



Governance in Health – The Need for Exchange and Evidence

Comment on “Governance, Government, and the Search for New Provider Models”

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Abstract

Governance in health is cited as one of the key factors in balancing the concerns of the government and public sector with the interests of civil society/private players, but often remains poorly described and operationalized. Richard Saltman and Antonio Duran look at two aspects in the search for new provider models in a context of health markets signalling liberalisation: (i) the role of the government to balance public and private interests and responsibilities in delivering care through modernised governance arrangements, and (ii) the finding that operational complexities may hinder well-designed provider governance models, unless governance reflects country-specific realities. This commentary builds on the discussion by Saltman and Duran, and argues that the concept of governance needs to be clearly defined and operationalized in order to be helpful for policy debate as well as for the development of an applicable framework for performance improvement. It provides a working definition of governance and includes a reflection on the prevailing cultural norms in an organization or society upon which any governance needs to be build. It proposes to explore whether the “evidence-based governance” concept can be introduced to generate knowledge about innovative and effective governance models, and concludes that studies similar to the one by Saltman and Duran can inform this debate.

Keywords: Governance, Evidence, Operationalization, Decision-Making

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Citation: Chanturidze T, Obermann K. Governance in health – the need for exchange and evidence: Comment on “Governance, government, and the search for new provider models.” *Int J Health Policy Manag.* 2016;5(8):507–510. doi:10.15171/ijhpm.2016.60

Article History:

Received: 11 March 2016

Accepted: 14 May 2016

ePublished: 17 May 2016

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Governance is a priority area in the move towards achieving universal healthcare as well as improving quality, efficiency, effectiveness, and responsiveness of health systems. Mechanisms of establishing good governance practice and measuring its impact has been an issue of ongoing debates with some commentators focusing on structures, while others preferring to concentrate on the health outcomes.¹ This commentary continues the discussion brought up by Saltman and Duran,² expands on the definition of governance, and adds some thoughts on governance in health.

Richard Saltman and Antonio Duran examine some of the main operational complexities of *provider* governance, while discussing governance efforts targeting health service providers. They start from the notion that in a number of countries the role of the state has started to change with focussing more on governing (private) providers rather than directly providing services. These changes generated the need to revisit governance arrangements in an altered service delivery landscape, with the introduction of market-like incentives and management structures, as well as non-state actors attaining an important role alongside with public entities.²

The authors use the framework developed by Duran and colleagues³ which identifies governance in the health sector at the three levels of macro (national, policy-making), meso (institutional), and micro (operational at provider level), to examine challenges and suggest mitigation solutions at these

levels that might ideally complement specific management techniques for effective service delivery practices.

Saltman and Duran look at tax-based systems, where governments have – in a somewhat secular trend – gradually pulled out of direct service provision and focussed on governing the more independent providers of care, recognising that the engagement of non-governmental actors require regulations about minimum standards on quality and access and allowing to compete in a fair environment. The authors confine their analysis to the meso-level governance, described as “[a] set of processes and tools related to decision-making in steering the totality of institutional activity, influencing most major aspects of organizational behavior and recognizing the complex relationships between multiple stakeholders. Its scope ranges from normative values (equity, ethics) to access, quality, patient responsiveness, and patient safety dimensions. It also incorporates political, financial, managerial as well as daily operational issues.”³

The authors describe emerging (innovative) provider models and use the example of England to indicate that complicated public sector contracting rules are a substantial barrier for market entry. Saltman and Duran then review the cases of Sweden (with new providers and governance structures in primary healthcare) and Spain (with different hospital governance models) and show the inherent complexity involved in developing new public and mixed public-private provider models. They rightly conclude that good governance in healthcare will need to reflect a country’s practical and

political experiences at the ground level.

What Is Governance?

Looking at the discussion on governance, two strands of thinking emerge: (i) governance derives from a broad ethical and philosophical debate within society leading to values and cultures in an organization,⁴ and forms the basis for more specific management discussions on how to organize and steer service providers to achieve broader health systems objectives; and (ii) governance is used as a kind of placeholder for describing the need/willingness for “doing a better job,” thus allowing for grand aims, but sometimes leaving the processes and targets rather vague, thus ultimately non-enforceable.

Definitions of “governance” are often broad and encompassing,⁵ making it difficult to use them. This is sometimes compounded by compounding political aspects and vague separation of governance and management. The World Health Organization (WHO) defines governance (sometimes called “stewardship”) in the health sector as “a wide range of steering and rule-making related functions carried out by governments/decisions-makers, as they seek to achieve national health policy objectives that are conducive to universal health coverage” (<http://www.who.int/healthsystems/topics/stewardship/en/>).

“By ‘governance,’ we mean all ‘steering’ carried out by public bodies that seeks to constrain, encourage or otherwise influence acts of private and public parties. This includes structures that ‘delegate’ the steering capacity to non-public bodies (ie, professional associations). By ‘steering,’ we mean to include binding regulatory measures (laws) and other measures that are sometimes called ‘new governance’ measures – that is, ‘a range of processes and practices that have a normative dimension but do not operate primarily or at all through the formal mechanism of traditional command-and-control-type legal institutions.’”⁶

Governance for present purposes is defined as “the structures and processes by which the health system is regulated, directed and controlled.”⁷

Savedoff has identified five dimensions of governance as it has been used widely for governments, corporations, and financial markets: (i) Coherent decision-making structures, (ii) Stakeholder participation, (iii) Transparency and information, (iv) Supervision and regulation and (v) Consistency and stability.⁸

There remains much debate on the concept of Governance and the different approaches to its definition, most notably related to the issue of shared cultural values and norms. Governance concepts cannot be transferred, they need to be built on what is culturally appropriate. In 1971, the American philosopher John Rawls coined the term “reflective equilibrium” to denote “a state of balance or coherence among a set of beliefs arrived at by a process of deliberative mutual adjustment among general principles and particular judgments.”⁹ In practical terms, reflective equilibrium is about how to identify and resolve logical inconsistencies in the prevailing moral compass of a group or society and eventually develop its moral structure. Extending the concept of Greer and colleagues,¹⁰ we suggest to define governance as “*The culturally appropriate rules, processes and institutions through which decisions are made*

and authority is exercised in order to achieve transparency, accountability, participation, integrity, and capacity.”

Extending Governance Debate Beyond Healthcare Provider Governance

For better understanding the challenges in governing healthcare providers, it is useful to extend the governance debate beyond the service provider models to health financing and funding structures¹¹ (amongst many other aspects like pharmaceuticals, teaching, research, etc). This aspects had been deliberately left out by Saltman and Duran, while acknowledging their importance.

Regardless of how funds are collected and pooled, any publicly organized financing scheme faces the challenge of “prudent purchasing,”¹² ie, how to spend the available means in a way that satisfies concerns around responsiveness, quality, equity and efficiency while preserving clinical autonomy and allowing for developing innovative forms of diagnosis and treatment. Governing fund pooling, resource allocation, health service purchasing, together with health service provision is an important element in achieving such critical, and, at times, conflicting aims.

There is an intense debate about how a governance model for providers might look like.⁸ We strongly believe the prevailing logic of neoliberalism with its promise of more efficiency and stipulating a major role for market-oriented healthcare does *not* mean to leave the markets alone but rather requires strong governance arrangements. Focussing on efficiency and treating the patient as a customer has an important role in many standard healthcare encounters, especially those which are non-acute and non-life-threatening – a fact that the medical profession still struggles to accept. It is here, where approaches like “performance-based payments” might be put to a good use.¹³ Where appropriate (and measurable), paying for high quality care can help in developing a culture of quality and fostering innovation and collaboration. However, effectiveness, empathy and professional dedication remains a non-substitutable priority in case of emergency and acute care, assigning cost-savings a lower priority. This is where market forces can be destructive. Appeals *only* to the rational “economic man” within the clinician and fostering self-interest by paying bonuses for achieving targets might actually damage the motivational fabric of those providing care and finding reward from being intrinsically motivated.¹³ If I pay a doctor for immunizing children but not for counselling the mothers, I will affect the way this doctor is allocating his time, disconcerting health outcomes.

Evidence-Based Governance?

Given these challenges, the idea of “evidence-based health policy” should be brought into the governance debate. The idea is coined after the approach of “evidence-based medicine,” described by David Sackett as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”¹⁴ The concept of combining best available evidence, clinical experience and patient preferences is based on identifying, disseminating, and, most importantly, applying research that is properly conducted and clinically relevant.

Jeffery Pfeffer and Robert Sutton promoted the idea of

“evidence-based management” 10 years ago, as they saw similarities between clinical and management decision-making.¹⁵ *“The same behaviour [of doctors] holds true for managers looking to cure their organizational ills. Indeed, we would argue, managers are actually much more ignorant than doctors about which prescriptions are reliable—and they’re less eager to find out.”*

Taking this idea just a little step further, there is an argument to base governance on such a pragmatic approach of “what works, what does not and why?”¹⁶ However, the complexity of the governance concept, the number of actors involved at different levels, and the multiplicity of scenarios that can develop in a diverse context makes such an approach challenging.¹⁷

Still, evidence-based models of governance might create a platform for sharing useful instruments and different accountability arrangements, and point to new roles for various layers of the society in accelerating health system outcomes. Eg, the involvement of civil society organizations like patient associations or provider associations have a lot to contribute to health governance as does the astute use of (routine) data. Twenty-first century health governance has the challenge to find ways to make meaningful use of them in a way that dovetails with cultural norms.

The Way Forward

Governance, similar to other encompassing terms like “management” or “quality,” needs to be succinctly defined and operationalized in order to become meaningful and useful.⁸ Nowadays the connotation of governance has been broadened, as it is no longer “regarded as one – way traffic from those governing to those governed,”²⁵ and multiple new actors have entered the political arena¹⁸; “the government is hardly anymore the most powerful actor in the policy arena.”¹⁹ Moretti and Pestre show in their linguistic analysis of World Bank reports, how the use of the term “governance” has evolved since 1990, unilaterally tilted towards being “good governance” (italics added) and having ethical claims attached to it.²⁰ In order to attain such good governance, it is hard to overstate the benefits to an organization of a clear sense of mission that will allow its staff to focus on delivering it. A often missed argument in favour of establishing a new and independent health financing organization is just this importance of having a clear mission and being held accountable for achieving it.

Good governance models should set a balance between being specific enough to guide management in producing the best attainable results while reflecting institutional values, and permitting a leeway for managers to be creative in countering unforeseeable needs and circumstances. They have to be rooted in understanding and reacting on the predominant culture of a system or an organization upon which to build on, at the same time incorporating (at least to some extent) the prevailing cultural values and norms of a society.

Good governance models should try to attain such a balance by using a solid evidence-base, by setting transparent processes, and by bringing in relevant work practices, structures and technologies enabling the application of lessons learnt.

Nevertheless, we believe that a good governance also requires a mind-set, which acknowledges “that true wisdom does not

come from the sheer accumulation of knowledge, but from a healthy respect for and curiosity about the vast realms of knowledge still unconquered.”¹⁵ It is a fair point to reflect whether such pragmatism and humbleness might be at odds with the technical rigidity of generating “evidence.” At any rate, studies like this one by Richard Saltman and Antonio Duran contribute to the systematic understanding of governance and help building up a joint understanding and empirical base for good governance in healthcare.

Acknowledgments

The authors would like to thank Bernd Glazinski and four anonymous reviewers for helpful discussions and suggestions.

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors’ contributions

Both authors jointly developed and wrote the commentary.

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References

- Lewis M, Pettersson G. *Governance in Health Care Delivery. Raising Performance. Policy Research Working Paper 5074*. Washington: The World Bank; 2009.
- Saltman RB, Duran A. *Governance, Government, and the Search for New Provider Models. Int J Health Policy Manag.* 2015;4:1-10. doi:10.15171/ijhpm.2015.198
- Duran A, Dubois HFW, Saltman RB. *The evolving roles of hospitals and recent concepts of public sector governance*. In: Saltman RB, Duran A, Dubois HW, eds. *Governing Public Hospitals: Recent Strategies and the Movement Toward Institutional Autonomy*. Brussels: European Observatory on Systems and Policies; 2011:15-34.
- Magretta J. *What Management Is*. New York: The Free Press; 2003:4.
- Kooiman J. *Societal governance: levels, models, and orders of social/political interaction*. In: Pierre J, ed. *Debating Governance: Authority, Steering and Democracy*. Oxford: Oxford University Press; 2000:138-166.
- Mossialos E, Permanand G, Baeten R and Hervey T. *Health systems governance in Europe: the role of European Union law and policy*. In: *Health Systems Governance in Europe: The Role of EU Law and Policy*. Cambridge University Press; 2010:3. http://www.euro.who.int/__data/assets/pdf_file/0007/138148/E94886_ch01.pdf?ua=1
- Dwyer J, Eagar K. *Options for reform of Commonwealth and State governance responsibilities for the Australian health system. Commissioned paper for the National Health and Hospitals Reform Commission*. Canberra; 2008.
- Savedoff WD. *Governance in the health sector. A strategy for measuring determinants and performance*. Policy Research Working Paper 5655. Washington: The World Bank; 2011.
- Rawls J. *A Theory of Justice*. Cambridge, MA: Belknap Press; 1971.
- Greer SL, Wismar M, Figueras J, McKee C. *Governance: a framework*. In: Greer SL, Wismar M, Figueras J, eds. *Strengthening Health System Governance. Better Policies,*

- Stronger Performance*. Maidenhead: Open University Press; 2016:27-56
11. Jowett M, Kutzin J. *Raising revenues for health in support of UHC: strategic issues for policy makers*. Health Financing Policy Brief No. 1. Geneva: World Health Organization; 2015.
 12. Kramer W. *Why Aren't State Exchanges Embracing Prudent Purchasing Strategies?* HealthAffairs Blog, March 19, 2012. <http://healthaffairs.org/blog/2012/03/19/why-arent-state-exchanges-embracing-prudent-purchasing-strategies/>. Accessed February 19, 2016.
 13. Woolhandler S, Ariely D. *Will Pay For Performance Backfire? Insights From Behavioral Economics*. HealthAffairs Blog. October 11, 2012. <http://healthaffairs.org/blog/2012/10/11/will-pay-for-performance-backfire-insights-from-behavioral-economics/>. Accessed February 19, 2016.
 14. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. *Evidence based medicine: what it is and what it isn't*. *BMJ*. 1996;312(7023):71-72. doi:10.1136/bmj.312.7023.71
 15. Pfeffer J, Sutton RI. *Evidence-Based Management*. *Harvard Business Review*. January 2006. <https://hbr.org/2006/01/evidence-based-management>.
 16. Gwatkin DR, Wagstaff A, Yazbeck A. *Reaching the Poor. What Works, What Doesn't, and Why*. Washington: The World Bank; 2005. doi:10.1596/978-0-8213-5961-7
 17. Saltman RB, Duran A, Dubois HF, eds. *Governing Public Hospitals: Recent Strategies and the Movement Toward Institutional Autonomy*. Brussels: European Observatory on Systems and Policies; 2011.
 18. Rhodes RAW. *The new governance: governing without government*. *Political Studies*. 1996;XLIV:652-667. doi:10.1111/j.1467-9248.1996.tb01747.x
 19. Alvarez-Rosete A. Modernising policy making. In: Hann A, ed. *Health Policy and Politics*. Aldershot: Ashgate; 2007:41-57.
 20. Moretti F, Pestre D. *Bankspeak. The Language of World Bank Reports*. *New Left Review*. 2015;92:75-99.