

# Leadership and effective government



*The preceding chapters have described how health systems can be transformed to deliver better health in ways that people value: equitably, people-centred, and with the knowledge that health authorities administer public-health functions to secure the well-being of all communities. These PHC reforms demand new forms of leadership for health. This chapter begins by clarifying why the public sector needs to have a strong role in leading and steering public health care reforms, and emphasizes the fact that this function should be exercised through collaborative models of policy dialogue with multiple stakeholders, because this is what people expect and because it is the most effective. It then considers strategies to improve the effectiveness of reform efforts and the management of the political processes that condition them.*

## Chapter 5

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## Governments as brokers for PHC reform

### Mediating the social contract for health

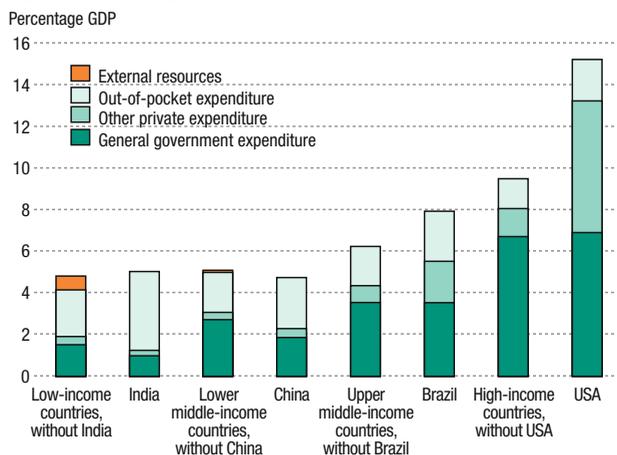
The ultimate responsibility for shaping national health systems lies with governments. Shaping does not suggest that governments should – or even could – reform the entire health sector on their own. Many different groups have a role to play: national politicians and local governments, the health professions, the scientific community, the private sector and civil society organizations, as well as the global health community. Nevertheless, the responsibility for health that is entrusted to government agencies is unique and is rooted in principled politics as well as in widely held expectations<sup>1</sup>.

Politically, the legitimacy of governments and their popular support depends on their ability to protect their citizens and play a redistributive role. The governance of health is among the core public policy instruments for institutionalized protection and redistribution. In modern states, governments are expected to protect health, to guarantee access to health care and to safeguard people from the impoverishment that illness can bring. These responsibilities were progressively extended, incorporating the correction of market failures that characterize the health sector<sup>2</sup>. Since the beginning of the 20th century, health protection and health care have progressively been incorporated as goods that are guaranteed by governments and are central to the social contract between the state and its citizens. The importance of health systems as a key element of the social contract in modernizing societies is most acutely evident during reconstruction after periods of war or disaster: rebuilding health services counts among the first tangible signs that society is returning to normal<sup>3</sup>.

The legitimacy of state intervention is not only based on social and political considerations. There are also key economic actors – the medical equipment industry, the pharmaceutical industry and the professions – with an interest in governments taking responsibility for health to ensure a viable health market: a costly modern health economy cannot be sustained without risk

sharing and pooling of resources. Indeed, those countries that spend the most on health are also those countries with the largest public financing of the health sector (Figure 5.1).

**Figure 5.1** Percentage of GDP used for health, 2005<sup>4</sup>



Even in the United States, its exceptionalism stems not from lower public expenditure – at 6.9% of GDP it is no lower than the high-income countries average of 6.7% – but from its singularly high additional private expenditure. The persistent under-performance of the United States health sector across domains of health outcomes, quality, access, efficiency and equity<sup>5</sup>, explains opinion polls that show increasing consensus of the notion of government intervention to secure more equitable access to essential health care<sup>6,7</sup>.

A more effective public sector stewardship of the health sector is, thus, justified on the grounds of greater efficiency and equity. This crucial stewardship role is often misinterpreted as a mandate for centralized planning and complete administrative control of the health sector. While some types of health challenges, e.g. public-health emergencies or disease eradication, may require authoritative command-and-control management, effective stewardship increasingly relies on “mediation” to address current and future complex health challenges. The interests of public authorities, the health sector and the public are closely intertwined. Over the years, this has made all the institutions of medical care, such as training, accreditation, payment, hospitals,



entitlements, etc., the object of intensive bargaining on how broadly to define the welfare state and the collective goods that go with it<sup>8,9</sup>. This means that public and quasi-public institutions have to mediate the social contract between institutions of medicine, health and society<sup>10</sup>. In high-income countries today, the health-care system and the state appear indissolubly bound together. In low- and middle-income countries, the state has often had a more visible role, but paradoxically, one that was less effective in steering the health sector, particularly when, during the 1980s and 1990s, some countries of them became severely tested by conflicts and economic recession. This resulted in their health systems being drawn in directions quite different from the goals and values pursued by the PHC movement.

### Disengagement and its consequences

In many socialist and post-socialist countries undergoing economic restructuring, the state has withdrawn abruptly from its previously predominant role in health. China's deregulation of the health sector in the 1980s, and the subsequent steep increases in reliance on out-of-pocket spending, is a case in point and a warning to the rest of the world<sup>11</sup>. A spectacular deterioration of health-care provision and social protection, particularly in rural areas, led to a marked slowdown in the increase in life expectancy<sup>11,12</sup>. This caused China to re-examine its policies and reassert the Government's leadership role – a re-examination that is far from over (Box 5.1)<sup>13</sup>.

A similar scenario of disengagement was observed in many of the countries of central and eastern Europe and the Commonwealth of Independent States (CEE-CIS). In the early 1990s, public expenditure on health declined to levels that made administering a basic system virtually impossible. This contributed to a major decline in life expectancy<sup>17</sup>. Catastrophic health spending became a major cause of poverty<sup>18</sup>. More recently, funding levels have stabilized or even increased, but significant improvements in health outcomes have not followed and socioeconomic inequalities in health and health-care access are rising. Evidence and trends related to these rises, as well as increases in informal payment mechanisms

for health care, indicate that re-engagement is still insufficient.

Elsewhere, but most spectacularly in low-income countries and fragile states, the absence or withdrawal of the state from its responsibilities for health reflects broader conditions of economic stagnation, political and social crisis and poor governance<sup>19</sup>. In such conditions, public leadership has often become dysfunctional and de-institutionalized<sup>20</sup>, a weakness that is compounded by a lack of financial leverage to steer the health sector. Global development policies have often added to the difficulties governments face in assuming their responsibilities, for at least two reasons.

- The global development agenda of the 1980s and 1990s was dominated by concern for the problems created by too much state involvement<sup>21</sup>. The structural adjustment and downsizing recipes of these decades still constrain the reconstruction of leadership capacity today. Public financing in the poorest countries became unpredictable, making medium-term commitments to the growth of the health sector difficult or impossible. Health planning based on needs became the exception rather than the rule, since key fiscal decisions were taken with little understanding of the potential consequences for the health sector and health ministries were unable to make an effective case for prioritizing budget increases<sup>22</sup>.
- For decades, the international community's health agenda – including that of WHO – has been structured around diseases and interventions rather than around the broader challenges being faced by health systems. While this agenda has certainly contributed to a better appreciation of the burden of disease affecting poor countries, it has also profoundly influenced the structure of governmental and quasi-governmental institutions in low- and middle-income countries. The resulting fragmentation of the governance of the health sector has diverted attention from important issues, such as the organization of primary care, the control of the commercialization of the health sector and human resources for health crises.

The untoward consequences of this trend are most marked in aid-dependent countries because it has shaped the way funds are channelled<sup>23</sup>. The disproportionate investment in a limited number of disease programmes considered as

global priorities in countries that are dependent on external support has diverted the limited energies of ministries of health away from their primary role as mediator in the comprehensive planning of primary care and the public's health.

### Box 5.1 From withdrawal to re-engagement in China

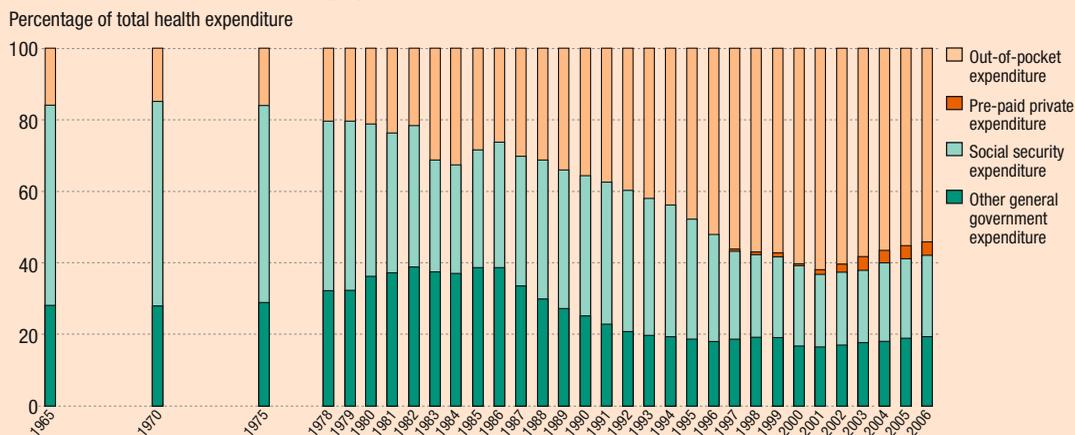
During the 1980s and 1990s, reduced Government engagement in the health sector exposed increasing numbers of Chinese households to catastrophic expenditures for health care. As a result, millions of families in both rural and urban areas found themselves unable to meet the costs and were effectively excluded from health care. In cities, the Government Insurance Scheme (GIS) and Labour Insurance Scheme (LIS) had previously covered more than half of the population with either full or partial health insurance. However, the structural weaknesses of these schemes reached critical levels under the impact of accelerating economic change in the 1990s. The percentage of China's urban population not covered by any health insurance or health plan rose from 27.3% in 1993 to 44.1% in 1998<sup>14</sup>. By the end of the century, out-of-pocket payments made up more than 60% of health expenditure. This crisis spurred efforts to invert the trend: pooling and pre-payment schemes were bolstered in 1998 with the introduction of Basic Medical Insurance (BMI) for urban employees.

Financed through compulsory contributions from workers and employers, the BMI aims to replace the old GIS and LIS systems. The BMI has aimed for breadth of coverage with a relatively modest depth of benefits, linked to flexibility that can enable the development of different types of packages according to local needs in the participating municipalities. Structurally, the BMI fund is divided into two parts: individual savings accounts and social pooling funds. Generally speaking, the financial contribution from an employee's salary or wages goes to his or her individual savings account, while the employer's contribution is split between the individual savings accounts and the social pooling fund, applying different percentages according to the age group of employees.

Financial resources under the new BMI are pooled at municipal or city level, instead of by individual enterprises, which significantly strengthens the capacity for risk sharing. Each municipal government has developed its own regulations on the use of the resources of individual savings accounts and social pooling funds (the two structural parts of the system). The individual savings accounts cover outpatient services, while the social pooling fund is meant to cover inpatient expenditures<sup>14</sup>.

Significant difficulties with the BMI model remain to be ironed out, in particular as regards equity. For example, studies indicate that, in urban areas, better-off populations have been quicker to benefit from the provisions of the BMI than households with very low incomes, while informal sector workers remain on the margins of the scheme. Nonetheless, the BMI has made progress in expanding health insurance coverage and access to services among China's urban population, and is instrumental in reversing the deleterious trends of the 1980s and 1990s and, at the same time, assigning a new, intermediary role to government institutions.

**Figure 5.2** Health expenditure in China: withdrawal of the State in the 1980s and 1990s and recent re-engagement



Sources: 1965 to 1975<sup>15</sup>; 1978 to 1994<sup>16</sup>; 1995 to 2006<sup>4</sup>.



As a result, multiple, fragmented funding streams and segmented service delivery are leading to duplication, inefficiencies and counterproductive competition for resources between different programmes. Consequently, the massive mobilization of global solidarity has not been able to offset a growing estrangement between country needs and global support, and between people's expectations for decent care and the priorities set by their health-sector managers. Moreover, the growth in aid-flow mechanisms and new implementing institutions has further heightened the degree of complexity faced by weak government bureaucracies in donor-dependent countries, increasing transaction costs for those countries that can least afford them<sup>24</sup>. So much effort is required to respond to international partners' short-term agendas that little energy is left to deal with the multiple domestic stakeholders – professions, civil society organizations, politicians, and others – where, in the long run, leadership matters most. As advocates have rightly argued in recent years, better inter-donor coordination is not going to solve this problem on its own: there is also an urgent need for reinvestment in governance capacity.

### Participation and negotiation

The necessary reinvestment in governmental or quasi-governmental institutions cannot mean a return to command-and-control health governance. Health systems are too complex: the domains of the modern state and civil society are interconnected, with constantly shifting boundaries<sup>25</sup>. Professions play a major role in how health is governed<sup>26</sup>, while, as mentioned in Chapter 2, social movements and quasi-governmental autonomous institutions have become complex and influential political actors<sup>27</sup>. Patients, professions, commercial interests and other groups are organizing themselves in order to improve their negotiating position and to protect their interests. Ministries of health are, also, far from homogenous: individuals and programmes compete for influence and resources, adding to the complexity of promoting change. Effective mediation in health must replace overly simplistic management models of the past and embrace new mechanisms

for multi-stakeholder policy dialogue to work out the strategic orientations for PHC reforms<sup>28</sup>.

At the core of policy dialogue is the participation of the key stakeholders. As countries modernize, their citizens attribute more value to social accountability and participation. Throughout the world, increasing prosperity, intellectual skills and social connectivity are associated with people's rising aspiration to have more say<sup>29</sup> in what happens at their workplaces and in their communities – hence the importance of people-centredness and community participation – and in important government decisions that affect their lives – hence the importance of involving civil society in the social debate on health policies<sup>30</sup>.

Another reason that policy dialogue is so important is that PHC reforms require a broad policy dialogue to put the expectations of various stakeholders in perspective, to weigh up need, demand and future challenges, and to resolve the inevitable confrontations such reforms imply<sup>31</sup>. Health authorities and ministries of health, which have a primary role, have to bring together the decision-making power of the political authorities, the rationality of the scientific community, the commitment of the professionals, and the values and resources of civil society<sup>32</sup>. This is a process that requires time and effort (Box 5.2). It would be an illusion to expect PHC policy formation to be wholly consensual, as there are too many conflicting interests. However, experience shows that the legitimacy of policy choices depends less on total consensus than on procedural fairness and transparency<sup>33,34,35</sup>.

Without a structured, participatory policy dialogue, policy choices are vulnerable to appropriation by interest groups, changes in political personnel or donor fickleness. Without a social consensus, it is also much more difficult to engage effectively with stakeholders whose interests diverge from the options taken by PHC reforms, including other sectors that compete for society's resources; for the “medico-industrial complex”<sup>36</sup>, for whom PHC reform may imply a realignment of their industrial strategy and for vested interests, such as those of the tobacco or alcohol industries, where effective PHC reform constitutes a direct threat.

### Box 5.2 Steering national directions with the help of policy dialogue: experience from three countries

In Canada, a Commission examining the future of health care drew on inputs from focus group discussions and public hearings. Diverse stakeholders and groups of the public made clear the value placed by Canadians on equitable access to high-quality care, based on need and regardless of ability to pay. At the same time, the Commission had to ensure that this debate would be fed by evidence from top policy experts on the realities of the country's health system. Of critical importance was the evidence that public financing of health care not only achieves goals of equity, but also those of efficiency, in view of the higher administrative costs associated with private financing. The discussion on values and the relevant evidence were then brought together in a policy report in 2002 that set out the direction for a responsive, sustainable and publicly funded PHC system, considered to be "the highest expression of Canadians caring for one another"<sup>37</sup>. The strong uptake by policy-makers of the Commission's recommendations reflects the robustness of the evidence-informed analysis and public engagement.

In Brazil, the first seven *Conferências Nacionais de Saúde*, the platform for national policy dialogue in the health sector between 1941 and 1977, had a distinctly top-down and public-sector-only flavour, with a classic progression from national plans to programmes and extension of the network of basic health services. The watershed came with the 8th conference in 1980: the number of participants increased from a few hundred to 4000, from a wide range of constituencies. This and subsequent *conferências* pursued agendas that were driven far more than before by values of health democracy, access, quality, humanization of care and social control. The 12th national conference, in 2003, ushered in a third consolidation phase: 3000 delegates, 80% of them elected, and a focus on health as a right for all and a duty of the State<sup>38</sup>.

Thailand went through similar phases. The extension of basic health care coverage by a proactive Ministry of Health, encouraged by the lobby of the Rural Doctors Association, resulted in the 1992 launch of the Decade of Health Centre Development. After the 1994 economic crisis, ministry officials started mobilizing civil society and academia around the universal coverage agenda, convening a few thousand delegates to the First Health Care Reform Forum in 1997. Liaison with the political world soon followed, with a bold move towards universal access and social protection known as the "30 Baht policy"<sup>39</sup>. With the National Health Act of 2007, stakeholder participation has been institutionalized through a National Health Commission that includes health professionals, civil society members and politicians.

### Effective policy dialogue

The institutional capacities to enable a productive policy dialogue are not a given. They are typically weak in countries where, by choice or by default, *laissez-faire* dominates the approach to policy formation in health. Even in countries with mature and well-resourced health systems there is scope, and need, for more systematic and institutionalized approaches: negotiation between health authorities and professional institutions is often well established, but is much less so with other stakeholders and usually limited to discussions on resource allocation for service delivery. Policy dialogue must be built. How to do that depends very much on context and background. Experience from countries that have been able to accelerate PHC reforms suggests three common elements of effective policy dialogue:

- the importance of making information systems instrumental to PHC reform;
- systematically harnessing innovations; and
- sharing lessons on what works.

### Information systems to strengthen policy dialogue

Policy dialogue on PHC reforms needs to be informed, not just by better data, but also by information obtained through a departure from traditional views on the clients, the scope and the architecture of national health information systems (Figure 5.3).

Many national health information systems that are used to inform policy can be characterized as closed administrative structures through which there is a limited flow of data on resource use, services and health status. They are often only used to a limited extent by officials at national and global level when formulating policy reforms, while little use is made of critical information that could be extracted from other tools and sources (census data, household expenditure or opinion surveys, academic institutions, NGOs, health insurance agencies, etc.), many of which are located outside the public system or even outside the health sector.

Routine data from traditional health information systems fails to respond to the rising demand for health-related information from a multitude of constituencies. Citizens need easier access to their own health records, which should inform them about the progress being made in their treatment plans and allow them to participate in decisions related to their own health and that of their families and communities. Communities and civil society organizations need better information to protect their members' health, reduce exclusion and promote equity. Health professionals need better information to improve the quality of their work, and to improve coordination and integration of services. Politicians need information on how well the health system is meeting society's goals and on how public money is being used.

Information that can be used to steer change at the policy level is quite different from the data that most conventional health information systems currently produce. There is a need to monitor what the reforms are achieving across the range of social values and the associated outcomes that are central to PHC: equity, people-centredness, protection of the health of communities and participation. That means asking questions such as:

- is care comprehensive, integrated, continuous and effective?
- is access guaranteed and are people aware of what they are entitled to?
- are people protected against the economic consequences of ill-health?

- are authorities effective in ensuring protection against exclusion from care?
- are they effective in ensuring protection against exploitation by commercial providers?

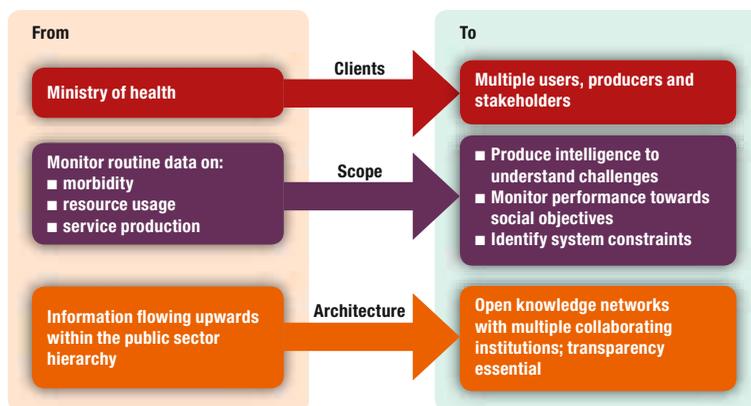
Such questions go well beyond what can be answered by tracking health outcome indicators, resource use and service output, which is what conventional health information systems focus on. The paradigm shift required to make information systems instrumental to PHC reform is to refocus on what is holding up progress in reorienting the health system. Better identification of priority health problems and trends is important (and vital to anticipate future challenges) but, from a policy point of view, the crucial information is that which allows identification of the operational and systemic constraints. In low-income countries in particular, where planning has long been structured along epidemiological considerations, this can provide a new and dynamic basis for orienting systems development<sup>40</sup>. The report by the Bangladesh Health Watch on the state of the country's health workforce, for example, identified such systemic constraints and corresponding recommendations for the consideration of health authorities<sup>41</sup>.

The multiplication of information needs and users implies that the way health information is generated, shared and used also has to evolve. This critically depends on accessibility and transparency, for example, by making all health-related information readily accessible via the Internet – as in Chile, where effective communication was

considered both an outcome and a motor of their “Regime of Explicit Health Guarantees”. PHC reform calls for open and collaborative models to ensure that all the best sources of data are tapped and information flows quickly to those who can translate it into appropriate action.

Open and collaborative structures, such as the “Observatories” or “Equity Gauges” offer specific models of complementing routine information

**Figure 5.3** Transforming information systems into instruments for PHC reform



systems, by directly linking the production and dissemination of intelligence on health and social care to policy-making and to the sharing of best practices<sup>42</sup>. They reflect the increasing value given to cross-agency work, health inequalities and evidence-based policy-making. They bring together various constituencies, such as academia, NGOs, professional associations, corporate providers, unions, user representatives, governmental institutions and others, around a shared agenda of monitoring trends, studies, information sharing, policy development and policy dialogue (Box 5.3).

Paradoxically, these open and flexible configurations provide continuity in settings where administrative and policy continuity may be affected by a rapid turnover of decision-makers.

In the Americas, there are observatories that specifically focus on human resource issues in 22 countries. In Brazil, for example, the observatory is a network of more than a dozen participating institutions (referred to as “workstations”): university institutes, research centres and a federal office, coordinated through a secretariat based at the Ministry of Health and the Brasilia office of PAHO<sup>44</sup>. These networks played a key role in setting up Brazil’s current PHC initiatives. Such national and sub-national structures also exist in various European countries, including France, Italy and Portugal<sup>45</sup>. Comparatively autonomous, such state/non-state multi-stakeholder networks can cover a wide range of issues and be sensitive to local agendas. In the United Kingdom, each regional observatory takes the lead on specific

### Box 5.3 Equity Gauges: stakeholder collaboration to tackle health inequalities<sup>43</sup>

Equity Gauges are partnerships of multiple stakeholders that organize active monitoring and remedial action around inequity in health and health care. So far, they have been established in 12 countries on three continents. Some operate at a countrywide level, some monitor a subset of districts or provinces in a country, a few operate at a regional level and others focus specifically on equity within a city or municipality; nine have a national focus and three work at the municipal level (in Cape Town (South Africa), El Tambo (Ecuador) and Nairobi (Kenya)). The Equity Gauges bring together stakeholders representing a diversity of local contexts, including parliamentarians and councillors, the media, ministries and departments of health, academic institutions, churches, traditional leaders, women’s associations, community-based and nongovernmental organizations, local authority organizations and civic groups. Such a diversity of stakeholders not only encourages wide social and political investment, but also supports capacity development within countries.

Equity Gauges develop an active approach to monitoring and dealing with inequity in health and health care. They move beyond a mere description or passive monitoring of equity indicators to a set of specific actions designed to effect real and sustained change in reducing unfair disparities in health and health care. This work entails an ongoing set of strategically planned and coordinated actions that involves a range of different actors who cut across a number of different disciplines and sectors.

The Equity Gauge strategy is explicitly based on three “pillars of action”. Each one is considered to be equally important and essential to a successful outcome and all three are developed in parallel:

- research and monitoring to measure and describe inequities;
- advocacy and public participation to promote the use of information to effect change, involving a broad range of stakeholders from civil society working together in a movement for equity;
- community involvement to involve poor and marginalized people as active participants in decision-making rather than passive recipients of measures designed for their benefit.

The Equity Gauge strategy consists, therefore, of a set of interconnected and overlapping actions – it is not, as the name might suggest, just a set of measurements. For example, the selection of equity indicators for measurement and monitoring should take account of the views of community groups and consider what would be useful from an advocacy perspective. In turn, the advocacy pillar relies on reliable indicators developed by the measurement pillar and may involve community members or public figures.

Equity Gauges choose indicators according to the particular needs of the country as well as of the stakeholders. Emphasis is placed, however, on generating trend data within all Gauges to enable understanding of progress over time. Indicators are measured across a variety of dimensions of health, including health status; health-care financing and resource allocation; access to health care; and quality of health care (such as maternal and child health, communicable diseases and trauma). All indicators are disaggregated according to the “PROGRESS” acronym that describes a broad range of socioeconomic factors often associated with inequities in health determinants: Place of residence, Religion, Occupation, Gender, Race/ethnicity, Education, Socioeconomic status and Social networks/capital.