 48).

According to the civil servants interviewed for the present study, the health financing framework lacks the optimal use of resources and transparent, effective scrutiny because of the absence of political will for reform (among political leaders and the MOH), administrative instability, centralization in decision-making and corruption (INT).

Since the overthrow of the Qadhafi regime, the new regime has tended to increase health spending, reaching a peak of 210 million Libyan dinars in 2012: this is the result of a critical juncture (political change), but it is constrained by corruption and the lack of transparency and financial control (INT). This issue will be discussed in depth in the following chapter.

5.6 Accountability Mechanisms

A framework to assess accountability can be derived from the source of control: whether it is internal or external to the agency. As seen in Chapter 2, external accountability includes legal accountability and political accountability, whereas internal accountability involves hierarchical accountability, managerial accountability, professional accountability, and consumer accountability.

5.6.1 External Accountability

As explained in chapter 2, external accountability refers to the relationship between the MOH and outside (institutions and citizens). To this end, in this study legal, political, and financial accountability will be discussed as external accountability that imposes external oversight.

Qadhafi allowed no political parties, independent media or political associations outside the regime's governing structures. This led to the inability to achieve external accountability in Libya during his regime. Furthermore, the absence of a democratic parliament led to a lack of transparency. Libyans were not able to evaluate public policy and decision-making, because of the lack of mechanisms of political accountability such as answerability, amendatory, redresses of grievances and sanctions. In Qadhafi theory the 'State of the Masses' represented rule by the people as every decision was debated at the lowest level among BPCs and implemented by PCs, but in reality there was a narrow elite that had control over all decisions , and

the RC represented another important source of power (Pargeter, 2006). El Kikhia (1997) stated that the political system in Libya under the Qadhafi regime exhibited problems; the political system did not allow any compromise because it saw a compromise between government and opposition as a threat to its validity and its ability to function.

In fact, the unwillingness of a large proportion of the Libyan people to attend the meetings of the BPCs is an indication of the failure mechanisms of political participation (Obeidi, 2001; Vandewalle, 2012). The main reason for the unwillingness to participate is that the RCs had a control function over all the state in terms of formulating and implementing policies, political control over appointments, and selective recruitment and repression.

Moreover, it is the nature of the distributive or rentier state, states which derive their national revenues from the sale of a commodity to external clients and do not extract income from people (Vandewalle, 2008), that the abundance of income has an impact on the role of the state, which becomes the main actor in providing welfare and wealth to its citizens. These countries rarely follow a path of democratization, but rather lead to a reinforcement of traditional loyalties and a lack of bureaucratic capacity. Rentier states conserve socio-political norms in societies and polities, such as the patrimonial nature of social interactions and primordial loyalties (Schwarz, 2008). Social interaction and decision-making are determined by loyalty, proximity to rulers, and family relationships.

As discussed in chapter 4, Libya's oil is instrumental in creating jobs, economic institutions, and development. Also, oil revenues strengthen the Libyan government's ability to promote and implement policies of economic and social transformation. Qadhafi adopted socialism path that aimed at ensuring control over the population rather than economic development. Qadhafi also put restrictions on foreign investment, foreign trade and the private sector in Libya, and he used state-owned enterprises to prevent the emergence of other forces in society. This situation made the majority of people depending financial on government. As Sandbakken (2006) explain the hinder of political participation in Libya, he wrote,

A majority of the population depends financially on the state, and are therefore less likely to oppose Qaddafi. This case illustrates clearly the dangers of Exit (loss of income) and Voice (repression), which make Loyalty the most likely alternative. (p147)

According to the 2010 Freedom of the Press Index, Libya's score was 160 out of 178 countries. Libya is continuing to drop into the Index's lower rankings because of its policy of systematic repression enforced by government leaders in Libya against any person who expresses an idea contrary to that of the regime (<http://www.humansecuritygateway.com/>).

In short, Libya during Qadhafi lacked accountability and transparency; this is because there was not constitution. The political system, in theory, depended on BPCs and PCs, but in reality didn't have real power. Real power rested with Qadhafi, his sons, military officials, and RC that can be seen as tools of repression against people. In other words, according to this study, authoritarianism constrained the accountability mechanisms during the Qadhafi regimes. The political system prohibited the activities of political organizations, e.g. political parties, thus leaving citizens devoid of opportunities to engage in political processes. Decision-making processes and oil revenues at that time were also controlled by the ruling elites.

After toppling the Qadhafi regime on 20th October 2011, Libya witnessed the establishment of a new phase of its political system. Now, Libya is moving towards democracy that led it to move from one of the world's longest dictatorship regimes with skewed political participation to an elected regime which gave citizens the right to take political participation (see Chapter 4). This democratic transition in 2011(critical juncture) led to the dissolution of the dictatorship regime and opened the door to enhanced political accountability. Such democratic transformation gave citizens the right to elect the members of the GNC. In August 2012, the GNC became the first democratically elected institution, thus opening the door for citizens to have the opportunity to make public policy, conduct public affairs, choose political leaders at the local and national levels and discuss the national budget. This has led to outputs that meet the demands of society. In fact, after forty-two years of repression of the free media, Libya now has free, independent and pluralistic media as a source of information and knowledge. The position of the media has become strong and they play an important role in decision-making and public opinion.

Representatives of the GNC and the Committee on Health Affairs have played a key role in formulating health policy which aims to expand hospitals and health centres and to develop a plan to improve health delivery and the political and legal accountability structure in the country's health system (MOH, 2012). The Minister of

Health is responsible for the activities of the Ministry and is accountable to the Prime Minister, and to the GNC.

Regarding legal accountability in the health sector, medical liability in Libya is organised by law No. 17 of 1986, issued in order to make medical practitioners responsible and to ensure that they comply with legal obligations. This law is still valid today. It established the Medical Council, which protects medical practitioners and patients in order to improve health services and have a positive effect on health services. However, the Medical Council has not introduced a law covering licensing and registration mechanisms for doctors. As explained in an interview with the Director of Public Services Department in the State Audit Institution:

The Law does not include identifying issues of classification of medical professionals and registration of doctors with the Medical Council; the ineffectiveness of the Medical Council in the promotion of legal accountability for medical staff is due to its inability to impose legal sanctions against violators. In addition, several of the reports of the Audit Bureau highlight the weakness of the MOH in the activation of accountability, making health care providers accountable to their professional obligations. (INT)

Another kind of external accountability is financial accountability, which, as discussed in Chapter 2, is one of the main causes of corruption and fraud. Financial accountability is thus an important criterion for achieving good governance. In Libya during the Qadhafi regime, there were general audits, local audits and GPC accountability. These measures existed in theory, but in reality, they were not effective, leading to extensive corruption.

Looney (2005: 6) explained the reasons behind the corruption in Libya as follows:

The prevalence of authoritarian rule (lack of voice and accountability) in the region constitutes a hindrance to transparency and accountability at both the state and private levels. Lack of accountability often means state budgets are insufficiently itemized to permit close scrutiny, while important state revenues are managed in extra-budgetary funds or parallel institutions that allow for discretionary spending. Libya's oil revenues, for example, constituting 95 percent of the nation's exports, are held in secret funds and controlled exclusively by Colonel Muammar al-Qaddafi and his associates. Furthermore, most MENA governments compensate for low popular support or poor legitimacy by granting opportunities for bribery to leading families or cliques.

The Audit Institution in Libya, which was initially founded by Law 7 of 1988, was supervised by the highest authority, the GP and, after the revolution, the GNC. This authority aims at improving accountability and standards of governance across the country. It is also dedicated to ensuring that the public funds are spent wisely. In addition, the Audit Institution has branches in all municipalities: these branches are responsible to the General Audit Institution. The findings of a study conducted by Kamba and Sakdan in 2012 show that Libyan audit institutions were characterized by a lack of transparency in their processes and weakness of accountability and effective follow-up, which have resulted in weak government performance and contribute to the absence of accountability and the spread of bribery.

Although Libya introduced a democratic system on July 2012 by holding the first fair election, corruption still exists; in part this is because of the lack of security by militias that has led to the inability of public institutions to fight corruption and mismanagement. The researcher believes that militias are the main element that constrains rebuilding the state and setting up a governance framework for transparency and accountability. Christopher and Chivvis refer to the control of the militias over the state and government as follows:

The lack of security stems primarily from the failure of the effort to disarm and demobilize rebel militias after the war. Both international advisors and Libya's political leadership recognized the importance of rebel disarmament from the outset, but neither has been able to implement it. As a result, various types of armed groups control much of the country and the elected government is at their mercy. Until the security situation is brought under control, progress on all other fronts will be very slow and always at risk. (2014: PX).

The weakness of financial accountability in the health sector affects health policy implementation and health outcomes in various ways. For instance, corrupt health officials working in the health ministries and hospitals misuse material resources for their own financial gain (GPC, 2011:96). In this respect, the Minister of Health revealed that health services have been in bad shape, both before the revolution and after, because of the absence of a control mechanism over all public sectors. He observed that "Quality assurance at present does not exist. There are no quality control bodies to oversee and manage this" (Barakat, 2012:10).

Several of the doctors and civil servants interviewed in the present study expressed similar views regarding the weakness of accountability and effective follow-up having adverse effects on the capacity of the health sector to ensure effective decisions and to prevent corruption and fraud. According to a member of the Administrative Audit Institution, the cause of corruption is the absence of prosecution against those involved in corrupt practices. Both before and since the revolution, no specific institution has served as a tool against corruption. It seems to be the case that people know they can get away with it and not get caught and punished. Effective law enforcement and legal system are important (INT).

5.6.2 Internal Accountability

Internal accountability relates to systems and devices that are intended to achieve compliance to set standards internally.

5.6.2.1 Management Accountability

As previously mentioned, the Libyan health care system and the process of reform are centralized. This has resulted in the municipalities implementing health policies and plans without playing any role in health agenda building.

As noted earlier, the Cultural Revolution in 1973 was the formal adoption of the PCs as the key source of public administration, under this new popular management, all public institutions and ministries became administered by popular management. This popular management theoretically provides participation in decision-making to achieve efficiency in administrative work, but in reality, is characterised by a centralized system with a strong power structure, which means a lack of independence in decision-making at all levels of popular management.

It is important to mention that the centralisation of state power during the rule of Qadhafi had given central government greater oversight and control over budgets, performance and spending, which had in turn resulted in inefficiency in the provision of healthcare services and education and the lack of autonomy in local government.

The Libyan National Planning Council (NPC) affirmed in its 2004 report that Libya is facing a lack of management accountability and absence of clear lines of management resulting from weakness and backwardness of the administrative and functional legislations to keep pace with developments in the field of public administration, the continuous change in the administrative framework and the

cancellation or merging of administrative units. This has been exacerbated by the absence of efficiency accountability and weak performance of employees and inability to deal with the modern administrative systems in public institutions.

Senior civil servants in the health sector who were interviewed for this study spoke about the strengths and weaknesses in several key features of public bureaucracy, such as superiors, subordinates, structure, rules and regulations, and tasks and job descriptions.

The Assistant Undersecretary of the Ministry of Health observed that

Superiors are not selected on the basis of the criteria of efficiency and previous experience, and therefore they are unable to perform their duties as required. He also added that subordinates do not take part in decision-making and they do not get sufficient training and development. (INT)

With regard to structure, rules and regulations, he explained the following:

The continuous change in administrative framework prevented modernization of the structure, rules and regulations in the health sector. This is because of centralization and the fact that administrative changes are often illogical: for example, the abolition of the Ministry of Health during the period 1996-2006. Also, tasks and job descriptions are usually non-specific, leading to conflicts and clashes within the organization, and this has adverse effects on the performance of employees. (INT)

The above shows that there is a lack of management accountability in the public health sector. There is no clear relationship between the actors in the accountability (accountor and accountee) (see Chapter 2). The main reasons for poor management accountability are the absence of task and job descriptions and administrative instability. Identifying tasks and responsibilities is an important element to ensure the effectiveness and efficiency of public sector accountability between supervisors and subordinates.

According to another interviewee, a financial controller in the Ministry of Health,

The main reason for the poor management accountability in the Libyan health sector is the absence of performance measurement in order to evaluate whether organizations and staff have accomplished the authority's goals. (INT)

It is very important to understand that this poor management accountability remains even after the revolution. The legacy of the Qadhafi regime has had adverse effects

on the rebuilding of the Libyan health system. The Qadhafi regime did not pay attention to improvements to the accountability system including supervisory relationships, rules, standard operating procedures, and detailed scrutiny of employee or agency performance. Moreover, the lack of political accountability, security and transparency are the main obstacles to applying management accountability.

5.6.2.2 Professional Accountability

As discussed in Chapter 2, professional accountability in the community is achieved through an increased focus on the proper implementation of professional codes of ethics. In other words, ethical and professional accountability of public sector management depends on the commitment and enthusiastic compliance of professionals employed to structure with a view to delivering services.

During the Qadhafi regime, people were not permitted to form or join unions and professional associations, nor to strike or bargain collectively. Compromise was not allowed between citizens and state. Mogherbi (2011:35) explains how unions and professional associations fall within state control in Libya:

Despite the existence of a plethora of voluntary associations, syndicates and unions representing the interests of all professional groups, they are strictly controlled by the state and their interest articulation and interest representation functions are tightly delineated and defined by the state. They depend on the state financially and they are largely extensions of state institutions. They are created and abolished by decrees and the selection of their leadership is supervised and manipulated ... they are not to act as collective-bargaining units vis-à-vis the state and other organisations.

In the health sector, before and after the revolution, governments have not given attention to the need to enhance professional accountability through codes of ethics, professional conduct and regulation in order to achieve government objectives. The greatest challenge facing professional accountability in Libya is that medical staff have no licenses to practice, which means that the government has no body that aims to protect patients, nurses and doctors. The WHO, in its 2007 report, showed that Libya is in critical need of establishing an independent regulatory body to oversee and regulate the medical profession, to check the credibility and credentials of practicing doctors and to enhance international standards in Libya (p56).

In addition, there is no code of ethics and professional conduct in Libya to ensure that professionals and experts are fully responsible for their actions. During interviews, health professionals at the MOH and local levels suggested that the weak performance of doctors and nurses is a result of the lack of independent regulation of the practice of the profession and the absence of a Charter of Ethics to ensure compliance by doctors and nurses with professional and ethical systems (INT).

5.6.2.3 Consumer Accountability

As discussed in Chapter 2, the role of consumer accountability is to make the public sector more accountable to citizens. The government must be accountable to the entire citizenry: this kind of accountability is based on citizens' perceptions of the services that they receive. This type of accountability is a key element of democracy. According to Behn (2001), the main element of improving citizen accountability is to develop a process, a mechanism, and a system that ensures accountability for its citizens.

As discussed earlier, Libya has been ruled by an authoritarian system, and the decision-making process has taken place in a closed environment with the non-participation of citizens, so the political system did not allow citizens to take part in decision-making. Furthermore, the media was not free, and the government did not disclose information to the public. This situation has led to very poor mechanisms of citizen accountability because of the absence of transparency. Libya, like many other developing countries, either restricted access to official information or made no effort to publish it widely. Such lack of disclosure makes it impossible to highlight and correct mistakes—and possible to camouflage malfunctions (Humphreys, 2003:42).

Moreover, the government has not set up a national ombudsman to receive citizens' complaints. The World Bank (2000:30-32) in an analysis of efforts to improve relations between public organizations and citizens, pointed out that the focus on citizen accountability is important in two ways. First, it reduces access costs to public services for citizens, and second, user feedback can be utilised to improve the performance of public organizations.

According to all the interviewees participating in the present study, the Libyan health institutions, before and after the revolution, have not provided citizens with the right to participate in the mechanism of accountability in order to provide feedback that could be used to improve health services. The reason is the absence of policies that

could develop the accountability of the health system through external communications such as media, public relations and customer service initiatives in order to positively promote health strategies, business and performance amongst stakeholders in government and the community (INT).

5.7 Conclusion

This chapter has focused on several issues in the public health sector in Libya by applying the path dependency approach and showed the importance of critical junctures in the determination of diversified transition trajectories.

The study of health care policy in Libya showed that the predominant role of the Libyan state in all stages in determining the contemporary standard of living for Libyan society is reflected in its commitment to improving the provision of basic health services; one example is its consistent provision of free and universal coverage of health care. However, the state's provision has also been marked by periods of instability. This is because health care policies have been shaped by critical junctures which the ideology of the military coup and Qadhafi theory of the functions of the state set the framework for the processes of public policy and administration.

It is clearly critical juncture which started a path dependent process in shaping health care policy, starting with the military coup in 1969 followed by cultural popular in 1973 and a new political system in 1977. As a result, the political and administrative structures of the state were established to conform with the theoretical foundations of the Third Universal Theory as set by Qadhafi, a socialist approach playing a vital role in shaping health development. The outcome was the health sector forming an integral part of the command economy, with health services and all public services being centrally controlled. The finance of health came from the public budget that was decided at the highest political level and local government and citizens did not participate in deciding on health policy and resourcing. This chapter found that the health decision-making was top-down: the system did not give municipalities and hospitals opportunities to decide their budget.

In addition, this chapter has found that, during the period 1969—1985, the government responded better to ensure the quality of health services. This view is confirmed by four factors that played a vital role in making the relationship between the state and patients one of trust: political will, clear objectives of the health policy,

financial resources, and equity of health services. After 1985, public policy was affected by internal and external factors. Internal factors were the mismanagement and inefficiency of the PCs, whereas external factors include international oil markets and fluctuating prices as well as the international sanctions by the UN. Consequently, the role of the state declined in the health services. The state failed to formulate a strategy for optimal use of resources, manpower development and services, and the health system became weak in terms of responsiveness and performance. It suffered from a lack of equity regarding the distribution of hospitals, health centres and beds. The absence of political will at the highest level constrained the reform process. There is evidence that health plans were abolished after 1985, and the MOH was abolished between 1992 and 1997 as a political body to develop health sector. In addition, government spending on health was characterised by instability.

The collapse of the Qadhafi regime in 2011 inevitably brought an increase in the role of the state in reforming the health sector, in that new plans to rebuild the sector were introduced. It remains the case, however, as outlined in this chapter, that the accountability mechanism in the Libyan health sector is weak, with no performance measurement or indicators. Consumer or citizen accountability and professional accountability remain absent because the Libyan government has not set up regulations or structures for health authorities that enhance the participation of both citizens and professionals in the mechanism of accountability.

Since overthrowing the Qadhafi regime, the new regime has increased expenditure on health reforms in order to improve health delivery and to build new health facilities. Decentralisation has given municipalities and hospitals the opportunity to participate in the process of deciding on health budgets.

The next chapter will be dedicated to a comparison of the decentralisation and accountability of the health care systems of the UAE and Libya, based on the analysis of Chapters 3, 4 and 5. Through this comparative analysis, this research will suggest lessons for Libya to enhance decentralisation and accountability and examine the contextual factors that have facilitated or constrained the implementation of health sector reforms in the country.

Chapter Six : The UAE and Libya: Comparisons, Lesson Drawing and Conclusion

6.1 Introduction

Chapters 3 to 5 examined the ways in which the UAE and Libya deal with the health care system with regard to health policies, decentralisation, accountability and other related issues. The main focus throughout has been on the public health sector. This examination was preceded by the identification of the elements of policy transfer and path dependency in Chapter 2, and a summary of the relevant literature in Chapter 2.

Regarding policy transfer, this research depends on the assumption that lessons can be drawn from the UAE in order to improve public health services in Libya. This has been achieved by applying the framework of policy transfer presented by Dolowitz and Marsh (1996, 2000). In order to build a more complete picture in relation to the success or failure of the transfer, the path dependency approach is used to explain the importance of old trajectories and to illustrate how past legacy could lead to "lock-in" or decrease the ability of the lesson-drawing. This chapter therefore provides a comparison of the health care systems of both countries, considers how some factors constrain policy transfer in Libya, and suggests lessons for Libya from the UAE.

The study's conclusion is then discussed. It commences with an overview of the study's main findings. The last sections discuss the study's contribution to the body of literature in the field of policy transfer and path dependency, limitations of the thesis, recommendations for policy makers in Libya, and further areas of research.

6.2 Comparison of the Health Care Systems

As seen in previous chapters, there are some notable similarities between the UAE and Libya. Both countries are authoritarian regimes: in the UAE, seven families rule

the country, there are no political parties, and no electoral democracy, and all decision-making is controlled by the FSC (Chapter 3). There is not, also, a strong civil society. Similarly, Libya during the Qadhafi regime was ruled by one person who had control over the whole country; there were no real channels for political participation, civil society, or free media. After 2011, the country faced political change that has led to the beginning of a democratic regime by holding the first election in the country, but this political change has proved to be ineffective because of the power of the militias. In relation to the rule of the militias in Libya the President of the GNC, Mr. Mohamed Magarief, expressed his rejection of bullying of colleagues and the imposing of certain decisions by members of the National Congress as follows:

I cannot understand or accept that a number of members of the National Congress, who were among the ranks of the true revolutionaries who chose to join the political process, and entered the general national elections and who presumably accepted the democratic process, use their affiliation with revolutionary brigades and regional loyalties to intimidate their colleagues in the Congress and pressure them to vote in one direction or another. (The Tripoli Post, 2013)

In Chapter 2 it was suggested that participation plays a vital role in improving the interaction of stakeholders in order to meet the interests of citizens. In its 2009 report, the UNDP in the Arab States affirmed that the citizens of the Arab States are facing the problem of exclusion. It argued that the lack of individual empowerment and representation in public institutions has led to the marginalization of citizens in the decision-making process. According to the report, such a lack of local responsible bodies is responsible for the Arabic Spring.

As discussed in Chapters 3 and 4, there are some commonalities between the UAE and Libya in terms of societal culture. Islamism, Arabism, and tribes are important components that constitute a template for culture. Tribes play a vital role in political life in both countries. As Ghosheh mentions, the tribe is the basic unit of social organization in all Arab countries and is the focal point of social life in both urban and rural areas; this social organization is significant in producing administrative and political leadership, since the loyalty of the individual is towards his or her family, tribe, religion and, finally, country (1984:222).

Given that the UAE and Libya have different political systems, as seen in Chapters 3 and 4, both countries are rentier states which derive their national revenues from the sale of oil rather than obtaining income from a taxation system. There are also similarities between both countries with regard to the provision of universal health care free of charge, and the financing of the health systems largely through public revenues. Moreover, the health care system in the UAE and Libya were strongly shaped by a rentier state in which political leaderships chose development plans for achieving developmental changes in order to provide goods and services.

However, there is one notable contrast involving the health care system between the two countries and this is related with globalisation. As seen in Chapter 2, globalisation has had a considerable impact on government and public administration and, in the UAE, there is evidence that globalisation has affected the country: the economy has become closely integrated into the world economy, achieved by investing the oil and gas revenue and transforming the UAE into an important centre in the Middle East in essential fields such as financial services, renewable energy, tourism and technology (Al-Suwaidi, 2011). The development of infrastructure and economic activities has also brought a considerable number of migrant workers to the country. In fact, the UAE has one of the highest migrant/citizen ratios in the world, with over 80 percent migrant population (Khondker, 2008:4). However, although it is clear that the UAE economy has been influenced by globalisation, other elements which are associated with good governance such as elections and a free press are still not to be found. According to Freedom House, political rights and civil liberties are not free from government control (<http://www.freedomhouse.org/>).

Globalization involves opportunities for reforming public administration. In the UAE it appears that the country has taken up some elements of the NPM agenda. As Common argues, the NPM, which is an international reform movement, may take root in the administrative systems of the Gulf States (2008:180). As seen in Chapter 3, the UAE has introduced decentralisation and institutional capabilities, as well as managerial values of accountability, performance measurement, and ethics. With regard to decentralisation, the government has given local institutions autonomy, which can be observed in the fact that medical districts now have the responsibility and power to provide efficient health services. In addition, accountability mechanisms have been introduced with a view to enhancing public sector efficiency,

customer satisfaction, and professional responsibility; all of these represent a clear indication of the modernization of public administration in the country.

In contrast, there is little evidence in the public administration in Libya that modernisation is taking root. As seen in Chapter 5, the country, especially after 1985, suffered from an inefficient public sector resulting from weakness and backwardness of the administrative and functional legislations to keep pace with developments in the field of public administration. The argument that “Authoritarianism and ‘rentierism’ appear to provide easy and immediate explanations for the lack of modernization” (Common, 2008:190) finds justification in Libya. Qadhafi's ideology rejected the party system, constitution and parliament. Officially, the people of Libya held the power, but in reality Qadhafi, his sons, and the RCs had control over the country. Under the circumstances, Qadhafi created chaos in institutional and administrative structures by the frequent merger of or complete abolition of public institutions (Chapter 5). In addition, the Qadhafi regime employed oil wealth to buy the loyalty of people and tribes without any attempt to tackle the problems of economy and mismanagement, and this led to the absence of real incentive to reform in the country and hindered the modernisation and reform process (Chapter 4).

There is no doubt that corruption is widespread in Libya, and the main is the weakness of accountability mechanisms (Chapter5). The government has not adopted any strategies to control the causes of corruption and to move from traditional, centralized, and often corrupt behavior to professional, accountable, transparent, and ethical performance (Jreisat, 2009). Table 6.1 shows that in 2010, for example, Libya was bottom of corruption, with a CPI score of 2.2, whereas the UAE was rated with the highest CPI score of 6.3 out of a clean score of 10. According to the majority of the participants interviewed, the main factors responsible for this corruption are the weak judicial system and lack of accountability.

Table 6-1: Comparison of Corruption between the UAE and Libya

	2003	2004	2005	2006	2007	2008	2009	2010	2011
Libya	2.1	2.5	2.5	2.7	2.5	2.6	2.5	2.2	2.0
UAE	5.2	6.1	6.2	6.2	5.7	5.9	6.5	6.3	6.8

Source: <http://www.transparency.org/>

Regarding health policy, policy-making in UAE can be said to be a success in that it has helped produce clear policies and strategies that meet residents' needs and international standards. In addition, there is political will that has played a significant role in reforming the public health sector in terms of decentralisation (Chapter 3). In Libya, on the other hand, the policies and plans for the health sector are not in place, especially since 1985. The absence of policy formulation and medium-term plans, together with poor governance, are some of the key issues that face the health system in Libya. This is in addition to inadequate capacity and the lack of decentralisation and coordination between the MOH and local government (Chapter 5).

Briefly, given all the issues of accountability raised in Chapters 3 and 5, it is helpful to assess the level of accountability in both countries by comparing certain accountability parameters between the two health systems. Table 6.2 presents this comparison. For more details about accountability in the UAE see Chapter 3, and for Libya, Chapter 5. The content of the table makes the situation clear: the systems that encourage effective practice and a high level of accountability in the UAE are definitely not yet available in Libya. To this extent, it is reasonable to argue that the level of accountability in Libya is weak.

Table 6-2: Accountability Comparison between the UAE and Libya

Accountability	UAE health system	Libyan health system	
		Pre-revolution	Post- revolution
Political accountability	Available and effective, Especially since 2006, citizens have the right to elect half of the members of the FNC	Not available	Available and effective, citizens have the right to elect members of the NTC.
Legal accountability	Available and effective	Available but not effective	Available but not effective
Financial accountability	Available and effective (Parliament and Audit)	Only audit but not effective	Parliament is effective but audit still is weak
Consumer Accountability	Available and effective, as there is interaction between citizens and health service providers (Customer Services Centres and Patient Satisfaction Survey)	Not available	Not available
Professional Accountability	Available and effective, as there are professional codes of ethics and a regulatory body to oversee doctors and nurses	Not available	Not available
Management accountability	Available and effective (decentralization of authority, performance measurements, and information system)	Available but not effective (centralization of authority)	Available but not effective (centralization of authority)

6.3 Factors Constraining the Reform of Health Sector in Libya

Basic problems of the health care system in Libya (Chapter 5) clearly demonstrate the need for efficient health policies. These problems include the legacy of the former regime and the weakness of state capacity. However, policy makers should understand that the context of problems could constrain or prevent the reform. The history of authoritarian regime in Libya, which lasted forty-two years, left a legacy of bad governance. Furthermore, Libya shares common features of the developing countries in terms of lack of modernization in public administration.

The path-dependency approach can be seen as a tool to explain constraints that may have impacted on lesson-drawing. This section presents two factors, namely the Qadhafi regime legacy and state capacity.

6.3.1 The Qadhafi Regime Legacy

The analysis in Chapter 2 showed that there are certain conditions that can facilitate or constrain transfer/learning (Dolowitz and Marsh, 1996). Furthermore, according to path dependency (see Chapter 2), the importance of old trajectories or past legacy could lead to “lock-in” or decrease the ability of the new path. In fact, more recent research also stresses that there are reasons for the legacy of the past being an important factor for reforming public administration. In an empirical study, Goetz and Wollmann (2001) argue that the historical legacies were a decisive obstacle to the reform of public administration in Bulgaria, the Czech Republic, Hungary and Poland because of the tensions and incongruities between inherited and imported policies. They also mention that the communist legacies had negative effects on public administration developments for post-communist reform ambitions: “The communist inheritance of a politicized personnel system, which put party loyalty and reliability above professional qualification, expertise and merit” (p879).

As has been illustrated in Chapter 4, the overturning of the Qadhafi regime liberated Libya from four decades of authoritarian rule but also left a legacy of weak institutional capacity that will remain in place for years to come. This weakness is located at both central government and sub-national governmental levels. During the Qadhafi regime, the administrative system was built on Qadhafi’s theory (see Chapter 4) that led to the abolition of bureaucratic management and replacement of the same with “Popular Revolution” in the municipalities and provinces as well as

public institutions. The administrative system put in place by these practices highlighted the absence of major values in public administration: democracy, participation, the rule of law, efficiency and effectiveness (Wimmer, 2009). The period of the Qadhafi regime ended in 2011, but the inadequacy of effective governance became very deeply ingrained in Libya because of the weakness and backwardness of the administrative and functional legislations, and the lack of discipline in keeping up with developments in the field of public administration. Thus public administration has been heavily influenced by the Qadhafi regime culture. The challenge of public administration in Libya involves overcoming the culture of weakness and backwardness of administrative and functional legislations and inefficiency, and an attempt to break the legacy requires a greater effort from the new government. The legacy of the Qadhafi regime is the source of poor performance in the country.

In the present study, a professor in the University of Benghazi stated the following:

The regime of Qadhafi was marked by the absence of efficient and effectiveness in public institutions because the regime had no real desire for reform. To this end, the regime's policies worked to marginalize the institutions and the government did not seek to tackle the problems of improving performance because the centre of power was Muammar al-Gaddafi, thus creating an absence of political will. (INT)

In the health sector, these legacies are still in place and constrain any reform. Although the political change in 2011 represents a potential “conjunction” that could favour the introduction of reform, the health sector had a “lock in” effect that made change difficult. Ministers and scholars confirm evidence of this and claim that Libya needs a considerable period of time to overcome the legacy.

Dr Fatima Hamroush was appointed Health Minister after the fall of Qadhafi. In her 2012 report she writes that the legacy of the Qadhafi regime will constrain reform in Libya. She argues that the many legislations and proceedings inherited from the former regime will constrain the reform of the health system as well as the bureaucratic cadres that object to reform in order to maintain their personal interests. She adds that local and international studies have shown that the health system needs to be fully rebuilt in order to improve reform governance, financing, service delivery, human resources and information systems in the health system (Ministry of Health Report, 2012).

An important question is how the new regime can overcome the legacy of the Qadhafi regime. Such transferred policies may fail due to what path dependency calls a 'punctuation point' that constrains the acceptance of a new policy (see Chapter 2), and bureaucrats embody a certain legacy and assumptions which may constrain new reform (Peters, 2005). Public administration in Libya is challenged by the need to overthrow the culture of weakness and backwardness of the administrative and functional legislations and inefficiency. The attempt to break free from this legacy requires more efforts from the new government because the legacy of Qadhafi is the source of poor performance in the country. This was emphasised by Professor Youssef Sawani, the former Director of the Gaddafi Foundation, who resigned in February 2011 to join the uprising. He states the following:

Libyans are in need of a long period in order to deal with the consequences of Qadhafi's rule and the negative impact of his policies. Qadhafi destroyed the concept of state and institutions and made war on society and its political and civil organizations. The worst of his deeds were not those connected to repression and killing and squandering the national resources in comparison with his role in shaking the value system of society and upsetting the components of its political culture. This places Libya before many challenges that demand patience and the employment of all energies to ensure the shortest possible interval of time necessary to embark confidently on a process of building. (2012:p22)

If the Libyan government wants to deal with the legacy of Qadhafi, the government should rethink its public administration. Ivanova and Evans (2004:101) wrote the following after detailing the state-building in Ukraine in order to break the legacy of communism:

State building in the Ukraine would prove a daunting task for not only was it necessary to develop a whole new system of public administration but it was also necessary to construct new public infrastructure and develop the human resources and appropriate institution of governance and forms of public management to deliver on national development goals. (p101)

These words hold certain relevance when considering the ability of the Libyan government to cope with the legacy of Qadhafi. In addition, political will is an important way of tackling the problems of legacy: the ability to overcome the

negative effects of the Gaddafi legacy depends on the extent to which the new government desires to modernize Libya.

6.3.2 State Capacity

State capacity is central to any reforms or development programmes that these countries seek to promote. State capacity is defined as the state's ability to formulate and develop programs to implement public policies as well as manage resources and evaluate current activities to guide future action (Honadle, 1981; Bangura, 2000).

Although oil revenues strengthen the Libyan government's ability to promote and implement policies of economic and social transformation, the findings of this study indicate that Libya faces many challenges that constrain the development of the country. As discussed in Chapter 5, there has been administrative instability in the structure of the state; this has led to a lack of government support for health programs and to a waste of resources. According to the majority of interviewees, we can summarize their view as there was instability in the structure and organization of the administrative apparatus of health and this is an obstacle to the achievement of good performance. Consequently, there has been no clear reform process of the administrative system over the past three decades because of the cancellation or merger of administrative units and the loss of efficient administrative leaders (INT).

As explained in Chapter 5, the national health system failed to formulate a strategy for the optimal use of resources, manpower development and services, and the Libyan health system became weak in terms of responsiveness and performance. It suffered from a lack of equity regarding the distribution of hospitals, health centres and beds. Following the Qadhafi regime, the healthcare system worsened because of the armed conflict, which had a direct effect on the deterioration of health service delivery.

Rose argues that the main obstacle to lesson drawing is the lack of an adequate number of trained professionals (2004). According to the Libyan Audit Bureau report in 2012, the public health sector faces many staffing problems caused by the high rate of absenteeism, the low productivity of public medical staff, and corruption and fraud. These factors play a major role in undermining health service delivery. In addition, some of the interviewees in the present study expressed the view that there are no health information systems or guidelines and this situation reduces

effectiveness and efficiency in analysing departmental performance (INT). According to the WHO, the absence of a health information system in Libya has led to many problems such as uninformed decisions, poor planning and evaluation, and a waste of time and resources (2007:43).

It is important to understand that the problems of medical staff do not come from the lack of doctors and nurses in public health institutions, as can happen in some developing countries, since, according to Table 6.3 , the number of human and physical resources in Libya is greater (per capita) than the UAE.

Table 6-3: Human and Physical Resources-Rate per 10,000 Population in 2011

	Physicians	Nursing and midwifery	Dentists	Pharmacists
Libya	20	68	6	6
UAE	14.7	6.2	6.1	0.7

Source: WHO <http://rho.emro.who.int/rhodata/?vid=2623>.

According to the WHO, the standard of doctors and nurses is inadequate due to poor quality nursing education and a lack of clinical experience content (2007: 54-55). This report recommended four approaches to develop human resources in Libya as follows:

- Long-term strategic planning for human resources development as part of the national policy and strategic planning functions;
- Redesigning the way health professionals are trained to emphasize evidence-based practice and providing more opportunities for interdisciplinary training;
- Modifying the ways in which health professionals are regulated and accredited to facilitate changes needed in care delivery;
- Using the reward system to support changes in care delivery while preserving its role in ensuring accountability among health professionals and organizations.

Because of administrative instability, the MOH did not take steps to implement the above recommendations. As discussed in the previous chapter, the public sector in Libya experienced several changes during the Qadhafi regime which led to a weakening of administrative capacity and changing responsibilities of the

government in the health sector. The instability in the public health sector was detrimental to performance and led to high inefficiencies in the application of plans and use of available resources.

From the above discussion, it is evident that the Libyan government is unable to provide proper health services because of the lack of specialist doctors and the quality of nursing care.

One of the most important tasks for the new Libyan regime is strengthening the capacity of government in terms of development programs, and human resources. The importance of strengthening state capacity was emphasised by Dr Nagi Barakat, the first Health Minister appointed after the fall of Qadhafi. He emphasised the need for partnership and capacity management in order to develop health services:

The partnership with the private sector should continue to develop but needs regulation and attention...there should be a direct partnership with individual hospitals, to cover all priorities. Libya's health services need good quality leadership, experienced managers, dedicated working doctors, nurses and technicians. (Barakat, 2012)

Clearly, the lack of state capacity in Libya undermines the ability of state to manage the reform process.

As discussed in Chapter 2, decentralization is a vital aspect of good governance and a key part of political and administrative reform. Decentralisation of a health care system seeks to make health services efficient and effective by transferring power to low level administrators and giving local institutions autonomy.

The study has shown that Libya has a long history of authoritarianism and political life dominated by the military and central government and characterized by a high degree of centralization in policy formulation and decision-making. This has created the phenomenon of the state being unable to raise interest in a fair and proportionate manner towards the actual needs of differing segments of society to achieve social cohesion and social justice. The Qadhafi regime failed to determine the precise political and administrative relations between the central government and local governments. This failure was because of the absence of effective decentralization. It is interesting to note that all interviewees participating in the present study agreed that centralization in Libya played a major role in constraining reform to improve the delivery of services and goods. In addition, the general consensus among those interviewed was that Libya's health system is centralized (INT). In this respect, the

decision-making process and setting priorities are centralized, but this provides neither for political participation nor for channels between citizens and providers of public services.

The implementation of decentralization in the health sector after the revolution has led to a number of benefits but is constrained by the absence of an interface between local people and local governments, and the lack of coordination between central and local administration. According to a consultant in the Ministry of Labor, the government has failed to provide sufficient incentive at local level to support their autonomy, and this situation puts obstacles in the way of local level trying to provide health services that are efficient and effective (INT). According to the 2010 World Public Sector Report, “Decentralization is not a one-time action but an ongoing process that requires innovative ways of structuring and institutionalizing the interface between people and their local governments” (p 88). This suggests that it would be a good idea for the Libyan government to develop the interface between people and government in order to enhance decentralization. The above report includes several elements for successful decentralization as follows:

- Legal frameworks and structural arrangements to devolve power not only to local governments but also to local communities;
- Strengthened local government capacity to perform governance functions;
- Local government responsiveness and accountability to both citizens and the central government;
- Enhanced role for civil society, with civil society organizations and the private sector working in partnership with local and national governments; and
- Evidence of government intent to improve the quality of life in local communities, and demonstrable progress in doing so. (Ibid., p88)

The Libyan health system needs to improve program coordination and to increase support for local government as well as citizen participation in rebuilding public support for the Ministry of Health (Krut et al., 2010:94). This has constrained wider participation from other important stakeholders, such as health departments in municipalities and hospitals, in the formulation of health goals and the provision of better services (see Chapter 5). This absence of coordination and participation between central and local government has hindered the government capacity to improve health delivery.

Another problem of state capacity is the lack of accountability. The previous chapter concluded that the accountability mechanism in the Libyan health sector is weak, with no performance measurement or indicators. It is therefore significant to understand factors that have led to the lack of accountability as this will enable us to understand and examine the instruments of accountability in the UAE that can lead to reformation of the public health services in Libya. As Madavo (2006) observes, state capacity relies on its ability to deliver quality public goods and services that meet the needs of the population. Effective states require accountability and for this to occur the government must ensure participation between government and people. The main source of the weakness of accountability is the lack of public official responsibility. As was noted in Chapters 4 and 5, the prohibition of political organizations, political participation, elections, parties and media during the Qadhafi regime led to the inability to achieve external accountability. Furthermore, the absence of a democratic parliament led to a lack of transparency. Libyans were unable to evaluate public policies and decision-making because audit institutions were characterized by a lack of transparency in their processes and weakness of accountability and effective follow-up.

In the case of the public health sector, those interviewed in this study feel that lack of public official responsibility has had the most negative effect on providing better services (INT). They expressed the view that the weakness of accountability has adverse effects on the capacity of the health sector in ensuring effective decisions and in the prevention of corruption and fraud. As indicated in Chapters 4 and 5 when discussing financial accountability, corrupt health officials working in the health ministries and hospitals misuse material resources for their own financial gain (GPC, 2011: p 96).

Although in July 2012 Libyans were able to vote in a national ballot for the first time in almost six decades (see Chapter 4), considerable improvements in enhancing accountability were not made until recently. The lack of public official responsibility of the Libya public sector now derives largely from three factors as outlined in the following paragraphs.

Firstly, as discussed at the beginning of this chapter, the Qadhafi regime period ended in 2011, but the inadequacy of effective governance had become very deeply ingrained in the country, as a result of the weakness and backwardness of the administrative and functional legislations, and lack of discipline in keeping up with

developments in the field of public administration. The public administration has been heavily influenced by the Qadhafi regime culture. In addition, the Ministry of Health shows that legislation and proceedings inherited from the former regime have had a constraining impact on the reform of the health system, while bureaucratic cadres have acted against the reform in order to maintain their personal interests. According to a study by Kim (2008), developing countries need to be more focused concerning administrative reform in order to improve and enhance the culture of responsibility in the public sector.

Secondly, Libya is now facing the problem of security because of militias having more power than the state (see Chapter 4). According to the General Audit report in 2012, the lack of security in the country has had a negative impact on the public institutions and public companies, and this has led to the emergence of negative and criminal actions against these institutions, such as theft and vandalism, as well as threats towards public officials.

Finally, Meyer-Sahling (2009) argues that the constitution is important in defining the relationship between politics and public administration in order to put civil service systems under the rule of law. In Libya, under Qadhafi, there was no constitution after 1977. This has led to the absence of clear lines of responsibility. Following the Qadhafi regime, Libya is now on the road to building a constitution.

In relation to trust in the Libyan health system, as explained in the previous chapter, a report issued by the General Planning Council of Libya affirmed that Libya faces a lack of confidence on the part of citizens with regard to Libyan doctors, and this is evidenced by the fact that many Libyan patients travel to neighboring countries such as Egypt, Tunisia, Jordan and Germany for treatment. It is clear that the poor performance of public facilities is one of the main reasons for this. Almost all respondents in this study (doctors and civil servants) believed to a greater or lesser extent that the government failed to design an effective system to provide better services. This can be attributed to the failure of the national health system to formulate a strategy for optimal use of resources, manpower development, service delivery, particularly within health professional manpower, corruption, and a lack of equity (see Chapter 5).

Ryzin (2011:747) argues that governmental processes should seek to achieve "Fairness, equity, respect, and honesty" and added that these elements are very important because "they may well matter to people as much as do outcomes". In the

case of Libya, the lack of equity principle was mentioned by most of the interviewees in the present study as well as the centralization of the health system, suggesting that this system has failed to provide opportunities for municipalities and hospitals to control their budgets because the allocation of resources between municipalities is unequal. Furthermore a shortage of equipment causes a further lack of confidence (INT). The WHO's report in 2012 shows that none of the Libyan hospitals has a complete supply of basic medical equipment and that not all available equipment is fully functional.

In addition, the conclusion reached by Siddiquee in his 2005 study of public accountability in Malaysia may be appropriate for the diagnosis and the reality of accountability in Libya. He observed that the weaknesses and deficiencies of accountability are the result of the political and administrative culture in the country that have an adverse effect on professionalism and integrity in public service. This requires a review of the existing mechanisms and developing comprehensive strategies to fight the weaknesses (2005:125-126). In the case of Libya the challenges and constraints that hinder promoting accountability are described as political and administrative culture by Siddiquee.

6.4 Analysis of the Extent to which Lessons from the UAE Might be Transferred to Libya

As noted in Chapter 2, according to Dolowitz and Marsh (2000), policy-makers at the national and international level depend on advice from consultants, whether individuals or companies, in the development of new programs, policies and institutional structures. Experts play an important role in identifying best practices that policy-makers can then learn from. In spite of the fact that voluntary policy transfer is a rational action, Dolowitz and Marsh (Ibid, 14) mention that problems will drive actors voluntarily to search for new ideas in order to reform the status quo. As also noted in Chapter 2, Common argues that voluntary policy transfer may take two forms, namely learning and copying. In this review, the main features of the public health system in the UAE were discussed in Chapter 3: the UAE's health system provides lesson-drawing that can potentially help with the reorganization and improvement of the Libyan health system services.

As discussed in the beginning of this Chapter and Chapter 5, the Libyan Health system is an inefficient and underperforming system that has failed to formulate a strategy for optimal use of resources, manpower development and services and thus has become weak in terms of responsiveness and performance. Thus, lesson-drawing is important; Stone (1999) states that an inclination towards lesson-drawing helps decision-makers to respond to crises appropriately because they will examine lessons elsewhere which are linked to the existence of evidence.

The study has found that the UAE has a modern health care system with facilities and professionals capable of providing excellent care and performing advanced medical procedures. This shows that the UAE health system is interested in the efficient use of public health resources, as reflected in the health information system dealing with the quality, safety and efficiency of the health services, professional accountability and measurable healthcare performance. This is undertaken with the sole aim of evaluating performance of healthcare in order to achieve accountability. It is possible, therefore, to learn from the practices of the UAE public health policy as a benchmark for a number of key improvements for the existing system of public health services and policies in Libya.

To this end, it can be said that the study findings have significant lessons for policy making and reform in the Libyan health sector. This study recommends the learning/transfer of a number of elements: health strategy, decentralization, professional regulation, public sector performance measurement, and managerial accountability, all of which are internationally applicable but are not place in Libya at the moment.

6.4.1 Health Care Strategy

The first potential lesson identified is that the UAE Health Care Strategy embraces a wide range of issues including better health, access, quality, and efficiency. As seen in Chapter 3, the UAE government launched a strategy for the highest standards of living for its citizens by raising the standards of health care. This strategy included principles that aimed to achieve effective coordination and cooperation among entities and with local governments. This involves mobilizing and coordinating resources and efforts in the various sectors to promote health and to control the social determinants that have a major impact on health such as housing, education, and income. Moreover, this strategy seeks to ensure universal access to healthcare

services, to provide world-class healthcare and to reduce epidemic and health risks (Chapter 3).

As discussed in Chapter 5, the national health system in Libya has not emphasized the development of a comprehensive plan that can examine the health system as an integrated system. On the subject of health plans, a senior official of the MOH acknowledged in an interview that the MOH suffers from lack of policies, programs, clear objectives and priorities, which has led to slow administrative procedures, in addition to other constraints which have impacted negatively on the overall output of the health system (INT).

The WHO's report in 2011 points out the following challenges that face the Libyan health system:

- Lack of technical health policy and planning function inside the planning department.
- Need for strengthening capacity of national institutions and personnel to implement health programmes.
- Lack of framework to facilitate joint action by health related sectors and institutions. (p30)

It is clear that the health care strategy appears to work well in the UAE. As Common (2004) states, the learning from an international environment is the most effective way to improve organizational performance, as it offers policy-makers an opportunity to adopt ready-made solutions from elsewhere. In Libya one of the most important lessons to be drawn is the importance and the possibility of formulating a health strategy in a similar way to that of the UAE. Learning about health strategies from the UAE will contribute to remedying the troubled health care organizations in Libya. McIlwain and Johnson (1998:638-639) confirm that "The importance of the strategy process is to help an organization develop a philosophy, process, and procedures for being more efficient and effective in its environment while carrying out its purpose with a sense of vision and value".

According to Common (2004:47), when making recommendations that might help policy makers and technocrats to reform the Libyan health sector, "Policy learning appears to offer a clear account of how various agents actively disseminate policy innovations".

The health system in Libya needs to formulate health strategies that include clear targets, concrete plans and feasible implementation instruments. Annette King,

former Minister of Health in New Zealand, emphasizes the importance of health strategy to set the direction for action:

Goals and objectives translate the broad intentions of the Government into the focused actions ('strategies') required to make a difference to improving health. Decisions on setting priorities and the effective use of resources are made all the time throughout the health sector. Developing a nationwide set of goals and objectives will assist the whole sector to direct their actions in a more co-ordinated and effective way. (2000:8)

In summary, the most important priority for strengthening the health system is to develop a strategic vision for the health system. This strategy should be accompanied by the re-engineering of the health system to fulfil its goals.

6.4.2 Decentralization and Institutional Capacity

Libyans are dissatisfied with the centralized system because they consider that the former regime adopted centralization in order to take over the decision-making process in line with the interests of the ruling elite. It is worth mentioning that since the revolution the government has taken steps to enhance decentralisation, but it is still weak. The majority of participants in the present study mentioned that centralization hinders the wider participation by important stakeholders and thus constrains providing good services.

The lessons from the UAE should be of interest to those currently planning the future of the health system in Libya. In particular, in the UAE health sector, decentralization has meant that the MOH is responsible for formulating national health policies which regulate all health and medical practices in the country, while nine medical districts have administrative and institutional capacity to plan, organize, supervise and develop their own health care services. The administrative set-up at the district level represents all sectors of the ministry in the form of corresponding departments and sections. Each medical district also contains several health organizations within health centres and hospitals. However, the role of the MOH is to ensure and guarantee the provision of decentralized administrative services according to applied quality, efficiency and credibility standards. Policy decentralisation in the UAE is indicative of what Bossert calls "Decision-Space" (Chapter 2), as this thesis found that health districts have a high degree of decentralization and power in setting priorities and decision-making while the role of the MOH is policy-making,

coordination and cooperation between the ministry and districts. Decentralization and institutional capacities in the UAE health sector at both the central and local levels have resulted in many benefits including the achievement of better services delivery.

In the case of Libya, the decentralization of the health sector and achievement of successful goals should focus not only on the distribution of powers but on the building of institutional capacity. However, the decentralization and institutional capacities in Libya still require further work. The success of decentralization in the health sector requires learning from the experience of the UAE through improvements in the following:

- i. The decentralization of health services and transfer of responsibility to local authorities in the provision of comprehensive health services for the local population. Each regional authority should have the administrative capacity to plan, organize, supervise and develop its own health care services. In addition, the MOH in Libya should work to break up the traditional bureaucracies and give autonomy to local authorities. Senior management should be delegated to make decisions with clear responsibility and accountability relationships.
- ii. Adopting the board of directors model in order to enhance decision-making to improve health outcomes. The board of directors is a significant tool for improving management. It is subject to development of the authority's public policy, and to approval of plans that are necessary for the implementation of policy and for the development of mechanisms for responsibility and accountability (Wilks, 2007).
- iii. The MOH in Libya should devolve responsibility for budgets and financial control to decentralized units. Health care providers must act in ways designed to ensure that each facility is economically and efficiently managed and has, at all times, access to adequate financial resources to ensure that it can carry on the provision of healthcare services at each of the facilities operated by it (<http://www.haad.ae/haad/>). In addition, the MOH in Libya should be attentive towards creating mechanisms that focus on how funds are allocated and how they are actually spent.
- iv. The UAE has taken considerable action towards building capacities at both individual and institution levels: this is a development which should be transferred to the Libyan health sector. The capacity implications of decentralized management in the UAE health system can be summarized as the Federal

Authority for Government Human Resources (FAHR) was established by the federal government to strengthen the capacity of employees and develop their skills. This authority has succeeded in improving operational performance management by creating the best standards that make the work environment extremely successful. This is what public administration in Libya requires. Bureaucratic and managerial behavior in Libya tends to pursue personal rather than organizational goals: a situation which has had an adverse effect on civil servants' performance. The public sector in Libya should be entrusted with obligations and responsibilities to serve society. The creation of a foundation that seeks to develop the capacity of the civil servants and the introduction of a Code of Ethics and Professional Conduct are both significant ways in which Libya can provide a better service to the public, and increase confidence and credibility in the government sector.

What can be concluded from the above discussion is that the lack of decentralization and institutional capacity are the major issues that impact negatively on the ability of the public health sector to provide better health services and to strengthen the trust between citizens and public health sector. The findings of this section offer recommendations for the Libyan health system. Decentralization and institutional capacities in the UAE can be applied in Libya in order to encourage local health officials to be more responsive in providing better health services.

6.4.3 Professional Regulation

Hutton and Massey (2006), in their discussion of the issues involved in improving public sector performance, argue that what is required is professional bodies that have the power to issue licenses to practitioners and to provide practitioners with responsibility for using their experience and professional codes of ethics. Such professional bodies contribute to improving deliverance of goods and services to the public by developing professional behaviour. In other words, professional bodies seek to achieve public interest and public accountability and to protect their members from unfair or unethical demands made by managers or politicians. As discussed in the previous chapter, the Libyan health sector, both before and after the revolution, has lacked a regulatory body that checks and follows up professional practices. A report from the WHO (2007:56) stated that Libya is in critical need of establishing an independent regulatory body to oversee and regulate the medical

profession, to check the credibility and credentials of practicing doctors and to enhance international standards.

El Oakley et al (2010) observe that the lack of an effective professional organization in Libya has led to poor performance of health professionals as well as the loss of public confidence in the medical profession. They recommend professional regulation as an important instrument for the modernization of the health care system in Libya for the following two reasons:

- a) There is a need for the establishment of independent professional regulatory bodies to regulate the medical, dental, pharmaceutical, nursing, and other allied health professions. These bodies should be statutory and non-governmental institutions. They also should work independently yet in tune with each other. Their remits are to regulate the professions through registration, certification, and re-certification. They should also be responsible for issuing professional guidance, ethical standards, and codes of conduct. They should be responsible for assessing the professional fitness to practice when this comes into question. They should monitor medical and paramedical education at both undergraduate and postgraduate levels to ensure that training programmes and university curricula meet the agreed standards and are delivered effectively and reliably.
 - b) Re-certification should only be possible if the professional has a good, continuous professional development record and demonstrates evidence of safe performance through audit.
- (2010:6)

Professional regulation in the UAE plays a vital role in overseeing and regulating health care practitioners. Until now the UAE has lacked independent organizations who can organize and follow-up licenses for practitioners: the MOH is the only authority responsible for the medical profession in the UAE. In many developed countries, such as the UK, the medical professions are supported by self-regulatory bodies such as the General Medical Council (GMC). This body was established in order to ensure patient safety and quality of care (Crinson, 2009). The Medical Licensing Department in the UAE is responsible for both issuing and withdrawing licenses for medical practice in all medical districts. Its aim is to raise the level of healthcare services in the country and to regulate medical practices and licensing in the private sector, which includes healthcare professionals and facilities, according

to federal policies and procedures. The MLD is the sole authority responsible for licensing and monitoring doctors (<http://www.moh.gov.ae/ar/About/Pages/default>).

In addition, the Nursing and Midwifery Council (NMC) was established in 2009 to regulate the nursing and midwifery professions and promote and advance nursing and midwifery services. It was also given the responsibility of protecting, promoting and ensuring the health safety of the public based on the highest standards (NMC, Annual Report 2011).

It is clear from the above that the UAE has given attention to the enhancement of professional bodies and regulations in order to achieve government objectives. This is achieved by making doctors as well as nursing and midwifery professionals accountable for quality service provision and maintaining the highest standards.

As previously noted, the health care system in Libya has suffered long periods in which there has been no independent regulatory body, professional guidance or ethical standards. In this context, the Senior Planning Officer from the Ministry of Health stated:

I am sure that the poor performance of professionals is the lack of professional organization that works to raise the level of the professional of medicine, and evaluate the qualifications of the medical practitioners in order to ensure that practitioners comply with the standards. (INT)

He added that “The absence of a professional body has made it difficult to deal with doctors whose medical skills are in doubt”.

Another problem is the absence of modernization in health legislation. As the Medical Director of the Central Hospital in Benghazi stated:

The Health Act of 1972 was old and did not undertake changes responding to international developments in the delivery of health services and all cancellations and merging of administrative units in the health system happened while ignoring the principles of the Health Act. (INT)

There is no doubt that Libya should learn from other countries in order to improve the performance of its professionals. Libya needs to enhance the confidence of its citizens in the health system and this requires the building of professional self-regulation.

6.4.4 Performance Measurement

As seen in Chapter 3, performance measurement lies at the heart of public sector management because it achieves two tasks: providing comprehensive information and helping to achieve greater accountability. In practice, performance measurement in institutions helps stakeholders to access diverse information about performance, and the extent to which the institution is able to achieve its goals (Mimba et al., 2007).

The Libyan government needs to instil greater public sector performance measurement. Health service performance indicators and measurement must become central to the work of health system managers in order to achieve the overall goals of the health system and to tackle low performance and corruption. In this it can learn from the UAE, which is experienced in using performance measurement. As explained in Chapter 5, the MOH has applied performance measurement to improve health services through different levels of the public health system, including performance of individuals, programmes, agencies, and evaluation, in order to provide a clear line of accountability and efficiency (Chapter 3). Performance measurement in the UAE health system has adopted tools to measure progress in accordance with national and international goals as well as using comparative data in decision-making.

6.4.5 Managerial Accountability

As discussed in Chapter 5, and earlier in this chapter, the accountability mechanism in Libya appears to be weak and ineffective and reform is urgently needed. The internal lines of accountability in the Libyan public health sector are absent and require the establishment of rules of operation for the relationships between middle managers, senior officials and ministers and the delegating of authority to managers, who are then held accountable for their performance and cost.

As noted in Chapter 3, the UAE has emerged as a successful state in the fight against corruption. According to the Transparency International (TI) report in 2011, the UAE was rated with the highest CPI score of 6.8 out of a clean score of 10 and won 28th place globally in the index (see Chapter 3). In a 2013 report by the United Nations the UAE was evaluated as being compliant with the requirements of the United Nations Convention Against Corruption and the team hailed the steps taken

to prevent corruption (<http://saiwb1.saiuae.gov>). The UAE government has paid attention to the strict enforcement of anticorruption laws, professionalism, and code of ethics. For example, in order to ensure the safety of public funds, proposals for the improvement and reform of internal control and funds, management systems that will assist in the safeguarding of these funds through better governance arrangements are required. In 2011, the SAI issued the Fraud Control Framework, which is a system of co-ordinated measures put in place by organisations to prevent, detect and respond to any instances of fraud (<http://saiwb1.saiuae.gov.ae>). Consequently, Libya has much to learn from the UAE experience and should follow its example in relation to its anticorruption mechanisms, ethical standards for public servants, and the release of information to the public to promote transparency. In addition, Libya needs to establish an independent anti-corruption agency in order to check administrative abuse and hence ensure public accountability. As Siddiquee (2005:118) emphasises, “an independent anti-corruption commission can go a long way in fighting this social evil”. If such an agency is to be successful in reducing governmental venality, it should include the following elements as described by Heilbronn (2004:14-15):

- It is required that the agency be given legal authority to take any measures necessary to fight corruption.
- The agency must be independent from interference by the political leadership. If the agency is linked to parliament and security agencies, the agency loses credibility as it becomes nothing more than a tool of the parliament.
- The agency should receive reports from the Auditor General without interference from any hierarchy. If the Auditor General reports directly to the president in a confidential report, the president might withhold information that can potentially be damaging to the administration and this will lead to the lack of transparency and accountability.
- The existence of an oversight committee in the anti-corruption agency is necessary to prevent any political persecution of the opposition politicians.

Comparative analysis between the UAE and Libya also suggests that the Libyan public sector should learn performance budgeting. As discussed in the beginning this chapter, globalisation and modernization have had a greater impact on public administration in the UAE than in Libya. This appears applying some idea of the

NPM. As seen in Chapter 5, the health budget in the UAE is determined by the objectives of the government and performance, and thus encourages improvements in the efficiency and effectiveness of the use of public money. This budget links spending and the performance of results in order to demonstrate efficiency in the implementation of activities, programs and objectives that are expected to provide quality and efficient services with optimum use of funds and with priorities of spending. In Chapter 5, the weakness of financial accountability in the Libyan health sector was shown as significantly affecting health policy implementation and health outcomes in various ways, such as corrupt health officials working in the health ministries and hospitals, and the misuse of material resources for their own financial gain. In this context, performance and objective budgeting can be seen as the primary way of increasing efficiency and effectiveness for using public money in Libya. Performance budgeting can help the control of money in the public sector and combat corruption. In this way, it will improve public health sector effectiveness, accountability and transparency by linking performance with outcomes.

In external accountability, the strengthening of parliamentary oversight is an important factor in reducing ineffectiveness and the lack of accountability in the public sector (Chapter 2). As discussed in Chapter 4, after the fall of the Qadhafi regime, Libya witnessed the establishment of a new phase in its political system. According to the provisional constitutional proclamation, the GNC became the first democratically elected institution. However, because of the power of the militias (Chapter 4), the GNC has failed to achieve parliamentary accountability of the government and its administration by what Siddiquee (2005) calls “a powerful watchdog”.

In order to enhance the responsibility of ministers and the administration before parliament, Libya needs to learn from the experiences of developed countries like the UK, where there are mechanisms that help to create civil servants' accountability to parliament, such as the parliamentary ombudsman, who watches over government activity in the interests of citizens, oversees the investigation of complaints of improper government activity against the citizen, and enhances bureaucratic accountability to parliament. With regard to the health system, the issue of equity/fairness will benefit greatly from this kind of accountability.

It is also important to consider a different kind of accountability, namely consumer or client accountability. In Chapter 5 it was explained how Libyan governments, before

and after the revolution, implemented no regulations or structures in health authorities for the purpose of involving citizens in the mechanism of accountability. Thus, the relation between providing services and receiving services is still absent. Mechanisms need to be created for citizens to judge the effectiveness of services. According to the World Bank (2003), for the government to be responsive to the needs of the citizens, government agencies need to know what citizens want and how citizens evaluate the quality of public services provided.

The UAE has been successful in improving client accountability. Although political participation is almost insignificant, the government has placed units in health authorities as a part of the reform of public services. The government established a Customer Services Centre (CSC) which aims to ensure that customers are provided with the right services and information and which doubles as a tool to measure patient satisfaction. The CSC can be seen as the primary way of interacting with customers. This institution aims to create a culture built to meet the priorities of the clients, to prepare and develop a comprehensive plan for customer service, and respond to customers' complaints (see Chapter 3).

6.5 Conclusion

This thesis has two main aims: to provide a comprehensive and systematic picture of the public health service and its attendant decentralization and accountability system in Libya and, at the same time, to learn lessons from the UAE which can be transferred to the Libyan context in order to achieve a more effective health service. To address thesis aims, the research has built a conceptual framework in Chapter 2 which is relevant to understanding how Libya has reformed its public sector. In this study both policy transfer and path dependency have been applied.

The first stage of the research involved an investigation of the public health sector in the UAE (Chapter 3), the health care system in the UAE was examined by focusing on health care policy, organisation, delivery and finance, decentralisation, and accountability. This revealed that the UAE health system is interested in the efficient use of public health resources, as reflected in the health information system dealing with the quality, safety and efficiency of the health services, professional accountability and measurable healthcare performance. This is undertaken with the sole aim of evaluating the performance of healthcare in order to achieve

accountability. It is possible, therefore, to learn from the practices of the UAE public health policy as a benchmark for a number of key improvements for the existing system of public health services and policies in Libya. In addition, this research offered reasons for why a lesson could be drawn from the UAE. A range of arguments and discussion were put forward as to how, for example, globalization has made policy transfer a key feature of the contemporary state. Both developed and developing countries have improved their public sectors and upgraded the quality of public services by learning from foreign experiences. Moreover, a similarity in the transitional phase between Libya and the UAE, and their common cultural and economic backgrounds, are important factors that can potentially work to facilitate policy transfer between the two countries in order to recommend lesson-drawing for Libya.

Chapters 4 and 5 were dedicated to the analysis of the socio-economic and political environment in Libya and how far the political, socio-economic and policy environments in Libya have affected the public health sector. Chapter 5 outlined how the tracing of political and economic factors can help in understanding the trajectory of the delivery of health services in the Libyan administration and how far they are embedded in the Libyan health care system pattern. Viewing the picture in terms of the periods of evolution of the health services during the Qadhafi regime, two seemingly contradictory reform episodes were explored: the path-dependent dynamics of the reform of the public health services in the period 1969-1985, and the path-breaking reform after 1985. During the first period, the government was responsible for providing health services, and this was translated into social development plans and an increase in the state activities in the health sector through providing comprehensive better health services to all citizens. The second episode (path breaking reform) after 1985, saw a decrease in the role of the state in the health services. This is explained by endogenous and exogenous factors (mismanagement, corruption, a decrease in the oil price, the abolition of social development plans, and the UN sanctions on Libya). In analyzing these episodes, the starting point is the rentier state: Libya derives its income from the sale of oil, and oil revenues are used to relieve social pressures and to obtain the loyalty of the people. This led to the weakened state capacity because the government functioned as a centre for redistributing revenues rather than for planning and development. Furthermore, decision-making within government structures was highly centralised,

the result of the nature of an authoritarian system that was characterized by a centralized system with a strong power structure which resulted in a lack of independence in decision-making at all levels, with the health care system being no exception. Another point is the weakness of the accountability mechanism. There are several factors which help to explain the poor accountability in the delivery of health services in Libya: these include the lack of autonomy, administrative instability, political intervention in selecting public managers without the criteria of efficiency and experience, lack of task and job description, and the absence of professional bodies and a professional code of ethics.

The rentier state, the authoritarian system, centralization, the low of institutional capacity, and the weakness of the accountability mechanism all constrained the development and modernisation of the administrative system during the Qaddafi regime, and they became part of the administrative system and have produced a strong historical legacy. After the overthrow of Qadhafi in 2011, the new government introduced the reform of the health sector, including decentralization policies, but the legacy of the former administrative system is still in place. The empirical findings of the study showed how legislations and proceedings inherited from the former regime have constrained the reform of the Libyan public health sector. This reveals how legacies can help to explain resistance to reform that might constrain policy learning from the UAE. Learning successfully from the UAE depends largely upon the ability and commitment to reduce the adverse effects of the Qadhafi regime legacy. As discussed in Chapter 1, such transferred policies may fail due to what path dependency calls a 'punctuation point', which highlights the introduction of a new policy. Findings of this study have shown that the Libyan health system policies and experiences under the legacy of Qadhafi were the main cause of the weak health service delivery and this legacy may constrain the reform of the health system. In view of this, the new government needs to deal with the consequences of Qadhafi's rule and the negative impact of his policies. This requires constructing new public infrastructure and developing the necessary human resources and an appropriate institution of governance and forms of public participation.

Based on this comparison between Libya and the UAE, Chapter 6 identified the deficiencies of the Libyan system and the potential improvements regarding decentralisation and accountability. It was identified that the health care system in

Libya has suffered long periods of low institutional capacity, centralization, a lack of trust and a lack of accountability. This was further complicated by the low productivity of public medical staff, corruption and fraud, the undermining of the health service delivery and inequity. It was revealed that no reforms took place during the Qadhafi regime because of the lack of desire to adopt decentralization or to strengthen institutional capacity and accountability. After the revolution, the new government showed willingness to reform the health system, but it still needs to tackle the problem of improving performance. Analysis of the interviews underlined several issues and concerns: the absence of efficiency and effectiveness in public institutions, instability in the structure and organization of the administrative apparatus, a lack of confidence, a lack of decentralization, a lack of public official responsibility and the absence of mechanisms of citizen accountability. These concerns all require a governmental response. However, the study found that the reform of the public health system also requires learning from other countries' experiences.

According to the findings of this study, some lessons can be drawn from the UAE in building public health services in Libya; this was achieved through the application of a framework of policy transfer presented by Dolowitz and Marsh (1996, 2000). As discussed in this study, while policy transfer has not occurred between Libya and the UAE, the framework helped in the examination of the Libyan health system throughout the different regimes and suggested potential learning instruments and how to solve the public health system problems. By applying Dolowitz and Marsh's model, what this thesis has shown is that the UAE health system can be described as providing quality, safety and efficiency, professional accountability and measurable healthcare performance, or what Dolowitz and Marsh call "best practice". The Libyan government should emulate or learn from the experience of the UAE in order to overcome problems in its public health system, and the change of the political system in Libya in 2011, combined with a strong desire by the new government to reform the health system, will provide a motive for the lesson-drawing from abroad. I have suggested that health strategy, decentralization, professional regulation, performance measurement and managerial accountability can be transferred from the UAE to Libya in order to find a solution for inefficiency and the underperforming health system in Libya. The UAE experiences should be of interest to those currently planning the future of the health system in Libya because they

need to consider not only how to reform the status quo in the health system, but also enhance the democratic system and modernise public administration in Libya.

Recommendations resulting from this analysis provide a greater understanding of the mechanisms and effects of policy transfer that can be used to improve the health service delivery in Libya. However, learning successfully from the UAE depends largely upon the ability and commitment to reduce the adverse effects of the Qadhafi regime legacy. As discussed in Chapter 1, such transferred policies may fail due to what path dependency calls a 'punctuation point', which highlights the introduction of a new policy. Findings of this study have shown that the Libyan health system policies and experiences under the legacy of Qadhafi were the main cause for weak health delivery and this legacy may constrain the reform of the health system. In view of this, the new government needs to deal with the consequences of Qadhafi's rule and the negative impact of his policies. This requires constructing new public infrastructure and developing the necessary human resources and an appropriate institution of governance and forms of public participation.

6.5.1 Research Contributions

The literature review revealed that there is no detailed research/scholarship concerned with policy transfer in Libya, and the study intends to fill the gap in the existing literature. Furthermore, the majority of the policy transfer literature focuses on developed countries. According to Evans, 'Policy transfer analysts focus too much attention on policy transfers between developed countries and are largely ignorant of policy transfer activity in the developing world' (2004:25). In this respect, this study has filled a gap in the literature by looking at developing countries in general and the Arab World in particular.

Studies on policy transfer mostly concentrate on transfers that have already taken place; this thesis has applied a policy transfer approach in order to consider the situation existing now in the Libyan public health care sector and then to recommend a transfer. In this respect, through conducting a case study of the Libyan health care system, this study contributes to policy transfer research through applying voluntary policy transfer as a rational decision chosen by policy makers when looking for a solution to the status quo in order to suggest what lessons can be learned from

other countries. In addition, the study adds to previous studies on policy transfer, in that the policy transfer perspectives can be used as a platform for policy transfer.

The use of the additional approach of path dependency contributes to the policy transfer by offering a more complete picture, especially in relation to the success or failure of the transfer. The approach of path dependency has been validated in this research. The explorations of the elements of punctuations, causal impact and policy legacy in the case of Libya have demonstrated the presence of 'path dependency' and have an effect on the new trajectories. In this respect, through the use of the case of Libyan health care reforms, this study has discovered that the legacy of the past is not only a specification of the legacy of the past but also an important reason for introducing policy reforms, irrespective of whether they fail or are successful. As such, one reason why policy transfer may not work is precisely because of path dependency; a policy may be so ingrained (dependent) that an attempted policy transfer fails. This is what has happened in Libya; the fall of the dictator provided what in path dependency terms would be called a punctuation point, thereby allowing a new policy pathway to take shape, but the legacy of the Qadhafi regime is still in place and has hindered reforms.

The study has made empirical contributions to the knowledge of health care reform, decentralisation, and accountability in developing countries. In this regard, this study has provided a wide-ranging description of the Libyan and the UAE health sectors. A detailed study concerned with health policy and practice in Libya is useful in providing insights into how the various policies have been developed and implemented and how the Libyan health sector operates to reform health services in terms of decentralisation and accountability. Such a study can be used for improving the public health sector in Libya. Thus, the finding suggests that policy learning from the UAE is inevitable in the near future.

The comparison between the sectors in the two countries enables this research to reveal similarities and differences in the two regimes, and it opens the door for suggesting lessons for Libya from the UAE, especially with regard to decentralisation and accountability. Using original documentation and interviews relating to the Libyan health sector together with original documentation concerning the UAE health sector provides reliable evaluation. These comparative findings significantly contribute to understanding the ways in which the UAE and Libya deal with the health care system with regard to health policies, decentralisation, accountability and

other related issues. This is also valuable in identifying how certain factors constrain the reform and policy transfer in Libya, and suggests lessons for Libya from the UAE.

6.5.2 Limitations of the Thesis

This section intends to shed light on some limitations of the study. These can be divided into: First and foremost, the events of 2011 in Libya disrupted the research; as a researcher, I started my PhD in October 2010, and the Libyan uprising began in February 2011. This situation adversely impacted on both the researcher and the project, making access to people, organizations, and documents especially difficult. A further complication is that the experience of the new regime is still too new for a proper assessment.

Secondly, the coverage of this study was limited by the time and resources available for completion of a Ph.D. thesis. Thirdly, it became evident during the interviews that there were a number of cultural and political barriers which impacted on a few participants, who seemed uncomfortable in sharing certain information of a sensitive nature.

6.5.3 Recommendations for Policy Makers

This section presents some important aspects that are relevant for policy makers in Libya. Based on the conceptual framework outlined in Chapter 2, it can be argued that voluntary policy transfer can occur as a rationale chosen by actors because of dissatisfaction and problems with the status quo. Dissatisfaction with the home environment motivates policy-makers to seek out new ideas that have been developed in different countries.

As discussed in this thesis, the health sector suffers from many problems that have led to poor efficiency and a lack of effectiveness. It is worth mentioning here that all sources of data mention dissatisfaction and problems with the Libyan health care system. Governmental reports, before and after the revolution, expressed dissatisfaction with the performance of the health services. For example, the report issued by the National Planning Council of Libya in 2010 described problems such as the absence of a clear plan for health services, and poor accountability and a lack of administrative stability. In addition, the interviewees (scholars, doctors, and civil servants) expressed their opinions concerning the problems of the current Libyan

health care system. Thus, it is clear that the system requires reform to correct the status quo, and it is important for policy-makers to seek solutions from foreign experience in order to learn how to make the health care system better. The interviewees also responded positively to the idea that Libya should take lessons from the UAE, and they believe that the UAE's experiences are important in finding a solution to the problems facing health in Libya.

The findings of this research indicated that one of the key issues in the process of policy transfer/learning is the selection of the best practice that can help to tackle the problems of the home country. This finding provided a comprehensive and systematic picture of the public health service in Libya and, at the same time suggested lessons from the UAE which can be transferred. The researcher recommends that Libyan policy-makers should be acquainted with these findings, since they are relevant for decision-makers with an interest in maximising the reforms and modernisation in the Libyan public sector in general and health care system in specific. This study can be used as a platform for policy transfer.

Libya needs to adopt a health care strategy which includes clear objectives and priorities, because the absence of a clear strategy has led to the lack of continuity and a waste of time and resources without achieving targets. The UAE health care strategy embraces a wide range of issues including better health, access, quality, efficiency, and coordination and cooperation among entities and with local governments.

For more good governance, the decentralization policies in Libya require not only the transfer of power but also more autonomy and institutional capacity. The researcher recommends that each municipality should have the administrative capacity to plan, organize, supervise and develop its own health care services. Senior Managers in local authorities should be delegated to make decisions with clear responsibility and accountability relationships, as seen in the UAE.

In addition, the Libyan government needs to establish professional regulatory bodies for strengthening professional accountability similar to the MLD and NMC in the UAE, which are responsible for licensing and monitoring doctors, nurses and midwives in order to achieve the highest level of patient safety and quality of care. Such professional regulatory bodies are important authorities for solving the problems of lack confidence between doctors and patients and poor professional accountability among medical practitioners, in that they ensure that doctors and

nurses are accountable to codes of ethics, society, politicians, institutions, and clients.

The UAE has applied performance measurement to improve health services through different levels of the public health system, including performance of individuals, programmes, agencies, and evaluation, in order to provide a clear line of accountability and efficiency. The health sector in Libya has not yet used performance measurement. Taking advantage of the lesson, the potential benefits of performance measurement in the health sector are improving outcomes of care, maximizing patient satisfaction, and enabling accountability. Corruption has been a major obstacle for reform and the cause and consequence of structural decay bequeathed by decades of authoritarian regime in Libya. Performance measurement is one of the most effective tools to reduce the incidence of corruption and this recommendation is expected to lead to positive impacts.

Accountability mechanisms in Libya are weak and ineffective. The UAE experiences should be of interest to those currently planning improvement of the health services in Libya, since the UAE experiences have clearly enhanced and modernized accountability mechanisms, especially with regard to internal accountability.

The public sector in Libya has a high degree of corruption. According to national and international reports, as well as the interviews conducted in this study, corruption has become the main problem facing the delivery of public services (Chapter 5), largely due to the weakness and backwardness of administrative and functional legislations, and lack of discipline of civil servants. Greater civil servant accountability requires setting up rules of operation for the relationships between middle managers, senior officials and ministers and the delegating of authority to managers, who can then be held accountable for their performance and costs, as seen in the UAE. The research recommends learning from the managerial accountability in the UAE in solving problems of corruption and poor performance by following policies such as strengthening the control system and performance budget, and establishing an independent anti-corruption agency. This recommendation is expected to decrease the opportunities for public health organisations and civil servants to engage in corruption.

The study also found weaknesses in the role of citizens in the accountability relationships, resulting from the absence of client and professional accountability. Such types of accountability will serve to reduce vertical accountability by

concentrating on citizens and codes of professional conduct. Therefore, it is recommended that Libyan policy-makers should pay attention to initiatives to strengthen client accountability through the creation of relationships between health organisations and citizens. This can be seen as a mechanism for citizens' input into the health organisations, and assessment of citizen satisfaction can contribute to strengthening managerial accountability by citizen participation in decision-making, as seen in the UAE.

There is considerable potential for successful lesson-learning from the UAE to overcome problems in the Libyan health system (Chapter 5), since, as discussed in Chapter 5, there are several similarities between the two countries in terms of societal culture. Islamism, Arabism, and tribes are important components that constitute a template for culture in both the UAE and Libya, and this social culture dominates organizational behaviour. This factor can be seen as a real incentive for policy-makers to transfer a lesson from the UAE. In this context, Common (2013) argues that there is little policy transfer in Saudi Arabia from Western countries because of the different cultural context.

However, there are two factors which may hinder the success of the transfer, namely the legacy of the past regime and state capacity. The awareness of policy-makers regarding the need to reform will help to overcome the factors which constrain policy transfer. According to Ivanova and Evans (2004), in the Ukraine, breaking the legacy of communism is required in order to construct the human resources, appropriate institution of governance and forms of public management to deliver on national development goals; this argument finds justification in Libya's attempt to overthrow the culture of weakness and backwardness of the administrative and functional legislations and inefficiency. I recommend that policy makers should deal with these constraints by concentrating on developing public administration in terms of participation in decision-making, the rule of law, efficient administrative leaders, efficiency and effectiveness. Success in achieving this depends on the extent to which the current system desires to modernize the public sector by learning from international experience.

6.5.4 Further Areas of Research

In analysing the possible nature of Libya's emulation of public health reforms in the UAE, this thesis has discussed several issues that arose from the interview and documentary data. Some of these issues necessitate further research. One of these areas concerns the nature of policy transfer framework. This study has provided a comprehensive and systematic picture of the public health service in terms of decentralization and accountability in Libya. This has been done by paying attention to what occurs in the UAE system so as to see how the Libyan government can take lessons from the UAE. In essence, the focus of the investigation was on how to strengthen public health service accountability and decentralization in Libya. This does not mean that the process of policy transfer/learning occurs only between states. It would be interesting to design a study that examines the role of the WHO in recommending a transfer to reform the public health sector. This would go further in focusing on the extent to which the WHO can play a role in reforming the health care system.

The policy of transfer/learning has implications for developed countries, for example between the USA and the UK, and between developing countries, such as those in Central Europe after the collapse of communism. This study suggests that scholars deal with policy transfer as a rational, voluntary learning activity. In this regard, scholars may be able to recommend a transfer that is in line with the Libyan conditions and, if not, such policies could be used for inspirational purposes rather than wholesale application.

From this case study, the researcher found that the Libyan public sector has been little influenced by modernisation. In global terms Libya is a small country, but its resources enable it to modernise. This study has observed that the public sector is a less developed system of bureaucracy, legislations, and practices. This unique situation requires scholars of public administration to investigate how Libya can learn from international reform movements such as the NPM, in particular now that Libya is moving to a democratic regime.

This study has indicated that Libya had no constitution during Qadhafi's rule but is now on the road to building a constitution. A constitution is important in defining the relationship between politics and public administration in order to put civil service systems under the rule of law. This study was carried out during the Qadhafi era,

and is influenced by the current changing and fluid democratization process in the country. Once a new constitution and a stable system have been achieved, it will be necessary to carry out further studies in the new public sector context of Libya, which will concentrate on the relationship between the state and the health sector, as well as extending the study to look at how other sectors, such as oil, finance and education, can also learn from policy transfer from other countries.

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<http://saiwb1.saiuae.gov.ae/English/Pages/default.aspx>

UAE Cabinet, Constitution of U.A.E: <http://www.uaecabinet.ae>

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(<http://www.dsg.ae/en/home/index.aspx?&PriMenuID=2&mnu=Pri>).

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<http://www.uaestatistics.gov.ae/EnglishHome/tabid/96/Default.aspx>).

UAE The Ministry of Health : <http://www.moh.gov.ae/ar/About/Pages/default.aspx>

United Nations Development Programme (UNDP), UNDP United Arab Emirates:

(<http://www.undp.org.ae/undpuae/governance.html>).

WHO Global Health Expenditure Database:

<http://apps.who.int/nha/database/DataExplorer.aspx?ws=0&d=1>

Appendices

Appendix (1) Certificate of Ethical Approval



**COLLEGE OF SOCIAL SCIENCES
AND INTERNATIONAL STUDIES**

Amory Building
Rennes Drive
Exeter UK EX4 4RJ
www.exeter.ac.uk/socialsciences

CERTIFICATE OF ETHICAL APPROVAL

Academic Unit:
Politics

Title of Project:
The Public Health Sector of Libya: Structural Administration, Accountability and Reform

Name(s)/Title of Project Research Team Member(s):
Ayad Ben Ismail

Project Contact Point:
atb204@exeter.ac.uk

This project has been approved for the period

From: 01.11.12
To: 30.01.13

College Ethics Committee approval reference: 20.06.12-4

Signature  Date 18/10/2012

(Lise Storm, Chair, SSIS College Ethics Committee)

Appendix (2) Interview Guidelines Questions

English Version

From your point of view, what are the main factors that affected the health sector (political - social - economic)?

How have policy-makers defined the objectives and priorities of public health policies?

What are major initiatives or policies being made to ensure health institutions to achieve efficiency health services? And why were these policies chosen?

In your opinion, have the Libyan decision makers considered implementing the decentralisation of the public health sector?

What do you think of health care services provided by the MOH?

From your experience, why was the inefficiency of health services?

What internal and external control activities are in place to provide assurance of the accountability activities such as legal, management, client and professional? And how do staffs deal with comments or questions received from the citizens?

What are performance measurements have been put in place to monitor and evaluate the health services?

From your experience as a senior civil servant or doctor, what do you see as the strengths or weaknesses of the following

- Your superiors in the civil service
- Your subordinates and lower staff in general
- Organisation structure, rules and regulations
- Task and job description
- Organisational processes
- Budget allocation and usage
- Selection, recruitment and promotion

From your experience, how would you evaluate Libyan Commission for Health Specialties for many activities such as healthcare standards, the effective classification and registration of healthcare practitioners, medical ethics, and training programs and innovation?

Is there an office of complaints in the MOH and Municipalities? If yes, can you explain how they operate?

Is there a professional code of ethics? If yes, can you explain how it is implemented and operated?

What factors facilitated or constrained the implementation of health sector reforms in Libya?

In your opinion, what are the benefits of transferring a lesson from foreign experience to reform the public health sector?

Do you recommend the transfer of mechanisms and programs providing health services from the UAE to Libya in order to improve the level of health services? What are the conditions that may constrain learning from the UAE?

Appendix (3) List of Interviews

Position	Date
Director of Public services Dept at the State Audit Institution	2/12/2012
Head of Financing Dept at the Health Secretariat	3/12/2012
President of the Libyan international medical university	5/12/2012
Director of Administration in the General Directorate of Health Affairs Benghazi	8/12/2012
Medical Manager at the Kidney Hospital	9/12/2012
Director of Legal Affairs at Health Region of Benghazi	9/12/2012
Senior Planning Officer MOH	10/12/2012
Professor in Political Science	11/12/2012
Dean of the Faculty of Pharmacy	12/12/2012
Former Head of the Libyan Medical Supplies Organisation	12/12/2012
Professor in Public Policy	12/12/2012
Assistant Undersecretary of the MOH	16/12/2012
Director of Health Services	16/12/2012
Director of the Inspection Dept at Benghazi Health Authority	16/12/2012
Financial Controller at the MOH	17/12/2012
Former Public Manager of Benghazi Municipality	18/12/2012
Medical Director of Central Hospital in Benghazi	24/12/1202
Member of the Administrative Audit Institution	27/12/2012
Administrative Expert of the Public Civil Service	6/1/2013
Head of Information Office at the MOH	8/1/2013
Consultant in the Ministry of Labor	8/1/2013

Appendix (4) Consent Form for Interviews ‘Arabic Version’

قطاع الصحة العامة يلعب دور كبير في تقديم الخدمات الصحية للمواطنين ولذلك هذا الدور يدفعنا لفهم قطاع الصحة في ليبيا وتقوية عناصر الكفاءة والفاعلية . هذه الدراسة ستساهم في زيادة كفاءة الخدمات الصحية العامة في ليبيا وتقوية اليات المساءلة . وهذه المقابلة جزء من متطلبات درجة الدكتوراه في الإدارة العامة في جامعة اكستر . في حالة رغبتك في الحصول علي معلومات حول هذه الدراسة يرجى الاتصال بي :

بنغازي - ليبيا ayadxp@yahoo.com 2241599

اكستر - المملكة المتحدة atb204@exeter.ac.uk 07895598426

بروفسور أندوا مسي : او الاتصال بمشرفي:

a.massey@exeter.ac.uk 01392722042

سوف تسجل المقابلة لشرأة وسجلات وهذه المعلومات تستخدم للأغراض العلمية فقط ولن يسمح لاي شخص الإطلاع عليها . ومع ذلك لك الحق في طلب نسخة من محضر المقابلة الخاص به للتعليق .

المعلومات الممنوحة من طرفكم ستبقي في سرية تامة ومحفوظة في نظام برمجة عالي الكفاءة . قائمة المشاركين لا يستطيع اي شخص الاطلاع عليها مهما كان .

وعند الانتهاء من الدراسة العملية وتحليل النتائج سوف يتم تدمير جميع المشاركات وقوائم المشاركين .

المعلومات الشخصية للمشارك لن تظهر في الدراسة . وسوف تستخدم الاليات اللازمة للحماية الشخصية للمشاركين وهويتهم وفقاً للقوانين .

انا موافق علي المشاركة في البحث طواعية وعندني الحق في سحب مشاركتي في اي وقت .

/ الأسم

/ التوقيع

/ البريد الالكتروني

/ توقيع الباحث

حررت هذه الموافقة من نسختين :

1- للمشارك

2 – للباحث

Appendix (5) Interview Guidelines Questions "Arabic Version"

من وجهة نظرك، ما هي العوامل الرئيسية التي أثرت على القطاع الصحي (السياسية - الاجتماعية - الاقتصادية)؟

كيف يقوم صانعي السياسات تحديد أهداف وأولويات السياسات الصحية العامة؟

ما هي المبادرات والسياسات الرئيسية التي اتخذت لضمان تحقيق كفاءة الخدمات الصحية؟ ولماذا تم اختيار هذه السياسات؟

من خلال وجهة نظرك ، ماهو دور صانعي القرار في تنفيذ اللامركزية في قطاع الصحة العامة؟

ما رأيكم في خدمات الرعاية الصحية التي تقدمها وزارة الصحة؟

من تجربتك، لماذا عدم كفاءة الخدمات الصحية؟

ما هي الرقابة الداخلية والخارجية المعمول بها لضمان تحقيق المساءلة القانونية، والإدارية، والمواطن؟ وكيف يتعامل الموظفون مع تعليقات أو أسئلة وردت من المواطنين؟

ما هي مقاييس الأداء الموجودة لرصد وتقييم الخدمات الصحية؟

من تجربتك كموظف حكومي أو طبيب، ماذا ترى في العناصر الآتية - من حيث القوة أو الضعف :

- رؤسائك
- المرؤوسين لديك
- القواعد واللوائح
- المهام والوصف الوظيفي
- تخصيص الميزانية والاستخدام
- اختيار والتعيين والترقية

من تجربتك، كيف تقيم مجلس التخصصات الطبية بالنسبة للعديد من الأنشطة مثل معايير الرعاية الصحية، وتصنيف فعال وتسجيل ممارسي الرعاية الصحية، والأخلاق الطبية، وبرامج التدريب والابتكار؟

هناك مكتب للشكاوى في وزارة الصحة والبلديات؟ إذا كانت الإجابة بنعم، اشرح كيف يعمل؟

هل يوجد مدونة لسلوك و اخلاقيات المهنة ؟ وكيف صدرت وما هي اليات تطبيقها ؟

ما هي العوامل التي تسهل او تعيق تنفيذ إصلاحات القطاع الصحي في ليبيا؟

في رأيك ما هي فوائد نقل درس من الخبرة الأجنبية من أجل إصلاح قطاع الصحة العامة؟

هل توصي نقل برامج و آليات تقديم الخدمات الصحية من دولة الإمارات العربية المتحدة إلى ليبيا من أجل تحسين مستوى الخدمات الصحية؟ وما هي الظروف التي قد تحد للتعلم من دولة الإمارات العربية المتحدة؟