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**Public administration perspective on implementing the internationally agreed goals and commitments in regard to global public health**

## Mainstreaming of health issues and human capacity-building in public administration

### Note by the Secretariat

*Summary*

The present note by the Secretariat serves as a background paper for the deliberation and recommendations of the Committee of Experts on Public Administration on the mainstreaming of health issues and human capacity-building in public administration, in accordance with Economic and Social Council decision 2008/254. The annual ministerial review of the 2009 high-level segment of the Council will address progress made by Member States in this area.

The promotion, restoration and maintenance of global public health are becoming a growing challenge. While health risks such as the possibility of pandemic influenza call for cooperation among authorities around the globe, other health issues, such as primary health care, require a comprehensive and cooperative approach among all relevant partners at the local level. In examining the cases of diarrhoea, primary health care and pandemic influenza, this paper postulates that the challenges are more than medical and pharmaceutical. The sector orientation of public health is a handicap for related challenges. To overcome this, health issues need to be mainstreamed within the public sector. All institutions need to be aware of their current and potential future impact on public health and have to revise their own administrative work accordingly.

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Linked with the mainstreaming of health issues is the issue of an increasing demand for horizontal and vertical cooperation. That, in turn, requires an upgrading of skills and heightened participatory approaches among all involved. Thus, the human factor becomes even more decisive than before on the supply side of health services. In its conclusions and recommendations, the paper states that in order to cope with the increasing complexity of challenges and to better achieve the Millennium Development Goals, it is necessary to strengthen participatory approaches and to mainstream health issues at the same time. In both fields it is expected that public administration will play a key role in achieving health-related goals.

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# I. The need to overcome the sector orientation of public health and to strengthen participatory approaches

1. Health is more than the absence of illness and pain. Health embraces the entire physical, mental and social well-being of a human. Because of its fundamental relevance, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being".[1] Aside from being a human right, health is a condition for the development of the individual and of society.

2. The World Health Organization (WHO) defines health systems as all the activities whose primary purpose is to promote, restore or maintain health. Health systems that offer socially equitable and efficient basic health care strengthen social and economic development. The achievement of Millennium Development Goals such as the eradication of extreme poverty and hunger is strongly related to health. Millennium Development Goals such as that of reducing child mortality (goal 4), improving maternal health (goal 5) and combating HIV/AIDS, malaria and other diseases (goal 6) are directly targeted at health as a basis for development. Little time is left until 2015 to achieve the Millennium Development Goals. Particularly, the health-related goals mentioned above continue to pose daunting challenges.[2]

3. For the achievement of the Millennium Development Goals, it is paramount to introduce good governance that will establish and maintain an effective health delivery system.[3] Most common visualizations of health-service delivery show doctors giving aid to children or other patients. The symbolism of such pictures is appealing, and it illustrates the point that health-service provision is about people-to-people actions. Whatever medicine or medical equipment may be used, also needed are health workers who treat each patient according to his or her individual situation and needs. The human factor is most evident in such instances. Ultimately, the delivery of health services to the patient depends on often highly sophisticated supply chains in which public institutions and administration most often play a key role.

4. This interrelation between the health sector, public governance and the human factor is demonstrated in the sections below using three examples. The first is diarrhoea, a disease that is relatively easy to intervene against, but that nevertheless kills about 2 million people each year. The second example is the case of systems for primary health care. They follow a more comprehensive approach to secure public health. The third example deals with potential public health emergencies of international concern, the most feared of which is pandemic influenza. Although very different, all three examples demonstrate that only a comprehensive and coordinated governmental policy and governance strategy can reduce risk and contribute to global public health.

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[1] Constitution of the World Health Organization.

[2] See http://www.un.org//millenniumgoals/2008highlevel/pdf/addendum.pdf.

[3] *Achieving the Health Millennium Development Goals in Asia and the Pacific: Policies and Actions within Health Systems and Beyond*, United Nations publication, Sales No. E.07.II.F.19), p. 19.

## A. Limitations of single-issue policies and projects: the case of diarrhoea

5. Diarrhoea currently is neither among the top threats in global public health nor a disease that requires the focus of research to identify its causes and possible interventions. However, it is relevant to global health, as it occurs worldwide and causes 4 per cent of all deaths and 5 per cent of health loss. It is most commonly caused by gastrointestinal infections and kills about 2.2 million people globally each year, mostly children in developing countries.[4] Diarrhoea is a relatively "simple" case, as the disease itself, how it affects people and the possible interventions are well known. In addition, interventions do not require large investments in research, medicine and medical equipment. In spite of these advantages, there is the need for a relatively sophisticated supply chain and coordination to reduce infections.

6. According to WHO, key measures to reduce the number of cases of diarrhoea include access to safe drinking water; improved sanitation; good personal and food hygiene; and health education about how infections spread. On an individual basis this can often be achieved by rather simple measures. From a governmental point of view, the provision of safe drinking water, improved sanitation, good hygiene and health education to all citizens is a major challenge that requires substantial planning, logistics and other administrative efforts and the availability of necessary funds. At the beginning of 2000, one sixth of the world's population (1.1 billion people) was without access to improved water supply and two fifths (2.4 billion people) lacked access to improved sanitation.[5] Efforts to improve these numbers are still far from succeeding.

7. Key measures to treat diarrhoea usually do not require costly medicine or medical equipment. What is needed is mainly information and education. Affected patients need to be informed that a salt solution to treat dehydration can prevent death or health loss. In addition, it is sufficient that a health worker be available for consultation. As simple as this may be in principle, in practice it takes major efforts by governments at all levels to ensure that information is provided to everybody throughout the country in question. The education of health workers, the financing of their salaries and necessary infrastructure are other challenges that have to be met to ensure that measures against diarrhoea become effective in every country. With an estimated 2.2 million people killed each year, it becomes apparent that the supply chain of information, consultation and affordable essential medicines is not functioning well enough.

8. To further reduce the number of cases of diarrhoea and to treat it, coordination and cooperation are needed at least among the following departments within public administration: health, sanitation, science, education, public information, human resources, infrastructure, environment, water management, statistics and finances. While the direct treatment of diarrhoea is not cost-intensive, other measures to reduce the risk of infection (e.g., better sanitation and water management) can be costly and require a greater amount of funding.

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[4] http://www.who.int/water_sanitation_health/diseases/diarrhoea.

[5] Global water supply and sanitation assessment report, WHO and United Nations Children's Fund, 2000.

## B. More comprehensive policies: the case of people-centred primary health care

9. The case of diarrhoea has already made it apparent that further improved interventions depend on an integrated set of measures. In general, "a shift towards the need for more comprehensive thinking about the performance of the health system"[6] is recognizable in public health. To that end, the *World Health Report 2008* promotes the setting up of a system for primary health care. Its scope is people-centred and thus goes beyond conventional ambulatory medical care and disease control programmes (see table).

10. The people-centred primary-care approach brings promotion and prevention, cure and care together in a safe, effective and socially productive way at the interface between the population and the health-care system. WHO found evidence that person-centredness contributes to the quality of care and better outcomes:[7]

(a) Improved treatment intensity and quality of life;

(b) Better understanding of the psychological aspects of a patient's problem;

(c) Improved satisfaction with communication;

(d) Improved patient confidence regarding sensitive problems;

(e) Increased trust and treatment compliance;

(f) Better integration of preventive and promotive care.

**Aspects of care that distinguish conventional health care from people-centred primary care**[a]

| *Conventional ambulatory medical care in clinics or outpatient departments* | *Disease control programmes* | *People-centred primary care* |
|---|---|---|
| Focus on illness and cure | Focus on priority diseases | Focus on health needs |
| Relationship limited to the moment of consultation | Relationship limited to programme implementation | Enduring personal relationship |
| Episodic curative care | Programme-defined disease control interventions | Comprehensive, continuous and person-centred |
| Responsibility limited to effective and safe advice to the patient at the moment of consultation | Responsibility for disease-control targets among the target population | Responsibility for the health of all in the community throughout the life cycle; responsibility for tackling determinants of ill health |
| Users are consumers of the care they purchase | Population groups are targets of disease-control interventions | People are partners in managing their own health and that of their community |

[a] WHO, *World Health Report 2008*, p. 52.

[6] WHO, *World Health Report 2008*, Director-General's message.

[7] Ibid., p. 47.

11. When one looks at the administrative and managerial side of this approach, the related challenge becomes visible: each centre for primary health care should offer a comprehensive range of integrated diagnostic, curative, rehabilitative and palliative services. It needs to be ensured that these distinctive features become directly and permanently accessible, without undue reliance on out-of-pocket payments and with social protection offered by universal coverage schemes. Another set of arrangements is critical for the transformation of conventional care — ambulatory- and institution-based, generalist and specialist — into local networks of primary-care centres:[8]

(a) Bringing care closer to people, in settings in close proximity to and in direct relationship with the community, relocating the health-system entry point from hospitals and specialists to close-to-client generalist primary-care centres;

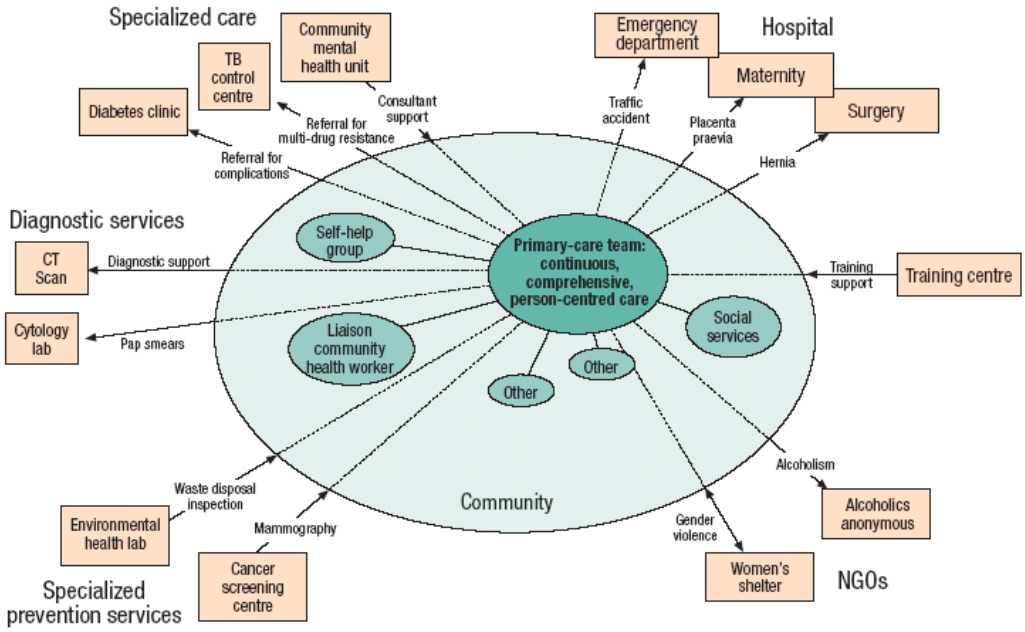
(b) Giving primary-care providers the responsibility for the health of a defined population, in its entirety: the sick and the healthy, those who choose to consult the services and those who choose not to do so;

(c) Strengthening primary-care providers' role as coordinators of the inputs of other levels of care by giving them administrative authority and purchasing power.

12. This brings many changes and challenges to health-care workers and teams, but also to the people and communities. Support from specialized services, organizations and institutions outside the community are also required. The coordination of this set transforms the primary-care pyramid into a network. The relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy and bottom-up referral, but on cooperation and coordination. Thus, primary care becomes a hub of coordination (see figure 1).

[8] Ibid., p. 55.

Figure I
**Primary care as a hub of coordination: networking within the community served and with outside partners**[a]




[a] WHO, *World Health Report 2008*, p. 55.

13. The coordination function provides the institutional framework for mobilizing across sectors to secure the health of local communities. WHO regards this not as an optional extra but as an essential part of the remit of primary-care teams, and sees also the policy implications:

> coordination will remain wishful thinking unless the primary-care team has some form of either administrative or financial leverage. Coordination also depends on the different institutions' recognition of the key role of the primary-care teams. Current professional education systems, career structure and remuneration mechanisms most often give signals to the contrary. Reversing these well-entrenched disincentives to primary care requires strong leadership.[9]

14. At this point WHO ends its analysis of the institutional setting for primary health care. In the wider context of public administration and governance, the analysis must be extended, because the system for primary health is not a closed shop or system on its own. As a people-centred system it involves the entire community, and because of its administrative and financial requirements it is closely linked to other parts of the public sector. The purpose of health-related good governance is to establish and maintain an effective health delivery system, but considering the

[9] Ibid., p. 57.

challenges for the administration described in the case of diarrhoea, and especially with regard to primary public health, it is inevitable that related developments have an impact on the entire setting of public administration and governance.

15. For example, it is not enough that health workers tell parents to provide their children with healthy food. It is important that public health issues be integrated into the curriculum of schools. The government may also need to formulate media policy banning or restricting the advertisement of certain kinds of products that have adverse health effects. Similarly, the media should encourage the promotion of healthy lifestyles and create awareness of wider public health issues, such as the need to vaccinate children. Thus, the departments (ministries) of education and media also become partners in the provision of primary health care. Other government departments, such as public works, sanitation and water supply, may also have supporting roles. By all such interrelations and synergies, health turns into an issue of horizontal relevance for public administration and governance.

## C. Interdependency of national health systems: the case of pandemic influenza

16. Interventions against a disease such as diarrhoea are possible at any time, and efforts to set up systems for primary health care can also be taken, but how to respond to future threats of global health is a more complex issue. Infectious diseases are spreading faster and appear to be emerging more quickly than ever before. Since the 1970s, newly emerging diseases have been identified at an unprecedented rate of one or more per year. High mobility and an interdependent and interconnected world provide myriad opportunities for the rapid spread of infectious diseases and radionuclear and toxic threats. About 2 billion passengers travel on airlines each year, which makes it possible for an outbreak or epidemic in any one part of the world to be only a few hours away from becoming an imminent threat somewhere else. That these threats are real has become apparent over the years. From September 2003 to 2006, WHO verified more than 1,100 epidemic events worldwide, and it would be extremely naïve and complacent to assume that there will not be another disease like AIDS, Ebola or SARS sooner or later.[10]

17. In 1996 WHO initiated a global system of epidemic alert and response to compensate for gaps in the health systems of many countries. The public health security of all countries depends on the capacity of each country to act effectively and contribute to the security of all. According to WHO, the first steps that must be taken towards global public health security, therefore, are to develop core detection and response capacities in all countries and to maintain new levels of cooperation between countries to reduce the risks to public health security. This entails countries' strengthening their health systems and ensuring that they have the capacity to prevent and control epidemics that can quickly spread across borders and even across continents. Where countries are unable to achieve prevention and control by themselves, it means providing rapid, expert international disease surveillance and response networks to assist them – and making sure these mesh together into an efficient safety net.[11]

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[10] WHO, *World Health Report 2007,* pp. x-xiii.

[11] Ibid., p. xiii.

18. For governance strategies, one main challenge of global public health emergencies is that they have to be internationally open and integrated. The message of the WHO report with respect to governance strategies is clear:

> No single country — however capable, wealthy or technologically advanced — can alone prevent, detect and respond to all public health threats. Emerging threats may be unseen from a national perspective, may require a global analysis for proper risk assessment, or may necessitate effective coordination at the international level.[12]

Knowledge has to be exchanged, and agreed standards for surveillance have to be applied. The second challenge is that countries have to be ready to react fast in the case of an outbreak of a pandemic influenza. They have to strengthen their health systems and ensure that they have the capacity to prevent and control epidemics that can quickly spread.

19. The first remarkable steps towards coordination of the international level have been taken. Most outstanding are the International Health Regulations (IHR 2005), which came into force in June 2007. These Regulations are an internationally and legally binding agreement designed to achieve maximum security against the international spread of diseases. Nonetheless, the Regulations themselves do not stop the trend that brought more than 1,100 epidemic events worldwide between September 2003 and 2006. Actions against bird flu or SARS require the willingness to change. Considering the many challenges for politics and administration (including the current financial crises), the effectiveness of the coordination of health and other policy priorities at the international, national and regional/local levels needs to be proved anew in the case of each epidemic event.

## D. Obstacles preventing better health delivery systems

20. Many obstacles hinder the achievement of the overall objective of public health, and most of them have been mentioned in the context of the examples described above. In striving for a more comprehensive and coordinated approach, it is necessary to look also at the obstacles in a more coherent way. To do this, the analysed examples were revisited and, in addition relevant publications[13] were evaluated. This led to a list of obstacles differentiated according to obstacles classified as being either within or outside traditional health systems.

### 1. Obstacles within health systems

21. The Economic and Social Commission for Asia and the Pacific (ESCAP), the United Nations Development Programme (UNDP) and the Asian Development Bank (ADB), in their study on the achievement of health-related Millennium Development Goals in Asia and the Pacific,[14] speak about three types of deficiencies within health systems:

(a) Deficiencies in physical infrastructure;

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[12] Ibid., p. xxii.

[13] *World Health Report, 2006, 2007 and 2008* and *Achieving the Health Millennium Development Goals in Asia and the Pacific*, op. cit.

[14] *Achieving the Health Millennium Development Goals in Asia and the Pacific*, op. cit.

(b) Deficiencies in human resources;

(c) Deficiencies in access to essential and reliable medicines and vaccines.

22. These deficiencies weaken the ability of health systems to deliver good-quality health-care services. At a lower level, they are in turn determined by a wide range of interrelated factors:

(a) Insufficient spending;

(b) Undeveloped health-protection systems;

(c) Inequitable allocations of health budgets;

(d) Poor working conditions, professional prospects and work ethics;

(e) Poor governance and low efficiency in health systems;

(f) Weak health-information systems;

(g) Low capacity at the local level in decentralized health systems.

### 2. Obstacles outside health systems

23. The fight against a single disease, efforts to set up systems for primary health care and activities to prevent and react to epidemic events all go far beyond the inner circle of health workers, their institutions and activities. In addition, increasingly, public health in one country depends on actions taken in other countries.

24. The obstacles outside health systems include especially the following:

(a) Socio-economic determinants;

(i) Poverty and hunger;

(ii) Education and health literacy;

(iii) Gender inequality;

(iv) Exclusion, stigmatization and discrimination;

(b) Environmental demands;

(i) Water and sanitation;

(ii) Air and pollution;

(iii) Food quality;

(c) Determinants associated with international economic regimes;

(i) Skewed research and development;

(ii) Trade agreements and the production and trade of generic drugs.

### 3. The obstacle of uncoordinated actions

25. In addition to the obstacles listed above, the lack of coordination constitutes a horizontal obstacle with an impact on all other obstacles. Fragmented actions on single issues often promise faster progress than coordinated efforts on complex issues. Apparently, not even diarrhoea can be prevented this way. Unfortunately,

addressing complex challenges by means of fragmented actions turns the achievement of health objectives into a matter of chance. In addition, it is more likely that available funds will not be used in the most economical way to reduce health risks. Be it primary health care or the prevention of pandemic events, uncoordinated policies and activities are an approach that is not only too risky but also too costly. Coordination requires more efforts and funds to get started, but it can be expected that synergies and other advantages of better coordination reduce both health risks and expenditures for public health in the long run.

# II. Towards a wider and more comprehensive understanding of public health systems

26. It is interesting to note that in their study, ESCAP, UNDP and ADB address the issue of the institutional changes required to implement policies more effectively within and outside the health sector, in order to deliver health services in an equitable and efficient manner. Consequently, they underline in their report the interconnectedness among determinants within and outside the health sector. For example, it is stated that poverty (one of the outside determinants) is at the root of the lack of progress towards achieving the health-related Millennium Development Goals, and is also a consequence of ill health. This differentiation between within and outside may be traditional and common, but it is neither convincing nor does it help to achieve the objectives of health policies.

## A. The domain of public health: observations from an actor-centred point of view

27. According to WHO, health systems comprise “all the activities whose primary purpose is to promote, restore or maintain health”.[15] The wording indicates that the division between within and outside depends on the definition of the term “primary purpose”. Doctors, nurses, medicines and hospitals indeed share this primary purpose, but this is not sufficient as evidence. The budget policy of Governments has also a strong impact on what happens with respect to public health, but it would be wrong to state that health is the primary purpose of budget policy. In China almost 13,000 children became sickened by tainted milk. This was a case of the work ethics of a producer of milk powder having an adverse impact on health, but it certainly cannot be said that health was the producer’s primary purpose. In a similar way, many other policies and orientations of various actor groups have an impact on health without having this as a primary purpose. This leads to the assumption that the traditional understanding of a health sector and its health systems is too narrow.

28. At this point it is useful to look at public health from a different and theoretical point of view that is not encompassed in the traditional view of the health sector. For the present paper, the perspective of actor-centred institutionalism was chosen. This approach, developed by Renate Mayntz and Fritz Scharpf,[16] is not

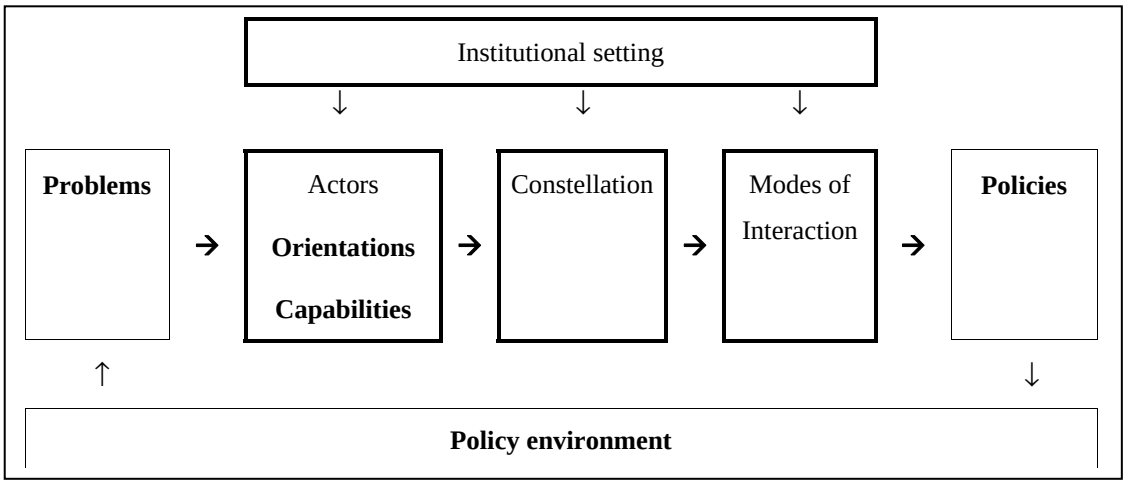
[15] WHO, *World Health Report 2000*, p. 5.

[16] Scharpf, Fritz, *Games Real Actors Play: Actor-Centered Institutionalism in Policy Research* (Westview Press, Boulder, United States of America, and Oxford, United Kingdom, 1997).

a theory per se. Rather, it is a theory-based model for analysis allowing as much the analysis of systemic as of individual aspects of policy developments. With respect to the policy field of public health, this means that the constellation of the main actors in the field is not to be seen as a static picture. Instead, it is important to look at the actors, their orientations and their capabilities, and to analyse their modes of interaction in the given institutional setting. Without a focus on interactions, it seems unlikely that it will be possible to come to conclusions related to the human factor and the building of capacities in the context of health systems and public administration.

29. An outline of the domain of interaction-oriented policy research is given in figure II. Terms such as "system" and "sector" are not used in this domain. Rather, research starts with problems (e.g., health risks) and looks at the process for formulating and implementing related policies (e.g., deciding upon and implementing measures to reduce health risks by providing health services).

Figure II
**The domain of interaction-oriented policy research**[a]




[a] Scharpf, op. cit., p. 44.

30. The next box in figure II refers to actors: individual and corporate actors. In striving to achieve health-related Millennium Development Goals, much depends on well-trained and motivated individual actors such as health workers, corporate actors such as ministries of health and collective actors (e.g., associations of doctors or of members of the pharmaceutical industry). These actors all have specific action orientations, i.e., their own perceptions of a problem and their own preferred actions. This is also the point where ethical orientations come into play. Orientations may be stable, or they may be changeable through learning and persuasion. They will be activated and defined by the stimulus provided by a particular policy problem or issue.

31. WHO dedicated the *World Health Report 2006* to the development of health workers as a central group of actors in the domain of public e-health. In spite of its concern for the health worker, WHO goes beyond this actor group and features in

the same report a wider constellation of actors, including national Governments and financial institutions. Nonetheless, to get the full picture of all relevant actors and their constellation it is necessary to include all those (non-partners) who are not concerned about public health but who have an impact on public health by their own activities (e.g., military conflicts, environmental pollution, directing funds to uses other than public health, etc.).

32. Thus, on the supply side of health services, actors comprise health workers, ministries of health, WHO and all other movements, associations and organizations dealing with health. In addition, the departments in charge of food, environment, sanitation, education and budget carry out health-related actions. Most of these actors are non-primary in striving to promote, restore or maintain health, but without them no health systems would function. Public administration in this context is a corporate actor, but its employees are also individual actors. As an institution and as individuals, they require understanding about the impact of their actions on health-related issues. The absence of coordinated mainstreaming may lead to horizontal conflict (between employees of different departments) and vertical conflict (between employees of the same organization — the principal-agent relationship). Therefore, it is essential that relevant actors have the capabilities necessary to cope with such challenges.

33. In addition to the supply side there is the demand side: it is always the individual person (potentially everybody) who is suffering a disease, receiving services from primary health care or being threatened by a pandemic influenza. Individuals cover or contribute to the financing of health services, and, last but not least, their health situation affects how they contribute to the economy and society. They and the organizations of civil society have an impact on the development and deliveries of health services within a community.

34. In this full constellation of actors, public administration most likely will have different and sometimes conflicting perceptions and preferences. Ministries and other public offices in charge of public health have a clear mandate favouring public health, while foreign offices and ministries of defence or finance have other priorities. As a matter of fact, most public institutions do not have a mandate that includes public health as one of the priorities. Public health may just not be on their screen, and their potential and/or real impact on activities to promote, restore or maintain health has to be analysed. Especially where health interests are in conflict with other (e.g., budgetary/financial) interests, it easily may be the case that public authorities with a mandate for balancing the budget and those with a mandate for public health have contradictory preferences. In such cases, the efforts of a public administration to promote, restore or maintain health may be weakened or even made ineffective by activities of other actors from the public sector.

35. To prevent this situation it is necessary that governments at all levels develop an integrated health policy, i.e., a health policy coordinated with all other policies that have a direct or indirect impact on public health and the delivery of health services. This would make it possible, for example, for investments in public health and school feeding programmes eventually to be beneficial for the budget as they reduce the cost of expensive treatments, etc.

36. Next to the development of an integrated health policy is the development and implementation of a related governance strategy. At this point, public administrations must look not only at the problems to be solved, the actors

concerned and the actor constellation, but also at the modes of interaction between actors. A country — in the perspective of actor-centred institutionalism — is no single actor, but a specific actor constellation in a defined territory. As discussed above, even within public administration (not to mention the many private actors) different perceptions and preferences might prevail. Needed are governance strategies that are able to coordinate interactions within countries and at the international level. Interaction modes include hierarchical directions, unilateral actions, negotiated agreements and majority vote. Actors have to always be aware of what the possible and appropriate modes of interaction to achieve commonly agreed objectives are.

## B. Mainstreaming public health issues and human capacity-building while reducing complexity

37. A common slogan in the 1980s was “Think globally, act locally”. It was an effort to give an answer to increasing global interrelations and to the parallel requirement that each individual has to find a way to handle growing complexity and his or her own limitations. In view of the approach of actor-centred institutionalism, it may seem as if now an even greater complexity has to be faced. It is true that interrelations grow and that each individual and institution has to be aware of this, but it would be wrong to assume that to make rational choices each actor would have to have full information about not only health but all policies in the world and their possible interrelations and impacts on one another. This certainly would overwhelm everybody. In the same way it would not be promising to set up a kind of centralized health authority replacing individual efforts with a central and top-down approach. Firstly, it is unlikely that such an authority would be able to collate full information, and secondly, it is unlikely that a centralized authority could take all appropriate actions in the appropriate way to promote, restore and maintain health at any given time everywhere in the world.

38. If it is not possible to get everybody directly involved in everything and to centralize all information and decision-making, how could it be possible for actors in public health to face the entire complexity of the domain as it is in reality? The way to cope with this challenge might be found through a combination of two activities: awareness-raising and loose coupling of arenas.

### 1. Awareness-raising, training and education

39. Firstly, all actors both directly and indirectly involved in public health and health delivery systems have to be aware of the fact that in the twenty-first century public health is a global challenge and that actions taken by an actor in one country have an impact on health in another country. To be aware of the principle of interconnectedness is more important than to strive for full information on all issues by everybody.

40. Secondly, all individuals and corporate actors have to be aware of their own specific positions and opportunities with respect to health. This comprises awareness of one’s own personal health and its impacts on the environment, but also the awareness of institutions on their direct or indirect impact. As in the case of gender mainstreaming, it is also necessary in the case of health mainstreaming that all institutions reflect on their relationship to public health and evaluate areas where

they do not support, and may even impede, the promotion, restoration or maintenance of health.

41. Thirdly, increased awareness must lead to revised training of health workers and other relevant employees across public administration. In addition the increased awareness of experts should be incorporated into education curricula at schools, and also into training programmes for leadership-building in public administration. In this way the mainstreaming of health issues and human capacity-building becomes integrated and can be of mutual benefit.

### 2. Loose coupling

42. The pattern of loose coupling[17] was developed in organizational science and is understood as an instrument to avoid the joint decision trap. The risk of joint decision traps always exists where interests and competences of actors and arenas overlap and interfere. Of course, in the domain of public health this risk is extremely high: one of the most prominent risks is the overlap between horizontal policies (e.g., budget) and vertical policies (e.g., health). The lack of mutual understanding between health authorities and other departments may lead to insufficient resourcing. Other examples are the shared health-related competences of national, regional and/or local authorities. If actions in one area depend on actions in another arena, the demand for coordination to prevent blockages grows tremendously.

43. Organizing public health according to the pattern of loose coupling would allow assigning decision-making competences in the context (or arena) where they are most appropriate. Doctors would still decide about medication for their patients, Governments would decide about national health policies and international organizations would carry out their tasks in the framework of their mandates. The link between the actors in their specific context would be “loose” insofar as decisions in one arena would not always be binding for actors in other arenas. The point is that today many actors are not at all linked. If public institutions do not know the potential and practical impacts of their activities on health, then there is no coupling at all. This would be different if all public institutions were aware of their possible and real impacts. In addition, it might be helpful if all actors would get guidance (be it from other authorities, from the public or from self-defined principles). The coupling should be loose enough to protect the autonomy of actors and to allow independent and decentralized actions. At the same time, it should be strong enough to allow for efficient decision-making and implementation of integrated actions.

44. What awareness-raising and loose coupling mean for public administration needs to be analysed and defined on a case-by-case basis. Certainly, it seems to be appropriate for the entire public sector to undergo a screening regarding its direct and indirect impact on public health, and its possible and effective contribution to promoting, restoring and maintaining health delivery systems. It is to be expected that at the end of this process there will be a much broader and differentiated picture of health systems. Individuals and institutions within the traditional health sector will better understand their role in relation to those outside. More challenging probably will be the difference for those who currently consider themselves to be

[17] Weick, Karl E., *Der Prozeß des Organisierens* (Suhrkamp, Frankfurt, 1995).

outside of the health system. Many of them are likely to find themselves suddenly part of the wider health system, and this could be the starting point for a fruitful dialogue, better coordination and the development of more effective and efficient health delivery systems.

# III. Overcoming the silo mentality

45. On 24 October 2008, the Office for Economic and Social Council Support and Coordination of the Department of Economic and Social Affairs held a panel discussion on the theme "Globalization and health" in New York. On that occasion, the WHO Director-General mentioned in her presentation that "the silo mentality" is a major problem. The discussion of insufficient cross-sector coordination of health issues in sections I and II above confirmed the WHO position and went a step further by analysing the subject in the wider context of public administration. The aim of the present section is to give examples of what can be done or what has already been done to overcome related deficiencies. The examples cannot give a full picture of developments already under way. Nonetheless, they give a clear indication that improved coordination and cooperation beyond the traditional borders of health policy and services is possible and that a number of activities have already begun.

## A. Traditional medicine as part of health systems

46. Countries in Africa, Asia and Latin America use traditional medicine to help meet some of their primary health-care needs. In Africa, up to 80 per cent of the population uses traditional medicine for primary health care. In industrialized countries, adaptations of traditional medicine are termed "complementary" or "alternative". Traditional medicine has maintained its popularity in all regions of the developing world and its use is rapidly spreading in industrialized countries:[18]

(a) In China, traditional herbal preparations account for 30 to 50 per cent of the total medicinal consumption;

(b) In Ghana, Mali, Nigeria and Zambia, the first line of treatment for 60 per cent of children with high fever resulting from malaria is the use of herbal medicines at home;

(c) WHO estimates that in several African countries traditional birth attendants assist in the majority of births;

(d) In Europe, North America and other industrialized regions, over 50 per cent of the population has used complementary or alternative medicine at least once;

(e) In Canada, 70 per cent of the population has used complementary medicine at least once;

(f) In Germany, 90 per cent of the population has used a natural remedy at some point;

[18] http://www.who.int/mediacentre/factsheets/fs134.

(g) In the United States of America, 158 million adults use complementary medicines, and according to the United States Commission on Complementary and Alternative Medicine Policy, $17 billion was spent on traditional remedies in 2000;

(h) The global market for herbal medicines currently stands at over $60 billion annually and is growing steadily. Seventy countries have national regulations on herbal medicines, but the legislative control of medicinal plants has not evolved around a structured model;

(i) China, the Democratic People's Republic of Korea, the Republic of Korea and Viet Nam have fully integrated traditional medicine into their health-care systems, but many countries have yet to collect and integrate standardized evidence on this type of health care.

47. These examples demonstrate two things: firstly, the understanding of medicine itself is widening. Secondly, people matter not only as recipients but also by expressing their demand. This is another proof of the need to revise the understanding of the health system and the specific role of the different actors within the system.

## B. Coordination and harmonization of national policies at the international level

48. The linkage between health issues and development aid is of great importance for the achievement of internationally agreed development goals. The Paris Declaration,[19] endorsed on 2 March 2005, lays down a practical, action-oriented road map including indicators, to improve the quality of aid and its impact on development. The achievement of the indicators is measurable because they were agreed together with targets to be achieved by 2010. Owing to the relevance of this agreement, particularly for the health-related Millennium Development Goals of reducing child mortality, improving maternal mortality and combating HIV/AIDS, malaria and other diseases, the Paris Declaration is a major step forward towards better coordinated horizontal and vertical cooperation.

49. The Paris Declaration includes a strategy for governance, according to which partner countries and donors recognize the need for commitments. Both sides make commitments, although the Declaration also states in paragraph 13 "that commitments need to be interpreted in the light of the specific situation of each partner country". Although this does not constitute an exit option, it may limit the effectiveness of the Declaration by leaving its interpretation largely up to national Governments. For example, the outbreak of a pandemic event could be helped along if a single country decided to postpone preventive measures owing to the "specific situation" of that country.

## C. Mainstreaming health issues within national foreign policies

50. While the relation between health and the efficiency of aid management has already been on the agenda for many years, consideration of this issue has begun only recently. In March 2007 the Ministers for Foreign Affairs of Brazil, France,

[19] http://www.oecd.org/dataoecd/11/41/34428351.pdf.

Indonesia, Norway, Senegal, South Africa and Thailand adopted in Oslo a declaration entitled “Foreign policy taking up the challenges of global health: agenda for action”. They recognized that “no country can isolate itself from cross-border risks and threats to [its] national health security”. By introducing the term “global health security” they established a linkage between health and the foreign affairs objective of national security. The understanding of the adopting Ministers was that “Foreign policy actions in security, trade, conflict and crisis, environment, and human rights have a strong bearing on whether we can achieve national as well as global health security”. They considered the most effective responses to global health challenges to be alliances, cooperation and partnerships. They underlined, in the same vein as the Paris Declaration, that such efforts have to be transparent, trustworthy, accountable and fair.

51. The Foreign Ministers identified areas where the kinds of policy positions they adopt can make a significant difference. Their agenda has three main themes, and for each of them they have specified actions. In looking at the list, it is most interesting how many different cross-sector issues emerge in the context of where the work of foreign offices can make a significant difference to prospects of global health:

**Capacity for global health security**

(1) Preparedness and foreign policy

(2) Control of emerging infectious diseases and foreign policy

(3) Human resources for health and foreign policy

**Facing threats to global health security**

(4) Conflict (before, during and after conflict and as peace is being built)

(5) Natural disasters and other crises

(6) Response to HIV/AIDS

(7) Health and the environment

**Making globalization work for all**

(8) Health and development

(9) Trade policies and measures to implement and monitor agreements

(10) Governance for global health security

**Mainstreaming health issues as part of public sector reform in Mozambique**

The public sector reform project known as UTRESP was implemented from 2003 to the end of 2006 with the support of UNDP and the Department of Economic and Social Affairs of the Secretariat. It covered a wide range of activities. Under the heading "Support for HIV/AIDS and gender" it supported the mainstreaming not only of gender policies but also of HIV/AIDS prevention and management policies. One of the findings was that the mainstreaming of HIV/AIDS and gender is critical in the public sector and that it should be considered an important cross-cutting strategy in all public sector reform initiatives where relevant. The example demonstrates that the combined view of health risks (here HIV/AIDS) and other policies (here gender policies) is already in practice in public sector reform in Member States. For both types of policies it is instructive that mainstreaming is considered necessary and possible.

*Source*: Department of Economic and Social Affairs project MOZ/01/015.

## D. Information and communications technology and e-governance

### 1. E-health

52. The need to develop and organize new ways of providing efficient health-care services has resulted in a dramatic increase in the use of information and communications technology (ICT) applications in health care, collectively known as e-health or telemedicine. E-health is the use, in the health sector, of digital data — transmitted, stored and retrieved electronically — in support of health care, both at the local site and at a distance. Today the integration and assimilation of e-health into the everyday life of health-care workers is becoming a reality in developing as well as developed countries. One of the open questions is whether activities in e-health would divert precious resources away from basic needs in poor countries in want of everything.

53. Today, e-health can support the different functions of the health system, providing a unique opportunity for strengthening its information, intelligence and knowledge processes. Of course, it also allows for an easier promotion of alternative or traditional medicines. In addition, ICT facilitates interlinking between health authorities, other departments and the public. According to WHO, e-health should be an essential component of any plans and strategies for health-system reform in the twenty-first century. Developing countries' needs include capacity-building and the ICT training of public servants.

### 2. Platforms for information, dialogue and training

54. To further networking and exchange of information, the Department of Economic and Social Affairs provides a set of tools. The United Nations Public

Administration Network (UNPAN) is a central online portal.[20] It is designed to help countries, especially developing countries and countries with economies in transition, to respond to the challenges that Governments face in bridging the digital divide between the haves and the have-nots and to achieve their development goals. In short, the mission of UNPAN is to promote the sharing of knowledge, experiences and best practices throughout the world by means of ICT, sound public policies, effective public administration and efficient civil services, and through capacity-building and cooperation among Member States.

55. UNPAN provides news on public governance from all parts of the world, as well as online training opportunities. In addition, the Department of Economic and Social Affairs carries out surveys on e-government and publishes the results. The 2008 Global E-government Survey[21] assessed the same number of functionalities of the same or similar sites in each country to ensure consistency. In keeping with its conceptual framework of human development, these are the ministries/departments of health, education, social welfare, labour and finance, which are representative of the government services citizens require most. Each ministerial site was assessed on the basis of the same set of questions.

56. The Global Alliance for Information and Communication Technologies and Development[22] provides a global forum that comprehensively addresses cross-cutting issues related to ICT in development. Health is one of the focus areas.

57. The WHO programme on e-health is aimed at supporting countries in further developing their health systems by improving access, quality and efficiency through the use of ICT. The programme's main objectives are:

(a) To support Member States in identifying the most suitable applications, considering country needs, objectives and context;

(b) To facilitate the development of ethical and legal policies related to the collection, storage and use of health information in order to ensure privacy and confidentiality;

(c) To facilitate the sharing of best practices among Member States;

(d) To support the implementation of technical programmes in countries, providing information on opportunities and risks.

# IV. Conclusions and recommendations

58. The present paper does not argue that sector and vertical actions have been without success, but it demonstrates that global public health depends increasingly on the interrelations and cooperation between policies and across sectors. Traditional health institutions do not lose relevance. On the contrary, they are gaining importance, e.g., by becoming network hubs. Nonetheless, in order to promote, restore and maintain public health, awareness is necessary among all institutions, and especially within public administrations. They have to become

[20] http://www.unpan.org.

[21] http://www.unpan.org/Library/MajorPublications/UNEGovernmentSurvey/tabid/646/Default.aspx.

[22] United Nations, *Foundations of the Global Alliance for ICT and Development*, 2007. See also http://www.un-gaid.org.

aware of their current and potential future impact on public health and the delivery of health services. This increased awareness could be the starting point for better coordination and the development of more effective and efficient health delivery systems.

59. Increased cooperation requires cooperative approaches, and with respect to the public this means participatory approaches of governance. Private and public actors have to intensify their interrelations. Private actors have to give support and accompany public efforts, but it is the public actors that have to act as stewards. This does not mean that the people should not be key players. People are subject to health risks and they need health services. Therefore, it is evident that participatory approaches have to be applied.

60. **The following recommendations are put forth to Member States:**

(a) **Raise awareness in all sectors and at all levels of government regarding their respective responsibilities and opportunities to promote, restore and maintain public health and to provide health delivery services;**

(b) **Develop an integrated health policy, i.e., a health policy coordinated with all other policies that have direct or indirect impacts on public health and the delivery of health services;**

(c) **Adopt participatory and actor-centred approaches to developing national health policies. Tools to be used for an appropriate involvement should include ICT tools for governance;**

(d) **Enhance cross-sector cooperation and management as an integrated part of public administration. Health workers and other employees of public institutions need to be trained accordingly;**

(e) **Strengthen public administration's contribution to health information systems, e.g., through their statistical offices, but also by providing user-friendly websites and by making e-health an essential component of any plans and strategies for health-system reform;**

(f) **Be internationally open and integrated. As part of this global public health effort, the preparedness and response systems (prevention and monitoring of infectious diseases) have to be further developed;**

(g) **Promote long-term funding, including public-private partnerships where appropriate, for research on and development of new drugs and treatments. Considering that public health is not only costly but also essential for the development of the economy and society, Member States have to consider increasing investments in public health and viewing them as investments in the economic and social development of the country;**

(h) **Involve civil society organizations to enhance awareness of health issues among different stakeholders and public service providers.**

61. **The following recommendations are put forth to United Nations agencies:**

(a) **The United Nations agencies concerned should continue to assist Member States in promoting, restoring and maintaining public health and in providing health delivery services;**

(b) **The United Nations agencies concerned should continue their analyses of horizontal and vertical coordination of policies with the aim of providing assistance to Member States in developing integrated national policies;**

(c) **Developing ICT-based tools for information on and monitoring of health delivery systems is a valuable contribution by the United Nations agencies concerned and should be further developed, including the analysis of the threats and opportunities and the strengths and weaknesses linked to the various governance tools, especially those used in the context of e-governance and e-health;**

(d) **Last but not least, the research activities of the United Nations agencies concerned in the health sector should include actor-centred approaches, while their advisory work should be conducted taking into consideration participatory approaches for health-sector governance.**