

Strengthening capacities for policy development  
& strategic management in national health systems

*A background paper prepared for the  
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*“WHO has always been strong at responding to specific requests...(and) at fielding highly qualified technical experts... WHO has, however, been less good at helping senior policy-makers deal with the big picture.*

*We know that senior-policy-makers in ministries of health do not have the luxury of focusing on single issues. Health is one of the most politically and institutionally difficult sectors in any country. If WHO is to earn a leadership role in health, we cannot deny the responsibility of helping our colleagues to deal with complexity.*

*In many countries, national governments have tended to look to other agencies for advice on issues that effect the sector as a whole. WHO has to be a more reliable and effective supporter of countries as they reform and restructure their health sectors... It is a way of making sure that people – particularly poor people – get a better deal from their health system”.*

**Gro Harlem Brundtland, 1999**

*“In the final analysis, the pace of development and the ability to successfully respond to new problems in a society will depend on its indigenous human and institutional capabilities. A priority concern of governments should therefore be to see how the capabilities of its civil servants can be retained, strengthened and sustained over time...There is clearly a trade-off between the attention the government needs to give to specific policy reforms today and its willingness to invest in the long term capacity building...When capacity building is neglected, the chances are that its dependence on external advice to undertake policy reform will continue to the future...Capacity building may not yield answers to the policy dilemmas and choices faced by government today because the process takes time to generate the needed skills and institutional strengths. It should be seen as an investment that society must make today to be more self-reliant in the future in policy analysis and reform”.*

**Samuel Paul, 1995**

*“There has not as yet been any concerted effort to build capacity in countries to formulate their own health policy and systems thinking, so they are all the more vulnerable to ideas imported from outside”.*

**Anne Mills, 2001**

(The citations are from references in the bibliography items 42, 31, 45.)



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## Executive Summary

A new WHO effort has been initiated to support member states in strengthening the stewardship function or the governance of health systems in countries. The background is in the problems faced by member governments in a turbulent policy environment with a number of cross-pressures, growing needs and dwindling resources, as well as uncertainty and discontinuity in long-term policy-making and strategic management.

It was thought that one meaningful approach to respond to country needs is to establish a forum for senior policy-makers and managers in order to identify critical challenges for governing and managing health systems, and to identify the needs for support required, as well as the possible role that WHO and its partners could play.

The document contains a preliminary review of the issues at hand, particularly with regard to lessons from the past and the need to look into the future. Different perspectives on policy-making are illustrated, and special emphasis is given to the key but changing role of government in health systems. The main roles and functions of government in health systems are reviewed, and capacities in countries to fulfil them are briefly addressed.

In the light of the literature and experience there is a great need and demand for capacity-building for policy development and strategic management of health systems, but less clarity about what this means in practice. Lessons learned from capacity-building efforts in the UN and by the development agencies show that a very serious consideration should be given to a number of issues before launching major efforts in capacity-building. The need for tailored, context-specific, and long-term approaches is highlighted throughout. It is argued that building necessary capacities should be seen as an investment to be made as part of an overall national strategy for health and human resources. The implications of this for the possible role of WHO with regard to skills, resources, time frames and need for partnerships are pointed out.

The design for the forum and its methods of work have been based on a preparatory brainstorming session which explored the territory and made recommendations on the orientation and major thrusts of the endeavour. The idea is to start a stepwise process of a highly interactive and productive exchange among peers with rich and varied experience and expertise, driven by country needs for strengthening their health systems and the policies and management to do so, and facilitated by all levels (country, region, HQ) of WHO and eventual partners. The approach is consultative and not prescriptive.

It is expected that in its meeting in July 2001, the Forum will identify critical challenges for policy development and strategic management of health systems in their countries, articulate further on the needs and demands for strengthening capacities in member states in the field in question, and make recommendations on the modalities of support that WHO and its partners could provide in the short and medium term longer term, and on preliminary plans for the longer term. The forum will propose how it wishes to organize the work further in the key areas identified and action plans envisaged at different levels of WHO. After the Forum meeting, in consultation with stakeholders, a programme and budget for 2002-3 will be proposed.

## 1. Setting the scene

The policy environment for health and health systems is in a state of flux in a number of member states of WHO. Ministries of Health are under many cross-pressures in terms of growing needs and often dwindling resources, as well as uncertainty and discontinuity in long-term policy-making and strategic management. The arena is changing fast due to many factors beyond health sector's control.

The policy agendas are often set by short-term demands for urgent trouble-shooting or quick problem-solving. There is little room for critical reflection, proper policy analysis, and preparing for the challenges of the future. The challenges faced by health policy-makers and senior managers are daunting. One should be able to manage and respond to most complex issues in a turbulent context, lead and guide through demanding change processes, and be credible and influential with regard to other key sectors of socio-economic development.

One important challenge in the policy environment is the constantly evolving role of the state in state in the overall socio-economic development (1) and in the health sector as part of it (2, 3). In the health sector the major trend has often been described as “less rowing, more steering”, meaning that the central government should be less directly involved with operational service provision and focus more on the strategic directions in major policy-making issues, legislative and other regulatory functions, and on monitoring and assessing performance with regard to policies and systems. Growing pluralism in service provision and tendencies towards various forms of decentralization accentuate this shift.

A recent WHO framework (4) for health systems performance and assessment puts forward five goals for the health system: health and its equitable distribution, responsiveness and its equitable distribution, and fairness in financing. It further deals with four essential functions: financing, provision of services, resource generation, and stewardship. The role of government described above comes very close to the concept of stewardship. It could also be called governance of health systems.

WHO has advocated a higher priority for health on the development agenda (5–7). This has been most welcome in the member states struggling with the marginal position often given to health in government policies. But effecting this change at country level also poses challenges for political and managerial leadership for health.

As part of the new recognition of the significance of health in human, social and economic development, there is a growing international awareness of the political imperative to tackle forcefully the major public health threats and escalating burden of illness that impede overall development, particularly in the poorest parts of the world. Tackling this challenge successfully in a sustainable manner will not be possible without addressing the deplorable state and deteriorating trends of health infrastructures in the countries in question. The situation in most of the least developed countries and even in many middle-income countries is such that weaknesses, fragmentation and inefficiencies in the health system jeopardize effective implementation of policies and programmes designed to tackle major public health problems. This is why disease-oriented policies and programmes must go hand in hand with improving capacities to implement them. Such a balanced approach – working both towards technical solutions and towards strengthening capacities of health systems in countries – has been WHO's unique contribution to world health in the past. It is as topical in the new millennium as it was before. It has been recently reaffirmed in both the policy for HFA in the 21<sup>st</sup> century (8) and in the corporate strategy of WHO (9).

The proof of the pudding is in the eating. The proof of policies and programmes is in effective implementation. The crucial part of a successful response to practically any health challenge for which technical solutions exist, is in the capacity to deliver, and to do so in a sustainable manner. Capacity to implement does not depend on money and products only. It depends on other resources as well: people, skills, organization, management, leadership and governance. Without organized and functioning health systems and broad involvement of communities and stakeholders there is little chance for effective, equitable and efficient implementation. Scaling up efforts to tackle major health problems entails scaling up capacities of health systems to do so. Seen in this perspective, the challenge of capacity-building in general and that of strengthening governance or stewardship of health systems is great and urgent.

Although there is a good deal of theoretical understanding of policy-making and strategic management in general, there is not much systematic knowledge of the practical needs of senior policy-makers and managers and their organizations in the real world of current health systems and policy arenas. The crucial question to be addressed is: what are the country needs with regard to strengthening governance of health systems? Once this question has been at least partially answered, the second one is: what can be done to meet those needs, how, by whom, and what is the role of WHO in all this?

It was thought that after an initial exploratory stage one would address the questions by identifying a group of current senior policy-makers and managers in health (and related fields) and working with them in a forum to define and elaborate on the critical challenges they are facing. Exchange of information and experience in such an interactive body would facilitate learning and mutual support among peers. One could build and systematize through such a forum the experiential knowledge existing about the art and craft of doing the job, including assessment of the needs and possibilities for future capacity-building. Furthermore, based on insights gained, one could perhaps design modalities of support that WHO and its partners might provide in the future.

The approach described is to start a process whereby a number of key actors in member states together with WHO would share relevant information in order to learn from each other and to strengthen governance of health systems. The content of the exercise in terms of major issues, tools available and the role of WHO and its partners can and must be anticipated in some degree, but to a large extent it should be left to evolve out of the brainstorming, Forum meetings, workshops, consultations and other forms of mutual exchange. The approach suggested is definitely not top-down. It is essentially an exchange among peers with rich and varied experience and expertise, driven by country needs in policy development and strategic management of changing health systems, and facilitated by all levels (country, region, HQ) of WHO. The approach is consultative and not prescriptive.

## 2. Learning from the past, looking to the future

### 2.1 Two perspectives on policy-making and management for health systems

A review of recent literature makes it clear that much has been published on the substantive issues and problems for which solutions are sought, and a wealth of literature dealing with the *technical aspects* – the content and the tools – that policy-makers and managers could make use of to improve systems in terms of health outcomes, effectiveness, equity in access, responsiveness, and fair and sustainable financing (10, 11).

On the other hand, there is much less systematic coverage of the *processes* of policy-making for health systems – the way agendas are set, the role of key actors or stakeholders and their power relations, internal and external policy environments and the pressures, including the considerable differences in the historical, institutional, political, legal and cultural context, in which policy instruments for change are being applied (12–14).

There is not much in the literature on underlying values, either explicit or implicit, which are always crucial in any attempt for major policy initiative (15–19). There is also little about the consideration of options and choices that were made and the necessary compromises to accommodate real life situations due to conflicting objectives (17, 20) or political expedience, both early on and in the legislative phase. There is little about attempts to ensure ownership of the policy process by those whose input is required to make the policy changes work (21, 22). How can skills, dedication and commitment be built-in to make change sustainable? There is a remarkable scarcity of systematic accounts of the crucial implementation phase (23, 24) in any policy endeavour, both with regard to how it was anticipated and how it was managed, monitored and evaluated, modified, or reconfigured. And there is very little coverage of experiences gained in trying to respond to some of the needs identified as major weaknesses in so many countries: how to build the necessary capacities to do better in the future (2, 25)?

These examples reflect in fact *two major approaches* or orientations to policies and systems (26, 27). One tradition may be called a *rationalist* school of policy and management, with a fundamental assumption that better information – measurement, indicators, epidemiological and economic approaches and managerial tools – are the keys to successful policy-making and change management for health systems. Another tradition, which draws mainly on political science and sociology, policy analysis, and policy and management sciences, stresses the inevitability of understanding the political and institutional context and the policy processes involved in decision-making (12, 13, 15, 21). The *institutional* or incrementalist view of policy-making has gained considerable currency for the simple reason that it appears to describe most aptly what decision-makers actually do (26). It typically sets out to explore the kind of issues identified as less prevalent in the literature.

The position taken here is that both traditions have their merits. They should not be seen as mutually exclusive but as complementary. In order to support policy-makers and senior managers of health systems in their work, both approaches should be taken into account. Better information and new managerial tools are useful and may even be necessary. However, they are not sufficient. In order to find out what happens in the black box of policy-making in practice and how that practice might be improved, it is necessary to understand the context, the political dimensions of policy processes which the institutional approach addresses. One of the strengths in that tradition is that it goes beyond health sector (and has in fact been applied much more elsewhere) and therefore may provide policy-makers and managers with useful insights originating from other fields of public policies.

These different orientations also have major implications to the alternative approaches to remedial action or change management (21). The rationalist (or conventional) mindset tends to adopt

approaches that are top-down, externally-motivated, blueprint-based, generic to all circumstances, time-bound, wholesale and confrontational. The incrementalist mindset is inclined to adopt approaches that are internally motivated, experimental, incentive-based, locally adaptive, incremental and continuous, piecemeal, and co-operative or participatory. This is further clarified in another background paper (25). The relevance of these differences in orientation will become obvious later when we discuss lessons drawn from capacity-building for policies and systems.

## 2.2 The role and functions of government in health and health systems

There is a widespread view that there is a lot of room for improvement in the role and functions of government in health sector. It is also commonly understood that the policy environment of most countries has changed considerably in the last two decades as described above. There seems to be an emerging consensus that in order to improve performance in health policies and systems, the *role of government is crucial*; however, there is a recognition that the role it has to play may differ from what it used to be.

Most analysts would agree that the key roles of government *in the health sector* include at least the following: setting overall policies and strategies for health and health systems; ensuring that the legislative and regulatory framework is in place, is kept updated and is properly enforced; taking responsibility for the generation and improvement of necessary human (manpower) and material (fund flows for recurrent and capital expenditure, appropriate technology, equipment, and pharmaceuticals) resources in a balanced, efficient and equitable way, and for a health financing system that is fair and sustainable. In addition, it is essential for government to steer, lead, supervise and monitor the performance of the overall health system, i.e. the public health functions as well as personal service provision (public and private). All this entails a number of intelligence, information, communication requirements, and intervention when appropriate.

One key function of government in health is *policy co-ordination between sectors*. Major determinants of health are outside the health system, in sectors such as overall economic and social policies, education, agriculture, local government, public works, transport, labour and social protection, and environment. If a higher place for health in the development agenda is striven for, it puts great demands for the government as a whole and the health sector in particular, in terms of knowledge, understanding, skills in advocacy, negotiation and persuasion. One particular problem of developing countries is related to external finance and its co-ordination. Another dimension, which is of increasing importance in policy coordination and is faced by most countries, relates to globalization of markets and liberalization of trade. Taking part and guarding the health interest in the processes of global or regional economic integration processes is something that compounds the complexity of issues that national ministries of health are faced with.

Finally, most people would agree that an important role of the government is to provide information, *communication and dialogue* concerning health. Despite the great variety in political systems, there is an emerging trend of democratization of societies, not only in the formal sense of government and legislature, but also in the growing role of actors, pressures and influences outside the national governments and the health sector: the *media*, the *interest groups* and organized *civil society*. *Leadership* for health is more demanding than ever before.

The list of functions above is not at all exhaustive but is a fair selection of some key roles that most national governments have to play. The way in which they carry out these and other functions, varies enormously among countries, depending on political systems and political and administrative cultures, institutional and organizational settings, and economic and human resources available, just to name a few.

## 2.3 On the need for strengthening governance of health systems

From the point of view of governance of health systems the crucial questions are how well or poorly the key functions are fulfilled? How could performance be improved if need exists? What can be said about this?

The *dominant view* in the literature (11–13) is that ministries of health generally have a weak position, are often not very effectively managed, and often lack skills and capacities that are necessary for their key functions. Particular weaknesses pointed out relate to their narrow scope of expertise; centralized, hierarchical and compartmentalized organization, fragmented by vertical programmes or professional lines of accountability; poor performance in management in general and financial management in particular; clientelist or patronage culture; weak capacity for policy analysis and development, implementation and rule enforcement. Depending on the different emphases in diagnosis, the proposals for remedial action vary from focus on broad-based public sector reform (3) to capacity-building (28) and better information and management tools (10, 11).

There is, however, *another significant view* saying that there has been too much emphasis on bad governance only, and that there are lessons to be drawn from the opposite end of the spectrum. Examples of good performance of government under difficult circumstances tend to be neglected in the literature (22). This is a reminder to look at such examples, which might be helpful when seeking ways for improvement.

An obvious task for the proposed forum is to sharpen the identification of critical challenges for governance of health systems. Participants will *identify* major functional *strengths and weaknesses* in policy development and strategic management of health systems; then they will ask *what is highly context-specific* and *what is more generic*. It follows then to ask what areas of governance are generic enough to be addressed in detail, and how should they be approached?

Some preliminary considerations are offered as a starting point for debate, without any attempt to pre-empt the discussions of the forum. Two perspectives are suggested as entry points: first, *questions emanating from the role of government* outlined above, and second, a closer look at *current policy agendas in countries*.

Elaborating on the role and functions of government (stewardship role) in health systems outlined above, the following might be examples of worthwhile topics for exchange:

- How strong is the government in its role of *setting overall policies and strategies* for health and health systems? Do the necessary skills exist for policy analysis, including the health, economic, legal and political dimensions of planning? Is there the capacity to design and draft legislation and budgetary reallocations (which are usually necessary for any major policy change) and carry it through the decision-making processes of government and legislature? Are the necessary skills and capacities for successful policy dialogue with stakeholders in place and properly used? Is there the capacity to implement effectively, to monitor and assess progress being made with a view to modify the process if necessary?
- Does the setting for policy-making and strategic management enable a *longer-term view* and a *broader horizon* than the usual short-term trouble-shooting or crisis management? Does it allow for and foster policy co-ordination, such as effective consultation, negotiation, influence, and consensus or coalition seeking or conflict resolution with regard to other ministries, interest groups, labour market parties and other relevant players?
- Are the *capacities* there to address the need to *negotiate* with external agencies (such as donors for SWAP policies or financial institutions on poverty reduction strategies), to take an active

part early enough in issues of regional or global trade and other agreements with great potential impact on health and health systems (such as pharmaceuticals, TRIPS, forthcoming GATS, or FCTC) to guard the public health interest, and at the same time to deal effectively with the 'bread and butter' work with the regional, provincial or other levels of the health system itself?

- Is the *legal and regulatory framework* in place and properly enforced? Does it cover all the essential elements such as human resources, finance, service provision (both personal and non-personal, public and private), pharmaceuticals and biologicals, human rights related to health care, and so on? If appropriate regulation exists in the statute book is it followed in action; is the necessary managerial and administrative capacity for enforcement and intervention there?
- Is the *balance between different levels of the system* appropriate, with clear responsibilities and accountability, and are the systems for budgeting, financial and human resource management adequate; do they ensure that the powers are where the responsibilities lie? If there is devolution or decentralization of power, is sufficient care taken that all echelons have the skills and capacity to live up to expectations?
- Do the *intelligence functions*, information systems and communication mechanisms come to grips with the needs of government, policy agendas and important stakeholders?

This is just a start of a series of possible serious concerns; much more would follow if one goes deeper in the more specific aspects of stewardship or governance related to service provision, resource generation or financing.

Another approach for delineating focus of interest may come from current agendas of policy-makers and senior managers for health systems in countries. Substantive issues to be tackled depend on the policy agendas, which may be more or less rationally set, but are certainly based on some pressures in the policy environment. Agendas start with identification and recognition of issues and considerations of policy responses, both of which are based on some values (either explicit or implicit) and some assumptions or evidence (or lack of it) about how the world works and what could work in the situation at hand.

Taking the fact that the *government policy arena* is usually the heart of policy-making, the policy-makers and senior managers of health systems are themselves an important part of the *agenda-setting actors* in most countries. Nevertheless, often there are major *influences from the external environment*. These may include pressures from ministries of finance or planning, international financial institutions or donors, international agreements on trade-related legislation and practices, media attention, court cases or public outcry on certain issues.

One of the great challenges policy-makers and senior managers constantly face is the balancing act between strategic policy-making for the medium and longer term and the short-term nature of day-to-day policy and management issues, without allowing the latter to dominate their own agendas. As one senior policy planner put it, "These people (senior policy-makers and managers) generally have a very good grasp of what ought to be done but they don't have the time to do it." One of the functions of the forthcoming forum would be exactly to take some time to pull together what it is that ought to be done, and start finding ways to get it done.

Currently topical on the policy agendas of many (if not most) countries are *generic questions* related to sustainable financing, financial management and cost containment. Another major group of challenges in a number of countries relates to the trends in public management (including various forms of devolution of powers or decentralization, institutional reforms of administration and/or civil service). There is a renewed and enhanced focus in many countries on human resource and health labour market issues (numbers, skills and competencies, regulation, remuneration, motivation

and well-being of staff), which tended to get little attention in the reform wave of early 1990s (29, 30). The same applies to the public health functions and infrastructures, which have weakened in many countries while the focus has been exclusively on personal services and economic efficiency (29, 30). And there are certainly the overarching themes of improving equity, effectiveness and efficiency of health systems.

On the other hand, the agendas may be dominated by more *specific content issues* related to perceived needs, be they in terms of the health system's response to major public health problems or disease, or to specific issues of organization and management of care delivery (such as pharmaceuticals, equipment, managerial supervision of hospitals or health centres, shifting balance of care from tertiary to primary level, access to and quality of care, waiting times and lists, and so on). Given the importance of developmental or intersectoral dimensions of health policies, one would expect that they figure high on chief executives' agendas. Most probably there are several issues of both generic and specific types to be tackled simultaneously in countries.

Whether one approaches the issues from the perspective of the role and functions of government, or the current agendas in countries, a key theme running through much of present debate is how to move from a reactive to a proactive policy stance, from defensive and slow responses to offensive styles of action, from short-term agendas governed by fire-fighting to longer term agendas, including preparation for the future through adaptive capacity-building to continuously improve performance. Policy agendas are not static but very dynamic. The capacity of government to govern and manage proactively should also be seen as dynamic, evolving and adapting.

Whatever the more accurate assessment will be, at this stage there seems to be a common concern that present-day governance for health systems often falls short of its potential and is ill-prepared for the new challenges. Therefore, the question of what remedial action may be required and what will work under what conditions is relevant. To put it in another light, if health and health systems really matter as everybody keeps saying, and if health ought to have a higher priority on the development agenda, then shouldn't the health sector be in the vanguard of efforts to improve governance, both in national governments and intergovernmental agencies?

What are the implications for the project? In the beginning phase of the project at hand one should not fix agenda issues in detail. This should arise from the brainstorming and the Forum. After all, the purpose is to find out how policy-makers and senior managers identify and interpret issues, as well as responses and support required to address them. Suffice it to say at this stage that both perspectives outlined above – a focus on content issues on the one hand, and a focus on policy processes and the capacities required to improve them – shall be kept in mind. It is anticipated that generic issues would receive greater focus than specific ones, and that particular attention would be given to strengthening the policy-making functions and capacity of the ministries and related bodies for health systems development. While there is no intention to pre-empt the discussion or fix in detail the agenda it is presumed that it would be useful in the Forum to outline some – however preliminary - thoughts about some key areas on which action should be focused and possible options about how to tackle them in a tangible, feasible and affordable way. This will be considered further towards the end of this working document.

## 2.4 Capacity-building for health policies and systems

The needs for capacity building have been emphasized in connection with health sector reforms in low-income countries (28, 31). The issues may range from strengthening ministries of health in their strategic policy-making and regulatory function, through stress on basic skills and administrative practices of managers at different levels, to empowering district health systems and

their sub-units in managerial and other skills. In the context of the present project, two questions seem crucial. The first relates to needs and demands identified and articulated by senior policy makers and managers from countries, and the ways to meet those needs and demands in countries. The second relates to the possible role of WHO and its partners in providing support to member states in doing so.

### 2.4.1 Lessons drawn from capacity-building efforts

Regarding the need for capacity building in countries, it is important to bear in mind a number of principles and lessons learnt. There is a thorough summary of the state of the art by Samuel Paul (31), on which the following draws heavily.

“In brief, the lesson is that human and institutional capabilities in developing countries are critical to the success of their physical investments and policy reforms. External expertise and assistance can help initiate change, but to internalize and sustain change and reform, deliberate efforts are required to expand and upgrade human and institutional capabilities. Prescription of reforms and conditionalities imposed from outside are no substitute for this task”.

He elaborates the concept of capacity building along four different dimensions:

- human vs. institutional
- planning vs. implementation
- micro vs. macro
- cognitive vs. practice.

The need for *training and skill development* are normally accepted as necessary in any change for improving systems, but there is much less recognition of the fact that *trained personnel will be effectively utilized only in organizational settings with certain characteristics*. People need to work together to achieve common goals. They need to be given the required resources and be supervised and motivated. They tend to be productive in an enabling and supportive institutional framework. The capability to create and manage these institutional mechanisms and arrangements is distinctly different from the capability of a person to perform a specific task. Human (in the individual sense) and institutional capabilities are thus different, but complementary and mutually reinforcing. In a given context, it is important to diagnose the problem since the remedies will not be the same for these two types of gaps. Standard training courses for staff in policy analysis can be organized locally or abroad, whereas institutional capabilities may require customized approaches.

Similarly, the capabilities for successful *planning and implementation* differ from each other. The former focuses on analytical skills, breadth and depth of environmental understanding and interdisciplinary collaboration, while implementation focuses more on organizational action, incentives, teamwork and results.

Regarding the distinction between *macro and micro* dimensions, Paul goes on to stress that at the macro or sector level much greater attention should be given to policy analysis and to fine-tuning the *choice of policy options* and mid-course corrections. While *implementation* is of great concern at higher levels, the macro level role in implementation is one of planning and supervision rather than direct action, says Paul. However, in view of the fact that so many failures of the past in the health sector have been due to poorly anticipated implementation problems or lack of a proper implementation strategy, the role of implementation also at macro level may require much more attention.

The health sector is well known for its emphasis on the cognitive dimension of capacity building. However, the ability to apply and adapt knowledge in the intellectual sense depends a great deal on the opportunities one gets to practice over a period of time. This is even truer of institutional capabilities that invariably call for the orchestration of many parts, teams and organizations. Understanding the context, establishing rapport, designing new systems and practices, bargaining and negotiation, and other capabilities take time to develop and fine tune even for those who have excellent theoretical knowledge. Organizational teams develop and internalize ways of working these processes by practice over time. This explains why a long-term perspective is essential to the strategy for capacity building.

Paul (31) approaches needs assessment and applicable strategic interventions in different country settings through a four-fold table based on supply (weak or strong) on one hand and demand (weak or strong) on the other, again emphasizing the importance of carefully tailored measures to meet country needs in each specific context.

Figure 1. Strategic interventions for building capacity for policy development

		Demand	
		Weak	Strong
Supply	Weak	<ul style="list-style-type: none"> <li>Invest in long-term training</li> <li>Study tours for policy-makers</li> <li>Dialogue with government to stimulate demand</li> </ul>	<ul style="list-style-type: none"> <li>Support government unit</li> <li>Create autonomous capacity/centres</li> <li>Invest in consultant capacity</li> <li>Twinning arrangements</li> </ul>
	Strong	<ul style="list-style-type: none"> <li>Grants to MoH to use capacity</li> <li>Stimulate use of capacity</li> <li>Upgrade skills</li> </ul>	<ul style="list-style-type: none"> <li>Top of capabilities</li> <li>Promote regional use of capacity</li> <li>Support dissemination of work</li> </ul>

(Adapted from Paul, 1995)

Lessons and policy implications for the governments according to Paul are as follows:

*“The creation and efficient use of human and institutional capabilities in a wide variety of fields including policy analysis is a basic challenge for all developing countries. In their preoccupation with numerous projects, mobilization of funds and operational problems that require immediate attention, governments may sometimes get distracted from this fundamental function. In the final analysis, the pace of development and the ability to successfully respond to new problems in a society will depend on its indigenous human and institutional capabilities. A priority concern of governments should therefore be to see how the capabilities of its civil servants can be retained, strengthened and sustained over time... There is clearly a trade-off between the attention that a government needs to give to specific policy reforms today and its willingness to invest in the long term capacity building for policy reform. When capacity building is neglected, the chances are that its dependence on external advice to undertake policy reform will continue into the future... Capacity building may not yield answers to the policy dilemmas and choices being faced by government today because the process takes time to generate the needed skills and institutional strengths. It should be seen as an investment that society must make today to be more self reliant in the future in policy analysis and reform”.*

Lessons for the donors include that capacity building efforts are likely to be more effective when designed and managed in a participative mode with national counterparts actively committed to the process; assessment of needs must be informed by this approach. Most of the interventions discussed are not only time consuming, but also skill intensive. Some measure of continuity will be required of those who wish to support these efforts. Small countries face special problems, and

acceptable arrangements should be designed to share common institutional infrastructure between countries.

There is a separate comprehensive review available as a background document for the meeting on the updated knowledge base about what seems to work and what does not and under what conditions (25). There is therefore no need for repetition here. Suffice it to say that the more recent literature strongly amplifies the general lessons presented by Paul and cited above. There is, however, one theme running through much of the debate on capacity-building, which is worth exploring further here. That is the implications of thinking seriously of *capacity-building as an investment*.

## 2.4.2 Capacity-building as an investment

As in the passages quoted above, one often finds the *notion* of capacity-building as an *investment* necessary for improving performance of government functions. In light of the emphasis given to this *powerful idea*, it is striking how *little guidance* comes from the published literature about *what it takes* in practice in terms of an investment. We do know that time-frames are long, and we know that skills required are demanding. But what is known about the size of the investments required to do it well, compared even roughly with some optional meaningful spending, for instance with either capital investment expenditure in a given country or recurrent spending for health? The answer is: very little. There is a plenty of literature and some figures available in the context of capacity development in technical co-operation about “wasteful spending in endless training workshops that produce nothing sustainable”, but this information is based on misguided or failed programmes that have been designed against main rules of good practice.

One reason for the difficulty of obtaining such information is that when properly executed, the investment in question is part and parcel of normal good management and functioning of the system, and invisible as a separate activity or a budgetary expenditure item. There is seldom any separate budget line for “capacity-building”. There are often budget lines for “training personnel” or “staff development”. There are some international benchmarks or good practice indicators. In the private sector the “good employers” are said to spend some 5-7% of their staff costs in such activities. In UN agencies this is of the order of 1,5-2.0%. In many developed countries there are labour market agreements to the effect that a certain percentage (usually 2–3%) of employers’ expenditure in personnel should go to such purposes.

However, the concept of capacity-building adopted here is different than that of training or staff development. The focus here is on the capacity for policy development and strategic management (macro level). It is broader in the sense that one is not talking about training (cognitive development) of individuals in key positions only, but about improving over the years the skills, practice and working patterns of individuals, teams, organizations and institutions that are crucial for improving governance and stewardship.

What kind of investment does that entail? First, one can say that it will vary greatly according to the magnitude of the performance gaps identified, for instance based on an assessment of how well or poorly the essential functions of government outlined in section 2.2. are currently performed. Second, it depends on types of the root causes of those gaps and the types of capacities that need to be strengthened to improve performance on essential functions. Third, it may also be that the intervention or investment cannot be limited only to the level of primary interest in isolation (for instance, MOH or state/provincial /district level of health administration), but to take into account the wider context of the action environment as well (for instance, capacities and constraints and developments in other parts of the public sector or civil service). Fourth, both the nature and

magnitude of the investment will depend on how one assesses the situation with regard the demand and supply of critical capacities, as outlined in Paul's typology above. Fifth, one can say that the investment should be designed, owned and carried out by the country itself, according to its own policy and priorities. Finally, external resources and support may be required, but they will only be helpful and sustainable when they are geared to support national policy towards self-reliance.

If such an investment is planned as a part of overall national health policy and a strategy for human resources for health, which is the approach proposed by recent literature, and which was recommended by the brainstorming session of senior policy makers and managers based on their experience, the investment in question should be incorporated explicitly into such a national overall strategy. The resources required in terms of budgetary spending are probably a very modest part of government spending for health or even its health administration.

One way to provoke discussion is to say: if the government thinks it ought to invest in its own capacity for policy development and strategic management as a national priority, why does it not invest, or invests too little? Further, let us think about government investment in capital projects. Many governments (and donors) spend considerable sums of money annually on brick and mortar – often even in facilities that the countries can ill afford or sustain. What about setting aside a small part of the current level of “capital investment” into “investment in human and institutional capital”? This may be technically difficult with current budgetary practices (which are usually based more on the traditional idea of control than the idea of development). However, the heart of the matter is not a question of budgetary technique, but a question of acting on the very key principle of investment: its is something put aside from current consumption (spending foregone) in order to function better in the future. *The idea of investing in people and institutions, not only in physical capital, is the heart of the matter.*

### **2.4.3 Resource institutions in support of policy development and strategic management**

An important potential for strengthening capacities for policies and systems lies in institutions for research and training in public health, health systems or policy research, institutes of public policy and management, or allied bodies.

There is a plenty of such institutes in the North, some outstanding examples in developing countries and transition economies, but generally the “inverse care law” applies here as elsewhere: the capacities are weakest where the needs are greatest. Therefore it is important for the Forum to address the question of how such capacity could best be built over time and what mechanisms could be used to catalyze and facilitate its development.

There are relevant overviews in the literature on different options for developing such institutions in other fields of public policy, and the experiences gained about how to make them sustainable, quality-driven, policy relevant, and how to ensure that their work is usable and utilized by policy-makers (32, 33).

There is no such overview readily available in public policies for health and health systems in developing countries. There is an inventory of research institutions in the field (34) and an overview of collaborating centres of WHO (35). What is missing, however, is an analytical overview, preferably by regions, of experiences in building such capacity, and particularly experience related to successful examples of institutions with good track record in the research-training-policy interface in developing countries.

The brainstorming session in January highlighted the importance of at least two types of institutions in this context. One is institutions closely related to the central level, which are in a position to generate knowledge and evidence and explore and analyse policy options, and thereby inform and influence policy-making through dialogue among government, other stakeholders in the policy arena, civil society organizations and the media. It was stressed that in order for such institutions to be effective, one needs a critical mass, careful consideration of recruitment, good mentoring and apprenticeship, and possibilities for career development, all in a way which is relevant for country needs. It is the very issue of practical policy relevance in the country perspective that makes much of the training and research provided in the institutions of the North questionable as an investment for developing countries in this particular field.

Another important potential role for such institutions in countries is in training managers, planners and analysts who are needed at different levels of the system. Experiences from different set-ups in countries (government institutions for policy and management, national institutes of public health, schools of public health, other academic departments, foundation-based or private institutions) would be worth an inventory.

In this connection, it is worth bearing in mind that there are in many countries, also in the developing world, institutes whose purpose it is to support national health development. Often these are geared towards a narrow biomedical orientation, sometimes traditional public health laboratories. Structures and functions may be obsolete for present-day challenges. One could think about investing in the medium-term into transformation and modernization of such existing bodies to cover the multidisciplinary expertise and policy-analytical skills that national health development in the modern sense entails. Examples of such institutional transitions would be useful.

In the more narrow view of capacity-building as training and skills development of individuals or small groups of key people, two major international initiatives in the last decade deserve special mention. One is the Flagship Courses for Health Sector Reform and Sustainable Financing, run by the World Bank Institute since 1997 (36). Over 2000 senior and middle-level managers have attended courses of several weeks duration in Washington and seven regional institutes. The annual budget of the activity is around 1 million USD. The evaluation of impact has been initiated. Another attempt, oriented to strengthen research-policy-interface, has been The International Health Policy Program, supported by private foundations, WHO and World Bank over the years 1986-2000, and recently internally assessed (37).

The obvious way ahead would be first to take stock of existing capacity in terms of resource institutions within WHO regions and working with selected collaborating centres, with focus on the South. There is no difficulty in listing a great number of institutions but in identifying some of the successful examples (in terms of a track record of high-quality, policy-relevant work) and build on lessons learned from experience. Institution-building is long-term investment and must be planned accordingly.

#### **2.4.4 Some advance considerations for the project**

In the light of lessons from the past, it is necessary to realize that whatever the needs with regard to capacity-building for improving governance of health systems may turn out to be, it is likely to be time-consuming, skills-intensive and resource-intensive (24, 31, 38–40) Therefore, it is essential in the work at hand to be realistic about time (41), skill and resource implications of any forthcoming proposals and recommendations. On the other hand, one can look at the issues in a different light. If senior policy-makers from governments of member states of an intergovernmental organization identify issues in capacity building at the core of the support required, should this not have major

implications for the organization and its partners? Put in another way: should not long-term capacity-building efforts be supported strongly in parallel, or in addition to, the more conventional and more visible issue-specific programmes?

In this connection, and in relation to WHO's mandate and responsibility in supporting member states in such endeavour, the following quote from the Director-General's preface to the World Health Report 1999 (42), is pertinent:

*"WHO has always been strong at responding to specific requests...and at fielding highly qualified technical experts...WHO has, however, been less good at helping senior decision-makers deal with the big picture.*

*We know that senior policy-makers in ministries of health do not have the luxury of focusing on single issues. Health is one of the most politically and institutionally difficult sectors in any country. If WHO is to earn a leadership role in health, we cannot deny the responsibility of helping our colleagues to deal with complexity.*

*In many countries, national governments have tended to look to other agencies for advice on issues that affect the sector as a whole. WHO has to be more reliable and effective supporter of countries as they reform and restructure their health sectors...It is a way of making sure that people – particularly poor people – get a better deal from their health system".*

One word of caution is warranted. If the WHO at all levels (country, regional, HQ) recognizes the need to move much further and deeper into supporting capacity-building for strengthening the governance and management of health systems in countries, this would have major repercussions in terms of resources, skills, and partnerships. WHO secretariat at different levels of the organization have currently insufficient numbers of people with a first-hand experience and expertise in governance and management of national health systems, and the same applies to many other important actors in the field. Pooling of expertise and resources should be addressed seriously; it is obviously a task the forum would take on board once it has identified critical issues and the support needed to respond to them.

There has been a strong call from the Member States, endorsed by the World Health Assembly (43) and in greater detail by the Executive Board of WHO (44), to take major steps in order to strengthen health systems development in countries. Thus the challenges, strategic approaches, constraints and lines of action to be taken by WHO in collaboration with partners in development have all been reviewed recently, and provide one relevant starting point for the discussions of the forum.

### 3. Objectives and expected outcome

The objectives of the project are, within WHO policies and programmes of work, and in collaboration with governments, regional offices, country offices and international agencies active in the field:

- to work, through the advisory mechanism of the Forum, towards strengthening the capacities for policy development and strategic management of health systems in countries
- to identify key areas of concern in policy development and strategic management, where capacity gaps in countries call for urgent action, and to design approaches and mechanisms to tackle them
- to identify the greatest needs for support to countries that policy-makers and managers think WHO and its partners best could provide in the short, medium and long term.

Expected results in the very short term (by the end of August 2001):

- the forum has been established and it has got started, is networking effectively and has agreed on recommendations for further work
- there is a report containing identified critical issues for governing and managing health systems faced by senior policy-makers and managers in countries, assessment of needs for capacity-building towards improving governance for health systems, and recommendations for action by WHO and its partners
- there is work plan and budget for 2002-3

The expected outcomes for the medium term can only be defined on the basis of the Forum's deliberations and recommendations.

### 4. Design for the forum and the method of work

The design for the Forum is outlined in section 5 of the report of the brainstorming session towards the Forum, held in January 2001. There is nothing to add at this stage. The recommendations for preparations and background materials for the Forum were also agreed in the brainstorming, and have been pursued accordingly.

The method of work should be as interactive and participatory as possible. The forum could be organized without a chair or a bureau, with several of forum members taking turns as facilitators in sessions or working groups. WHO secretariat would take responsibility for preparation and reporting of meetings. Mechanisms for ongoing communication have been established.

## **5. Preliminary thoughts on identification of possible key areas for action and options for mechanisms to tackle them**

The preparatory work towards the Forum has shown that the critical challenges identified are numerous and the various needs for capacity-building seem almost endless. Under such conditions, unless one focuses future work carefully into priority areas, however defined by the Forum, there is a risk of scratching the surface only, spreading thinly, and not getting anything tangible and feasible done in practice.

Therefore, based on the discussions at the brainstorming and in anticipation of the forthcoming Forum the idea is that identification of possible key areas for action would stimulate discussion on priorities and facilitate more precise definition of the approaches, mechanisms, tools, resources and time frames that are seen relevant and tangible by policy-makers and managers in countries. One would then deem what is feasible in terms of support by different levels of WHO and its partners to do in collaboration with countries, so that it would not overlap with or duplicate effort made elsewhere.

The focus would be on strengthening and improving capacities in countries for policy development and strategic management of health systems. Essentially, this revolves around the governance (or stewardship) function of health systems. In practice, strengthening such functions in member states is a task that must be driven by the countries themselves. The possible role and modalities from WHO and its partners can only be defined after articulation of key areas of action required.

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