

Health governance: principal–agent linkages and health system strengthening

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Governance is increasingly recognized as an important factor in health system performance, yet conceptually and practically it remains poorly understood and subject to often vague and competing notions of both what its role is and how to address its weaknesses. This overview article for the symposium on health governance presents a model of health governance that focuses on the multiplicity of societal actors in health systems, the distribution of roles and responsibilities among them and their ability and willingness to fulfil these roles and responsibilities. This focus highlights the principal–agent linkages among actors and the resulting incentives for good governance and health system performance. The discussion identifies three disconnects that constitute challenges for health system strengthening interventions that target improving governance: (1) the gap between the good governance agenda and existing capacities, (2) the discrepancy between formal and informal governance and (3) the inattention to sociopolitical power dynamics. The article summarizes the three country cases in the symposium and highlights their governance findings: health sector reform in China, financial management of health resources in Brazilian municipalities and budget reform in hospitals in Lesotho. The concluding sections clarify how the three cases apply the model's principal–agent linkages and highlight the importance of filling the gaps remaining between problem diagnosis and the development of practical guidance that supports 'best fit' solutions and accommodates political realities in health systems strengthening.

Keywords Governance, health systems, reform, capacity, politics, developing countries

KEY MESSAGES

- A health governance lens that focuses on principal–agent relationships among health system actors can provide useful insights into the dynamics of health system performance that can lead to the identification of underlying institutional incentives problems.
- The contributions to this symposium demonstrate how governance analysis can be applied at different levels within the health system, from national, to sub-national, and to the individual health facility. The findings from the country cases reveal the importance of principal–agent issues to understanding the behaviours of health system actors and to diagnosing performance problems.
- Effective interventions to improve health governance in ways that contribute to sustainable and country-owned health system performance avoid 'one-size' good governance prescriptions, adapt reforms to existing capacities, recognize that governance has both formal and informal dimensions and pay attention to sociopolitical power differentials and dynamics.

Introduction

Just as governance has come to be acknowledged as a key contributor to socio-economic development, its importance for health system performance has similarly been increasingly recognized. Despite this recognition, what constitutes health governance and how to improve it, and how it contributes to better health systems, remain questions that policymakers continue to wrestle with. Lack of clarity, competing frameworks and normative biases have variously contributed to conceptual misunderstanding and policy confusion. With today's renewed emphasis on health systems strengthening (HSS), better governance frequently surfaces as an element of strategies and action plans (see Shakarishvili *et al.* 2010). Thus, clarifying health governance is a necessary contribution to effective approaches to HSS.

In the health sector, governance has been treated largely as a set of tasks or functions that are, more or less explicitly, assumed to be carried out by, or under the direction of, health ministries. The World Health Organization's (WHO) health system building blocks model embodies this assumed role of health ministries, labelling one of the building blocks 'leadership and governance' (WHO 2007). WHO's concept of 'stewardship' constitutes a set of six task domains: generating intelligence (information and evidence), formulating strategic policy direction, ensuring tools for implementation through incentives and sanctions, building coalitions and partnerships, developing a fit between policy objectives and organizational structures and cultures and ensuring accountability (see Saltman and Ferroussier-Davis 2000; Travis *et al.* 2002).

This task/function conceptualization of health governance, however, does not sufficiently address: (1) the multiplicity of societal actors in health systems, (2) the distribution of roles and responsibilities among those societal actors and (3) their ability and willingness to fulfil their roles and responsibilities. In this article, we offer a health governance model that fills these gaps. Using as a starting point the definition of governance as state-society problem solving in public arenas (Kettl 2000), the model draws on the institutionalist perspective that sees governance in its broadest sense as concerning the rules that distribute authorities, roles and responsibilities among societal actors and that shape the principal-agent interactions among them. These rules can be both formal, embodied in institutions (e.g. democratic elections, parliaments, courts and sectoral ministries); and informal, reflected in behavioural patterns (e.g. trust, reciprocity, civic-mindedness and patron-client relations).

One approach to analysis of the different actors in governance is principal-agent theory, which is founded upon the core assumption that the goals of principals and agents diverge and that agents may take advantage of 'information asymmetry'. Agents are able to maximize their interests at the expense of the principals' aims in part because they have better information than principals about what they are doing, while principals seek to increase their control over agents without expensive efforts to overcome the information gaps (see Pratt and Zeckhauser 1991). From its private sector origins, principal-agent theory has been widely applied in the public sector, recognizing the complexity of relationships characterized by multiple principals, externalities and a wide variety of

administrative processes and 'contracts' that connect principals and agents (Waterman and Meier 1998). Opening up the principal-agent relationship beyond the reconciliation of goal divergence to consider the possibility that in certain situations the goals of principals and agents may converge takes this expanded application further, in a direction that some have termed stewardship theory (Davis *et al.* 1997; Saltman and Ferroussier-Davis 2000; Van Slyke 2007).

Following the presentation of the model, the discussion turns to the gaps between the normative focus on good governance and the realities facing health system governance: these concern: capacity, formal vs informal governance and political economy. We note where the symposium cases illustrate elements of the model and shed light on the issues of capacity, formality/informality and political economy. The next sections summarize the three case study contributions to the symposium, flagging their key governance-related findings and how they illustrate elements of the health governance model. We close with several observations and conclusions regarding the utility of the model, some suggestions for ongoing research and practical guidance and finally a commentary on remaining gaps related to governance and HSS.

Health governance: a model

There are three generally accepted health system goals: (1) improved health status through more equitable access to quality health services and preventive and promotion programmes, (2) responsiveness to legitimate patient and public expectations and (3) fair financing that protects against financial risks for those needing health care (WHO 2000; Roberts *et al.* 2004). While lead governance responsibility for these goals lies largely with state actors, achieving them requires the active engagement of other actors as well. Various analyses have specified the actors in the health system (e.g. Frenk 1994; WHO 2000). Here, we put forward three categories, and elaborate on the connections among them that establish the pathways through which health governance becomes operational.

The first is state actors, which includes politicians, policy-makers and other government officials. Clearly, actors in the public sector health bureaucracy are central, such as the health ministry, health and social insurance agencies and public pharmaceutical procurement and distribution entities. However, other public sector actors beyond those usually associated with the health system have roles as well. These can include, e.g. parliamentary health committees, regulatory bodies, the ministry of finance, various oversight and accountability entities and the judicial system (see Brinkerhoff 2004). The Brazil case focuses on such actors: municipal health councils, mayors and the federal comptroller-general.

The second set of actors constitutes health service providers. Depending upon the particulars of a given country's health system, this set mixes public, private and voluntary sector providers (see Bennett *et al.* 2005; Lagomarsino *et al.* 2009). For example, the mix can include hospitals, clinics, laboratories and educational institutions in all three sectors. The provider category also includes organizations that support service provision: insurance agencies, health maintenance organizations, the pharmaceutical industry and equipment manufacturers and

suppliers. The symposium's China case takes a health system-wide perspective on providers, whereas in contrast the Lesotho case looks specifically at hospitals.

The third set of actors contains clients/citizens: service users, the general public and organized civil society. This set can be categorized in a variety of ways: e.g. by income (poor vs non-poor), by location (rural vs urban), by service (maternal and child health, reproductive health, geriatric care), by disease or condition (HIV/AIDS, TB, malaria, etc.). Civil society organizations may be community-based groups, advocacy organizations, professional associations, etc. (e.g. Tantivess and Walt 2008). The China case incorporates members of this category of actors into the analysis of the fate of the country's health reforms.

These actors are linked through the governance relationships illustrated in Figure 1, which builds on work at the World Bank on service delivery and accountability (2004, 2007). As specified here, these principal-agent relationships are both instrumental—related to how governance helps to achieve health system goals, and normative—reflecting commonly accepted principles of good governance (see UNDP 1997). The next section discusses these health governance relationships in more detail.

Linking the state, providers and clients/citizens

The arrows in Figure 1 characterize the nature of the relationships among the various actors. 'From client/citizens to state actors', in which the client/citizens are the principals and the state actors are the agents, the key feature of the relationship is the exercise of voice, i.e. the expression of needs, preferences and demands to politicians, policymakers and public officials. Individuals can and do exercise voice—e.g. a citizen can visit his/her mayor or vote for a parliamentarian who has promised health reform—but in terms of health systems and governance, how individuals come together in collective efforts to make their voice heard around common interests is a key issue. Formal efforts through political parties and elections are one

form of interest aggregation and expression of voice; and advocacy and public information campaigns are another, less formal avenue. The Brazil case illustrates the salience of elections as expressions of citizen voice; a higher degree of competitiveness in mayoral contests mattered in reducing corruption in health spending. In the China case, popular discontent with health services contributed to putting health reform on the agenda of politicians and technocrats.

Citizen efforts to exercise voice and hold public officials accountable can be pursued through various means: e.g. community initiatives to lobby local officials, specialized civil society organizations that develop expertise in budget monitoring and service delivery report cards or cyberactivism that taps the power of information technologies to expand voice both nationally and internationally. All these measures seek to align the goals and interests of citizens, as principals, with public officials, as their agents.

'From state actors to client/citizens', the overriding health governance relationship is responsiveness to client/citizen needs, preferences and demands. This relationship varies in quality and degree. In countries with authoritarian governments, political leaders and health officials may not see themselves as agents acting on behalf of citizen-principals. In fact, many authoritarian leaders espouse the view that they act in the best interests of their citizens and the nation, thus assuming away any divergence between the interests of principals and agents. As a result, they may not be very responsive to the health needs of their citizens, and/or they may respond through patronage networks to some citizens, but not to all. However, as the China case demonstrates, even authoritarian regimes need some popular support, and some pay attention to popular opinion and citizen satisfaction so as to defuse potential resistance to their rule. In democratic systems, health care is an issue that is often of interest to politicians, as it touches the lives of almost all of their constituents. However, it can be difficult to mobilize voters, whose attention to health

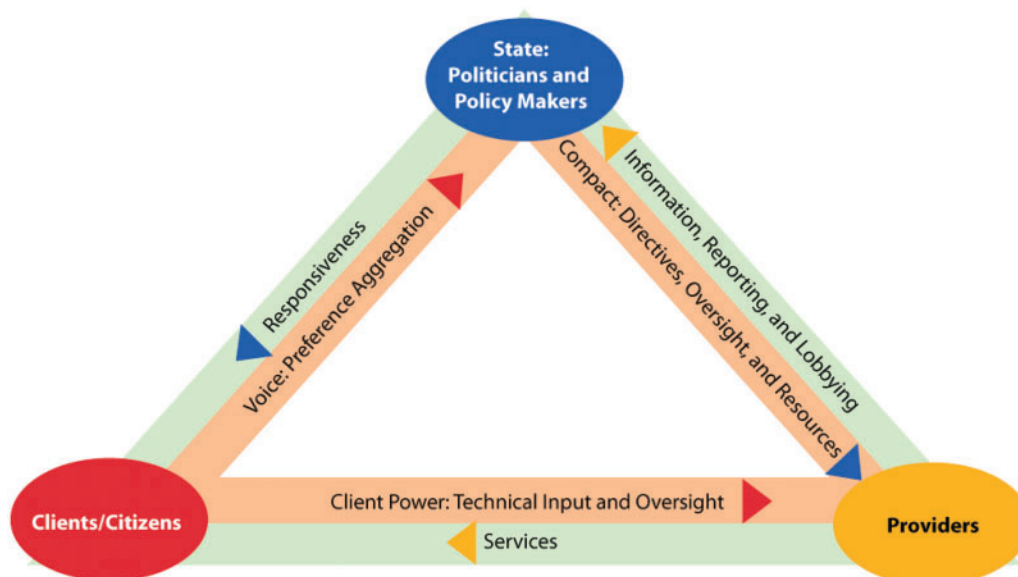


Figure 1 Health Governance Framework. Source: Brinkerhoff and Bossert (2008) adapted from World Bank (2004, 2007)

concerns may be sporadic, and powerful interest groups often resist changes.

Established health interests may be better able to deliver campaign support and votes than the general public. So democracies are not immune from the patronage and clientelism that characterize politics in authoritarian regimes. While health as a public good is not so easy for political patrons to employ as a reward to clients, the health resources they control or influence can be amenable to clientelist exploitation. Rewards can take the form of, e.g. the allocation of disproportionately generous funding to particular localities, the siting of specific facilities or channeling services to certain groups (e.g. urban elites and ethnic compatriots) over others (e.g. the poor, disadvantaged and politically powerless). The Brazil study demonstrates that the presence of effective monitoring institutions, in this case municipal health councils, can serve as checks on clientelism and corruption.

The governance interactions between 'state actors and providers' constitute the clearest expression of principal-agent relationships. Public policymakers, as principals, specify objectives, procedures and standards; provide resources and support; and exercise control and oversight relative to providers, who function as their agents. In exchange for the resources, providers carry out the agreed-upon desires and instructions of health policymakers. Principal-agent relations are subject to well-recognized problems—information asymmetries, moral hazard and conflicts of interest—that health system principals seek to address in crafting the directives aimed at providers. These directives determine various providers' roles and responsibilities, set parameters for accountability and influence incentives for compliance. Examples include health regulatory policies and procedures, auditing programmes (as in the Brazil case), financing mechanisms and provider payment systems, quality assurance, human resources policies, etc. Pay-for-performance is a tool that a number of countries are experimenting with to align accountability with health outcomes (see Ridde 2005; Eichler *et al.* 2007; Eldridge and Palmer 2009). The Lesotho case is an example; there, the government sought to employ performance-based budgeting (PBB) in public hospitals.

Accountability is not the only health governance relationship that connects the health ministry and related agencies to providers. There are linkages that provide knowledge and technical information, e.g. through medical education and in-service training. These linkages can also serve as transmission vectors for shared professional and medical norms and values, which can serve to promote goal convergence between provider-agents and their principals, in line with the stewardship model mentioned earlier (see Saltman and Ferroussier-Davis 2000; Van Slyke 2007).

'From providers to state actors', key governance relationships revolve around reporting: i.e. the provision of information for purposes of monitoring and accountability. In theory, such reporting reduces the information asymmetry problem, enables effective and informed oversight and increases the probability that agents will pursue principals' goals. The design of provider payment schemes is one example, and the China case offers some insights into the unintended consequences of payment reforms in practice. Besides accountability and motivation, another important function of the governance link between

providers and state actors is to furnish data for policy making. If health policymakers are to set direction based on evidence-based policy, then providers have a critical role as an important source of evidence.

As numerous analysts have noted, dealing with information asymmetries is an important piece of making health governance effective (e.g. Lagomarsino *et al.* 2009). Providers' privileged position in terms of knowledge and expertise also makes the provider-state linkage a political one. Providers are not neutral sources of information; they have interests and exercise voice and lobbying to influence state health policy and practices. Another problem affecting the state actor-provider governance link is that of attribution. In the complex, multi-actor realm of the health system, it is difficult to assess whose contributions made a difference, or whose efforts fell short. Health outcomes are the result of numerous factors, many of which are outside of the control or influence of providers or health ministries.

In theory, clients/citizens can convey their needs and demands for services—and their level of satisfaction—directly to providers, who in turn offer a mix of quality services that satisfy those needs and demands. Yet from an institutionalist perspective, the governance links 'from clients/citizens to providers' and 'from providers to clients/citizens' are fraught with principal-agent problems: power and information asymmetries, capacity gaps, accountability failures, perverse incentives and moral hazard (overconsumption of health care). As with the governance link from clients/citizens to the state, connections to providers to increase the alignment of the goals of principals and agents can be strengthened through collective action. For example, civil society organizations can exercise voice on behalf of service users, or village health associations can participate with health providers in needs assessments and community mobilization (e.g. Cornwall *et al.* 2000). Reforms that create health service markets and introduce competition among providers can enhance client power and increase provider incentives for accountability to service users, who have the ability to choose among providers, and/or whose views are incorporated into provider performance assessments that inform funding decisions, e.g. through service delivery surveys. Measures to reinforce the purchasing power of particular societal groups—such as, subsidies for the poor, elderly or HIV/AIDS affected—are another example of offsetting imbalances between providers and service users.

Health governance: challenges for reform

An ongoing debate among governance specialists is the extent to which the normative principles of good governance constitute a practical and realistic guide to reform in poor countries. This debate is relevant for health systems reform as well. Critics cite three key 'disconnects'.

First is the gap between the requisite capacities needed to act upon the good governance principles and the available capacities in many countries, especially fragile states (see, e.g. Berry and Igboemeka 2004). Health governance requires sufficient state capacity, power and legitimacy to manage the policy-making process effectively, to plan and design programmatic interventions, and to enforce and implement health

policy decisions made. Governance, whether in health or other sectors, depends upon facilitative institutional structures and procedures that enable policy adoption and implementation; the divided government literature, e.g. explores how presidential and parliamentary systems can create policy inefficiency and gridlock (see Elgie 2001). A major stream in the literature on decentralization examines the extent to which it facilitates responsiveness to citizens and enables efficient and effective service delivery (see Bossert 2008). The Brazil case analysis focuses explicitly on decentralization issues, looking at, among other factors, the impacts of local accountability institutions and intergovernmental transfers on the incidence of corruption.

Governance also depends upon the operational capacity of government institutions to function effectively in providing public goods and services, and in responding to citizens' needs and demands (see, e.g. Grindle 1997). At the most basic level, government needs the capacity to amass resources through tax collection and/or from donor agencies and to programme and allocate those resources effectively. Assessments of progress with global health initiatives, such as the President's Emergency Plan for AIDS Relief and the Global Alliance for Vaccines and Immunization, have highlighted such institutional capacity issues. Answering the question of what constitutes the collective set of requisite capacities gets at the heart of the 'good enough' governance discussion (e.g. Andrews 2008; Grindle 2007; Brinkerhoff and Morgan 2010). The Lesotho case confirms the dangers of seeking to promote 'best practices' where capacity is lacking; the author deems the effort to install PBB in the hospitals studied a failure partially due to weak implementation capacity.

Capacities among non-state actors are critical to the exercise of voice and client power, yet in numerous developing countries, civil society is weak. Social capital—trust between community members and local officials, knowledge and information sharing, and greater participation in voluntary organizations—has been shown to contribute to improved health governance and service delivery (e.g. Tendler and Freedheim 1995; James *et al.* 2001; Harpham *et al.* 2002). However, reformers too often make unrealistic assumptions about its strength. An example of an intervention to strengthen social capital in the health sector is a U.S. Agency for International Development (USAID) project that sought to improve health behaviours and democratic governance in Nicaragua by strengthening local leadership to build trust and expand participation (Bossert *et al.* 2003). Whether or not donor-supported civil society strengthening is effective in building social capital or fosters democratization is subject to extensive debate (see, e.g. Ottaway and Carothers 2000). A critical issue is the extent to which such interventions can lead to broader and sustained health system changes.

Second is the frequent disparity between formal governance 'on paper', i.e. what exists in laws, regulations, procedures and so on, and the extent to which these are actually put into practice or are supplanted by a less formal but no less real set of tacit rules. This gap can stem from both capacity problems, i.e. weak organizations, insufficient resources, non-existent and/or underskilled staff and poorly performing systems. Here again, the Lesotho case is an illustration: weak ministry capacity to manage the budget reform process meant that the intended formal changes in hospital governance were not implemented in practice. The Brazil case confirms the

importance of capacity; the analysis finds that effective municipal health councils were positively associated with reduced incidence of corruption.

However, besides capacity deficits, this gap can also derive from underlying sociopolitical factors that mediate health system actors' incentives according to *de facto* governance rules, rather than the *de jure* ones. As the China case demonstrates, many of the health reforms, which appeared far-reaching and significant on paper, were diluted and diverted by the *de jure* practices that shape interactions among political and technocratic elites.

Thus, the governance relationships in the health system illustrated in Figure 1 may operate in two different institutional spheres: the formal realm and the informal domain. Donor-supported HSS interventions tend to be situated largely within the formal governance system, and focus on idealized notions of good governance (see Grindle 2007). However, a focus on *de facto* governance can reveal a very different reality, where, e.g. service delivery and accountability are governed by principles of clientelism rather than of good governance (Brinkerhoff and Goldsmith 2004). George (2009) provides an example from India of the distortions that arise when actual practices related to health worker supervision bypass and subvert official practices, resulting in formalized lip service to accountability and creation of space for corruption and domination of health workers by political actors.

The third lacuna, related to the other two, is the neglect of power and political economy when considering health governance (e.g. González-Rossetti and Bossert 2000; Fox and Reich 2011). Governance is fundamentally about power. Although Figure 1 could be interpreted as portraying each category of actors as having equal influence and power, this is not the case. The degree of power and authority among the three differs substantially (Reich 2002). The state and providers for the most part hold more power (based on institutional and legal authority, information and expertise) than clients/citizens. The China case exemplifies a health system where state actors and providers have dominant power.

Where clientelism and corruption are prevalent, the less powerful who want access to services have strong incentives to do whatever the more powerful require of them. This is one of the lessons of efforts to reduce informal payments. As Lewis (2007, p. 985) observes, 'informal payments allow patients to jump the queue, receive better or more care, obtain drugs, or simply any care at all'. Clientelist relationships may exist as well between state actors and providers, where politicians and/or health ministry officials channel resources and favours to selected providers in exchange for political support. The Brazil case highlights the risks of such clientelist interactions at the municipal level for increased corruption.

Power distributions are also influenced by political systems, with more democratic governance tending to give increased power options to clients and citizens than more authoritarian systems. For example, policy processes tend to be restricted in more authoritarian regimes, making it difficult and perhaps counterproductive to involve NGOs and grassroots advocacy groups in the promotion of participation in health policy and management (Gómez 2006a). For instance, the Russian government is relatively hostile to civil society organizations,

making initiatives to combat HIV/AIDS difficult to develop with bottom-up lobbying (McCullough 2005; Gómez 2006b). Another example comes from Pakistan, where Khan and van den Heuvel (2007) document how semi-authoritarian political structures have limited broad participation in health policy making, and how changes in governments have disrupted health planning and implementation. In a similar vein, Israr (2006) discusses how a World Bank project to develop Pakistan's district health management teams was not as effective as it could have been in part because it was not able to influence the power dynamics in a 'culture of rigid bureaucratic traditions and behaviour'.

Contributions to the symposium

We have noted earlier instances where the three country cases reflect aspects of our health governance model and illustrate the governance issues we highlight. Here, we take a more detailed look at the symposium contributions. The three articles offer perspectives on health governance that vary from the national to the facility level and provide a geographic distribution across Asia, South America and Africa. At the national level, Ramesh, Wu and He present a broad assessment of the evolution of China's healthcare reforms from the 1980s to the present. Avelino, Barberia, and Biderman examine municipal-level management of public health resources in Brazil to explore governance factors that influence accountability and corruption. Vian and Bicknell look at facility-level budget reform in hospitals in Lesotho to assess the extent to which the introduction of PBB was successful in improving hospital governance.

Ramesh *et al.* recount the trajectory of China's health reform from a public-sector dominated health system in the 1980s to a mixed public-private one today. In their view, as measured in terms of health outcomes, responsiveness to patients and financial protection, the reforms of the 1980s and 1990s largely failed. Recent efforts to address these failings are ambitious, and seek to mitigate the negative effects of past reforms. Building on the model presented here, the authors' analysis of the governance linkages among government, providers and citizens reveals how privatization, increased provider autonomy and state decentralization sowed the seeds for the breakdown of insurance coverage, increased out-of-pocket expenditure, fragmented health policy, weakened government supervision and oversight and the dominance of provider interests.

Market reforms increased providers' (both facilities' and individuals') freedom to generate fee-for-service revenue at the expense of patients and of government efforts to manage health costs and achieve health outcomes. Ramesh *et al.* note that because the power of Chinese citizens to pursue collective action to influence provider behaviours or government policy is low, effective reforms must rely predominantly on the capacity of health policymakers to craft incentives, design service delivery and financing programmes and manage regulatory regimes that can rein in the dominance of providers. To date, such capacity is limited, and the authors are cautious regarding the potential for success of the latest wave of reforms absent more explicit consideration of how power differentials and incentives affect governance. Among the interesting governance

aspects of the China case is that although the collective action options for citizens are relatively limited, nonetheless the government has paid attention to public opinion polling and has sought to mitigate the possibility that dissatisfaction with health (and other) services could contribute to resistance to continued Communist party rule.

In contrast to Ramesh *et al.*'s wide-ranging governance assessment of China's health system, Avelino *et al.* undertake an in-depth institutional analysis of accountability for health resources, decentralization and corruption in Brazil, using quantitative audit data from a sample of 980 municipalities. They develop a regression model that unpacks the effects of a set of sub-national governance variables related to accountability on corruption in health spending. They examine the impacts of free and fair municipal elections, as a measure of vertical accountability (between citizens and elected officials); and of the management capacity of municipal health councils, as a measure of horizontal accountability (across institutions with public oversight functions). To measure fiscal decentralization, they employ a variable on the extent to which municipal health expenditures are funded through federal intergovernmental transfers.

Avelino *et al.*'s findings reveal the importance of governance arrangements for health corruption outcomes. Strong electoral competition offers a check on clientelism and corruption through creating incentives for monitoring the performance of elected officials, and for those officials to fulfil their functions honestly and effectively. Capable health councils are associated with lower levels of corruption as well, indicating the significance of local oversight and decentralized accountability institutions for sound financial management of health resources.

The article by Vian and Bicknell explores issues of transparency, accountability and performance incentives in financial management reforms in Lesotho hospitals. They trace the fate of donor-supported efforts to improve the efficiency and effectiveness of hospital governance—planning, budgeting, reporting and decision making—through the introduction of PBB. Focusing on four hospitals, their study measured progress in reform implementation along four dimensions: existence of performance-based plans, existence of performance-based budgets, evidence of performance monitoring and reporting and evidence that management decision making used performance data for resource allocation and accountability. They found only limited progress in implementing PBB reforms, with the highest relative advances in performance-based planning and the least in managers' use of performance data for decision making and oversight.

Vian and Bicknell attribute the failed reforms to a number of factors. First, the PBB reforms depended upon a level of capacity in data collection, information processing and costing of services that far exceeded what was available in the hospitals or the health ministry. Second, the formality and technical rationality of the PBB reforms clashed with the informal governance practices that had evolved over time to cope with the capacity gaps. Third, the dysfunctional nature of the principal-agent relationships among ministry and hospital actors (e.g. mistrust among staff, professional silos and weak leadership) undermined the motivation and incentives necessary for the PBB reforms to succeed. They conclude with some cautions for how international donors and health policymakers

in assisted countries address governance and HSS: build ownership for reforms prior to and during the implementation process, and avoid overambitious and unrealistic good governance agendas.

Applying the health governance model

The health governance model presented here reorients the WHO task/function perspective inherent in the health system building blocks towards an actor-driven focus that concentrates on the nature of the principal-agent connections among actors as key elements of governance and contributors to health system performance. The articles in this symposium employ the model to varying degrees. Ramesh *et al.*, in their macro-level analysis of China's experience with health reform, do so most explicitly and comprehensively. They describe each of the actor categories and assess the linkages among them, and their graphic illustrations of the evolution of the Chinese health system (Figures 3 and 4) mirror our Figure 1. Their analysis stresses two principal-agent relationships: between client/citizens and the state and between the state and providers. Regarding the first, the case shows that the Chinese public, although lacking political power in a formal democratic sense, expressed sufficient dissatisfaction with health services that the government put health reform on its agenda. Regarding the second relationship, however, the combined effects of weak management capacity and the bureaucratic self-interest of the Chinese party-state, reform implementation did not significantly reduce the power of providers.

Avelino *et al.* focus on these same two principal-agent relationships from the model in their analysis of municipal corruption in health spending in Brazil. With the power that comes from competitive elections, citizen voice was effective in limiting the incidence of clientelism and corruption in municipalities. Regarding the state-providers relationship, the strength of Brazil's federal government oversight, which derived from expenditure auditing, was important to the creation of structural incentives to limit corruption. The information generated by the federal auditing programme contributed to overcoming the information asymmetry that strengthens agents relative to principals. Avelino *et al.*'s analysis, supported by their use of quantitative methodology, also points to the creation and nurturing of municipal-level oversight capacity as important for addressing principal-agent issues locally to improve governance.

Vian and Bicknell's micro-perspective selects a single principal-agent relationship from the model in their analysis of hospital reform in Lesotho: the state-provider linkage at the facility level. Their case illustrates ineffective communication between principals and agents; the study's interviews revealed that hospital staff could not articulate, and did not understand, the features of the budget reform that the health and finance ministries sought to implement. In their discussion of possible remedies for the failure to implement PBB, they raise the principal-agent link between citizen/clients and the state, suggesting that popular demand/voice for accountability and provider performance could have helped. Complementing the Brazil case findings regarding effective municipal health councils, Vian and Bicknell's analysis further articulates the

importance of management capacity for exercising governance in the health sector.

The three cases provide a variety of insights into the health governance linkages among the state, providers and citizens, and the actions and behaviours that those linkages motivate. They are obviously a selected and small sample of health system reforms. However, taken together, these analyses offer some provisional and indicative confirmation of the utility of a governance lens for understanding the relationships among health system actors at multiple levels, from health system to individual facilities; and for diagnosing underlying incentive and performance problems that derive from governance structures, processes and practices. They demonstrate the need for increased knowledge of institutional capacities, power distributions and socio-political drivers to identify the consequences for health systems of governance policies and institutional arrangements.

Each of the actor nodes in the model (state, providers and client/citizens) contains a vast amount of variety; and the governance linkages in health systems, and the outcomes they produce, are contingent rather than guaranteed. Future research should address the relationships in the model and the situation-specific context of a particular country's health system, which influences what can be achieved from the design of health governance and HSS strategies. Additional investigation is called for specifically to address health system reform implementation, capacity development, and effective donor interventions, building on the already large literature on these topics beyond the health sector (see, e.g. Booth 2011; Brinkerhoff and Morgan 2010).

Gaps remaining

The current concerns with country ownership and sustainability emerging from global health initiatives have raised the profile of health governance as an element of HSS that requires attention if reforms are to take root. The good news is that more HSS analysts are paying attention to health governance. The model presented in this article, e.g. has been used to inform USAID-supported health systems assessments in more than 25 countries. Other efforts to clarify the meaning of health governance and trace implications for HSS and performance are emerging (e.g. Siddiqi *et al.* 2009; Savedoff 2011).

This symposium has sought to contribute to such clarification and to the design and implementation of interventions that can lead to sustained health systems performance, and that can balance the pursuit of good governance with realism regarding feasibility and incentives for change. The health governance model presented here and the accompanying country analyses aim to move the governance and HSS dialogue in the direction that Grindle recommends: away from 'the answer' to governance and performance problems, towards tools and guidance that enable the determination of 'an appropriate response to a given problem in a specific context' (2011, p. 417). Understanding health governance in terms of principal-agent dynamics and the incentives that they create is a step in this direction.

No model, however, can serve all purposes equally well. The model we have presented, along with the accompanying country cases in the symposium, focus on analysis and diagnosis of health governance problems and illumination of

their principal-agent dimensions. The model and the cases have less to say about specific remedies and practical guidance. While the governance dialogue is moving beyond 'best practice' to 'best fit', gaps remain in identifying both the socio-technical content and the political processes involved that will inform effective, context-specific interventions (see Booth 2011). Filling these gaps is a major challenge for HSS in the future. Our above suggestions for future research aim to contribute to confronting this challenge.

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