

## **Public Health, Health Ministries, and Governments: In Juxtaposition? Possible Strategic Approaches for the Road to Success**

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For Public Health approaches to have strategic impact, a vigorous and systemic approach is critically needed. This paper addresses three component parts, essential to achieving health system change. First, it paints a picture of the current approach in many Ministries of Health, with their strife of interests. Second, it distinguishes the elements of a health system, all of which need to be targeted and synergy achieved for effecting health system development. Third, it proposes additional competencies that Public Health experts need if they are to lead and contribute to needed health system change for achieving the promise of Public Health's potential.

### **Health: "A Strife of Interests"**

Public health has been characterized, in this decade, by attempts to revitalize its approach, including the creation of a new self-description: "New Public Health." However, public health operations often remain relatively narrow in their approach, at a time when a vigorous and systemic method is critically needed for public health interventions to have strategic impact.

The health system is characterized by a "strife of interests," reflected in organizational structures of ministries, where structures are used to perpetuate territorial demarcation. Many public health divisions in ministries continue to operate so that a centrifugal force is created, ensuring diminished strategic linkages within and across ministries, and, unfortunately, this practice is not confined to public health. However, public health divisions have the knowledge base to assume a leadership role in a "cross-cutting approach." Building a strong public health culture within their own team and among fellow public health practitioners interna-

tionally advances their own scientific thinking and, therefore, benefits specific public health issues. This approach can mitigate against strategically influencing the entire performance and focus of a country in advancing public health. In other words, a failure to strategically influence health system development can result. If strategic influence within a ministry is unsuccessful, then the strategic advice from a ministry to the government will be unsuccessful as well.

### **Ministries: Focused on Health?**

In the mid-1980s, a paper was published in Australia that posed this question: "If Health Departments aren't functioning to improve health, why are they there?" For me, this question resonated. At that time, I was the Assistant Secretary for Health in the Commonwealth Department of Health in Australia, my first formal foray into the bureaucracy. I had held the position for twelve months and had seen little evidence of anyone talking about health, other than one section that vigorously focused on what we, in Australia, then called "Better Health." However, no linkage existed between their work and the work of others, including my work. Certainly, no obvious linkages between the Better Health approaches and health financing were being achieved. The remainder of the department (or ministry) focused on their own tasks in a segregated manner, with no strategic linkages to the Better Health section, although the senior management probably desired collaboration. In other words, we were not required to prove that our work contributed to the goals of Better Health, and no system initiative stated that Better Health goals were the strategic intent for our work. Hindsight is a wonderful thing.

### **Chief Executives: Public Health Input**

I believe that the leaders of health ministries are critical for achieving system reform. A great deal of evidence on the importance of leadership supports this belief about their role. While the ultimate policy leader of any health system reform is government, the ultimate catalyst for achieving policy change is the government's "operational arm," led by the Ministry of Health and including partnerships, especially with the community.

Many titles are designated for the leaders of health ministries across the world; for simplicity, they can be called "Chief Executives." What are their backgrounds? Generally, their experience and education vary greatly. While my background is in health, and originally in nursing, I have essentially evolved into an "expert" in policy, strategy, leadership, and change management. These skills have enabled me to focus on holistic system development and organizational development. Other Chief Executives have included an accountant, a former political advisor and journalist, a former anesthetist specialist, a former specialist physician, a health economist, and a lawyer.

None of these people are intrinsically experts in health; indeed, one newly appointed Chief Executive has a forestry background. Is he any better or worse than the anaesthetist specialist who became the Chief Executive? Opinions will clearly differ. However, our culture's norms (of conflict of interests) mean that very few Chief Executives, even with a health background, are able to take a comprehensive view of their population's health and devise rigorous strategies to target needs, within a strategic framework, to cause real health improvement. Indeed, some people think that scientifically trained personnel make the worst Chief Executives of ministries, precisely because their attitudes have been molded towards inductive thinking, while deductive thinking is a hallmark of leading system change. It is prudent, however, to remember that deductive thinking requires influence by inductive thinking, if complex system issues are to be confronted, and system reform achieved.

### **What Does a Chief Executive Expect?**

A Chief Executive looks for, and needs, strategic advice from expert staff. "Strategic" means purposeful but linked, directed to an end with incorporation of contextual issues and realities (the system issues). A Chief Executive's time is consumed with many matters, including government interaction. Some of the matters are, often, not strategic, regardless of the effort one expends trying to avoid those that are not. The higher up the management ladder a person climbs, the more reliant he or she becomes on a synergistic and trusted senior team to provide the appropriate advice. Chief Executives cannot do everything themselves, nor should they. For most innovative people, a controlling Chief Executive stifles their innovative and creative abilities; some innovative people have described this personality aptly as "soul destroying."

However, in my experience, public health experts, innovative or not, largely remain within parameters described by the organizational chart (like many other experts in ministries). An organizational chart these days should be seen simply as a way of drawing up specific responsibilities and should no longer permit accumulation of bureaucratic and territorial fiefdoms. In other words, an organizational chart does not describe internal processes, values, and culture.

In Australia, the states of Tasmania and Victoria share similar portfolio responsibilities, based on determinants of health and well-being. These responsibilities encompass acute health services of public health, community support services ranging from child protection to domestic violence and public housing. Both states' ministries have departments known as "strategic development divisions." These divisions are essential for integrating activities, acting as change agents across the ministries, facilitating linkages, preventing overlap, and ensuring invigorated planning. No doubt, many other divisions would like the relative power to assert their interests as the dominant ones, but this is not the agenda of strategic development divisions. In fact, the reverse is the case.

If the New Public Health was a reality, public health experts, in my view, could have filled this void. I think that, in the twenty-first century,

public health experts will have a strategic responsibility that could, and should, encompass an entire department or ministry. This concept does not imply that they should have the responsibility to manage the whole ministry or become the dominant power. Instead, the implication is that they have an ethical, expert, and business responsibility to advise, facilitate, envision, and demonstrate (through evidence) the needed changes in policy focus and approach and to assist in achievement measurement.

The information that public health experts need to provide for Chief Executives are much more strategic than the information presently provided. More relevant questions should be asked: How can we measure health? How do we learn from our increasing knowledge of the determinants of health and well-being? What strategies and methodologies can we use to produce a gap analysis? What does this gap analysis demonstrate, when measured against our current policies and ministry emphasis? How is the emphasis of other ministries impacted? What is the HR department doing to refocus health workers? What are universities teaching, not just in MPH programs, but also in schools of medicine, nursing, health economics, and business schools (with health electives)? What actions are hospitals taking in targeting services that achieve the greatest benefits when measured in Disability Adjusted Life Years (DALYs)? How are hospitals promoting public health when they have a captured audience of patients and their families, as well as when they are the focus of communities and politicians? Have we spent excessive time complaining that hospitals spend too much, while we could be slightly resentful of the public and political focus on them? Have we missed opportunities to become allies with hospitals? Where are community health services focused? Where in the ministry is anyone focusing on Quality Adjusted Life Years (QALYs) or ethics? Where is the evidence that the millions of dollars poured into health have actually been used wisely? How should governments be best advised on health policies? Where is the public health expert when the Chief Executive is struggling to advise governments as they, in turn, juggle budgets, as well as community and internal political interests—

their own strife of interests? Where is the globally consistent public health strategy for giving information on comprehensive, system-wide approaches?

### **Leadership and Power versus Influence**

In these areas, public health experts can assume leadership roles; however, a difference exists between power and influence. When the term “New Public Health” was coined, its architects, undoubtedly, created it for noble reasons. However, a great deal of this international anticipation involved aspirations of a potential renaissance of power. In my view, the new term should have been an inspiration to strengthen operations at strategic levels of wisdom, as well as advice to influence and provide leadership to achieve health system reform. Many public health experts are outspoken about such issues as smoking, decreased fish in rivers, malaria, and tuberculosis. Often, in my experience, these experts do not view their responsibility as encompassing strategic health system issues, and when they do understand this, the necessary knowledge base to provide the advice is lacking.

A ministry’s Chief Executive needs to be equipped with knowledge about HR development, strategic planning, financial management, technology information advances, hospitals, community-based care, home care, and primary health care. When attempting multi-sectorial approaches to public health, as in Tasmania and Victoria in Australia, new knowledge must be acquired. A Chief Executive, therefore, absolutely relies on a trusted and innovative team in order to achieve a successful ministry.

### **Strategic Intent of Government and Ministries**

The strategic intent is the critical focus of any successful organization. Public health experts serve as an essential component of the Executive Management Team, assisting in the clarification of the strategic intent. They should facilitate linkages and provide insights and methodologies to ensure that sound policies are used throughout the ministry. They should provide the quality assurance needed to guarantee that all functions of the ministry are focused toward achieving their stra-

tegic intent. This strategic intent should be measurable improvement of a range of "cocktail measures" used for improving the public's health.

These "cocktail measures" should enhance and progress beyond the current approach of MMR and IMR, weighing factors, such as poverty, education, gender, GNP, employment, housing, air and water standards, food adequacy, sanitation standards, health services and financing, unemployment, and equity and access. Disaggregation of these "cocktail measures" allows enunciation of problems and policies in service areas, as well as in other portfolio areas. These "cocktail measures" could, therefore, provide the strategic intent for the entire government, so that national policies can be developed for ministry implementation. Government could then focus on its primary aim: to immediately improve people's quality of life and establish strong foundations for future generations.

Instead of collaborating to achieve common goals, we have perpetuated our conflict of interests. "Turf battles" have occurred between environmental and public health ministries, as well as between hospitals and public health offices. In human services departments, these "turf battles" exist between health and community services, and health and public housing, with each area promoting its own interests. In my view, if each area's goals were focused on "cocktail measures," a powerful change strategy could reorient ministries and governments towards clear partnerships for achievement. Then, debates would have less emphasis on structures (Where do we fit in? Where should we be?) and more emphasis on processes and partnerships for outcome achievement. When these commitments have been made, organizational structure decisions occur easily. Such a focus demands internal ministry linkages and linkages between ministries, as well as with local governments, the private sector, and non-governmental organizations. A fundamental change in the techniques used for ministry involvement and consultation with local communities is also required.

A focus on organizational structures can create rigidity, causing denial of processes and outcomes. For example, in one country, the road accident rate increased, becoming a major cause of morbidity and mortality. The response of international

health agencies in that country was that they were allowed to work only with the Ministry of Health, and they were not responsible for road accidents. I, personally, had a similar experience: I was told that the Ministry could not even initiate contact with the responsible department. Thus, while we discuss partnerships and linkages, many ministries have cultural norms that resist these collaborations.

The most intellectually and operationally challenging preventive health issue is war and civil strife. The health cavalry delivers excellent services during and after wars, but, in spite of evidence that war is a leading cause of morbidity and mortality, we do not consider it our responsibility to prevent war. We argue vociferously about poverty, tobacco and malaria prevention; perhaps our next major challenge should be to develop arguments to prevent war and civil strife - the ultimate public health issue for some communities, as well as a prime cause of poverty and an instrument for health deterioration.

### **Health System Reform and Development**

A comprehensive and integrated approach is needed for health system change. What are the elements of health system reform and development? How do all health professionals clearly contribute to sustainable health improvement, and what are our targets? How do we ensure a comprehensive approach in all pertinent areas? An understanding of the specific system elements that need strengthening or changing is required, if sustainable health improvements are to be achieved. These elements must be targeted within the framework of health determinants and must be the focus of our "cocktail measures." These measures will provide the information needed to develop focused policies, strategies and services, progress assessment, and achievement evaluation.

Figure 1 shows the elements of a health system and some of the sub-elements that shape and influence our success in achieving health system improvement. Most current approaches often target one or two of these elements or sub-elements, but common sense, physics, and management theory indicate that when one element is changed, a change, intended or unintended, is created in another aspect of the system. This model provides

**Figure 1: Health System reform and Development**

<p><b>Contextual Scan</b></p> <ul style="list-style-type: none"> <li>• Politics</li> <li>• Values</li> <li>• Stakeholders</li> <li>• Environment</li> <li>• Geography</li> <li>• Burden of disease</li> <li>• Health needs</li> </ul>	<p><b>Activities</b></p> <ul style="list-style-type: none"> <li>• Policies</li> <li>• Strategies</li> <li>• Services</li> <li>• Research</li> <li>• Monitoring</li> <li>• Evaluation</li> </ul>	<p><b>People in health</b></p> <ul style="list-style-type: none"> <li>• Workforce policies</li> <li>• HR policies</li> <li>• Attraction, recruitment, retention</li> <li>• Motivation</li> <li>• Attitudes, behaviour</li> <li>• Qualifications</li> <li>• Competencies</li> </ul>	<p><b>Money</b></p> <ul style="list-style-type: none"> <li>• Health Financing: equity, access, affordability, incentives</li> <li>• Efficiency</li> <li>• Budgets: management and accountability</li> </ul>
<p><b>Organizational Development: to create the synergy and strengths to achieve change</b>                  leadership development; management development; co-ordination &amp; efficiency; organizational culture of innovation &amp; partnerships; change management; enhanced communication; strengthened thinking capacity</p>			
<p><b>People in society</b></p> <ul style="list-style-type: none"> <li>• Expectations</li> <li>• Rights</li> <li>• Our 'product'</li> <li>• Its price</li> <li>• Its promotion</li> <li>• Its availability</li> <li>• Our processes</li> <li>• Quality</li> </ul>	<p><b>Assets</b></p> <ul style="list-style-type: none"> <li>• Investment</li> <li>• Maintenance of value</li> <li>• Return on investment</li> <li>• Management accountability</li> </ul>	<p><b>Information Management</b></p> <ul style="list-style-type: none"> <li>• For evidence</li> <li>• For monitoring</li> <li>• For evaluation</li> <li>• For accountability</li> </ul>	<p><b>Vital Signs</b></p> <ul style="list-style-type: none"> <li>• Evidence of 'doing good' and 'doing well'</li> <li>• "Cocktail measures" based on determinants of health &amp; well-being</li> </ul>

Source: Brian Lewis, 1998, Adapted by Gillian Biscoe, 1999

a framework to analyze the impact of a proposed change and to enable a more comprehensive approach to health system reform and development.

### Public Health Competencies in the Twenty-first Century

Senior-level people working in health fields will need leadership ability, strategic thinking and planning capacity, flexible management skills, and enhanced communication ability. Many other skills, including the development and use of effective and efficient measures, are needed to guide activities and motivate others; and several underlying issues exist within these skills.

At the most strategic level, public health experts need to gain real expertise in leadership and change management. Stifling bureaucracies, well past their prime, often repress gains in socio-economic and health development. Such bureaucracies are rule-bound to the point of rigidity, suppressing critical thinking and creativity and, frequently, exhibiting attitudes of blame toward oth-

ers instead of attitudes promoting accountability of their own departments. Politicians have their own conflicts of interest that need understanding, if advice to government is to be appropriate and appropriately received.

A modern and successful organization should always look toward the future, achieving better products and improving profits, and public health should be no different. Our "products" are our services and our advice to government. Our "profits" lie in measurable, improved health of the people, as well as in community satisfaction and greater individual and community responsibility for personal health. These concepts and realities are complex; our "profits" should be achieved in the most intelligent, efficient, and effective ways.

To face these complex challenges, we should build healthy cultures within ministries, health care institutions, and community settings. We should be role models for the enthusiasm and support needed as a public health strategy. This achievement needs, not just effective policies, but considerable efforts for organizational development (Figure 1) to main-

tain and enhance motivation and, increasingly, attract and retain people to work in the health system.

Most people in health are taught to do everything we can for all people. The World Health Report of 1999 mentions that no country, wealthy or poor, can afford to do all things for all people. As genetic medicine and other technology accelerate, this statement will become increasingly true. In time, our knowledge of genetics may dramatically change our whole approach to health, and costs may decrease. However, in the meantime, costs will increase, causing even more pressure on our scarce resources.

### **Goals for Public Health Experts in the Twenty-first Century**

The goal for public health experts should be the public's health, but not using a fragmented approach. As individuals and community members, we live in a continuum, within the context of our families, society, and our environment. Our health needs should be addressed in this comprehensive context. In achieving this, the public health expert can, and should be, a key facilitator and advisor.

An understanding of leadership and its application is an essential component of a modern public health expert's knowledge base. Change management knowledge and skills are also essential. Even though a vast body of literature concerning system change now exists, change is difficult to achieve. For public health experts to fulfil their potential, they must be competent managers of transition.

Strategic thinking is the next essential component. Not "just" health planning, but achievement-oriented, system-focused, strategic thinking and planning (which embraces a clear understanding of health determinants) is necessary. The planning must be specific about forging alliances external to the formal health system, including other portfolios.

Communication skills are next. These cannot be learned in a half day session. Communication skills are about understanding self and others, comprehending opportunities, and influencing others. They are linked to courage, motivation, skills in

change management, and leadership capabilities. Communication skills require that public health experts become citizens of the world, easily crossing boundaries between public and private sectors and the community, speaking the language of those people with whom they are communicating.

Then, there is the "first step" approach. All change begins with knowledge of the first action step. This step should take a person further along a path, so that the person can envision more and, then, take additional steps. The public health expert could potentially become the person whom the Chief Executive asks for help when finding a vital solution to a complex problem. But advice that does not help solve problems is inadequate advice. If the Chief Executive can provide advice to the government that results in solutions, then all the policies and strategies are contributing effectively. Government officials could potentially feel relief as they find a robust method to line up government policies in juxtaposition, with evidence to improve the public's health.

Public health experts can lead as role models for the health workforce in the twenty-first century by making an exponential leap towards adaptability, flexibility, and interdependency. They can work for both ethical and technical competencies, "current competencies" (not just qualifications), and integrated human resource strategies that will lead to integrated policies and services. These attitudes require developing skills for achieving lasting change. A mindset is needed which avoids control and, instead, has a dominant focus on influence and collaborative working. A spirit of involvement with management is needed, which inspires others and contributes to achievement. Professionals must have an impact long after they have left their jobs, finding the balance between changing too quickly and persevering. These attitudes require changing our language to achieve effective communication with others. It means developing a tolerance for ambiguity, a challenge for professionals who are educated to believe in absolutes. In the twenty-first century, all of these attributes pose challenges for public health experts, for ministries, and for governments, if they are to be in juxtaposition.