Round Table Discussion

Accountability and good governance are essential to deliver health services

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The world over — and in developing countries in particular — the manner in which health services are delivered leaves much to be desired. In these situations, the people who suffer most are those in the poorest strata of society.

The above article by Claire Bahamon et al. identifies some of the bottlenecks and suggests solutions to them. The strategy of many service delivery programmes to date, which is highlighted, emphasizes concern for effectiveness but, surprisingly, seems to have almost totally neglected institutional and governance issues.

Key factors that the authors are unaware of or chose to ignore are corruption and lack of transparency, particularly in the national health services of developing countries. Without addressing these crucial issues it will not be possible to scale up good practices. Corruption can be defined as the use of public office for private gain. In measuring the impact of corruption on effectiveness of health spending, Rajkumar & Swaroop [1] analysed data from 1990 to 1997: controlling for GDP per capita, female educational attainment and urbanization, among other factors, they found that effectiveness of public health spending in the reduction of child mortality hinges on the integrity rating (1–5 ranges based on level of perceived corruption), with higher integrity associated with reduced mortality.

Yet another example of a total lack of regard for accountability is the misuse of public funds. For example, public funds diverted for private use could be described as theft. In addition, in the process of calling for tenders and making payments, acts of misappropriation are known to be made.

Another bane in the health sector is the marked lack of transparency in most parts of the world: a series of studies has placed developing countries at the top of the list. Bribes are the order of the day in most countries. The practice is so rampant in certain countries (e.g. Bosnia and Herzegovina [2]) that 35% of health officials declared that those who refuse bribes face some sort of retribution from those who accept them!

Reform aimed at facilitating access to health services could also be a participatory process involving the public, who could work in tandem with health officials — a step that would ensure more accountability and stem corruption. While there is no record of such participatory methods being the panacea in this respect, they could still prove to be effective as the integrity of public health officials would be put to the test. Citizens could also h ighlight shortcomings, irregularities and misdemeanours — verbally or in writing — all of which would help a ministry of health (representing a government) and its employees to address vital issues and contribute to a better health service.

Tackling issues of corruption and transparency that prevent the health sector from achieving optimum performance is worthy of mention, as it is also likely to assist a decline in poverty, mortality and morbidity as stated in the Millennium Development Goals.

These considerations bring to the fore the need to ensure good governance at all levels within the health sector. After all, what would the pouring in of valuable funds achieve, if those at the helm overlook or shrug off their responsibilities in respect of the functions that govern all connected activities? To deliver health care in a world where sickness is rampant is a task that needs a committed and concerted effort. The responsibility does not lie only with the health officials: it requires commitment by those involved with governance at all levels. ■

1. AS, Swaroop V. *Public spending and outcomes: does governance matter?* Washington, DC: The World Bank; 2002. Policy Research Working Paper Series 2840.
2. Lewis M. *Governance and corruption in Public Health Care Systems.* Centre for Global Development. Working paper No 78, January 2006.

Closing the knowledge translation gap will help to improve health service delivery

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The second half of the 20th century witnessed a remarkable expansion in the scientific enterprise to improve health and health care. As a direct result of public and private sector investments in biomedical research, life expectancy increased substantially in developed countries, and the natural course of many diseases has been considerably modified. Most importantly, new donors have emerged to address global health challenges. These successes, however, cannot obscure the fact that in all countries we have yet to learn how to translate improved knowledge into enhanced health — both rapidly and efficiently. A study from the United States estimated that it takes on average 17 years to turn 14% of funded research to the benefit of patient care.[1] Ironically, then, the translation gap is blind to geography and the net resources of any nation. Moreover, the slow uptake of effective knowledge spans the continuum from basic public health interventions to the most sophisticated treatments.

The above paper by Bahamon et al. focuses on specific aspects of this challenge as it relates to health and development in countries with large and impoverished populations. The authors identify critical factors likely to be successful in bringing about change, including: the need for dedicated internal change agents; a clear purpose, with anticipated benefits and expected results; clear roles and responsibilities; and strategies to nurture an organizational climate that can maintain and scale up positive results. An essential observation that we ignore at our peril is that the pace of spontaneous adoption can be pitifully slow; other points regarding the process of change are similarly thoughtful and worthy of serious debate. Bahamon et al.

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provide a straightforward model from problem identification through to implementation, which clarifies a logical series of steps that should be considered prior to launching any effort to improve health and health care. In short, they articulate clearly that failure to attend to all details of how improvements will be implemented and sustained will doom the best-intentioned efforts and even those that are well funded.

These issues merit broad debate and further assessment in their own right. For example, while a growing literature clarifies the importance of "change agents" and "champions", we do not yet know how to identify or cultivate these individuals, and few studies evaluate whether champions are specific to interventions or to topics. All organizations — from the most sophisticated hospital to a rural village — are by definition complex ecosystems that attempt to cope with multiple challenges concurrently. Our need to understand how cultural and environmental aspects support or impede change across specific conditions or populations cannot be overstated. For example, are participatory initiatives more likely to succeed than those that are perceived as externally driven or top-down approaches?

If readers retain one message it should be this: knowledge is necessary but is far from sufficient to effect sustained change and improvement. Definitions of "best practices" need to expand to incorporate specific characteristics related to effective adaptation and implementation. This round table underscores that opportunities exist for collaboration across initiatives to identify effective strategies for accelerating the pace at which advances in knowledge improve health. ■

1. Balas EA, Boren SA. *Managing Clinical Knowledge for Health Care Improvement.* Yearbook of Medical Informatics; 2000.

A structured improvement process sustains change in health service delivery and enables future improvement

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Well-intentioned donors, academic researchers and nongovernmental organizations regularly introduce creative interventions aimed at improving the quality of health care in developing countries. These interventions can make a significant difference to the lives of millions of people and can also be important sources of learning. Often, however, these pilot projects wither after a promising start: improvements cannot be sustained because local systems infrastructure is not built during the pilot phase, changes cannot be replicated with local resources, or no plan is developed to scale up or expand the changes beyond the boundaries of the initial project.

Bahaman et al. review five steps that are required to introduce an intervention in a resource-constrained environment and to nurture the process so that it grows and becomes embedded in the local environment. A further critical requirement is that implementers introduce a systems improvement plan and implant modern improvement methods into the environment they are seeking to change. The review rightly emphasizes the key role of the change agent: an active agent should be part of any improvement activity, though all stakeholders in the change should quickly develop skill in analysing and enhancing performance. Establishing a common aim is also a crucial starting point for any endeavour to change the system, and can often act as a rallying point or compass when a project seems to be losing its way. Finally, the role of testing change ideas on a small scale before widespread implementation is an important part of the process, since it allows local health workers to develop confidence in and ownership of the change.

The authors accurately describe the process of identifying challenges, determining the root causes of the problems, prioritizing the highest leverage changes to be tested, testing solutions on a small scale and then implementing successful strategies on a broader scale. In our experience, this process can proceed quickly through formation of a core improvement team within each health unit (e.g. clinic) that meets regularly, perhaps weekly, and is mentored by the change agent in continuously making local improvements and analysing the data from tests of these changes.[1] Broad change and rapid spread of successful pilot schemes can be accelerated by forming learning networks of improvement teams from multiple sites. Every level of the health care system — tertiary, secondary and primary care sites — should be represented, brought together by a common aim and acting, as much as possible, as an interdependent system, with each hospital or clinic making its best contribution to optimize limited resources.[2] This collaboration process needs to be well-coordinated by an experienced improvement expert.

Introducing change into a system when the change agent is not part of the government infrastructure (e.g. nongovernmental organization or academic unit) can be problematic if the local or regional health authority is not part of the process. It is crucial that local health structures such as the district health office are engaged in the design and leadership of change, and that change does not threaten their authority or pre-existing strategies. Securing governmental buy-in is even more crucial when contemplating scaling up successfully tested changes. Collecting and repeatedly disseminating data showing the effects of the change powerfully engages the support of local and regional departments of health.

Ultimately, sustainability and spread of new ideas will depend on the success of the initial change process, ownership of the change processes by the local health workers, a robust infrastructure for learning, and concomitant support from health-care leadership to allow local adaptation and testing of new ideas for improvement. A successful improvement process can transform the culture of health systems accustomed to introducing change through top-down approaches, ultimately empowering front-line providers of care, and building capacity to make future progress via a similar, structured improvement process. ■

1. Berwick DM. Lessons from developing nations on improving health care. *BMJ* 2004;328:1124-9.
2. *An approach to rapid scale-up: using HIV/AIDS treatment and care as an example.* Geneva: World Health Organization; 2004.

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