



Health Governance: Concepts, Experience, and Programming Options

INTRODUCTION

Country health officials and donors have increasingly realized that resources allocated to health will not achieve their intended results without attention to governance. Particularly as global programs inject huge amounts of funding targeting specific diseases, weaknesses in health system governance threaten to undermine the effective utilization of the funds. Corruption is perhaps the most dramatic governance-related threat, but in addition poor accountability and transparency, weak incentives for responsiveness and performance, and limited engagement of citizens in health affairs contribute to low levels of system effectiveness as well.

Over the past decade, governance has moved to center stage in the international development agenda, marking a shift from attention to achieving micro-level project-specific results to macro-level questions of policymaking, politics, and state–society relations. As research findings demonstrated the links among successful socioeconomic development, the enabling environment, and good governance, donor agencies began to: i) emphasize targeting grants and loans to countries with demonstrated performance records (see, for example, Dollar and Svensson 1998, Burnside and Dollar 2000), and ii) design and provide capacity building and technical assistance targeted at improving governance. The popularity of governance as a conceptual and practical construct, however, has not led to clarity and agreement as to what it is or is not.

Governance has been the subject of multiple definitions and interpretations. Some definitions concentrate on technical government functions and how they are administered. For example, the World Bank (2000) views governance as economic policymaking and implementation, service delivery, and accountable use of public resources and of regulatory power. Other definitions address how government connects with other sectors and with citizens. For example, the US Agency for International Development (USAID) considers governance to "pertain to the ability of government to develop an efficient, effective, and accountable public management process that is open to citizen



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participation and that strengthens rather than weakens a democratic system of government."¹ The UK's Department for International Development (DFID) describes it as "how institutions, rules and systems of the state – executive, legislature, judiciary, and military – operate at central and local level and how the state relates to individual citizens, civil society and the private sector" (DFID 2001:11). The United Nations Development Program (UNDP 1997) sees governance as "the exercise of economic, political and administrative authority to manage a country's affairs at all levels."

All of these definitions emphasize policy implementation, and most of them emphasize accountability. Some have a more normative orientation, such as USAID's focus on democracy. Others tend toward the instrumental, focusing on efficiency and effectiveness. The latter definitions explicitly connect the political dimensions of governance to the more technocratic elements of macroeconomic management and public administration operational capacity.

As sectoral specialists looked for answers to problems of sustainability and systems strengthening, governance entered the vocabulary of environment, education, urban infrastructure, and health. In the health sector, the World Health Organization's (WHO's) *World Health Report 2000* is generally recognized as paving the way for expanded attention to health governance with its introduction of the concept of "stewardship." Stewardship, as elaborated by WHO, constitutes a set of six domains, which are closely related to governance: generating intelligence (information and evidence), formulating strategic policy direction, ensuring tools for implementation through incentives and sanctions, building coalitions and partnerships, developing a fit between policy objectives and organizational structures and cultures, and ensuring accountability (see Saltman and Ferroussier-Davis 2000, Travis et al. 2002). The Pan American Health Organization (PAHO) has carried

out a parallel analytic effort to reach agreement on essential public health functions, which has led to a list that overlaps somewhat with the stewardship domains and also reflects elements of the governance definitions.² The stewardship domains relate more closely to the instrumental effectiveness definitions of governance than to the political and normative ones. The essential public health functions, however, incorporate some of these latter governance definitions' features with the inclusion of participation and citizen empowerment and equity in the list of functions.

USAID's Global Health Bureau, through a series of field assistance and applied analysis programs, has helped countries address a range of governance-related issues within the framework of health systems strengthening. However, only recently has health governance become an explicit component of the Bureau's health systems agenda.³ To assist the Bureau and Missions to understand health governance and to develop intervention options that incorporate it into programs, this paper provides an overview with the following aims:

- Clarify the meaning of health governance.
- Identify health governance issues and challenges.
- Develop a model for health governance that highlights its practical dimensions.
- Review selected experience with interventions to improve health governance.
- Propose options for health governance programming that can strengthen health systems and ultimately lead to increased use of priority services.

² *The list of essential public health functions includes: disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, health policy development and management capacity, citizen participation and empowerment, service quality, equitable access, and disaster mitigation (see PAHO 2000).*

³ *Health governance is accorded explicit attention in the Global Health Bureau's current Health Systems 20/20 project. Other USAID health projects also include governance-related elements, for example: the Health Policy Initiative (HPI), Leadership, Management and Sustainability (LMS), and the Capacity Project. Predecessor projects that addressed some governance aspects include Health Financing and Sustainability, Latin America and Caribbean Health and Nutrition Sustainability Project, Data for Decision Making (DDM), Partnerships for Health Reform (PHR), and Partners for Health Reformplus (PHRplus).*

¹From <www.usaid.gov/our_work/democracy_and_governance/technical_areas/dg_office/gov.html>.

CLARIFYING GOVERNANCE

As the brief review of definitions presented above reveals, governance encompasses authority, power, and decisionmaking in the institutional arenas of civil society, politics, policy, and public administration. Governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them. These rules can be both formal, embodied in institutions (e.g., democratic elections, parliaments, courts, sectoral ministries), and informal, reflected in behavioral patterns (e.g., trust, reciprocity, civic-mindedness). Table I illustrates the different categories of rules in the institutional arenas of governance, and their functions.

In each of these arenas, the governance processes associated with the functions create incentives that condition the extent to which the various actors involved fulfill their roles and responsibilities, and interact with each other, to achieve public purposes. Good governance results when these incentives encourage and pressure both state and non-state actors to be efficient, effective, open, transparent, accountable, responsive, and inclusive.

HEALTH GOVERNANCE

Governance in health systems is about developing and putting in place effective rules in the institutional arenas outlined in Table I for policies, programs, and activities related to fulfilling public health functions so as to achieve health sector objectives. These rules determine which societal actors play which roles, with what set of responsibilities, related to reaching these objectives. Health governance involves three sets of actors. The first is state actors, which includes politicians, policymakers, and other government officials. Clearly, actors in the public sector health bureaucracy are central, such as the health ministry, health and social insurance agencies, and public pharmaceutical procurement and distribution entities. However, other public sector actors beyond the health sector have roles as well. These can include, for example, parliamentary health committees, regulatory bodies, the ministry of finance, various oversight and accountability entities, and the judicial system. The second set of actors comprises health service providers. Depending upon the particulars of a given country's health system, this set mixes public, private,

TABLE I. GOVERNANCE FUNCTIONS AND RULES BY INSTITUTIONAL ARENA

Institutional Arena	Governance Functions	Focus of Rules
Civil society	Socializing Enabling	<ul style="list-style-type: none"> On shaping how citizens learn about and engage around issues of public concern. On assuring access and facilitating participation of societal groups.
Politics	Aggregating Representing Legitimizing	<ul style="list-style-type: none"> On shaping how interests are combined by political institutions to contribute to policy. On structuring political institutions to represent and respond to citizens' needs and demands.
Policy	Distributive Redistributive Regulatory Constitutive Adjudicatory	<ul style="list-style-type: none"> On shaping how government institutions make policies that allocate benefits and costs, regulate behavior, and adjudicate conflicts and disputes.
Public administration	Implementing Managing	<ul style="list-style-type: none"> On shaping how policies are implemented, how government is structured and organized, and how public agencies are managed.

Source: Adapted from Hyden et al. (2004) and Brinkerhoff and Crosby (2002)

and voluntary sector providers. For example, the mix can include hospitals, clinics, laboratories, and educational institutions in all three sectors. The provider category also includes organizations that support service provision: insurance agencies, health maintenance organizations, the pharmaceutical industry, and equipment manufacturers and suppliers. The third set of actors contains beneficiaries, service users, and the general public. This set can be categorized in a variety of ways: for example, by income (poor vs non-poor), by location (rural vs urban), by service (maternal and child health, reproductive health, geriatric care), and by disease or condition (HIV/AIDS, tuberculosis, malaria, etc.). Box 1 summarizes the defining parameters of health governance.

Box 1. Health Governance

Rules that govern the distribution of roles/responsibilities and the interactions among:

- Beneficiaries/service users,
- Political and government decision-makers, and
- Health service providers (public, private, nonprofit)

That determine:

- Health policies pursued,
- Services provided,
- Health resource allocation and use,
- Distribution of costs,
- Recipients of services and benefits,
- Health outcomes to be achieved.

Source: Authors

A general consensus exists that health systems should achieve: i) improvements in health status through more equitable access to quality health services and prevention and promotion programs, ii) patient and public satisfaction with the health system, and iii) fair financing that protects against financial risks for those needing health care (WHO 2000, Roberts et. al. 2004).

These objectives reflect a particular set of societal values, which many, though not all, countries share. In this sense, the general principles about governance that can contribute to good political, policy, and program decisions in support of health system objectives have a normative dimension to them. The following governance principles are widely,

although not universally, accepted.⁴ First, governance rules should ensure some level of accountability of the key actors in the system to the beneficiaries and the broader public (see Brinkerhoff 2004).

Accountability means that there need to be formal mechanisms by which patients and the broader population can hold key actors – politicians who make general policy decisions, decision-makers in financing institutions (social insurance and private insurance), providers of curative and preventive services – responsible for achieving the objectives of access to quality services, satisfaction, and fair financing.⁵ Accountability mechanisms for holding these actors responsible include, for example, fair competitive elections, systems of judicial redress, procedures to combat corruption, transparency of information, advisory committees, community boards, and media access.

Second, health governance involves a policy process that enables the interplay of the key competing interest groups to influence policymaking on a level playing field. An effective process for improving quality of services, satisfying demands of patients and the public, and equitable financing requires some level of compromise among the various interests in the system – the different providers, insurers, administrators, and the representatives of different groups of beneficiaries. Again, an open policy-making process, accompanied by fair rules of interest group competition, is needed to ensure the level playing field and to address the governance equivalent of "market failures" – reducing unfair lobbying practices, limiting corruption, and ensuring responsiveness to underserved populations. In addition to these elements, the level playing field requires checks and balances to ensure that the rules of interest group competition are respected so that all voices can be heard and adequate representation is achieved.

⁴ These principles are grounded historically in Western political philosophy, which conceived of state-society relations in terms of a "social contract" whereby citizens cede their natural right of self-governance to the state in exchange for the societal benefits derived from state sovereignty. The social contract shifted the balance of power away from the absolutist state, which ruled over citizens as subjects, toward government by consent of the governed. Not all countries share this governance heritage.

⁵ These mechanisms reflect the operation of the principles of exit and voice that discipline these actors, which Hirschman's frequently cited classic elaborates (1970).

Third, health governance requires sufficient state capacity, power, and legitimacy to manage the policy-making process effectively, to plan and design programmatic interventions, and to enforce and implement health policy decisions. Governance, whether in health or other sectors, depends upon the operational capacity of government institutions to function effectively in providing public goods and services, and in responding to citizens' needs and demands (see, for example, Grindle 1997). At the most basic level, government needs the capacity to amass resources through tax collection and/or from donor agencies and to program and allocate those resources effectively.

Yet in many countries, the state in general, and particularly the health ministries, lack the requisite capacity. As Collins (2002: 136) notes,

Ministries of Health, or their equivalent, are not renowned... for their strategic policy-making and policy implementation capacity. They tend to lack the skills, systems and structures to allow them to take on the strategic change role. Neither do they possess the authority within the government to promote change, being often one of the weaker ministries or departments within the governmental structure.

Effective and responsive service delivery, which demonstrates to citizens that their government is concerned for their welfare, contributes to state legitimacy. Fragile states with highly corrupt governments, which cannot or will not deliver services, risk losing legitimacy. This loss is a well-recognized driver of conflict in fragile environments. Successful rebuilding in fragile states calls for capacity development that enables public sector institutions to take on policy and service roles. This increased capacity can help to create government legitimacy in the eyes of citizens (Brinkerhoff 2007a). A study of DFID-funded health sector support in Afghanistan, Nepal, and Burma highlights this link between service delivery and state legitimacy (Berry and Igboemeka

2004). Health and education are two basic services that all citizens want, so helping fragile states to provide them is an important contributor to reducing fragility. Further, investments in health and education are fundamental to the human capital countries need to move beyond crisis to stability and increased wellbeing.

Fourth, governance depends upon the engagement and efforts of non-state actors in the policy arena, as noted, as well as in service delivery partnerships and in oversight and accountability. Effective engagement of these actors may call for strengthening the power and capacities of societal groups that may not necessarily have the resources and skills to participate in an open policy process, to partner with providers, or to fulfill accountability or watchdog functions. For example, community groups and local non-governmental organizations (NGOs) may be disadvantaged relative to organizations of health professionals, or nurses' and doctors' associations. Participation is an essential element of governance, in health and beyond, and is facilitated not just by public structures and processes that support and encourage it, but also by a vibrant civil society (see, for example, Burbidge 1997). In many developing countries, measures to strengthen civil society are needed. In the health sector in particular, the development of social capital – trust in community members and local officials, knowledge and information sharing, and greater participation in voluntary organizations – has been shown to contribute to improved health governance and service delivery (e.g., Tendler and Freedheim 1995, Harpham et al. 2002). Such strengthening can build community-level capacities to work together to contribute to health objectives at the local level, as well as demand more services from other levels of the health system.

The principles outlined above constitute an idealized version of health governance. Few countries, developing or industrialized, have health systems that function according to a full application of all of them. Table 2 illustrates some of the challenges health systems in developing countries face in the various institutional arenas of governance.

TABLE 2. ILLUSTRATIVE HEALTH GOVERNANCE ISSUES BY INSTITUTIONAL ARENA

Institutional Arena	Health Governance Issues
Civil society	<ul style="list-style-type: none"> ● Civil society groups are insufficiently organized and resourced to identify and aggregate interests and exercise voice. ● Civil society does not effectively socialize and educate citizens to play a role in governance. ● Civil society stakeholders 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	<ul style="list-style-type: none"> ● Political systems systematically exclude the views and interests of poor and marginalized groups (e.g., people with HIV/AIDS) in health sector decisionmaking. ● Established health interests block reforms that threaten them. ● Health ministries and local governments do not have incentives and/or capacity to engage stakeholders in decisionmaking and priority setting. ● Health officials lack the technical and political expertise to argue effectively for resources, or to get health issues on the political agenda.
Policy	<ul style="list-style-type: none"> ● Policy processes are dominated by elites and technocrats. ● Health ministries plan and initiate programs that promise results but then are incompletely implemented or see funds diverted to other purposes. ● Health policy decisions are not made on the basis of evidence regarding needs and effectiveness of services.
Public Administration	<ul style="list-style-type: none"> ● Financial management practices in the government health sector are opaque, permitting corruption and causing the unreliable delivery of critical inputs. ● Information on health sector planning, operations, and financing is unavailable, unreliable, or inaccessible thereby reducing accountability and service delivery effectiveness. ● Few and/or inadequate administrative mechanisms exist to enable citizen participation. ● Capacity for oversight of non-state service providers is weak. ● Weak leadership, limited management capacity, and insufficient human resources damage efficiency, undermining state legitimacy. ● Government health actors are oriented toward pleasing their superiors rather than responding to citizens' needs.

Source: Authors

HEALTH GOVERNANCE: A MODEL

As previously described, health systems contain three categories of actors: government, providers, and beneficiaries/clients. Health governance involves the rules that determine the roles and responsibilities of each of these categories of actors, and the relationships and interactions among them. These elements can be combined to create a model of health governance, as illustrated in Figure 1, that builds on work at the World Bank on service delivery and accountability (2004, 2007). Several points regarding the model are important to note. First, although the figure could be interpreted as portraying each category of actors as having equal influence and power, this is not the case. The degree of power is

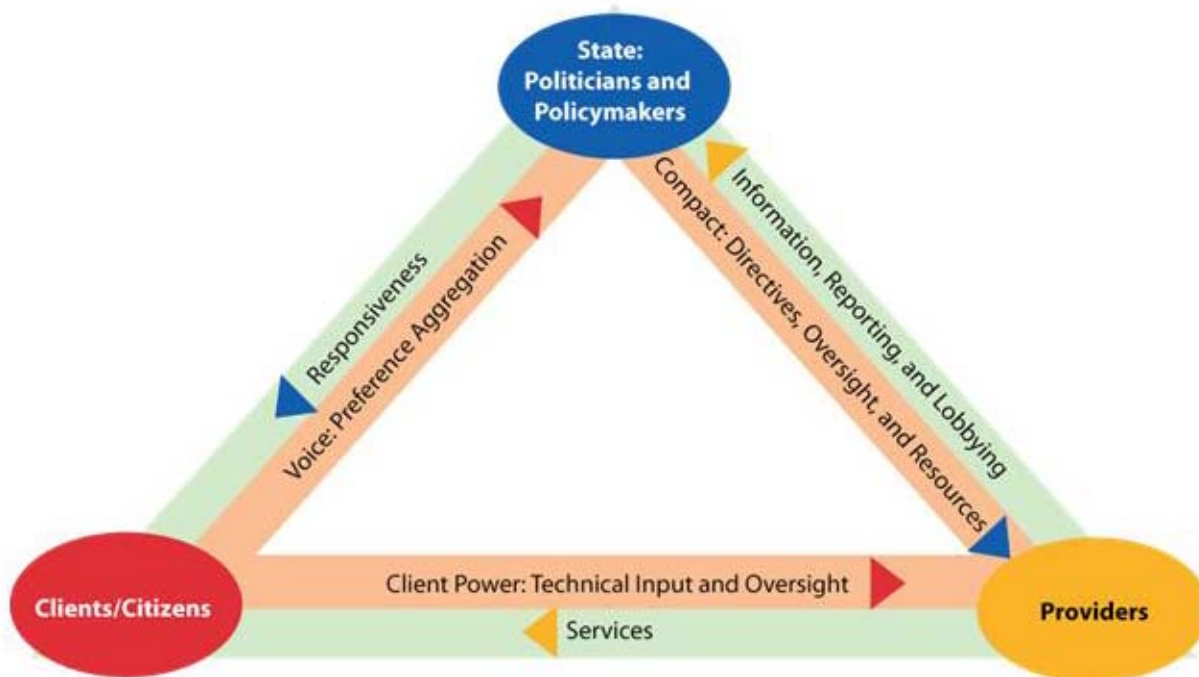
differentially distributed among the three, with the state and providers for the most part retaining the preponderance of power, information, and expertise relative to clients/citizens. Power distributions are also influenced by political systems, with more democratic governance tending to give more power options to clients and citizens than more authoritarian systems. Second, as the discussion below of context elaborates, the model should not be viewed as a closed system. The linkages among actors in the state, provider, and client/citizen boxes are strongly affected by external factors. These can range from global issues beyond a given country's borders, such as avian influenza and global HIV/AIDS activism, to factors inside the country but external to the health sector, for example as just mentioned, the extent of democratization.

LINKING THE STATE, PROVIDERS, AND CLIENTS/ CITIZENS

The arrows characterize the general nature of the relationships among the various actors. From client/citizens to state actors, the key feature of the relationship is the exercise of voice, that is, the expression of needs, preferences, and demands to politicians, policymakers, and public officials. Individuals can and do exercise voice – for example, a citizen can visit his/her mayor, or vote for a parliamentarian who has promised health reform – but in terms of health systems and governance, how individuals come together in collective efforts to make their voice heard around common interests is a key issue. Formal efforts through political parties and elections are one form of interest aggregation and expression of voice; advocacy and public information campaigns are another, less-formal avenue. Citizen efforts to exercise voice and hold public officials accountable can be pursued through various means: for example, community initiatives to lobby local officials, specialized civil society organizations that develop expertise in budget monitoring and service delivery report cards, or cyber-activism that taps the power of information technologies to expand voice both nationally and internationally.

From state actors to client/citizens, the overriding health governance relationship is responsiveness to client/citizen needs, preferences, and demands. This relationship varies in quality and degree. In countries with authoritarian governments, political leaders and health officials may not be very responsive to the health needs of their citizens (although even authoritarian leaders need some popular support), and/or they may respond through patronage networks to some citizens, but not to all. In democratic systems, health care is an issue that is often of interest to politicians, because it touches the lives of almost all of their constituents. However, it can be difficult to mobilize voters, whose attention to health concerns may be sporadic, and established interest groups often resist changes. The established health interests may be better able to deliver campaign support and votes than the general public. So democracies are not immune from the patronage and clientelism that characterize politics in authoritarian regimes. While health as a public good is not so easy for political patrons to employ as a reward to clients, the health sector resources they control or influence can be amenable to clientelist exploitation. Rewards can take the form of, for example, the allocation of disproportionately generous funding to particular localities, the siting of

FIGURE 1. HEALTH GOVERNANCE FRAMEWORK



Source: Adapted from World Bank 2004, 2007

specific facilities, or tilting services in favor of certain groups (e.g., urban elites, ethnic compatriots) over others (e.g., the poor, disadvantaged, and politically powerless).

The governance relationships **from state actors to providers** are encapsulated in the arrow labeled "compact." This term seeks to capture the notion of a contract-like connection in which policymakers specify objectives, procedures, and standards; provide resources and support; and exercise oversight relative to providers. In exchange for the resources, providers carry out the agreed-upon desires and directives of the policymakers. In essence, the compact is the sum of the rules that determine the roles and responsibilities of the various parties to the agreement; these in turn establish incentives for the actors involved.⁶ Health system reforms that separate payment from provision of services have introduced major changes in the role of state actors relative to providers. These changes have concentrated significant attention on the accountability dimension of health governance. This accountability is of several types (see Brinkerhoff 2004):

- Political accountability, where politicians press the health ministry and other health-related agencies to pursue objectives and employ resources so that providers respond to what citizens want regarding health care.⁷
- Performance accountability, which focuses on the wide array of systems and organizations involved in regulating, overseeing, guiding, and disciplining health service providers.
- Financial accountability, which involves budgeting, accounting, and auditing systems that seek to ensure that health service providers are using resources for agreed-upon and appropriate purposes, and to reduce corrupt practices.

Accountability is not the only health governance relationship that connects the health ministry and related agencies to providers. There are linkages that provide knowledge and technical information, for

example, through medical education and in-service training. And in some countries, clientelist relationships between state actors and providers exist as well, where politicians and/or health ministry officials channel resources and favors to selected providers in exchange for political support.

From providers to state actors, key governance relationships revolve around reporting: that is, the provision of information for purposes of monitoring and in fulfillment of the three types of accountability (political, performance, and financial). The particular features of provider payment schemes, for example, influence the nature of reporting relationships between providers and payers, and the incentives created for providers. Pay-for-performance arrangements join financial and performance accountability, and increasing numbers of developing countries are experimenting with them. Besides accountability, another important function of the governance link between providers and state actors is to furnish data for policymaking. If health policymakers are to pursue evidence-based policy formulation, then providers have a critical role as the source of evidence.

As numerous analysts have noted, dealing with information asymmetries – service providers will always know more about what they do or do not do than those they report to – is an important piece of making health governance effective. Providers' privileged position in terms of knowledge and expertise also make the provider state linkage a political one. Providers are not neutral sources of information; they have interests and exercise voice and lobbying to influence state health policy and practices. Another problem affecting the state actor–provider governance link is that of attribution. In the complex, multi-actor realm of the health system, it is difficult to assess whose contributions made a difference, or whose efforts fell short. Health outcomes are the result of numerous factors, many of which are outside of the control or influence of providers or health ministries.

The relationships between service users and providers are the heart of health systems. In principle, clients/citizens convey their needs and demands for services – and their level of satisfaction – directly to providers, who in turn offer a mix of quality services that satisfy needs and demands. Yet from a governance perspective, the links **from clients/**

⁶ As the World Bank (2004: 51) defines it, a compact is "a broad agreement about a long-term relationship."

⁷ It is important to note the distinction between direct political accountability of elected officials, and the more indirect accountability of public-sector health officials to political actors.

citizens to providers and from providers to clients/citizens are fraught with power and information asymmetries, capacity gaps, accountability failures, and inequities. The compact between health policymakers and providers cannot specify all the relevant factors for quality service delivery, and an effective client provider link is necessary for system functioning, quality of services, and service utilization; but the problems listed often weaken this leg of the governance triad substantially. As with the governance link from clients/citizens to the state, the connection to providers can be strengthened through collective action, for example, civil society organizations that exercise voice on behalf of beneficiaries, or village health associations that participate with health providers in needs assessments and community mobilization. Reforms that create health service markets and introduce competition among providers can enhance client power and increase provider accountability to service users, who have the ability to

choose among providers, and/or whose views are incorporated into provider performance assessments that inform funding decisions, for example, through service delivery surveys. Measures to reinforce the purchasing power of particular societal groups – such as subsidies for the poor, elderly, or HIV/AIDS-affected – are another example of offsetting imbalances between providers and service users.

UNPACKING THE BOXES

As with any model, Figure 1 is a shorthand for a highly complex set of interactions among health system actors and components. The above discussion has concentrated on delineating the nature of the governance relationships among the three sets of actors. Obtaining a full picture of governance in the health system calls for unpacking the contents of the three categories of actors that are contained in the figure: state, providers, and clients/citizens. Table 3 provides a generic listing for each category.

TABLE 3. HEALTH GOVERNANCE ACTORS

State: Politicians and Policymakers	Providers	Clients/Citizens
<ul style="list-style-type: none"> ● Health ministry ● Health and social insurance agencies ● Public procurement and distribution agencies for pharmaceuticals, medical supplies, and equipment ● Parliaments and parliamentary committees ● Elected officials (national and subnational) ● Decentralized units of government ● Regulatory bodies ● Finance ministry ● Anticorruption agencies ● Audit agencies ● Law enforcement agencies ● Courts ● Public employee unions 	<ul style="list-style-type: none"> ● Hospitals (public, private, nonprofit, faith-based) ● Clinics (public, private, nonprofit, faith-based) ● Doctors and doctors' associations ● Nurses and nurses' unions ● Insurance claims and disbursement agencies ● Midwives and traditional birth attendants ● Community health workers ● Traditional healers ● Medical and nursing schools (public, private, nonprofit) ● Private insurance firms ● Family planning organizations (public, private, nonprofit) ● Nutrition organizations (public, private, nonprofit) ● Pharmaceutical suppliers and manufacturers 	<ul style="list-style-type: none"> ● Community groups ● Village health associations ● Advocacy organizations ● Civil society watchdogs ● Elites (urban, rural) ● Middle class (urban, rural) ● Poor (urban, rural) ● Human rights organizations ● HIV/AIDS support groups ● Legal services NGOs ● Think tanks ● Political parties ● Business associations

Source: Authors

A few points of clarification are in order. First, as the table illustrates, some providers are part of the state: those that make up the public sector health service delivery infrastructure. In some health systems, state and non-state service providers are subject to different governance regimes. For example, private insurance schemes that cover wealthy urban populations operate under different rules from public health providers that serve the poor and uninsured.

Second, within each category various actors have governance links with each other, particularly related to accountability and checks and balances. For example, within the state category, parliaments can hold health ministry officials to account. State audit and anticorruption agencies can investigate the health ministry and its pharmaceutical and equipment procurement procedures. Courts can adjudicate health-related cases that involve state actors. Central levels of government can hold local levels accountable. Within the provider category, individual facilities (hospitals and clinics) often have boards that oversee policy and operations; in some cases these boards include citizen representatives. Relatedly, in many countries, medical practitioners' associations exercise governance, certification, and quality control oversight of providers who are members. The structure of health labor markets can influence checks and balances; for example, in countries where the state is the largest employer of health professionals, their ability to take independent positions on health issues may be limited.

TOWARD GOOD HEALTH GOVERNANCE

When the linkages illustrated in Figure 1 are operational and effective, then the interactions among state actors, providers, and citizen/clients produce good health governance and fulfill the governance principles discussed above (accountability, open policy process, state capacity, and engagement of non-state actors). The key features of good health governance are summarized in Box 2.

Good health governance rationalizes the role of government: reducing its dominance and sharing roles with non-state actors; empowering citizens, civil society, and the private sector to assume new health sector roles and responsibilities; and creating synergies between government and these actors. Health ministries redefine their roles as stewards of

the health system, with input from citizens, civil society, and the private sector; and establish oversight and accountability mechanisms. Policies incorporate evidence and analysis to allow assessment of progress and evaluation of effectiveness. Health insurance agencies oversee providers to ensure effective service delivery, respect for payment procedures, and absence of fraud. Procurement agencies employ transparent and fair contracting and purchasing mechanisms to ensure that resources are well spent and to reduce corrupt practices. Civil society and the media apply their skills and capacities to exercise oversight and hold policymakers and providers accountable. Health policymaking balances beneficiary participation with science-based determination of appropriate services.

Making this happy picture a reality is, of course, fraught with challenges, many of which have been mentioned in the preceding discussion of the health governance model. Health governance is a systems-level phenomenon, and pursuing changes that affect the whole system are largely beyond the reach of any single group of reformers, whether country-based or from donor agencies. Yet strategies and interventions that address particular components of governance can successfully promote improvements, without necessarily taking on the whole. For example, comprehensive health reform experience from countries in the former Soviet Union offers encouragement that an integrated sequence of discrete changes can lead to systemic change over time (see O'Rourke 2001). Each of the components listed in Box 2 can be seen as entry points and

Box 2. Good Health Governance

Roles/responsibilities and relationships governed by:

- Responsiveness to public health needs and beneficiaries'/citizens' preferences while managing divergences between them
- Responsible leadership to address public health priorities
- The legitimate exercise of beneficiaries'/citizens' voice
- Institutional checks and balances
- Clear and enforceable accountability
- Transparency in policymaking, resource allocation, and performance
- Evidence-based policymaking
- Efficient and effective service provision arrangements, regulatory frameworks, and management systems.

Source: Authors

potential change levers for improving health governance in the institutional arenas discussed above (civil society, politics, policy, and public administration). In practice, three major avenues have been pursued: one that addresses policymaking and the policy process, a second focusing on participation, and a third concentrating on accountability, transparency, and reduction in corruption. The next section examines some experience related to these three.

SELECTED EXPERIENCE IN IMPROVING HEALTH GOVERNANCE

Interventions related to the three avenues noted above have led to better health governance, although, because of the relative newness of thinking about health sector reforms in governance terms, their discussion in the literature does not always make the governance connections explicit. Here we highlight selected activities that have been pursued in:

- Improving the policy process in the health sector – promoting more effective stakeholder engagement, including NGOs and beneficiary groups; strengthening ministries of health use of data and evidence, and providing information to the public on their rights and duties in health sector activities.
- Enhancing participation at a variety of levels – local to national – to promote more effective governance of health programs.
- Improving accountability and transparency and reducing corruption in the health sector.

Table 4 illustrates how these avenues relate to the health governance framework presented above (Figure 1). Improving the policy process is associated with the linkages between the state and clients/citizens, and with those between the state and providers. As the discussion below reveals, the first category of linkages deals with creating more open policy processes where non-state actors have access to policy debates, informed by the media, to increase the voice of citizens vis à vis the state, and improve state responsiveness to citizens. Illustrations of the second category, between state and providers, include interventions that increase the capacity of health officials to exercise evidence-based policy leadership, and to translate those policies into programs that communicate appropriate incentives to providers so that policy intent is achieved during implementation.

Enhancing participation concerns the linkages between clients/citizens and the state, and between them and providers. The examples provided below illustrate that an extensive experience base exists on community participation in health service provision, which links clients/citizens and providers. Health sector decentralization, for instance, illustrates a structural intervention that, depending upon the scope of the responsibilities and authorities that are decentralized, can increase citizen participation in decisions about health service mix, staffing, and oversight. This intervention relates to the connection between clients/citizens and the state, as well as joining them with providers.

TABLE 4. RELATING HEALTH SECTOR REFORMS TO GOVERNANCE LINKAGES

	Client/Citizen ↔ State	State ↔ Providers	Client/Citizen ↔ Providers
Improving the policy process	✓	✓	
Enhancing participation	✓		✓
Increasing accountability, transparency, anticorruption	✓	✓	✓

The third avenue – interventions to increase accountability and transparency, and to reduce corruption – connects to all three of the governance linkages in the framework. Efforts to address voice failures so as to push the state to be more accountable to the poor, for example, are associated with the linkages between clients/citizens and the state. Procurement reforms, service delivery productivity improvements, and tightened regulation all illustrate interventions directly connected to how the state interacts with providers. Mechanisms to expand the role of community groups in oversight and assessment of frontline providers are concerned with the governance linkages between clients/citizens and providers.

IMPROVING THE POLICY PROCESS

The literature on policymaking and the policy process is in general agreement that policy emerges from the intersection of the political context, evidence, and the links between policymakers and other stakeholders (see, for example, Court and Young 2004). All three of these features of the policy process are important for health governance. Obviously, health policymaking is affected by the quality of a country's overall policy process, regardless of sector. The extent to which the policy process in general is: i) informed by independent and valid research and analysis, and ii) open and accessible to citizens and interest groups in ways that encourage equity, fairness, and responsiveness has implications for health policy. So if, in a given country, policymaking takes place from the top down, is determined largely among a closed circle of privileged elites, and is uninformed by policy-relevant research, then health policymaking is likely to share these characteristics.

More directly, the roles, practices, attitudes, and capacities of health sector actors involved in the policy process will condition the quality of health policymaking. Those of the health ministry are central, though not exclusively, to the extent that other health agencies are involved in policymaking. Health policymakers are often ill equipped to argue effectively for resources based on evidence, and to build constituencies within government or among non-state actors. Health sector officials often have limited ability to counter the power and influence of well-organized providers, who influence health care regulation both by lobbying and by defining standards

of practice (see Rigoli and Dussault 2003). Rather than leading the policy process, they tend to operate reactively.

Thus, improving leadership capacity among health sector officials is needed to enhance health policymaking and fulfill the stewardship role (WHO 2000). A special type of leadership is called for, one that involves managing both the administrative apparatus of service delivery and the political process of building legitimacy and political support for the institutions involved in health policy implementation (see Moore 1995, Heifetz 1994). According to Moore (1995), this leadership involves pursuing a "strategic triangle" of objectives: i) substantive value (such as protecting public health and improving equal access and universal coverage); ii) legitimacy and political sustainability; and iii) operational and administrative feasibility. To accomplish these objectives, health sector officials must manage the policy process, particularly its political aspects – mobilizing support from political actors, the media, interest groups, and oversight entities – and reengineer the operational management of the health bureaucracy to produce greater public value.

Of the many examples of interventions that target improving the policy process, most focus on the evidence and linkage features. Efforts to increase the quality and utilization of policy research have been undertaken in a variety of sectors besides health: economics, environment, sustainable livelihoods, agriculture, trade, and so on. One



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interesting example comes from Madagascar, where the MADIO project, between 1994 and 2001, supported local capacity building in economic, statistical, and social analysis, and diffusion of research findings in the media to encourage public debate on a variety of economic and governance policy issues (Razafindrakoto and Roubaud 2007).

In the health sector, improving the availability and quality of information for health decisionmaking has been an objective for more than a decade. One of the most well known initiatives is the promotion of National Health Accounts (NHA), an analytic framework and methodology that provide a comprehensive picture of health expenditure by type of service from all sources. From an early emphasis on obtaining expenditure data and refining the methodology through donor-funded technical assistance to small teams of technical staff, the NHA initiative moved to creating regional networks to apply and promote the tool and to focusing on utilization of the data for policymaking. Currently, the concern is to institutionalize NHA in country health ministries and/or health policy research and analysis units. Institutionalization is one step toward ensuring NHA's contribution to improved health governance; another step is expanding the users of NHA information beyond state actors to include civil society. This latter step contributes to the linkage aspect of the policy process.

In some cases, the health sector has exercised leadership in improving the policy process by strengthening central ministries of health, often with support of donor projects. These efforts have enlarged ministries' capacities in good health governance. Charged with new roles as stewards of the health system, ministries of health have had to reengineer their structures and staffing skills to develop stronger abilities to regulate both the public and private sector providers, and develop political skills to lead changes in laws and regulation and to press other stakeholders to do their part in implementation (WHO 2000). In Colombia, for example, to implement its innovative health reform in the 1990s, the Ministry of Health took the initiative to create the National Council for Social Security in Health, a forum for participation of other stakeholders that was led by the health minister. It also created a separate unit for the implementation of decentralization, as well as a reform unit to lead the

political process of establishing details of regulations and adjusting to changes in political landscape (Bossert et al. 1998).

Similarly, more recently in Mexico, under the leadership of Julio Frenk, the Ministry of Health led the process of developing stakeholder support for an ambitious reform that has expanded coverage of social insurance to the poor in many of the country's states. Carefully crafting coalitions of support both within the executive and legislative branches, with an evidence-based approach for building strong persuasive arguments, the ministry wove support among competing political and interest groups. This effort was one of the most successful policy reforms of the Fox government, and demonstrates the effectiveness of engaging ministries of health in building alliances with pro-health civil society groups (Frenk 2006).

Evidence-based policymaking combined with building strong advocacy packages, as in the Mexican case, is another governance improvement strategy that seems to have been effective. These packages may be designed to present persuasive evidence of major health problems, such as health disparities, but also may be presented in ways that show the benefits of policies for different interest and political groups. Several cases of changing national malaria treatment policy offer good examples of how this strategy can work. Drawing on cases from Malawi, Tanzania, South Africa, Kenya, and Peru, Williams et al. (2004) discuss the challenges faced in altering national malaria treatment policy in the face of growing evidence of chloroquine resistance across the globe. In each case, the consensus building process began early and with many stakeholders, including the local pharmaceutical industry and district management teams. They involved standardized data collection and operations research to develop compelling evidence that was persuasive to the key stakeholders. In Honduras, a safe motherhood initiative was initiated with the development of systematic and high-quality data by supporting maternal mortality surveys, which in 1990 demonstrated that Honduras' maternal mortality rate was nearly four times earlier reported levels (Shiffman et al. 2004).

In addition, mass media campaigns that inform patients of their rights in demanding better service or their duties in participating in, for example,

immunization campaigns are part of a health sector contribution to improved governance. These campaigns can strengthen the voice of patients and the public, and encourage their demands on the state and providers. An example is the African Broadcast Media Partnership Against HIV/AIDS (ABMP), which was launched in December 2006 with the aim of increasing the amount of HIV/AIDS-related programming by African broadcasters.⁸ The five-year pan-African HIV/AIDS public education campaign receives support from a number of partners, including US and African foundations, media associations, and private corporations. A similar initiative unites the media in 23 Caribbean island nations.⁹

Active engagement of advocacy groups in the political process can be particularly effective in putting health problems on the policy agenda and in influencing the adoption and implementation of major new health policies. The case of HIV/AIDS in Brazil is an excellent illustration of this strategy. Gómez (2006a) shows that involving civil society organizations depends on the openness of the regime to bottom-up lobbying and advocacy, the reciprocal relationship between civil society and policy elites, and international organizations (e.g., the Global Fund to Fight AIDS, Tuberculosis and Malaria [Global Fund] and the US President's Emergency Plan for AIDS

Relief [PEPFAR]). An example from Bangladesh reinforces these findings. In the mid 1990s, women's civil society organizations advocated successfully for the inclusion of gender equity in health policy reform and program design. However, during implementation the government agencies responsible for the program gradually closed the door to civil society engagement, and with the coming to power of a new administration in 2001, reform opponents were able to block the reforms with little outcry from advocacy groups (Jahan 2003).

ENHANCING PARTICIPATION

There is a large literature on participation in health services reform and delivery, much of which focuses on community-level participation. The community-focused analyses note the relationship between participation and targeting of services to address local needs, and the role of communities in extending the reach and effectiveness of health systems through co-management and co-financing. Related to governance, among the rationales for, and results of, community participation is increased accountability.

For instance, the case studies in Cornwall et al. (2000) provide examples of village health committees and local health councils where communities played an integral role in increasing the responsiveness and accountability of public health services to community needs. The case of Nepal's Baudha Bahunipati Family Welfare Program illustrates the evolution of community structures to sustain local participation to ensure responsiveness and accountability. The program established community consultation processes that evolved into formalized health service management committees to incorporate local input into the health service mix, decide upon user fees, address procurement delays, and eventually take charge of local service delivery in cooperation with the public health system. Ultimately, several of the management committees constituted themselves as registered local NGOs.

A well-recognized lesson of experience with community participation in health (and other sectors as well) is that its success depends upon community members' skills, organizational capacity, social capital, commitment, and resources. El Ansari and Phillips (2001) document the importance of these factors in



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⁸ See the ABMP website at: www.broadcasthivafrica.org.

⁹ This is the Caribbean Broadcast Media Partnership on HIV/AIDS. See www.cbmphiv.org.

participatory community health projects in South Africa. In a recent USAID project to develop social capital in Nicaragua, it was found that an intervention to develop leadership and management skills of community leaders was effective in a short period of time in improving levels of trust among community members in post-conflict communities that had suffered significant divisions among supporters of the Sandinista government and the Contra rebels. It was also effective in improving some selected health behaviors. While it did not have a significant impact on community-level participation in group meetings and activities, it did have a major effect on civic and political participation in elections and in advocacy with local officials (Bossert et al. 2003).

The empowerment dimension of participation is also important, particularly if communities are expecting to exercise oversight for accountability. The effectiveness of health committees, councils, and board membership in empowering communities is mediated strongly by both expertise and political power. A study of community involvement in hospitals in South Africa, for example, found that community members serving on hospital boards, ostensibly to increase hospital responsiveness to community needs, were at a disadvantage in the face of the superior technical authority and political clout of the medical profession (NPPHCN 1998). In some cases, gender issues affect empowerment if women face sociocultural impediments to participation, as is often the case in the area of reproductive health (see, for example, Schuler 1999).

Governance linkages between citizens and the state, and citizens and providers depend upon participation, but in many countries, significant barriers exist. Capacity building is needed for community groups to exploit organizational mechanisms to inject their views and needs into the policy-making and service delivery process. A clear lesson from decentralization experience is that communities, particularly disadvantaged or marginalized groups, will not have greater access or command increased responsiveness solely as a function of decentralization's ability to bring them closer to local officials absent measures to counter cooptation by local elites and to make community participation both programmatically and politically desirable for those officials (Fung and Wright 2003). Institutional incentives, backed up by an openness

among health officials to engage with citizens, are needed, as Golooba-Mutebi (2005) indicates in an analysis of decentralized primary health care in Uganda.

Besides incentives, however, public officials also need capacities and structures that enable them to act on citizen inputs. For external participation to be effective, local-level officials must be trained in participatory planning, negotiation, and consultative structures, and processes need to be developed and employed systematically to inject citizens' views into decisionmaking.¹⁰ These skills contribute to leadership, discussed above, and to the ability of officials to use citizen input to inform policy agendas, assess political feasibility, and develop implementation strategies that build support for reform (Moore 1992, Reich 1996). Such participatory leadership can help to mainstream stakeholders' health priorities into decisionmaking regarding service mix, resource allocation, contracting and procurement, regulatory issues, and other important questions. These structural and procedural aspects of health governance extend beyond citizen participation, and are the topic of the next section.

INCREASING ACCOUNTABILITY AND TRANSPARENCY, REDUCING CORRUPTION

Structural and procedural reforms in the health sector to increase accountability and transparency, and to reduce corrupt practices, play an important part in improving health governance. As noted above, accountability falls into three main categories: political, performance, and financial. There are relatively few examples of health sector reforms that specifically target political accountability, although decentralization efforts are an exception. The stronger focus has been on performance and financial accountability.

A unifying thread in accountability, transparency, and anticorruption reforms is attention to the availability and quality of information. In many health systems, information flows are limited, procedures are opaque, and actors are unaccountable. Two types of actions have been pursued: i) new management tools and systems improvements internal to the health

¹⁰ For additional discussion of the need for health sector personnel to develop skills to interact effectively with non-state actors to achieve health outcomes, see Bennett et al. (2005).

ministry, and ii) capacity building to exercise oversight. An example of the former comes from Afghanistan, where the health ministry, with donor assistance, employed a balanced scorecard to monitor progress in delivering a basic package of services (Noor et al. 2007). An example of the latter is in Peters (2002), which documents oversight capacity building in India for reproductive health services, and notes that it calls for increased skills for other stakeholders besides public officials.

Problems of corruption have stood out as one of the most visible signs of poor and inadequate health governance. The level of corruption in a country's health sector is reflective of the extent of corrupt practices more broadly. In countries where public officials fail to address citizens' needs, lack accountability, and operate with impunity, and institutional checks and balances are weak or nonexistent, such practices affect the health sector as well. Corruption is often defined as "use of public office for private gains" (Bardhan 1997). Several features of the health sector make it particularly fertile ground for corruption (Savedoff and Hussmann 2006). The variety of stakeholders involved in policy and programmatic decisions and in delivery of services (recall Table 3), the uncertainties inherent in health, and the pervasiveness of information asymmetries in health markets all provide fertile ground for corruption and fraud to take root. Manifestations of corruption in the health sector include the purchase of public positions, leakage of publicly funded supplies and services (e.g., sale of publicly funded drugs in private markets, fraudulent insurance billing practices), service- and procurement-related soliciting of bribes and under-the-table payments, and absenteeism (Lewis 2006, Transparency International 2006). Small-scale, facilities-level abuses can result in greater perceptions of system-wide corruption and loss of confidence in the system. For example, a USAID-sponsored corruption survey conducted in seven Eastern European countries found that respondents identified doctors' solicitation of bribes as a widespread problem (Vitosha Research 2002).¹¹

¹¹ The Bulgarian firm, Vitosha Research, conducted a series of annual corruption surveys in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Macedonia, Romania, and Yugoslavia (Serbia and Montenegro). The research used representative population samples of approximately one thousand people, and administered opinion polls. See: http://www.vitosha-research.com/publications_en.php?bc=63&c=404.

Three broad strategies in the health sector have been shown to help mitigate corruption and fraud. A first strategy involves dissemination of information on processes and performance. At the sectoral level, tools such as NHA and public expenditure tracking surveys (PETS) are means of heightening transparency and accountability, and can – if the information reaches actors with oversight responsibility and capacity – reduce the ability of health sector actors to engage in fraudulent activities. These tools have been used to identify and curb leakage of financing. At the facility and provider levels, service delivery studies, and provider/institutional report cards can help curb more micro-level abuses. In Bolivia, for instance, one study found perceived corruption in the health sector to be lower in municipalities with relatively strong management of staff oversight, such as written evaluations of performance (Gatti et al. 2002). Argentina's government implemented a policy of tracking hospital expenses for medical supplies and disseminating this information to them. The purchase prices for these items dropped by over 10 percent (suggesting lessened degree of fraudulent billing) but then rose once enforcement of the policy waned (Lewis 2006, Transparency International 2006). The media have an important role to play in information dissemination regarding service delivery performance and in exposing corrupt practices through both awareness building and investigative reporting (see Macdowell and Pesic 2006).



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A second strategy involves establishment of clear procedural rules (e.g., in contracting and procurement) and use of authority to enforce those rules (particularly use of audit and rewarding good performance/punishing abuses). At the macro level, a statistical analysis from the Philippines found that the frequency of audit by central government as well as autonomy of local government increased immunization coverage (Azfar and Gurgur 2001). An audit of insurer registries of low-income subscribers by the Colombian Health Secretariat found widespread fraud in the form of ghost subscribers. Only after establishing a unified database and improving monitoring was the government able to reduce millions of dollars of losses through fraud (Savedoff 2007). At the facility level, simple updating of financing information systems can be effective in reducing employee theft. Establishment of a computerized fee collection system in a Kenyan hospital reduced opportunity for embezzlement of user fees and resulted in a 50 percent increase in revenues with no change in utilization patterns (Transparency International 2006). In Albania, the introduction of simple computerized facility-level accounting and reporting systems led to reductions in informal payments and increased service utilization (Hotchkiss et al. 2005).

A third strategy involves establishing greater accountability through citizen oversight. Citizen oversight can take the form of heightened local control. In Bolivia, active citizen health boards and supervision of facility personnel helped reduce overpayment for drugs by procurement agents (Gatti et al. 2002). In Uganda, community-represented health unit management committees were able to impose accountability in the area of hospital drug management (Transparency International 2006). Such governance and accountability innovations, and others such as provider report cards, can also contribute to improved quality of care (see McNamara 2006). In Latin America, Canada's IDRC is supporting a multi-country effort to assist health policymakers, civil society organizations, and research organizations with health service delivery monitoring using a "benchmarks of fairness" methodology (see also Daniels et al. 2000). The purpose of the monitoring is to address inequities, increase transparency and accountability, and improve governance.

Citizen oversight may also be more indirect through pressure on locally elected governments. In Mexico, for instance, a National Survey on Corruption and Good Governance assessed the performance of 38 different public services in 32 states. The State of Chiapas responded to low rankings by implementing an e-government program for public service delivery; its ranking subsequently rose substantially, from 16th to 6th, in the next survey round two years later (Savedoff 2007). This case highlights the fact that some important interventions that can lead to improved health governance lie outside the health sector. USAID's democracy and governance programming recognizes these linkages. Democratic governance programs can promote sectoral synergies through, for example, strengthening checks and balances through legislative oversight, reinforcing courts and judicial systems, building capacity in auditing and monitoring bodies ("agencies of restraint"), strengthening local government, supporting civil society, and introducing participatory mechanisms into policymaking and public administration (see Brinkerhoff 2000b).¹² All of these can have positive pay-offs for health governance.

CONTEXTUAL FACTORS

The previous section closed with the point that interventions beyond the health sector can affect health governance; the corollary is that contextual factors beyond the sector can limit the options for sector-specific reforms to improve health governance. This selected review of some illustrative experience should be balanced with a caution about the need to take contextual factors into account in developing any health governance strategy. What works in one socioeconomic context, for one type of regime, or for one specific type of program may not be feasible or advisable under different conditions. For example, policy processes tend to be restricted in more authoritarian regimes, making it difficult and perhaps counterproductive to involve NGOs and grassroots advocacy groups in the promotion of participation in health policy and management

¹² Among public administration mechanisms, participatory budgeting has received a significant amount of attention as a means of bringing community members into the budgetary process, strengthening responsiveness of government by influencing spending priorities, expanding information flows about government performance, and matching citizen preferences to service provision. See, for example, Baiocchi (2003) and Brautigam (2004).

(Gómez 2006b). For instance, the current Russian government is relatively hostile to civil society organizations, making initiatives to combat HIV/AIDS difficult to develop with bottom-up lobbying (McCullough 2005).

In another example of the impact of political and institutional context, Khan and van den Heuvel (2007) document how Pakistan's semi-authoritarian political structures have limited broad participation in health policy making, and how changes in governments have disrupted health planning and implementation. In a similar vein, Israr (2006) discusses how a World Bank project to develop Pakistan's district health management teams was not as effective as it could have been in part because it was not able to change a "culture of rigid bureaucratic traditions and behavior."

In recent years, considerable attention has been focused on the importance of social capital – trust relationships, social networks, civic and voluntary organizations – as a contextual factor that may contribute to societal effectiveness in a variety of areas, including better health behaviors and health status, higher educational achievement, less violence, less poverty, more equity as well as more democratic practices, and improved government performance (see, for example, Putnam 1993, James et al. 2001, Hardin 2001, Kawachi and Berkman 2000). While the amount of available social capital is often treated as a contextual factor that influences efforts to promote better governance and better health practices, a recent USAID project has attempted to target building social capital at the grassroots as a means of improving health behaviors and democratic governance in Nicaragua by strengthening local leadership to build trust and expand participation (Bossert et al. 2003).¹³

Specific features of a country's health system are also a contextual factor. For example, forms of corruption that may be prevalent under a single-payer/publicly financed system (such as direct kickbacks and graft in procurement) may be less of a problem than those with a purchaser–payer split (where diversion of funds through fraudulent billing might be more common). Thus, anticorruption

programs need to be carefully designed to take such financing features into account. Further, the level of political will for tackling corruption is another contextual factor salient for the design and implementation of interventions in the health sector (Brinkerhoff 2000a).

Fragile states pose one of the most challenging contexts for health system improvement. As the literature on failed and post-conflict states suggests, very weak states require special tailoring of project activities and humanitarian assistance in ways that are particular to the multiple and often competing reconstruction objectives following conflict. In some cases, health programs are among the few organized activities that can form the basis for pushing forward a peace process or for gaining legitimacy to strengthen the state (Brinkerhoff 2007a, Waldman 2006).

Lubkemann (2001), for example, details the case of post-conflict rebuilding of the health system in Mozambique, where decentralizing health services was seen as important for extending services to local communities and for increasing state legitimacy. However, the new government's desire to control service delivery and associated resources to reinforce its legitimacy led the state to discourage or dominate independent community mobilization that could lead to expanding local voice. Building local capacity for responsive health service delivery challenged the government's intent to consolidate power and control local associational activity. From a health governance perspective, the outcomes were mixed; paradoxically, decentralized health service delivery reinforced local people's view of the government as intrusive and domineering. Lubkemann concludes that, "if the state ...is not encouraged to recognize the legitimacy of other local actors as participants in negotiating change, the political culture may simply reinforce exit over voice" (2001: 103-104).

Even in developing countries that are not failed or post-conflict states, there are limits to their ability to ensure that the health sector can adhere to all the principles of good health governance discussed above. Little demand for better governance may be present. Given the salience of health to basic well-being, many actors will opt for whatever access is available to them.

For useful details on social capital and health in developing countries and discussion regarding measurement see Harpham et al. (2002).

This is one of the lessons of efforts to reduce informal payments. As Lewis (2007: 985) observes, "informal payments allow patients to jump the queue, receive better or more care, obtain drugs, or simply any care at all." Donor expectations regarding country actors' interest in better governance are often out of touch with citizens' desires to get the state to provide resources and services, through recourse to clientelist connections if necessary (Brinkerhoff and Goldsmith 2004). Entrenched interests on the part of providers are another force for maintenance of the status quo, as the example of informal payments demonstrates. In addition, as noted in Table 2, citizens may have low expectations for government responsiveness to their needs. For example, in many African countries, large numbers of people take their own responsibility for covering health care expenditures out of pocket in recognition of the public health system's weak capacity to meet their needs and politicians' limited interest in their concerns.

The ability to pursue changes that will enhance health governance may be close to non-existent in situations of state failure and enduring civil conflict, where, for instance, the assumption that accountability to patients and the public will result in achievement of the broader health system objectives may not hold. Citizens desperate for health services will not accord priority to accountability when access is problematic. Post-conflict governments, as the Mozambique example cited above shows, may pursue health service objectives in ways that undermine and weaken good governance for purposes of consolidation of power.

In fragile states, then, donors will need to look for openings to introduce elements of good health governance, to the extent possible, as they provide the resources for post-conflict service delivery in anticipation of creating the architecture for a revived national health system that both fits the country context and reflects the principles of good governance. This approach is what is referred to as shadow alignment. For example, observers note some positive experiences in Haiti, Cambodia, and Afghanistan with introducing limited forms of performance contracting for health service delivery in fragile states, which, if institutionalized through subsequent health ministry adoption of pay-for-performance modalities, could hold promise for increasing provider accountability and responsiveness (see Eichler et al. 2007, Palmer et al. 2006, Ridde 2005).

PROGRAMMING OPTIONS

This overview has defined health governance broadly, as consisting of the rules, roles, responsibilities, and institutional arrangements among the state, providers, and citizens, as illustrated in Figure 1. Health governance takes place in four institutional arenas: civil society, politics, policy, and public administration. In terms of donor programming, the health governance landscape, as noted above, offers numerous entry points and change levers at various levels, and it is not possible to identify all options. This section begins with a review of several basic programming principles, and then offers an illustrative set of options to help guide thinking about what can be done to strengthen health governance and increase utilization of priority services.

BASIC PRINCIPLES

Three principles underlie the options offered here. These derive from accumulated evidence across a wide variety of country and sectoral cases on what is necessary to implement reforms (see, for example, Brinkerhoff and Crosby 2002). They are: build and reinforce political will for reform; balance supply-side interventions with support for demand; and integrate health governance with health systems operations, financing, and capacity building.



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Build and reinforce political will

The need to pursue objectives that are shared by key decision-makers in the country that donors are assisting is well recognized as a core principle of international assistance, and is supported by research on sustainability (see Bossert 1990). The aid effectiveness working group of the Organisation for Economic Co-operation and Development's Development Assistance Committee identifies country ownership as central to achieving development results. While acting on this principle is not always straightforward in practice, particularly in post-conflict settings, sustainable change depends upon mobilizing the political will of country actors at various levels to support change initiatives actively (see Brinkerhoff 2000a, 2007b). Reforms need champions in order to succeed (Brinkerhoff and Crosby 2002).

One approach to fostering champions that has been found to be effective in health reforms is the creation of a "change team" of technocrats from both within the health sector and in key ministries of the government. This team is protected by higher political officials and works together, often on an informal basis, to fashion a technically feasible policy that has the potential for gaining sufficient support from different sectors of the state. These change teams were created for the successful adoption of the reforms in both the authoritarian Pinochet period in Chile and the democratic regime in Colombia (González-Rossetti and Bossert 2000, Kaufman and Nelson 2004).

The main benefit of technocrat-led change teams is that they are able to develop solutions to health reform problems that are technically sound and likely to reflect the best knowledge about what technical factors are necessary to achieve intended results. The challenge is making sure that the technical solutions are acceptable to political leadership.

A cautionary tale on the limits of technocratic teams comes from Ghana's experience with reforming health insurance. Following the victory of the New Patriotic Party (NPP) in 2000 on a platform that included the abolition of health user fees (what Ghanaians referred to as the "cash and carry" system), the newly elected political leadership asked a

team of health professionals to design an insurance scheme that would be nationally scalable, identifiably distinct from the previous government's health programs, and implementable before the next election, in 2004. The design that the team of technocrats proposed, while technically sound, met none of these criteria and was rejected. Senior political leaders brought in a new team of consultants, made up of trusted cronies, who designed a politically acceptable national health insurance act, which was passed in 2003 and contributed to the NPP winning the 2004 election. The insurance scheme that the act established led to increased service utilization, but suffered from a host of operational and governance problems (e.g., overuse of services, mismanagement of claims, poor auditing, fraud and abuse), and according to some projections risks bankruptcy in the not-too-distant future. Among the lessons for change teams are that while reforms create windows of opportunity for change, they also open up potential for political opportunism, and technocrats need to build political feasibility into reforms if they are to be successful change agents and gain the support of political actors (Rajkotia 2007).

Another aspect to acting on this principle is to frame health governance objectives in terms that country health officials can readily relate to their concerns and interests. This approach is likely to be effective in building political will and commitment. For example, if health governance improvements can be plausibly linked to better HIV/AIDS or malaria



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outcomes, then officials with responsibility for single diseases/issues may take the lead in championing changes. Or, for a politically loaded issue like corruption, health officials may be more receptive to supporting change if it is discussed in terms of management efficiency, good governance, systems strengthening, or accountability improvement.

Finally, the prospects for building political will often depend upon timing. Changes of leadership can open – or close – windows of opportunity for reform, as the Ghana national health insurance case shows. Another example comes from Uganda, where a 1987 health policy review commission recommended changes in the public private mix of health care providers, including subsidies to mission facilities, but senior health officials were not supportive. A subsequent shift in health ministry leadership led to a reconsideration, and launched a series of policy reforms that over time integrated private and nonprofit providers more closely into the national health system (see Birungi et al. 2001).

Balance supply-driven improvements with support for demand

As with other change efforts, improving health governance requires new policies and institutional arrangements, improved skills and capacities, technical assistance, and new resources. These constitute the supply side of change. For example, good health governance, as encapsulated in Box 2, calls for health decision-makers to reach out to stakeholders for inputs into decisions and to provide the information and mechanisms for accountability. However, public officials often see stakeholder participation as time-consuming and unhelpful, and accountability as an unwelcome limitation on their discretionary power. So in the absence of effective legal mechanisms, coupled with external pressure, they have few incentives to supply good governance. The demand side constitutes this pressure: stakeholders expressing their voice to provide input into decisions and to hold those making decisions accountable. Incentives affect the demand side in that if stakeholders perceive no receptivity to their input or

confront too many procedural roadblocks (e.g., hearings announced with no lead time to allow interested parties to attend), then their incentives to engage are weakened.

Health specialists tend to be more familiar, and comfortable, with supply-side interventions that focus on various technical aspects of service delivery, health financing, and so on. As a result, often the tendency is to address health governance largely from the supply side, without sufficient attention to demand. However, similar to the supply side, the demand side also needs new organizational mechanisms, skills and capacities, and resources to be effective. Citizens and civil society groups must be able to exercise demand effectively, at the national and local levels. As public health officials, providers, and citizens gain confidence that more open approaches can yield better decisions and services, incentives for shared responsibility for health services and outcomes will increase. More openness on the demand side provides the incentive for more thoughtful participation by stakeholders in both providing input and in accountability mechanisms. It is important to recognize, however, that citizen demand does not necessarily lead to achieving desirable health outcomes, as in the case where curative services are preferred over preventive, or where citizen support groups for particular rare diseases lobby for resources. Good health governance means giving groups a voice, but not a veto, on health policies and services.

Health education campaigns that provide information on the benefits of prevention, for example, can lead to a shift in demand away from curative care alone. Policy forums and other venues that offer equal opportunities for multiple groups to express their views, accompanied by transparent procedures for how policy decisions are made, can help to counter dominance by single constituencies. Legislative procedures that provide for notice-and-comment opportunities on draft legislation are one example of a governance mechanism that can increase balanced expression of voice when accompanied by rules that are transparent and fair.

Integrate governance, financing, operations, and capacity building

The discussion in this paper has shown that the rules, roles, responsibilities, and institutional arrangements that comprise governance in a particular health system serve to direct how the system is financed, how it operates, and what capacities it can exercise. A singular focus on governance will not be enough to ensure sustainable improvements in the health system. Important for governance is operational and management capacity in public health service delivery and regulatory agencies. Better leadership and management improve the effectiveness of policy choices and increases legitimacy. Human resources are critical as well. An integrated approach to intervention offers the potential for greater benefits than concentrating on one or the other of these systems-strengthening elements alone (see *Health Systems 20/20 2007*). There may be situations where for various reasons – limited program funding, narrow access to key actors, or immediacy of need for services – an integrated approach cannot be pursued. However, such targeted program interventions, further along in time, may open the door to an expanded orientation to encompass all four elements.

ILLUSTRATIVE HEALTH GOVERNANCE PROGRAMMING OPTIONS

Clearly, the range of possibilities for intervening to improve health governance is extensive. Narrowing that range depends upon donor priorities and resources, the principles summarized above, and the specific country situation. Table 5 is not meant to exhaust all possible interventions, but to provide an illustrative list of interventions according to the four institutional arenas presented in this paper. The programming options presented are categorized in terms of which of the features of good health

governance, listed in Box 2, are their primary focus: responsiveness, sound leadership, voice, checks and balances, accountability, transparency, evidence-based policymaking, and efficient and effective service delivery and management. For any particular option, it could be argued that it addresses more of these features than the table indicates. However, the purpose of the table is to highlight which interventions relate most directly to one or more of the good governance targets as a way to identify what outcomes would most immediately result from a given option. For example, the table demonstrates that selecting one or more of the options in the civil society arena will yield primary results in voice, accountability, and responsiveness. While ultimately, as our governance model illustrates, such results will enhance efficient, effective, and equitable service delivery, the contributions of civil society interventions to these outcomes are somewhat indirect.

The options offered here can be used for a variety of programs. First, they could be pursued either individually or in some combination as stand-alone health governance interventions that address country-specific opportunities or USAID Mission objectives. Second, they could be integrated with other health interventions, to add a governance component, for example, to health insurance development or to specific services (e.g., HIV/AIDS, maternal and child health, reproductive health). Third, they could add a sectoral focus to democracy and governance programs, for example, building on decentralization or civil society strengthening. And finally, they could support improvements in structures and processes created through various international health initiatives, for example, Global Fund country coordinating mechanisms, GAVI Alliance inter-agency coordinating committees, or sector-wide approaches (SWAps) health sector coordinating committees.

TABLE 5. ILLUSTRATIVE HEALTH GOVERNANCE PROGRAMMING OPTIONS BY INSTITUTIONAL ARENA

Health Governance Programming Options	Primary Health Governance Targets							
	Responsiveness	Leadership	Voice	Checks & Bal.	Accountability	Transparency	Evidence-base	Efficiency & Effectiveness
Civil Society								
Provide support to selected groups to develop a public education campaign on citizens' rights to health care, the roles and responsibilities of service providers, and corruption issues.	✓		✓			✓		
Help one or more civil society organizations (CSOs) to develop knowledge about health and health services/budgets so as to become intermediaries and advocates for citizens.			✓		✓			
Increase representation of citizens on health service delivery governance institutions, e.g., local government councils, hospital boards, service review taskforces.	✓				✓			
Politics								
Identify interested members of parliament, the national ombudsman, lawyers, and journalists, and facilitate interaction among them and the selected CSOs on health issues.			✓	✓	✓			
Work with parliamentarians to exercise review of the health sector through public hearings.					✓	✓		
Support a network of CSOs to build citizen coalitions and monitoring for service delivery improvement, good governance, and anticorruption, building on the sources of capacity and commitment.		✓			✓			✓
Support independent policy analysis and advocacy groups to "demystify" health expenditures and service delivery so that ordinary citizens can understand them.			✓			✓		✓
Train media in opinion surveys and health reporting.				✓	✓			

TABLE 5. ILLUSTRATIVE HEALTH GOVERNANCE PROGRAMMING OPTIONS BY INSTITUTIONAL ARENA (CON'T.)

Health Governance Programming Options	Primary Health Governance Targets							
	Responsiveness	Leadership	Voice	Checks & Bal.	Accountability	Transparency	Evidence-base	Efficiency & Effectiveness
Policy								
Support public health officials to increase the use of evidence (e.g., NHA and PETS) in policy decisions, and to disseminate evidence-based findings regularly beyond the ministry of health (MOH) and specialized agencies.						✓	✓	✓
Assist MOH staff to prepare presentations and to do outreach to senior officials (e.g., cabinet members, legislators) to generate interministerial support, and to civil society leaders and journalists to create public support.	✓	✓		✓				
Develop policy and regulatory frameworks that create incentives for increased accountability, such as: i) licensing and accreditation of physicians, nurses, other categories of health care providers, and facilities; ii) health care financing and payment schemes that link funding to the amount and quality of services provided; and iii) quality assurance policies that establish standards and benchmarks, practice guidelines, and compliance mechanisms to improve quality of care, service utilization, and client satisfaction.	✓				✓			✓
Public Administration								
Assist the MOH in improving management systems. This could include:				✓				✓
<ul style="list-style-type: none"> • Planning for regular supervisory visits to facilities and coordination with local government officials in oversight. • Development of guidelines for staff performance reviews. • Controls and monitoring for pharmaceutical and medical supplies procurement and distribution. 								
Develop an information transparency program to publicize what health services citizens have a right to, which services are free and which may be subject to user fees, and what procedures and rules facilities are supposed to follow. This could include posting a statement of patient rights and					✓			✓

TABLE 5. ILLUSTRATIVE HEALTH GOVERNANCE PROGRAMMING OPTIONS BY INSTITUTIONAL ARENA (CON'T.)

Health Governance Programming Options	Primary Health Governance Targets							
	Responsiveness	Leadership	Voice	Checks & Bal.	Accountability	Transparency	Evidence-base	Efficiency & Effectiveness
responsibilities, a list of service fees along with exemption/fee waiver rules; and disseminating information about budget allocations for health at the local level. It includes translating materials in local languages and broadcasting spot announcements on the radio.								
Help the MOH to design and pilot test a pay-for-performance program where performance measures involve community members in assessing performance.	✓				✓			✓
Establish a working group in the MOH to engage with the finance ministry and the civil service commission on public sector salaries. Explore options such as: incentive schemes for postings to rural facilities, performance-based promotion standards, and public service awards programs.	✓	✓						✓
Assist regulatory agencies to improve oversight and enforcement systems for health sector management and service delivery.				✓				
Assist selected CSOs to work as partners with the MOH and pilot facilities to test and adapt new management systems and to report to their constituents on results. For example, involve CSOs in identifying disadvantaged groups eligible for service fee exemptions and waivers.	✓				✓			✓
Adopt transparent and competitive procurement practices, make public information on recruitment and staff assignments, develop a user's guide for citizens for PHN (population, health and nutrition) priority services, and publish health budget allocations by expenditure category.				✓		✓		
Support participatory planning/budgeting exercises.	✓		✓					✓
Assist local governments and health offices to organize town hall meetings and other venues for building citizen participation.	✓		✓			✓		

Source: Authors

CONCLUSION

Health governance encompasses a broad set of features related to health systems. The model presented here demonstrates that good health governance emerges from the actions and linkages among the state, providers, and citizens. Health governance improvements – through their impacts on rules, roles, responsibilities, and institutions – affect the availability, quality, distribution, and utilization of health services. We have reviewed a sampling of efforts that have led to better health governance, we have flagged some of the issues involved in undertaking governance improvements, and we have provided a framework to inform program design based on health governance priorities and related institutional-arena interventions. In closing, we offer several caveats concerning health governance as we have analyzed it here. First, any model that aspires to coherence and utility must simplify real-world complexity. Each of the boxes in the model (state, providers, and client/citizens) contains a vast amount of variety, both in terms of the actors involved (Box 3) and of the institutional arrangements within which they operate. Second, because of the variety and complexity inherent in the model, the governance linkages in health systems, and the outcomes they produce, are contingent rather than guaranteed. In

other words, as we noted above, the situation-specific context of a particular country's health system influences what can be achieved from the design of health governance strategies and the investments to implement them. Thus, third, it is important to contextualize health governance with regard to the larger set of governance institutions that surround it, and to the social, political, cultural, and historical terrain of which health governance is an integral part.

These caveats notwithstanding, we have argued that efforts to increase the quality of health governance constitute worthwhile and effective undertakings for improving health systems functioning and for increasing the provision and utilization of health services. The programming options we have summarized constitute a source of ideas that can be used to develop interventions in four institutional arenas to address specific targets associated with good health governance. As noted, health sector reformers have only rarely used a governance lens through which to design, implement, and assess programs. We hope that this paper contributes to increased health governance programming and to building the evidence base for documenting both the effectiveness and the limitations of health governance interventions and their relationship to increased service delivery and utilization.

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Health Systems 20/20

Health Systems 20/20, a five-year (2006-2011) cooperative agreement funded by the U.S. Agency for International Development (USAID), offers USAID-supported countries help in solving problems in health governance, finance, operations, and capacity building. By working on these dimensions of strengthening health systems, the project will help people in developing countries gain access to and use priority population, health, and nutrition (PHN) services. Health Systems 20/20 integrates health financing with governance and operations initiatives. This integrated approach focuses on building capacity for long-term sustainability of system strengthening efforts. The project acts through global leadership, technical assistance, brokering and grant making, research, professional networking, and information dissemination.

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The delivery of all health services, including the priority PHN services, depends on the underlying health system. To combat malaria, TB, HIV, and maternal and child health problems, the health system needs adequate and appropriately allocated financing, inclusive decision making and accountability, and financial and human resource management systems that deliver inputs where and when needed. A smoothly functioning health system maximizes the delivery of effective and life-saving technical interventions.

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