issues, such as inequalities, primary care, violence and health, or the health of older people[46]. All cover a wide range of issues of regional relevance (Table 5.1): they thus institutionalize the linkages between local developments and countrywide policy-making.

## Strengthening policy dialogue with innovations from the field

These links between local reality and policy-making conditions the design and implementation of PHC reforms. The build up to the introduction of Thailand's "30 Baht" universal coverage scheme provides an example of a deliberate attempt to infuse policy deliberations with learning from the field. Leaders of Thailand's reform process organized a mutually reinforcing interplay between policy development at the central level and "field model development" in the country's provinces. Health workers on the periphery and civil society organizations were given the space to develop and test innovative approaches to care delivery, to see how well they met both professional standards and community expectations (Figure 5.4). Field model development activities, which were supported by the Ministry of Health, were organized and managed at provincial level, and extensively discussed and negotiated with provincial contracts. Each province developed its own strategies to deal with its specific problems. The large amount of flexibility given to the provinces in deciding their own work programmes had the advantage of promoting ownership, fostering creativity and allowing original ideas to come forward. It also built local capacities. The downside to the high level of autonomy of the provinces was a tendency to multiply initiatives, making it difficult to evaluate the results to be fed into the policy work in a systematic way.

**Figure 5.4** Mutual reinforcement between innovation in the field and policy development in the health reform process

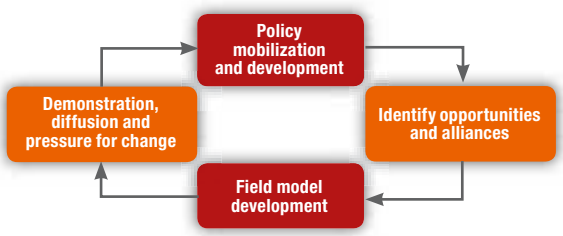



**Table 5.1** Roles and functions of public-health observatories in England[42]

| Roles | Functions[a] |
|---|---|
| Monitoring health and disease trends and highlighting areas for action | Study on the inequalities existing in coronary heart disease, together with recommendations for action[47] |
| Identifying gaps in health information | Study of current information sources and gaps on perinatal and infant health[48] |
| Advising on methods for health and health inequality impact assessment | Overview of health impact assessment[49] |
| Drawing together information from different sources in new ways to improve health | Health profile using housing and employment data alongside health data[50] |
| Carrying out projects to highlight particular health issues | A study of the dental health of five-year-olds in the Region[51] |
| Evaluating progress by local agencies in improving health and eliminating inequality | Baselines and trend data |
| Looking ahead to give early warning of future public health problems | Forum for partners to address likely future public health issues such as the ageing population and genetics |

[a] Example: Northern and Yorkshire Public Health Observatory.

On balance, however, the difficulties due to the locally-driven approach were compensated for by the positive effects related to reform dynamics and capacity building. By 2001, nearly half of Thailand's 76 provinces were experimenting with organizational innovation, most of it around issues of equitable access, local health-care systems and community health[52].

Thailand's "30 Baht" universal coverage reform was a bold political initiative to improve health equity. Its transformation into a concrete reality was made possible through the accumulated experience from the field and through the alliances the fieldwork had built between health workers, civil society organizations and the public. When the scheme was launched in 2001, these provinces were ready to pilot and implement the

scheme. Furthermore, the organizational models they had developed informed the translation of political commitment to universal coverage into concrete measures and regulations[53].

This mutually reinforcing process of linking policy development with learning from the field is important for several reasons:

- it taps the wealth of latent knowledge and innovation within the health sector;
- bold experiments in the field give front-line workers, system leaders and the public an inspiring glimpse of what the future might look like in a health system shaped by PHC values. This overcomes one of the greatest obstacles to bold change in systems – people's inability to imagine that things could actually be different and be an opportunity rather than a threat;
- the linking of policy development with front-line action fosters alliances and support from within the sector, without which far-reaching reform is not sustainable;
- such processes engage society both locally and at national level, generating the demand for change that is essential in building political commitment and maintaining the momentum for reform.

## Building a critical mass of capacity for change

The stimulation of open, collaborative structures that supply reforms with strategic intelligence and harness innovation throughout the health system requires a critical mass of committed and experienced people and institutions. They must not only carry out technical and organizational tasks, but they must also be able to balance flexibility and coherence, adapt to new ways of working, and build credibility and legitimacy[54].

However, that critical mass of people and institutions is often not available[31]. Institutions in low-income countries that have suffered from decades of neglect and disinvestment are of particular concern. They are often short on credibility and starved of resources, while key staff may have found more rewarding working environments with partner agencies. Poor governance complicates matters, and is compounded by international pressure for state minimalism and the disproportionate influence of the donor community. The conventional responses to leadership capacity shortfalls in such settings, which are characterized by a heavy reliance on external technical assistance, toolkits and training, have been disappointing (Box 5.4). They need to be replaced by more systematic and sustainable approaches in order to institutionalize competencies that learn from and share experience[55].

Documented evidence of how individual and institutional policy dialogue and leadership capacities build up over time is hard to find, but a set of extensive interviews of health sector leaders in six countries shows that personal career trajectories are shaped by a combination of three decisive experiences[56].

- At some point in their careers, all had been part of a major sectoral programme or project, particularly in the area of basic health services. Many of them refer to this as a formative experience: it is where they learned about PHC, but also where they forged a commitment and started building critical alliances and partnerships.
- Many became involved in national planning exercises, which strengthened their capacity to generate and use information and, again, their capacity to build alliances and partnerships. Few had participated personally in major studies or surveys, but those who had, found it an opportunity to hone their skills in generating and analyzing information.
- All indicated the importance of cooptation and coaching by their elders: "*You have to start out as a public health doctor and be noticed in one of the networks that influence decision making in MOH. After that your personal qualities and learning by doing [determine whether you'll get to be in a position of leadership].*"[56]

These personal histories of individual capacity strengthening are corroborated by more in-depth analysis of the factors that contributed to the institutional capacities for steering the health sector in these same countries. Table 5.2 shows that opportunities to learn from large-scale health-systems development programmes have contributed most, confirming the importance of hands-on engagement with the problems of the health sector in a collaborative environment.

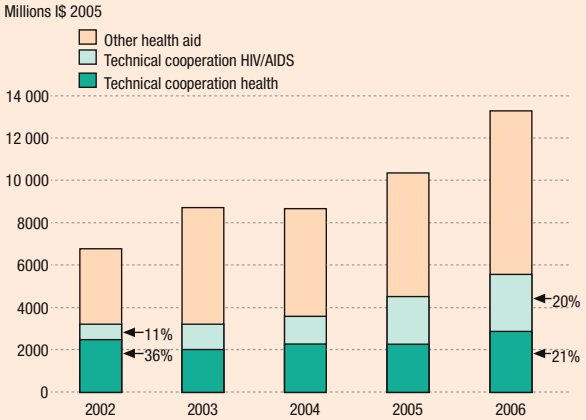
## **Box 5.4** Limitations of conventional capacity building in low- and middle-income countries[55]

The development community has always tended to respond to the consequences of institutional disinvestment in low- and middle-income countries through its traditional arsenal of technical assistance and expert support, toolkits and training (Figure 5.5). From the 1980s onwards, however, it became clear that such "technical assistance" was no longer relevant [58] and the response re-invented itself as "project management units" concentrating on planning, financial management and monitoring.

The stronger health systems were able to benefit from the resources and innovation that came with projects but, in others, the picture was much more mixed. As a recurrent irritant to national authorities, accountability to funding agencies often proved stronger than commitment to national development: demonstrating project results took precedence over capacity building and long-term development[59], giving disproportionate weight to project managers at the expense of policy coherence and country leadership. In more recent years, the wish to reinforce country ownership – and changes in the way donors purchase technical assistance services – paved the way for a shift from project management to the supply of short-term expertise through external consultants. In the 1980s and early 1990s, the expertise was essentially provided by academic institutions and the in-house experts of bilateral cooperation and United Nations agencies. The increased volume of funding for technical support contributed to shifting the expertise market to freelance consultants and consultancy firms, so that expertise has become increasingly provided on a one-time basis, by technical experts whose understanding of the systemic and local political context is necessarily limited[60].

In 2006, technical cooperation constituted 41% of total overseas development aid for health. Adjusted for inflation, its volume tripled between 1999 and 2006, particularly through expansion of technical cooperation on HIV/AIDS. Adapting to the complexities of the aid architecture, experts and consultants now also increasingly act as intermediaries between countries and the donor community: harmonization has become a growth business, lack of country capacity fuelling further disempowerment.

**Figure 5.5** A growing market: technical cooperation as part of Official Development Aid for Health. Yearly aid flows in 2005, deflator adjusted[61]




The second mainstay response to the capacity problem has been the multiplication of planning, management and programme toolkits. These toolkits promise to solve technical problems encountered by countries while aiming for self-reliance. For all their potential, rigour and evidence base, the usefulness of toolkits in the field has often not lived up to expectations for four main reasons.

- They often underestimate the complexity of the problems they are supposed to deal with[62].
- They often rely on international expertise for their implementation, thereby defeating one of their main purposes, which is to equip countries with the ways and means to deal with their problems themselves.
- Some have not delivered the promised technical results[63] or led to unexpected untoward side-effects[64].
- The introduction of toolkits is largely supply driven and linked to institutional interests, which makes it difficult for countries to choose among the multitude of competing tools that are proposed.

The capacity-building prescription that completes the spectrum is training. Sometimes, this is part of a coherent strategy: Morocco's Ministry of Health, for example, has applied a saturation training approach similar to that of Indonesia's Ministry of Finance[65], sending out large numbers of young professionals for training in order to build up a recruitment base of qualified staff and, eventually, a critical mass of leaders. Such deliberate approaches, however, are rare. Much more common are short "hotel" training courses that mix technical objectives and exchange with implicit aims to top-up salaries and buy political goodwill. The prevailing scepticism about the usefulness of such programmes (systematic evaluation is uncommon) contrasts sharply with the resources they mobilize, at a considerable opportunity cost.

In the meantime, new markets in education, training and virtual learning are developing, while actors in low- and middle-income countries can access Internet sites on most health systems issues and establish electronic communities of practice. With contemporary information technology and globalization, traditional recipes for capacity development in poor countries are quickly becoming obsolete[54].

**Table 5.2** Significant factors in improving institutional capacity for health-sector governance in six countries[a,56]

| Factors[b] | No. of countries where factor was an important contributor | Average score for strength of contribution |
|---|---|---|
| Sector programmes/ large-scale projects | 4 | 7.25 |
| Establishment of institutions | 3 | 6.7 |
| National policy debate events | 3 | 5.6 |
| Research, studies and situation analysis | 4 | 5.1 |
| New planning and management tools | 1 | 5 |

[a] Burkina Faso, the Democratic Republic of the Congo, Haiti, Mali, Morocco and Tunisia.
[b] Identified through document analysis and interviews with 136 key informants.

Especially noteworthy is the fact that the introduction of tools was rarely identified as a critical input, and respondents did not highlight inputs from experts and training.

The implication is that the key investment for capacity building for PHC reforms should be to create opportunities for learning by linking individuals and institutions to ongoing reform processes. A further consideration is the importance of doing so in an environment where exchange, within and between countries, is facilitated. Unlike the conventional approaches to capacity building, exchange and exposure to the experience of others enhances self-reliance. This is not just a recipe for under-resourced and poorly performing countries. Portugal, for example, has organized a broad societal debate on its 2004–2010 National Health Plan involving a pyramid of participation platforms from local and regional to national level, and 108 substantial contributions to the plan from sources ranging from civil society and professional organizations to local governments and academia. At three critical moments in the process, international panels of experts were also invited from other countries to act as sounding boards for their policy debate: a collaboration that was a learning exercise for all parties[57].

## Managing the political process: from launching reform to implementing it

PHC reforms change the balance of power within the health sector and the relationship between health and society. Success depends not only on a credible technical vision, but also on the ability to obtain the high-level political endorsement and the wider commitment that is necessary to mobilize governmental, financial and other institutional machineries.

As a technical sector, health rarely has prominence in the hierarchy of the political arena. Ministries of health have often had enough to deal with simply trying to resolve the technical challenges internal to the sector. They are traditionally ill at ease, short of leverage and ill equipped to make their case in the wider political arena, particularly in low- and low-middle-income countries.

The general lack of political influence limits the ability of health authorities, and of other stakeholders in the PHC movement, to advance the PHC agenda, especially when it challenges the interests of other constituencies. It explains the frequently absent or overly cautious reactions against the health effects of working conditions and environmental damage, or the slow implementation of regulations that may interfere with the commercial interests of the food and tobacco industry. Similarly, ambitious reform efforts are often diluted or watered down under the influence of the donor community, the pharmaceutical and the health technology industries, or the professional lobbies[26,66].

Lack of political influence also has consequences within governmental spheres. Ministries of health are in a particularly weak position in low- and low-middle-income countries, as is evidenced by the fact that they can claim only 4.5% and 1.7%, respectively, of total government expenditure (against 10% and 17.7%, respectively, in upper-middle and high-income countries)[67]. The lack of prominence of health priorities in wider development strategies, such as the Poverty Reduction Strategy Papers (PRSPs), is another illustration of that weakness[68]. Equally, ministries of health are often absent in discussions about caps on social (and health) spending, which

are dominated by debates on macroeconomic stability, inflation targets or sustainable debt. It is telling that, in highly indebted countries, the health sector's efforts to obtain a share of the debt relief funds have been generally slow, less than forceful and unconvincing compared to education, foregoing possibilities for rapid expansion of their resource base[69].

Despite these challenges, there is a growing indication that the political will for ambitious reforms based on PHC is taking place. India's health missions – "rural" and subsequently "urban" – are accompanied by a doubling of public expenditure on health. China is preparing an extremely ambitious rural PHC reform that also includes a major commitment of public resources. The size and comprehensiveness of PHC-oriented reforms in Brazil, Chile, Ethiopia, the Islamic Republic of Iran, New Zealand, Thailand and many other countries, reflect very clearly that it is not unrealistic to mobilize political will. Even in extremely unfavourable circumstances, it has proven possible to gain credibility and political clout through pragmatic engagement with political and economic forces (Box 5.5).

Experience across these countries shows that political endorsement of PHC reforms critically depends on a reform programme that is formulated in terms that show its potential political dividends. To do that it has to:

- respond explicitly to rising demand as well as to the health challenges and health system constraints the country faces, showing that it is not merely a technical programme, but one rooted in concerns relevant to society;
- specify the expected health, social and political returns, as well as the relevant costs, in order to demonstrate the expected political mileage as well as its affordability;
- be visibly based on the key constituencies' consensus to tackle the obstacles to PHC, providing reassurance of the reforms' political feasibility.

Creating the political alignment and commitment to reform, however, is only a first step. Insufficient preparation of its implementation is often the weak point. Of particular importance is an understanding of resistance to change, particularly from health workers[70,71,72,73]. While the intuition of leadership has its merits, it is also possible to organize more systematic exercises to anticipate and respond to the potential reactions of stakeholders and the public: political mapping exercises, as in Lebanon[34]; marketing studies and opinion polls, as in the United States[74]; public hearings, as in Canada; or sector-wide meetings of stakeholders, as in the *Etats Généraux de la Santé* in French-speaking Africa. Delivering on PHC reforms requires a sustained management capacity across levels of the system, embedded in institutions that are fit for the purpose. In Chile, for example, administrative structures and competencies across the whole of the Ministry of Health are being redefined in line with the PHC reforms. Such structural changes are not sufficient. They need to be instigated in conjunction with changes in the organizational culture, from one of issuing decrees for change to a more inclusive collaboration with a variety of stakeholders across the levels of the health system. That in turn requires the institutionalization of policy-dialogue mechanisms drawing practice-based knowledge up from the ground level to inform overall systems governance, while reinforcing social linkages and collaborative action among constituencies at community level[75]. This management capacity should not be assumed, it requires active investment.

Even with effective political dialogue to gain consensus on specific PHC reforms and the requisite management for implementation across levels of the system, many such reforms do not have their intended impact. The best-planned and executed policy reforms often run into unanticipated challenges or rapidly changing contexts. Broad experience in dealing with complex systems behaviour suggests that significant shortfalls or shifts away from articulated goals are to be expected. An important component to build into the reform processes is mechanisms that can pick up significant unintended consequences or deviations from expected performance benchmarks, which allow for course corrections during implementation.

Widespread evidence on inequities in health and health care in virtually all countries is a humbling reminder of the difficulties confronting

## Box 5.5 Rebuilding leadership in health in the aftermath of war and economic collapse

Recent developments in the Democratic Republic of the Congo show how renewed leadership can emerge even under extremely challenging conditions. The beginnings of the reconstruction of the country's health system, devastated by economic collapse and state failure culminating in a brutal war is, above all, a story of skilful political management.

The Democratic Republic of the Congo had seen a number of successful experiences in PHC development at the district level during the 1970s and early 1980s. The economic and political turmoil from the mid-1980s onwards saw central government authority in health disintegrate, with an extreme pauperization of the health system and the workers within it. Health workers developed a multiplicity of survival strategies, charging patients and capitalizing on the many aid-funded projects, with little regard for the consequences for the health system. Donors and international partners lost confidence in the district model of integrated service delivery in the country and instead chose to back stand-alone disease control and humanitarian aid programmes. While, between 1999 and 2002, the Ministry of Health commanded less than 0.5% of total government expenditure, its central administration and its Department of Planning and Studies – 15 staff in total – faced the overwhelming task of providing guidance to some 25 bilateral and multilateral agencies, more than 60 international and 200 national NGOs, 53 disease control programmes (with 13 government donor coordination committees) and 13 provincial ministries of health – not forgetting health-care structures organized by private companies and universities.

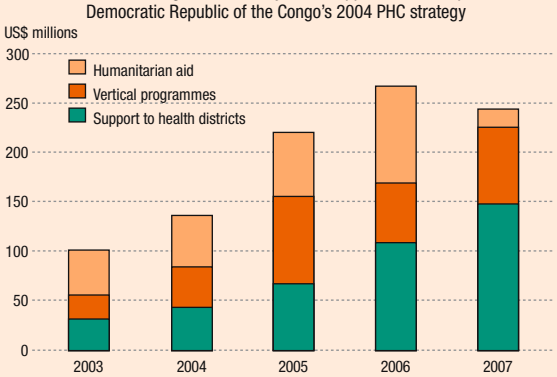
As the intensity of civil strife abated, a number of key Ministry of Health staff took it upon themselves to revitalize and update the district model of primary health care. Aware of the marginal position of the Ministry in the health sector, they co-opted the "internal diaspora" (former civil servants now working for the many international development agencies present in the country) in an open structure around the Ministry. This steering group drafted a national health systems strengthening strategy. It included (i) a progressive roll-out of integrated services, district by district, coordinated through regional plans and backed by a fundamental shift in funding from programme-specific flows to system funding; (ii) a set of protective "damage-control" measures to halt institutional inflation and prevent further distortion of the system; and (iii) an explicit plan to tackle the problem of donor fragmentation, which had reached critical proportions. In designing the strategy, the steering group made deliberate efforts to set up networks within the health sector itself and alliances with other government actors and social constituencies.

The formal endorsement of the national plan by donors and civil society sent a strong political signal of the success of this new mode of working. The national health systems strengthening strategy became the health component of the national poverty reduction strategy. Donors and international partners aligned existing projects, albeit to a variable degree, while others reshaped new initiatives to fit the national strategy.

Perhaps the most powerful testimony to the effective management of this process is the change in the composition of donor funding for health (Figure 5.6). The proportion of funds dedicated to general systems strengthening under provincial and district plans has increased appreciably in relation to the level of funding earmarked for disease control and humanitarian relief programmes. The advances remain fragile, in a context where much of the health sector – including its governance – needs to be reconstructed.

Nevertheless, the national strategy has strong roots in fieldwork and, in a remarkable turnaround against high odds, the Ministry of Health has gained credibility with other stakeholders and has improved its position in renegotiating the finances of the health sector.

**Figure 5.6** Re-emerging national leadership in health: the shift in donor funding towards integrated health systems support, and its impact on the Democratic Republic of the Congo's 2004 PHC strategy



PHC reforms. This chapter has emphasized that leadership for greater equity in health must be an effort undertaken by the whole of society and engage all relevant stakeholders. Mediating multi-stakeholder dialogues around ambitious reforms be they for universal coverage or primary care places a high premium on effective government. This requires re-orienting information systems the better to inform and evaluate reforms, building field-based innovations into the design and redesign of reforms, and drawing on experienced and committed individuals to manage the direction and implementation of reforms. While not a recipe, these elements of leadership and effective government constitute in and of themselves a major focus of reform for PHC. Without reforms in leadership and effective government, other PHC reforms are very unlikely to succeed. While necessary, therefore, they are not sufficient conditions for PHC reforms to succeed. The next chapter describes how the four sets of PHC reforms must be adapted to vastly different national contexts while mobilizing a common set of drivers to advance equity in health.

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