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Building institutions for health and health systems in contexts of rapid change

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ABSTRACT

Many Asian countries are in the midst of multiple interconnected social, economic, demographic, technological, institutional and environmental transitions. These changes are having important impacts on health and well-being and on the capacity of health systems to respond to health-related problems. This paper focuses on the creation of institutions to overcome information asymmetry and encourage the provision of safe, effective and affordable health services in this context of complexity and rapid change. It presents a review of literature on different approaches to the analysis of the management of system development and institution-building. There is a general agreement that the outcome of an intervention depends a great deal on the way that a large number of agents respond. Their response is influenced by the institutional arrangements that mediate relationships between health sector actors and also by their understandings and expectations of how other actors will respond. The impact of a policy or specific intervention is difficult to predict and there is a substantial risk of unintended outcomes. This creates the need for an iterative learning approach in which widespread experimentation is encouraged, good and bad experiences are evaluated and policies are formulated on the basis of the lessons learned. This enables actors to learn their roles and responsibilities and the appropriate responses to new incentive structures. The paper concludes with an outline of the information needs of managers of health system change in societies in the midst of rapid development.

Introduction: implementing the un-implementable

If one had brought the world's top social scientists together thirty years ago, none would have predicted China's sustained economic growth and rapid social and institutional change. Nor would they have predicted the many changes taking place in much of South and Southeast Asia. History seems to have overtaken the consensus frameworks for analysing economic and social development. This has major implications for health systems, which have had to adapt to a rapidly changing context. The title of this section comes from the conclusion of a mid-term review of a large health project in China in the late 1990s. It stated that the project was "un-implementable", because of a number of structural problems (Bloom, Liu, & Qiao, 2009. p. 20). Since the government was using this project to test its options for health system reform, the implication was that these reforms would also fail. Ten years later, after many of the structural issues had been addressed, the government launched a major health reform, which included many of the options it had been testing (Bloom, 2011). This experience illustrates the need to understand health system development as a change management process in a context of rapid social, economic and institutional change. This presents special challenges for the research community.

The aims of this paper are to increase understanding of the management of health system development in dynamic and complex contexts and to identify key knowledge needs of participants in change processes. It reviews several analytical approaches that have gained traction in analysing the management of change and the creation of stable institutions in health and other sectors and it identifies frameworks for thinking that are applicable to health system development. The remainder of this section discusses the emergence of increasingly complicated health systems in a number of Asian countries. The following section applies the lenses of complex adaptive systems and historical institutionalism to an exploration of strategies for building health-related institutions in complex and dynamic contexts. The section after that focuses on large-scale, non-linear change and transition, drawing on the concepts of socio-technical regime change, disruptive innovations in business and high reliability management. The paper concludes with a discussion of the implications for health system researchers in rapidly developing low and middle-income countries.

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Many Asian countries are experiencing a number of rapid and interconnected changes. These include economic growth, alterations to the proportions of people employed in agriculture, industry and services and large movements of people into urban areas. Links between rural and urban localities have been strengthened as a result of improvements in transportation, the spread of mass media and the increasing use of mobile telephones and the internet. Rapid economic development has put pressure on ecosystems with risks to human health from hazardous substances and from zoonoses, associated with intensified animal husbandry. Economic activities have been stimulated by rapidly spreading markets and the emergence of new types of private organisation. The development of government and civil society arrangements to influence the performance of markets has lagged behind.

These rapid developments have enabled many people to escape poverty and build better lives. They have also exposed populations to risks, which are creating new patterns of economic and social inequality. Governments need to find ways to enable rapid development and encourage potentially risky innovation, whilst helping people avoid the worst consequences of mistakes and unintended outcomes. One strategy for achieving this is by strengthening the health sector's capacity to protect people from the adverse consequences of ill-health. Efforts to achieve this need to take into account the institutional context within which health service providers are embedded.

Several decades ago, post-colonial and post-revolutionary governments invested in the creation of state-owned health systems managed through command and control bureaucracies. In theory, health facilities and individual health workers in these state-owned systems followed directives from above. In practice, incentives and local pressures also influenced them. A number of countries have transformed their health sector into a modern health system with similar rules-based institutions to those in the advanced market economies. There is no single explanation for this outcome. In concluding a multi-country review of "What makes a successful health system", Balabanova, McKee, and Mills (2011) emphasise government leadership, the provision of consistent financial and management support and a concerted effort to build capacity at the level of individuals and organisations.

In many other countries, a messier health system has emerged, in which the rules of behaviour are much less clear. There has been a rapid spread of formal and informal health markets and the boundaries between public and private sectors have become blurred (Bloom & Standing, 2008). Health facilities and individual health workers can now respond much more strongly to financial incentives and to opportunities for independent action. Users of health services also have more choice. The number of channels of flow of information to providers and users of health services, through the mass media, mobile telephones, the internet, drug detail men and so forth, has grown, as has the number and variety of organisations that produce content for these channels. Civil society organisations, such as trade associations, professional bodies, citizens' organizations and political parties also exert an influence. Governments of these countries face major challenges in playing an effective stewardship role and guiding health sector development.

Building institutions for an effective and fair health system

This section is concerned with efforts by governments and other stakeholders to create appropriate institutional arrangements for health systems in dynamic and complex contexts. It builds on the arguments of Gilson (2003) on the importance of relationships of trust to health systems, and on two papers that analyse the health sector as a knowledge economy, making widely available the benefits of specialised medical knowledge and commodities, such as drugs (Bloom & Standing, 2008; Bloom, Standing, & Lloyd, 2008). These papers argue that societies have established complicated institutional arrangements to support the development of trust-based relationships between providers and users of health-related goods and services. These relationships enable people to benefit from medical technologies safely and at an affordable cost. The development of these institutions and the degree to which they address the needs of the poor and powerless are strongly influenced by political and economic factors. There are no simple blueprint guidelines for institution-building. Nor, can a model that works well in one country necessarily be transferred to another (Fukuyama, 2004). This section draws heavily on two analytical approaches which focus on the way institutions and organisations emerge and develop; complex adaptive systems and historical institutionalism.

The concept of complex adaptive systems, which was first developed by natural scientists, is being increasingly applied in the analysis of social organisation (MacGuire & McKelvey 2011; Room, 2011). This approach views actors as continuously adapting to their environment and learning from one another (Eoyang, 2011; Milteton-Kelley and Ramalingam 2011). Porter (2006) focuses on the ways actors influence and are influenced by their environment and how organizations and their environment co-evolve. Economists, such as Harford (2012) and Beinhocker (2006), use the concept of the fitness of an entity to explore how organizations search for a niche through a process of trial and error. They show how diversification and responses to small errors enhance learning and contribute to success in a rapidly changing environment. Ramalingam, Jones, Reba, and Young (2008) apply this kind of thinking to international development and argue, for example, that debates about the relative importance of top-down and bottom-up approaches for managing change do not pay enough attention to the agency of development actors and the degree to which they react to internal and external stimuli. Bourgon (2011) applies this approach to an analysis of the new demands on governments in an increasingly complex context and an exploration of the implications for the theory and practice of public sector administration. All these analysts understand institution-building as an iterative process through which actors negotiate conflicting interests, learn new ways of doing things and co-construct new rules of the game.

Several recent publications have applied concepts of complex adaptive systems to the analysis of health system development in low and middle-income countries (de Savigny & Adam, 2009; Paina & Peters, 2011). They describe a health sector in which a large number of parts are co-evolving and in which actors (individuals, teams and organizations) respond to policies on the basis of their points of view, the incentives they face and the relationships they have with one another. Although this applies to all health systems, it is particularly relevant when institutions and their underlying rules of behaviour, are not highly developed. The findings of a recent retrospective study in low and middle-income countries are consistent with this way of seeing health system development. They showed that the quality of health system leadership and the processes of implementation had much more influence on outcomes than particular policy designs (Peters et al. 2009).

The largely complementary perspective of historical institutionalism provides a political and social analysis of the evolution of institutions and the complex webs of relationship within which they are embedded. It understands institutions as a set of regularized practices in which actors expect rules to be observed and transgressors to be punished. Hall and Thelen (2009) argue that these rules are co-constructed by policy entrepreneurs in government and non-government organizations. Institutions are constantly tested and subject to political negotiation and pressure and they continue to change in response to these pressures.

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