Governance and stewardship in mixed health systems in low- and middle-income countries

Tanya Caulfield
Nossal Institute for Global Health

Krishna Hort
Nossal Institute for Global Health
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Corresponding author:
Krishna Hort
The Nossal Institute for Global Health,
University of Melbourne
khort@unimelb.edu.au

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SUMMARY

The growth of mixed public-private health systems as low income countries transition to low-middle and middle income countries raises issues of stewardship and governance of health systems for policy makers. This paper builds on discussions at a roundtable meeting convened by the Nossal Institute in March 2012 to examine the application of the concepts of governance and stewardship to regulation of mixed commercialised health systems.

Governance is a complex concept with political, economic, legal and institutional dimensions and occurs at multiple levels within health systems. Governance is a feature of all organisations and systems and relates to the set of rules both formal and informal that governs the behaviour and allocates roles and responsibilities to actors in the system.

Stewardship, on the other hand, is the role of providing leadership and oversight of the organisations and actors within a system or organisation to direct them towards achieving certain goals. It involves the tasks of formulating strategic policy direction, ensuring good regulation and appropriate tools, and overseeing accountability and transparency.

Regulation is a mechanism, which aims to control the distribution, price and quality of products and services within a market. At a broad view, regulation overlaps to some extent with stewardship as a mechanism to steer health systems. A range of regulatory strategies have been identified, ranging from volunteerism to ‘command and control’ in what has been termed a ‘regulatory pyramid.’

We describe how the concepts of governance and stewardship have been applied in regards to health systems in LMICs in five ways:

(1) Strengthening the function of governance and stewardship as one of the six ‘building blocks’ of the health system as part of health system strengthening efforts
(2) Engaging the private sector and integrating activities and services of the private sector into the government’s health system goals
(3) Global health governance – applying governance to the emerging institutions operating at a global level in the health sector
(4) Governance of relationships between development assistance providers and partner countries in development assistance programs; and
(5) Governance of individual institutions operating in the health sector, notably hospitals.

Our analysis suggests that the concepts of governance could provide a useful ‘lens’ for further examination of policy making and regulation of health systems in LMICs, by shifting the focus from individual policy decisions to the policy making process, the roles and relationships among the stakeholders in this process; and policy implementation at different levels within the health system, and how actors with different degrees of autonomy respond to policy directives.

Application of the governance lens provides a way that governments in LMICs can become more aware of their roles as stewards, and how to apply the principles of good governance to policy making and regulation. Newer ideas around governance in more developed systems could also potentially be applied to the LMIC context, including collaborative and multi-level governance; governance for health not just of health; and models of clinical governance in health care organisations.
INTRODUCTION

The growth of the non-state or private sector in the provision of health services in Asian countries as they progress from low to low-middle or middle income has been identified as a key issue for policy makers. Recent studies carried out by the Health Policy and Health Finance Knowledge Hub in collaboration with country partners revealed an increasing number of non-state hospitals in Vietnam and Indonesia. The studies linked the growth of the private sector to broader changes in the health system, which some commentators have referred to as a shift towards commercialised mixed health systems (Macintosh 2007; Nishtar 2010).

The growth of the non-state sector raises issues for policy makers, including how to engage the sector in achieving public health goals (Lagomarsino, Nachuk and Kundra 2009) and how to regulate the behaviour of non-state providers to protect the public interest (Balabanova, Oliveira-Cruz and Hanson 2008). This requires the state to take a more active role in the regulation and direction of the whole health system, rather than focus on management of state-provided services, a role that has been termed stewardship (WHO 2000; Lagomarsino, Nachuk and Kundra 2009). Stewardship, which can be understood as the arrangement for decision making and control of a multi-participant system, is closely linked to governance.

To explore the ideas of stewardship, regulation and governance and their application to mixed health systems, the Nossal Institute for Global Health convened a round table of national and regional experts in March 2012. This paper grew out of the discussions at that meeting and aims to examine the application of concepts of governance, regulation and stewardship to the mixed commercialised systems of low- and middle-income countries (LMICs), particularly in Asia.

In this paper we:

1. describe the context of mixed health systems in LMICs and the policy challenges;
2. review the definitions and use of the terms governance, stewardship and regulation in the literature on health systems in LMICs;
3. identify how the concepts have been applied to studies and to policy discourse regarding health systems in LMICs;
4. assess the usefulness of these concepts.

METHODOLOGY

This paper is based on the identification of key concepts and issues through a round table on governance and stewardship of mixed health systems in LMICs held at the Nossal Institute for Global Health on 6-7 March 2012. The participants comprised Associate Professor Paul Dugdale, Centre for Health Stewardship (Australian National University); Adjunct Professor Abby Bloom, Menzies Centre for Policy (University of Sydney); Dr Kabir Sheikh, Centre for Health Governance (Public Health Foundation of India); Dr David Hipgrave, consultant, former UNICEF health program manager in China and Indonesia; John Grundy, consultant in health systems planning in the Mekong region; and Dr Peter Annear and Dr Krishna Hort from the Nossal Institute for Global Health (University of Melbourne).

The issues identified from the discussion were:

- concepts and theories of governance and stewardship;
- components of governance and stewardship;
- good governance;
- instruments or mechanisms of governance and stewardship;
- characteristics of mixed health systems in LMICs.

A review of the literature on governance and stewardship applied to health systems was undertaken. The main source was grey literature and reports prepared by researchers for international agencies. This included a series of studies undertaken by the Research for Development group with funding from the Rockefeller Foundation and reports from the World Bank and the World Health Organization. We also undertook a general literature search using databases such as PubMed and Medline, and Google and Google scholar search engines using the search terms ‘health system strengthening’, ‘health governance’, ‘health stewardship’, ‘mixed health systems’ and ‘global health governance’.

In addition, we examined studies and reviews by the Nossal Institute for Global Health with its collaborators. In particular, this included the articles by Sheikh, Saligram and Prasad (2012a), Hort and Annear (2012) and Akhtar (2011).

This paper is not an exhaustive review and is intended more as a scoping of the literature on governance, regulation and stewardship to identify the range of ways in which the terms are used.
Mixed Health Systems

An emerging characteristic of health systems in many LMICs and most upper-middle income countries is the provision of services by a mix of public and private organisations and institutions. Mixed health systems can be defined as involving ‘centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services’ (Oxfam 2009). As in many upper-middle income countries, health care in LMICs is delivered by a diverse range of providers that constitute a mixed health system. In LMICs, health systems are diversifying as a result of the growth in non-state providers that aim to treat illness and prevent disease via philanthropic or commercial means (Mills, Brugha et al 2002). In many LMICs, the mixed public-private health system has become increasingly commercialised so that the distinction between ‘state’ and ‘non-state’ facilities has become blurred. Commercialised mixed health systems can be defined as:

The provision of health care services through market relationships to those able to pay; investment in and production of those services and of inputs to them, for cash income or profit, including private contracting and supply of publicly financed health care; and health care finance derived from individual payments and private insurance (Mackintosh and Koivusalo 2005).

Mackintosh (2007) further develops the concept of commercialised mixed health systems by incorporating the following aspects:

• marketisation: the shift from provision and input supply without fee payments to fee-for-service provision and cash payment for inputs
• commoditisation: the specification of items of service provision in a form capable of being sold on a market
• privitisation: the shift of an asset from government ownership into private hands;
• liberalisation: removal of constraints on private provision of health care and purchase and sale of inputs

Governments are increasingly using market mechanisms to finance health care, such as tendering to encourage competition and activity-based funding to drive supplier efficiency (Harding 2003). While some countries combine public and private health care in different ways, mixed health systems in many LMICs are marked by specific characteristics. Sheikh, Saligram et al (2012) identify the following common features:

• Diversity in health care provision: health providers and practices range from solo providers and clinics in formal and informal sectors to large multi-speciality state and non-state hospitals; approaches to health care range from informal local traditions, formalised indigenous and/or alternative medicine, to Western medicine.
• Dominant, poorly organised private markets: increasing growth of non-state health services, which are more accessible and utilised more than public sector services. Out of pocket payments are the dominant form.
• Compromised public services: public spending on health care constitutes a minority of health expenditures. There is a poor standard of essential services and a lack of procedural transparency and accountability as a result of weakness in the management and oversight of government health care services.
• Blurred public-private distinction: overlapping financing mechanisms and employment arrangements often make the distinction between public and private behaviour ambiguous. Government practitioners often practise privately, and many government health systems partner with private providers.

The arrangement and intersection of these characteristics contribute to issues that compromise health care in LMICs. Nishtar (2010) refers to this as the ‘mixed health systems syndrome’, defined as a mixed delivery of health care that shows signs of compromised quality and equity. Nishtar states that characteristics of the mixed health systems syndrome can be identified by indicators of poor health system performance. Based on an analysis of related literature, Sheikh, Saligram et al (2012) identify four themes related to the failure of health care provision in mixed health systems in LMICs:

• High cost: the cost of health care is an obstacle to access, particularly for the poor. Out of pocket payments account for the majority of health expenditures and contribute to catastrophic
spending and impoverishment. This compromises a family’s ability to pay for future health care needs and contributes to a cycle of poverty and health deterioration.

- Poor quality of care: there are extensive instances of substandard quality of care in both government and private health facilities. There are frequent infringements of standard treatment guidelines for diseases, and the quality of services by informal providers and alternative systems of medicine is poor, even when poorly defined standards make these deficiencies difficult to measure.

- Unethical conduct of providers: some providers encourage or pressure patients into paying for unnecessary investigations and treatments. Medical negligence is widespread and unchecked and affects the poor and less literate in particular. In addition, some health workers discriminate against and disrespect the poor.

- Unequal distribution of providers: all countries have a disparate presence of qualified health personnel in urban and wealthier areas. Private providers favour locations where patients are able to pay more. Public providers are reluctant to remain in rural areas. This situation is exacerbated by absenteeism of staff who fail to attend their clinics, despite receiving a salary.

We are interested in how these problems can be addressed as challenges for health stewardship, rather than as absolute limitations of a mixed health system in LMICs.

**Concepts of Governance, Stewardship and Regulation**

There is increasing reference to governance and stewardship in the literature on health systems and health policy. However, the literature contains a variety of definitions of the concepts and roles of governance and stewardship, suggesting that it is not easy to differentiate the two. At the outset, it is important to distinguish governance from government. ‘Government’ refers to the formal institutions of nation-states, which make judgments within legal frameworks. ‘Governance’ is the system by which any formal social group, organisation or institution is directed and managed.

**Governance**

Governance is a complex concept with various elements. In broad terms, it can be defined as the collective actions and measures adopted by a group of people to achieve common goals. Group members need to agree to both formal and informal rules and procedures related to membership, obligations and responsibilities, decision making, communication, resource mobilisation and distribution and dispute resolution (Dodgson, Lee and Drager 2002). Governance is a multi-dimensional concept composed of political, economic, legal and institutional dimensions. The political dimension relates to how individuals in authority are elected, appointed and monitored. The economic dimension relates to the determination of how public resources are managed and policies implemented; the legal dimension covers the legal and regulatory framework, and political process of law making while institutional dimensions are concerned with how citizens and the state relate to public institutions (Balabanova, Oliveira-Cruz and Hanson 2008). Rosenau defines governance as ‘activities backed by shared goals that may or may not derive from legal and formally prescribed responsibilities and that do not necessarily rely on police powers to overcome defiance and attain compliance’ (in Dodgson, Lee and Drager 2002). Governance is associated with human activity in both public and private contexts, and these contexts often intersect. Governance is distinct from government in that it is a neutral term that involves authority, power and decision making in institutional areas (Brinkerhoff and Bossert 2008). Within the health sector, governance is viewed by different national and global actors as a fundamental function of health systems and a central component of health sector organisations and development strategies (Balabanova, Oliveira-Cruz and Hanson 2008). It is, therefore, a fundamental aspect of organised multi-actor activity, both state-sponsored and non-state.

Governance occurs at different levels of the health system, from the global and international, through national to sub-national levels and to individual institutions (Dodgson, Lee and Drager 2002). Each level influences the one below, forming a ‘cascade of governance’. Governance is not restricted to institutions of the state or formal government and occurs within both public and private health organisations; governance is both public and private or a combination of the two. Historically, national and sub-national governments of individual countries were responsible for the health of the population. Dodgson, Lee and Drager (2002) state that the governance function has been assigned increasingly to regional, district and local levels.
At each level, actors function within a broader governance framework defined by a more or less accepted set of rules. The rules allocate roles and responsibilities to actors and shape the interactions between them. These rules can be both formal and informal. Formal rules are those that are embodied in an organisation and are based on the rule of law and rules of engagement (Bossert 2008; Balabanova, Oliveira-Cruz and Hanson 2008). Informal rules, on the other hand, are the values, culture, expectations and power relations that govern the behaviour of actors. Both sets of rules adapt over time as a result of changing broader sociocultural values, expectations and relationships, and ultimately influence and alter organisational rules.

Organisations and systems adopt different models of governance to achieve specific goals. These include normative, instrumental and pragmatic models (Dodgson, Lee and Drager 2002; Balabanova, Oliveira-Cruz and Hanson 2008; Kickbusch & Gleicher 2012). Normative models are top-down approaches, based on social values and norms formalised through state legal and regulatory frameworks, whereas instrumental models 'focus on intermediate health system objectives such as efficiency, effectiveness, private sector regulation, anti-corruption and good governance' (Balabanova, Oliveira-Cruz and Hanson 2008). Pragmatic models emerge as a way for policy implementers to manage complexity at the micro or meso level (Balabanova, Oliveira-Cruz and Hanson 2008).

As the discussion above suggests, governance is a feature of all organisations and systems and is fundamental to the fulfilment of organisational and social goals. Stewardship, on the other hand, is the providing of leadership to and oversight of the organisations and programs which aim to achieve certain national goals. The following section provides a discussion of stewardship and its relationship with governance with a focus on the health system.

**Stewardship**

Alongside managing the health services of government-owned facilities, the government guides the whole health system by setting goals, objectives and rules that define how the goals are to be attained (WHO 2009). This function has been termed stewardship. Stewardship involves ‘formulating strategic policy directions, ensuring good regulation and appropriate tools for implementing it, and fostering the necessary intelligence on the health system’s performance to ensure accountability and transparency’ (WHO 2009). The WHO has defined six key activities for health system stewardship:

1. defining the vision for health and the strategy to achieve it;
2. applying intelligence when defining the vision and evaluating outcomes;
3. governing the health system in a way that is values based, ethical and conducive to
4. the attainment of its goals;
5. mobilising legal and regulatory powers of the health system to attain its goals;
6. ensuring the health system is designed so that it can adapt to changing needs;
7. exerting influence on other sectors and advocating better health.

The purpose of health stewardship can be understood as producing (and reproducing) a working assemblage of finances, knowledge and management arrangements for the operation of the sector. Health stewardship activities are the responsibility of the health ministry. These can be grouped into four interlocking domains:

- **legislation:** the development, implementation and enforcement of legislation and the statutorily associated regulatory and administrative actions;
- **structure:** the design of health institutions, services and managerial arrangements and the relationships between these elements;
- **financing:** the use of public funds, statutory charges and financial instruments to finance the activities of health system elements and services;
- **politics:** the provision of formal and informal policy and political advice to the minister for health and the cabinet.

Stewardship in mixed health systems is exercised through a variety of mechanisms, including collaborative decision making, financing and payment and regulation. The following provides an overview of the regulatory mechanism.

**Regulation**

Regulation of health care aims to control the distribution, price and quality of products and services
Regulatory activity consists of legislation, application, monitoring and evaluation, enforcement and judicial supervision. Three regulatory approaches have been identified focusing on different aspects of health systems:

- setting forth mandatory rules that are enforced by a state agency;
- efforts by state agencies to steer the economy, which includes state ownership and contracting, taxation and disclosure requirements;
- mechanisms of both intentional and unintentional social control (Saltman and Busse 2002).

This suggests that a broad view of regulation overlaps to some extent with stewardship in that regulation is used to steer health systems to improve service quality and patient safety (Healy and Braithwaite 2006). The domains of health regulation include health services, pharmaceuticals, health technology, health insurance and medical education. In addition, regulation cuts across the health system by ensuring quality and effectiveness, patient access and appropriate behaviour of providers, payers, physicians and pharmaceutical providers (Saltman and Busse 2002). The type of regulatory strategy appropriate to a particular system will depend on the context, culture and conduct of those being regulated. Healy and Dugdale (2009) call this responsive regulation, which they explain is applicable in the health sector, given its specialised knowledge, ethical base and tradition of service to communities. The authors outline the different regulatory strategies with regard to the sector:

- volunteerism—based on an individual or organisation undertaking to do the right thing without coercion;
- self-regulation—an organised group regulates the behaviour of its members;
- economic instruments—supply-side funding sanctions or incentives for providers and demand-side measures that give more power to consumers;
- co-regulation—a partnership between external and internal regulators;
- meta-regulation—an external body monitoring internal regulators to ensure they are regulating adequately;
- command and control—enforcement by government or its agents.

While the ideal is to regulate at the base of the regulatory pyramid with voluntary compliance measures, regulators may use stronger measures to ensure quality performance. The round table discussion emphasised the need for each level to be supported by the one above, and for the apex to have in reserve sanction powers to compel compliance in order for the levels below to function.

**Stewardship and Good Governance**

Some of the literature on the governance concept provides definitions that are similar to or even synonymous with the functions of stewardship. Travis, Egger et al (2002) suggest, however, that there are important distinctions between the two concepts. The principles of governance pervade all social systems, including health, and shape the environment in which health systems operate. Thus, governance also shapes the way in which stewardship functions. On the other hand, health system stewards are responsible for ensuring that the health system operates in line with good governance principles. In addition, both concepts are related to sets of actions. Travis, Egger et al (2002) state that there are many actions related to governance that are not related to improving health, whereas the actions of stewardship are specific to improving health. Stewardship, therefore, is a distinct entity that is a core function of the health system. The round table suggested that a potential distinction between governance and stewardship within the health sector was that governance relates to the structures and processes for decision making and implementation to achieve goals, while stewardship uses these structures and functions to determine and pursue specific goals.

Nonetheless, stewardship is central to good governance, and government responsibility for the health of its population is permanent and continuous. Principles of good governance for governments have been defined by many organisations and are similar to guidelines for corporate governance and non-government organisations. While governance is a feature of all institutions, one aspect of stewardship is to develop good governance; the way in which government performs its stewardship role influences the quality of health system outcomes (Travis, Egger et al 2002).

The OECD broadly defines good governance as a means by which democracy and human rights can be strengthened, economic prosperity and social
cohesion promoted, poverty reduced, environmental protection and sustainable use of natural resources enhanced and confidence in government and public administration enhanced (Kickbusch and Gleicher 2012. The concept of good governance assists health systems in different contexts to analyse progress based on good governance principles. Brinkerhoff and Bossert (2008) highlight four principles that contribute to good political, program and policy decisions, which support health system objectives in different contexts. The principles are related to accountability, fairness, capacity and engagement.

**Accountability:** As part of the governance rules in each country, there should be accountability of health system actors to the beneficiaries and broader public (Brinkerhoff and Bossert 2008). Health systems require formal mechanisms by which beneficiaries and the public can hold actors, including politicians, decision-makers and health service providers, responsible for achieving health system objectives. Brinkerhoff (2004) states that accountability can be more precisely defined with regard to three specific categories:

1. **financial accountability**—involves tracking and reporting the allocation, distribution and expenditure of financial resources by auditing, budgeting and accounting according to procedural compliance;

2. **performance accountability**—refers to demonstrating and accounting for performance outcomes based on service and output targets;

3. **political/democratic accountability**—relates to ensuring governments deliver on electoral promises, represent public interests, fulfil public trust and respond to social needs.

**Fairness:** This involves a policy process that engages competing interest groups to influence policy development on equal terms. To improve the quality of and access to health services, the process requires compromise to enable negotiation between the different groups, based on fair rules of competition (Brinkerhoff and Bossert 2008). The equality of the different groups is ensured by checks and balances, which guarantee the rules of competition and are respected so that all perspectives can be heard and represented.

**Capacity:** This principle is related to government capacity, power and legitimacy. These are required to manage effective policy making and implementation of policy decisions. Good governance is dependent on the operational capacity of government to provide public goods and services and respond to public needs (Brinkerhoff and Bossert 2008).

**Engagement/participation:** Engagement with consumers and potential consumers in the governance of health service planning and delivery is a useful strategy to achieve a good fit between needs and services. Services require patients to cooperate with both the style and the content of the care provided. This applies to both public and private health providers. For public sector institutions, engagement of citizens in the directing of services is an expression of democratic values. For the private sector, it may confer a market advantage. Participation can occur with various levels of intensity, from the simple provision of information through to full empowerment of citizens in the operation of the services (Pateman 1970).

**Governance and Stewardship in LMICs**

In this section we review examples identified from the literature and reports of how concepts of governance and stewardship have been applied to health systems in LMICs. We begin with a review of some of the features and characteristics of LMICs which impact on the application of these concepts. We then identify five areas where concepts of governance and stewardship have been applied:

1. **strengthening the function of governance and stewardship as one of the six ‘building blocks’ of the health system as part of health system strengthening;**

2. **engaging the private sector and integrating its activities and services into the government’s health system goals;**

3. **global health governance—applying governance to the health sector institutions emerging at a global level;**

4. **governance of relationships between providers and partner countries in development assistance programs;**

5. **governance of individual institutions operating in the health sector, notably hospitals.**
Contextual Features

In relation to applying the concepts of governance and stewardship to LMICs, it is important to identify contextual features that influence the feasibility and appropriateness of doing so. There is a distinction between failures of governing institutions and basic ungovernability of systems, both of which are contexts that occur in LMICs. These contextual features include:

- Government systems. In many LMICs, government is decentralised to varying degrees, which changes the balance of power and accountability channels between central and district government. In addition, decentralisation may increase regional inequalities and put public resources into the hands of local elites (World Bank 2004).
- Weak compliance with and respect for institutional rules. Corruption and bribery are common, which are difficult to control due to the lack of information on hidden activities. Avenues for corruption in health systems include absenteeism, patronage, procurement fraud, misuse of facilities, unwarranted services and bribes at the point of service. Health services can be diverted to the non-poor for political patronage (World Bank 2004).
- Weak regulatory capacity in government. Many governments in LMICs do not have the regulatory structures to monitor services and enforce quality standards. Some governments have legal frameworks but do not have the capacity to enforce them, while other governments have neither (Lagomarsino, Nachuk and Kundra 2009). Some health ministries overlook the evasion of regulations and turn a blind eye to corruption, bribery and moonlighting, which are difficult to tackle successfully (WHO 2000). Sheikh, Saligram and Prasad (2012) state that weaknesses in government capacity involve a range of phenomena including:
  - lack of capacity and financial resources and inadequacy of legal and organisational frameworks for regulation;
  - corruption and lack of transparency and accountability;
  - discrepancies between the functions and roles that regulatory institutions are supposed to perform and those they actually perform;
  - low political will for regulation, and capture of regulatory institutions by vested interests;
  - information asymmetries and unequal power relationships between providers and users, particularly for approaches based on community oversight and scrutiny.
- Policy making. Non-state actors may not be included in policy-making consultations and processes. In a few countries, there is some interaction between non-state actors and health policy makers, but this is often ad hoc and based on personal and/or political connections (Harding 2003).
  - Weak social accountability. Opportunities for citizens to voice their concerns and perspectives are limited because of weak institutions. Democratic systems are often fragile, leaving electoral systems a highly problematic means of achieving accountability (Litvack, Ahmad and Bird 1998). In addition, citizens may not be able to influence politicians due to their lack of knowledge about the quality of public services or may not vote for politicians who promise better services because of ethnic or ideological affiliations (World Bank 2004).

Application of Concepts of Governance and Stewardship in LMIC

This section provides more detail on the five areas identified from the literature where the concepts of governance and stewardship have been applied to studies of the health systems of LMIC.

(1) Strengthening stewardship and governance as key health system functions

Governance and stewardship have also been identified as key areas for health system strengthening. WHO (2007), in its guidelines on health system strengthening, renamed stewardship as ‘governance and leadership’, defined as ‘Overseeing and guiding the whole health system, private as well as public, in order to protect the public interest’. It also identified key requirements of health system stewardship as attention and support to strengthening of health systems in LMICs.

USAID has particularly focused on governance and how general concepts of governance might be applied in health systems of LMICs. Brinkerhoff and Bossert (2008) used a governance framework based on governance functions and rules in four general areas (civil society, politics, policy and public administration)
and applied this to the health system in LMICs. They identified constraints on health governance in these four areas, including:

- Civil society: civil society organisations do not hold public and private health sector actors accountable; citizens lack awareness of their rights and have low expectations of politicians and government.
- Politics: the views and interests of poor and marginalised groups are excluded from decision making; health ministries or governments lack incentives to engage stakeholders in decision making; health has a relatively low priority on the political agenda.
- Policy: policy is dominated by elites and technocrats; policy implementation is incomplete and lacks resources; evidence-based policy making is lacking.
- Public administration: poor financial management practices exist in the government health sector; information on health sector operations and financing is unreliable or unavailable; there is weak capacity for oversight of non-state providers; weak leadership, limited management capacity and insufficient human resources limit efficiency in public services.

As ways to improve health governance, Brinkerhoff and Bossert (2008) identified the following:

1. improving the policy process—promoting stakeholder engagement; strengthening ministries’ use of data and evidence; providing information to the public;
2. enhancing participation from local to national levels;
3. improving accountability and transparency and reducing corruption.

Other donors have addressed governance through strategies that focus on a broad range of public service deliveries, rather than a specific health governance strategy. AusAID (2011a) identified improvement in public service delivery as a key aspect of its governance strategy. This is addressed through two approaches: improving public sector and public financial management; and assisting governments to be more open, consultative, inclusive, accountable and responsive to people’s needs. Furthermore, AusAID strategies include actions on supply and demand sides:

- supply, through working with the elements of good government—including public financial management and public administration—linked to service delivery outcomes;
- demand, through supporting civil society and local populations to claim better and more responsive services from their governments.

While health services are mentioned as an example of public service delivery, the AusAID health strategy makes no specific reference to governance. However, the health strategy mentions a range of activities related to governance and stewardship.

(2) Engaging the private sector

Governance and stewardship have been identified as issues that need to be addressed in engaging with the private sector. Balabanova, Oliveira-Cruz and Hanson (2008) identified the increasing role and complexity of the private sector in health systems of LMICs and barriers to engagement with the state. These include suspicion of the private sector, lack of information and lack of a history of communication. They reviewed various governance frameworks and concluded:

... although there has been a range of frameworks seeking to represent actors involved in health sector governance and the relationships among them, these frameworks have not always explicitly demonstrated the significant role often played by the private sector. For example, the forms and mechanisms of government regulation and oversight in the private or public sector will be very different, requiring very different capacities.

They proposed a framework specifically identifying the private sector in a triangular relationship with government and donors, with citizens or users and civil society in the centre. Balabanova, Oliveira-Cruz and Hanson (2008) identified the roles and relationships of the key actors and concluded:

... the key element of governance is maintaining engagement—through dialogue, the sharing of information, and accountability by actors for their actions. Thus, it is important that all actors, but most of all the government, create and maintain spaces for this dialogue and make sure that flows of communication are sustained.
This led to defining how the government can engage with the private sector, through regulation, financing and stewardship.

Lagomarsino, Nachuk and Kundra (2009) focused more on the stewardship function, particularly in relation to the private sector. Policy mechanisms for stewardship of government-provided health services are somewhat different from those needed in the private part of the health system, since these services are not under the direct management of government and can receive funds from private sources. In addition, information about private service providers and their quality of service, costs and results is typically less readily available. The authors noted that LMIC governments face a number of challenges in this stewardship role, including:

- limited information about private actors in the health system, compounded by informal workers and fragmentation;
- administrative capacity constraints:
  - skills, resources;
  - tendency to prefer funding program delivery rather than regulation;
- policy capture and corruption:
  - incentives for informal payments, absenteeism, leakage of supplies, kickbacks from suppliers;
  - inspectors extort providers or regulated entities pay bribes.

In addition, many ministries of health have been structured to focus primarily on government-managed service delivery systems, rather than on regulating competing or complementary private systems. Lagomarsino, Nachuk and Kundra (2009) propose a series of steps that governments can undertake to expand their stewardship of the private part of mixed health systems. These include:

- investing in better collection of information about the private sector and health markets;
- supporting innovative models that might harness the private sector, such as approaches to reduce fragmentation (provider networks, franchising), changing financial incentives and increasing monitoring; providing subsidies for targeted population and high impact interventions; educating and encouraging patients to demand high quality services;
- developing a road map to build capacities for stewardship of mixed health systems.

The World Bank toolkit on health policy has further developed this approach, defining the functions of the health system that constitute ‘engagement’ of the private sector:

- policy and dialogue: private sector policy framework and dialogue;
- information exchange: information flow between private and public;
- regulation: regulation of the private sector; registration of private health facilities;
- financing: funding and arrangements to purchase services and goods from the private sector;
- public provision of services: goods and services provided by the public sector that impact on the private sector (World Bank 2011).

In addressing private behaviour in the public sector, however, many of the toolkits and frameworks, neglect the blurring of distinctions between public and private sectors which is frequently encountered in LMIC. Also, they do not account for extreme heterogeneity in health providers—a spectrum ranging from sophisticated indigenous traditionalists to outright quacks and untrained peddlars.

(3) Global health governance

The concept of governance has also been applied to health systems at a global level, particularly in relation to the rise of global health initiatives and new public-private partnerships in global health. Gostin and Mok (2009) identified some of the current problems of what they term global health governance, and argued that a ‘coherent system of global health governance’ is needed. The challenges they identify include: (1) the lack of global health leadership, (2) the need to harness creativity, energy and resources for global health, (3) the need for collaboration and coordination of multiple players, (4) the neglect of basic survival needs and health systems strengthening, (5) the lack of funding and priority setting and (6) the need for accountability, transparency, monitoring and enforcement (Gostin and Mok 2009).

Battams and Luchesi (2012) in their report, based on the session on ‘Governance for Health in the 21st Century’ at the 2011 World Health Summit, identified the following as one of the key messages:
We need to invigorate global governance arrangements in order to incorporate a broader range of actors and ensure transparency and accountability in global health initiatives. Emphasis was given to more community, national and regional level participation processes, and greater involvement by a range of stakeholders across levels of governance [emphasis in the original].

They report that accountability and transparency were identified as key elements of both good health governance and democracy.

Others have argued for improved global health governance to address the multi-sectoral challenges of the rise of non-communicable diseases. Magnusson (2010) argues that NCDs constitute a global rather than just a national challenge, and consequently will require a global collective response. He argues that there is a need for a framework of global health governance to map the respective functions, identify gaps and evaluate progress across multiple global initiatives.

Buse and Tanaka (2011) argue similarly that the proliferation of global health initiatives has resulted in governance issues, particularly in representation (inadequate representation of stakeholders on GHI boards), transparency (not all GHIs make publicly available adequate information on governance, operations and finances) and accountability (lack of a formal system of accountability, with clear deliverables and sanctions for non-performance).

(4) Governance of aid relationships

Governance can also be seen as a central aspect of the aid relationship. AusAID’s governance strategy states that ‘governance is a foundational element in aid effectiveness’ (2011a). The strategy further states: ‘Governance is important for improving overall effectiveness in aid delivery through partnerships between host governments and aid agencies. It has a dual purpose—a crosscutting element of effective aid and a goal in and of itself’ (AusAID 2011a).

Most attention, however, has focused on mutual accountability, as one of the five principles of the Paris Declaration on Aid Effectiveness. Recent reviews of aid have identified mutual accountability as one of the most neglected of the Paris Declaration principles. A recent policy brief from the AusAID Office of Development Effectiveness comments, ‘Progress towards it [mutual accountability] has lagged, reflecting the complex political challenges it presents to partner countries and donors alike’ (AusAID 2011b).

The central problem, as noted by the Office of Development Effectiveness and reflected in a recent report by Jones and Picanyol (2011), is that ‘mutual accountability means each partner is accountable for aid outcomes both to its domestic constituency and to its respective partner’.

These twin and competing accountability directions were also identified by the World Development Report in 2004. It comments: ‘[T]his geographical and political separation—between beneficiaries in the recipient country and taxpayers in the donor country—breaks the normal performance feedback loop in service delivery’ (World Bank 2004).

The World Development Report (World Bank 2004) proposed a number of ways in which donors could strengthen, rather than undermine, accountability between recipient governments and service providers, many of which were subsequently incorporated into the Paris Declaration. These include aligning with recipient country government priorities; use of government systems and avoiding parallel donor systems; avoiding fragmentation; and promoting the influence and ‘voice’ of clients and consumers to providers.

A review by Jones and Picanyol (2011) for Oxford Policy Management (OPM) noted that a key element overlooked in the Paris Declaration was transparency, which the authors see as an ‘indispensable foundation for effectiveness and mutual accountability’. Many of the OPM report’s recommendations to improve mutual accountability relate to other aspects of governance, including:

- broad dialogue between government and civil society;
- leadership by government;
- addressing the politics that constrain accountability.

(5) Organisational governance

Governance concepts have also been applied at the level of individual institutions, particularly hospitals. In
LMICs, the importance of governance has been noted by proponents of organisational reform for hospitals, particularly greater autonomy and exposure to market forces. Jakab, Preker et al (2002), in their guidelines on management reforms for public sector hospitals, include governance as an aspect of ownership and one of the external determinants of hospital performance. In this case they relate governance to the relationship of the owner and management of the hospital, where good governance ‘is said to exist when managers closely pursue the owners’ objectives rather than their own’ (Jakab, Preker et al 2002). They also note: ‘[A]utonomous and corporatized hospitals need stronger management skills and more sophisticated management systems than those in budget units that operate under detailed central regulation’ (Jakab, Preker et al 2002).

The importance of organisational governance for health sector performance in LMICs was also recognised by Gilson. She noted that macro reforms will not in themselves result in changes in provider behaviour, which will depend on institutional systems, and notably on organisational culture, leadership and management. However, her focus is more on the leadership and management issues than on the underlying governance. Much of WHO’s organisational focus has also been on management and leadership (Gilson 2007).

CONCLUSIONS

This paper has identified some of the policy challenges now facing governments in LMICs, particularly in mixed public-private health systems. The growing complexity of these systems and the growing role of the private sector render traditional ‘command and control’ methods less effective. The shift towards more complex policy initiatives such as universal health coverage, which require an integrated mix of policies, financing, purchasing and regulatory reforms, will further complicate this challenge.

Our analysis suggests that the concept of governance could provide a useful ‘lens’ for further examination of policy making and health system reform in LMICs. In particular the governance lens shifts the focus: (1) from individual policy decisions to the policy making process, the roles and relationships among the stakeholders in this process and how to address power imbalances; (2) from policy documents to policy implementation, at different levels within the health system, and within the organisations of the health system, and how actors at different levels with varying degrees of autonomy respond to macro policy decisions.

The governance lens provides policy makers with some additional policy aspects and potential levers, including accountability, transparency, engagement of stakeholders and the rules that regulate decision making and authority. It supports the development of self-regulating systems, with stakeholders contributing to the integration of the system, without being reliant on a forever growing collection of policy and regulatory documents.

Despite the conceptual complexities, we suggest that the governance and stewardship lens can provide practical policy options for policy makers in LMICs. This analysis, while not comprehensive, also suggests that there is considerable opportunity for application of the experience and lessons in high-income countries to governance issues in LMICs. Potential areas for further exploration include:

(1) new approaches to governance in complex systems, including ideas of collaborative governance and multi-level governance (Kickbusch and Gleicher 2011);

(2) ideas of governance for health, incorporating a multi-sectoral and citizen engagement approach, particularly in regard to addressing complex problems of NCDs (Kickbusch and Gleicher 2011)

(3) application of the experience and models of hospital and clinical governance developed in high-income countries, and the role of organisational governance in influencing provider behaviour and translating macro policy to service delivery (Dixon and Alakeson 2010; Saltman, Durán and Duboi 2011).
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