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Journal of Quality in Health care & Economics
ISSN: 2642-6250

Contemporary Health Policy and Management: Challenges Remaining

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Review Article

Volume 5 Special Issue 1

Received Date: May 31, 2022

Published Date: June 09, 2022

DOI: 10.23880/jqhe-16000S1-004

Abstract

The essay explores the broad outlines of the main barriers/enablers to health policy and management in the prevailing biomedical model from the late 19th century to the present. Based on this analysis, it proposes the modernisation of political leadership and multisectoral integration as key determinants of a resilient, holistic and equitable health system for the 21st century. The methodological process was based on the review and critical analysis of the relevant literature on the topic and the author's experience. We conclude with a call for reflection on the need for a clear understanding of these elements for a new vision of health policy and management.

Keywords: Health Policy; Health Management; Political Leadership; Multi-Sectoral Integration

Introduction

A health system is the result of multiple interactions developed by numerous and diverse actors, through a set of organisations - public and private - that share a set of complex and dynamic values and principles with the aim of improving, maintaining or restoring health; as well as providing sustained, equitable and supportive solutions to people's needs and choices regarding the quality of life conditions related to their right to health [1].

In this context, government policy on health - along with related policies on issues that affect health, such as education, employment, food and transport among others- provide the guidelines for identifying problems, defining priorities, proposing alternative solutions and setting a course of action to mitigate inequalities in the health/well-being of the population.

Health policies can facilitate new opportunities for health improvement through technical and social processes to achieve their objectives through effective and efficient use of resources taking into account social, economic, political and cultural realities (Adindu A) [2]; but they can also hinder progress because considerations addressing strategy, governance processes, as well as bureaucratic decisions tend to be more complicated to implement and are less taken into account than other processes in policy development and management [3].

Today, in spite of the expansion of public action in many nations to try to promote and preserve health, inequalities persist belligerently within both industrial and non-industrial societies. The health policy and management framework that is being developed is neither fit for purpose as set out by the International Organizations nor appropriate to the problems and challenges of multidisciplinary public health development in the 21st century [4].

We still find ourselves with a system of „medical care" so strong that it creates a fusion with „health policy" that is sometimes impossible to break and therefore unable to

reinvent the logic of health systems through the search for strategies, from which to respond to the complexity posed by the social determinants of health, to apply scientific knowledge and resilient organisational skills, and to generate new knowledge, methods and programmes [5].

In this short manuscript we do not pretend to be exhaustive, but rather to describe the main problems that still persist in the policies and management of the system in this first quarter of the 21st century, we will try to give our vision of how to untangle the two main Gordian knots that, in our opinion, determine the barriers/facilitators to achieve a change of the „status quo" and return to the future in the policies and management of health systems.

Method

Based on our expertise, we conducted a review of the traditional literature to identify some of the main academic contributions in the fields of health policy and health management. We identified articles for review and articles that show the importance of interests, ideas and institutions as explanatory variables influencing health policy outcomes and the role of health management. Relevant literature was mapped by theme, synthesised, and critically reviewed. The process was iterative and concluded once a clear understanding emerged of the elements for a vision on Health Policy and Management based on the evaluation of past experiences.

The Persistent Barriers

Public health policy has implications for human health and focuses on the promotion of health, the comprehensive protection of the individual and the community from the risks of disease, and the promotion of the health of the individual and the community as a whole. diseases and, ultimately, the well-being of the population it serves. This is why the complex interaction between existential threats, new political ideas, strategic interests and institutions caring for the well-being of individuals and populations makes it impossible to separate the elaboration of public policies from effective management to improve the quality of life, and vice versa.

But this is not always the case. Since the end of the 19th century, management has been based on germ theory, and subsequently, despite the political discourse of the reforms of the 1980s and 1990s, it has consolidated its expansion towards a biomedical model that is still prominent today with all its technological power [6].

The policies developed up to the present and the way in which health problems have been framed within the management have prioritised a technically sophisticated system of disease care as policy makers have, at different times, given greater emphasis to the provision of curative care. This is why most of these efforts are preferably devoted to building, expanding or modernising hospitals, supporting the training of health professionals, and funding medicines and biomedical research; despite their limited approach to the challenges faced by the population [7-11].

In this sense, summarising the main problems in policy and management that have maintained the status quo of health systems in the first quarter of the 21st century - both in high-income and low- and middle-income countries - we find firstly that health policy analyses generally involve a narrow and selective range of criteria and contribute to maintaining the system within existing structures and practices, to the exclusion of other experiences and perspectives. Such analyses restrict the ability to identify innovative solutions beyond actors and organisations with particular dimensions and interests linked to dominant circles, and when it is required to involve other non-governmental actors and the community, it is perceived as marginal to public health outcomes and therefore not worth investing in developing a working relationship [12,13].

Secondly, there is often a lack of evidence on how best to facilitate successful implementation beyond medical care. The capacity of State actors and organizations that create the drivers of change processes in health systems to respond to the and diversity of the population, do not always have experience in selecting and implementing appropriate interventions related to the social determinants of health, and have therefore had difficulties in meeting commitments to collaborate and work together to promote health [14].

This creates a third barrier: government messages in public health remain ambiguous at best, and lack evidence of real, felt needs for organised communities [15], so it is unlikely that the professionals who manage them will feel sufficiently empowered to seize any opportunities for change towards participatory approaches, and spend more time on increasing medical care coverage and reducing the financial deficits that lead to interventions.

Fourth, the gulf between national commitment, formal action and slow progress contributes to strengthening dilemmas in which the momentum of formal transformations and structural reorganisations is undermined by the lack of power resources of the lead entity - the ministries of health - to drive the required transformation in systems. The result is a hodgepodge of interests, organisational confusion and well-intentioned but unbalanced allocations, with no coherent direction on a common course of action and unequal resources available in the hands of those who

effectively hold the resources of power [16].

In addition, the lack of greater political ambition to improve synergy between health policy and other economic and social policy objectives has perpetuated the organisation and management of „specialised silos“ in highly complex medical care facilities, whose managers have comfortably defined their own mission parameters, through professional development and behaviour, through legislation, through networks of epistemic communities, through the establishment of hardware, and through the development of complex research and systems development. The result is multiple decision-makers on a given medical issue, diffusion of responsibility and accountability, delays in decision-making, and unresolved conflicts over issues involving other health-related sectors, which limit the impact of health promotion strategies [17].

In our view, these problems have exposed two types of Gordian knots: political leadership, i.e. the strategic role that actors play in ensuring that changes are sustained in changing political circumstances; and the disintegration of care, not only in terms of coordinating response, but also in mobilising management to develop anticipatory and planning capacities.

The Change Needed for the Common Good

Sustained policy and management change that favours investment in a holistic and equitable manner calls for urgent, effective, organised and sustained efforts to achieve resilient political leadership and a multi-sectoral bureaucratic change [18]. This is important to: a) address the challenges of adapting to power and interests of all kinds; b) mediate the policy process to ensure that it is accepted and implemented by all; c) improve connectivity between different levels of policy making, sectors and actors; d) strengthen the capacity of society to respond to the problem caused by the social determinants of health and anticipate long-term impacts and; (e) increase the adaptive capacity of governmental and community governance networks. Political leaders, along with public servants, academics and even private corporations, need to co-learn and co-create solutions within communities; but this will require a broadening of thinking, and the need to move from a reactive to a proactive approach, all in the context of equity and addressing problems holistically [19]. Achieving these goals will require, first and foremost, new actors, mechanisms and tools that take a whole-of-government and whole-of-society approach rather than predetermined top-down responses.

In this sense, leaders must care for followers by enhancing the integrative forces between them. They must also be aware of the importance of adaptive structures and effective and efficient decision-making processes for the achievement of goals and outcomes supported by change towards a culture of health/wellbeing, within organisations and the community in particularly. This includes facilitating cultural change in industry to openly discuss and reach transparent agreements around issues that benefit public health such as the right to housing, decent employment, healthy food and a decent standard of living [20].

Secondly, the relevance and the way in which information is processed and analysed for decision-making depends on several different mutually supportive factors, including a diverse workforce that recognises and embraces social determinants in public health, adequate training and educational opportunities, and an enabling political and policy context that fosters a broad perspective on health [21]. Health leaders must not miss this opportunity to build a common language of goals and solutions to compare trade-offs within and across sectors to address current and upcoming challenges, as well as to encourage institutions to synthesise, build and share knowledge about which health policies work and which do not, rather than trying to duplicate actions [22].

Third, it is an imperative effort for policy leaders to dedicate resources to facilitate community engagement, create platforms for citizen interaction and facilitate successful collaborations or partnerships within the health sector and beyond. However, addressing issues of power relations, developing trust with the community and understanding the political, social and economic contexts in which initiatives are supported requires skill in the use of methodological tools to integrate utilitarian purposes with social justice and mobilisation and collective action with empowerment [23,24].

As policy leaders consider new and effective ways to plan, implement, monitor and evaluate programmes that engage the meaningful participation of diverse groups of citizens, evidence can add clarity to the process and validate the development of comprehensive policies. Policy leadership in health must foster the consolidation of community networks based on social solidarity and two-way trust that can generate analysis, share knowledge, and bring pressure and legitimacy to bottom-up policy-making [25,26].

Finally, one of the most delicate, daunting and defining experiences for all political leaders is that of introducing institutional and structural change with long-term initiatives in health systems - especially in regions where political cycles are short - although there is broad consensus on the seriousness of a public health problem and the desirability of government action, the overall direction of policy is out of their hands and dependent on much broader trends in

economics, social norms and parties' attitudes. For policy innovation on a larger scale, skilled policy leaders must be prepared to: a) see conflict and ideologies as intrinsic elements of policy formulation and as determinants of government action and inaction; b) understand the political determinants of plans and programmes; c) anticipate and diagnose power-related problems in policy implementation and performance and; d) consider how programmes should be evaluated and refined over time [27].

In terms of the necessary systems management, the most advanced - or evolutionary - organizations share common characteristics: they are decentralised, collaborative and adaptive; and they operate from trust rather than fear, which gives them greater capacity to manage complex situations. These qualities are fundamental for bottom-up integration between communities and the organisation and horizontally within organisations. In that sense, public institutions should seek to implement management that is supported by cluster-like communication networks between all administrative levels and not be entrenched in the traditional hierarchical form [28].

Strong integration across institutional silos, policy areas, levels of government and with the organised community requires the development of planning that recognises the variation and flexibility of programmes, but above all provides clarity of purpose and shared responsibility. To this purpose, the essential management practice that must be harnessed from the beginning is the construction of an agenda that prioritises common values and goals to improve the quality of life and situate health in the policies of different sectors, seeking ways to help other sectors achieve their goals [29].

To ensure that priority setting is legitimate in both dimensions, management must be guided by principles that include: transparency to openly report on processes, decisions and outcomes; responsiveness; accountability; efficiency; and; fair distribution of resources. Putting these principles into practice can serve to engage everyone [30]. Successful adaptation approaches have pointed to the importance of engaging change entrepreneurs that include both formal (e.g. government officials) and informal (volunteers and community leaders) servants. Some entrepreneurs are more adept than others at these strategies, but teams can seek to develop capacities that encompass these techniques [31].

A key component of developing successful multisectoral management in health is that the capacity and skills of actors - at local, state and national levels - create a virtuous circle with the type of leadership. This process of attitudinal change depends on several different mutually supportive factors, including a diverse workforce that recognises and embraces its convergent role, adequate training and educational opportunities, and a favourable policy and regulatory context that encourages a broad public health perspective. The binomial between multisectoral management and resilient leadership also requires, among other elements: complex theoretical and methodological debates between disciplines, realignments of power and influence within the community, open-mindedness combined with rigour about health inequalities among those trained in public health practice, and the development of accessible mechanisms for participatory action-research to support and provide adequate and timely feedback [32].

But the central substance for reducing health inequalities must focus on strategies for incorporating organised community networks into governance structures. Over and over again, local organisations and networks have proved to be far more adaptable and responsive than government agencies when government actors help them build community ownership, collective efficacy, community capacity and competence; and vice versa. In this sense, effective management must take into account the interactions between the multidimensionality of social capital, actor dynamics, time, contexts and underlying psychological mechanisms to drive teams to form a productive movement that accelerates health system outcomes and transformation [33].

Conclusion

From the end of the 19th century to the present day, a highly specialised biomedical model has been consolidated. However, the complex interaction between existential threats, new political ideas, strategic interests and institutions caring for the wellbeing of individuals and populations, force to transform the health system and change its central objectives: today, the priority of policies and their management should focus on providing sustained, equitable and supportive solutions to people's needs and choices around quality of life conditions related to the right to their health in order to improve, maintain or restore health; and not the other way around. This special volume of the Journal of Quality in Health Care & Economics focuses on health policy and management for the 21st century, a dynamic that should lead to further debate and reflection on how to move forward with greater urgency, drawing on the lessons learned from the COVID-19 syndemic.

Health policies and especially the management of health systems have led to a series of barriers that impede the proposed evolution. These barriers range from the difficulty of identifying innovative solutions through the analysis of evidence in order to develop strategies and actions, to the weakness of leadership in driving the major transformations required. In our view, these barriers are concentrated in two

Gordian knots: the type of political leadership and multi-sectoral disintegration.

Resilient political leadership will demand new actors, mechanisms and tools that adopt a whole-of-government and whole-of-society approach in order to incorporate all actors with diverse ideologies in policy formulation and government action; institutionalise the social determinants of health in plans and programmes; understand the imperative to participate and share power with organised communities; and; consider that health equity and well-being are long-term goals to be achieved.

Health management that supports holistic and equitable investment in the coming years will require adaptive structures and integrated multi-sectoral decision-making processes to improve people's quality of life; the support of institutional and community networks rather than single-person services; and organisation under principles of transparency, multidisciplinary responsiveness, shared accountability, efficiency and fair distribution of resources. But, above all, it must generate a virtuous circle with resilient leaders.

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