HEALTH SYSTEM RESILIENCE DURING THE PANDEMIC: IT’S MOSTLY ABOUT GOVERNANCE

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Summary: Governance is the most important enabler of health system functioning. It provides a foundation and lever for resource generation, financing, and service delivery and ensures they operate well and in coordination with the rest of the system. It also extends beyond the health system through interactions between levels and actors. While there is no unanimously accepted framework for assessing governance, country examples can be used to illustrate how governance has contributed to health systems resilience during the crisis. Good governance prior to the pandemic, underpinned by strong state capacity, political leadership and community engagement, is key to responding resiliently during a novel infectious disease outbreak, such as COVID-19.

Keywords: Resilience, COVID-19, Governance, Health Systems Performance, Health Systems Strengthening

Resilience can be understood as the ability to maintain the performance of key health system functions

Health systems are complex, and shocks create diverse and sometimes unexpected consequences for health systems. A whole system approach, encompassing all functions and the interactions between them, is therefore needed to understand the implications of shocks on the functioning of health systems and which responses to adopt. In case of a major shock, such as the COVID-19 pandemic, an even wider analysis, extending to other sectors and broader contextual factors, can help to understand the best course of action.

A resilient health systems response to a shock means pursuing strategies that ensure sustained performance of health systems functions, thereby protecting overall system performance (see Box 1).

Governance plays a critical role in health systems performance, thereby also providing the principal lever for resilience

Constructive deployment of funding and resources relies heavily on governance. Governance – the way decisions are made and implemented – enables the financing, resource generation, and service delivery functions to operate as intended and in coordination with the rest of the system to achieve maximum overall system performance, and by extension, resilience. For example, public financial...
management (governance of financing) influences how nimbly and transparently financing can be made available for emergency response purposes while re-organising funding for health system operations. Health workforce planning and management of procurement systems (governance of resource generation) have been pivotal in redeploying and repurposing the workforce and directing emergency medicines and diagnostics in the current pandemic. Health facility management and local community engagement mechanisms (governance of service delivery) determine whether COVID-19 response measures are adhered to and whether services are delivered in accordance to need (see the later article by Rajan et al. in this issue for more on engaging with communities and civil society).

At the macro-level, governance enables the other functions to work in unison, for example, by ensuring there is a clearly articulated strategic vision for the health sector, to which governments can be held accountable, or by ensuring that evidence generation and use drives decision- and policy-making. The governance function, however, goes beyond the health system through interactions with other sectors, since population health is largely determined by actions outside of the health sector. Governance is also increasingly conducted across levels, from local to global, with multilevel governance becoming increasingly important. New adaptive approaches to governance surfaced during the pandemic, with more actors such as private sector companies (see article by Tille et al.), NGOs, civil society groups, religious organisations, and others providing support to the government in response to the pandemic. These many whole-of-society responses, often improvised, did not disempower or threaten governments and may well have enhanced overall quality of governance for the population. Indeed, as seen with joint efforts to fight the COVID-19 pandemic, the inputs of non-state actors can improve broader governance, delivering solutions that the state alone could not provide. The coordination problems of involving more actors in response can be worthwhile if we gain their contributions, resources, and skills, while ensuring their transparency, legitimacy, and accountability.

Box 1: Health systems resilience and the performance of health system functions

Application of the concept of resilience in the context of health systems has typically focused on understanding health system preparedness and the ability to absorb, adapt, and transform to cope with acute shocks. In terms of performance, a resilient health systems response to a shock can be understood as doing things that ensure sustained performance of health systems functions—governance, financing, resource generation, and service delivery—so that the ultimate health systems goals, especially that of improving health of the population, can be achieved. Thus financing, human and physical resources had to be mobilised and optimally deployed during the COVID-19 pandemic to prevent the spread of the virus and treat COVID-19 patients, while maintaining the provision of essential services for other patients. But health systems resilience can also be viewed as something that goes beyond what it was before, which may be neither feasible nor desirable, and includes a health system’s ability to evolve, learn, and transform, ideally improving its future performance. Making the link from recovery and learning from a shock to preparedness for upcoming shocks is crucial although often neglected in practice—once the shock has passed, decision-makers tend to revert to dealing with day-to-day system strains and stresses.

What have we learned about governing the COVID-19 response?

Analysing national responses during the first 18 months of the pandemic shows the broad range of measures that countries undertook to maintain performance of the key health system functions. It also provides an opportunity to distil the governance factors that supported (or undermined) a resilient health system response. We summarise these factors below, drawing on resilient response strategies identified in the forthcoming Observatory study on health systems resilience during COVID-19 (see Box 2) and the underlying country evidence collected through the Health Systems Response Monitor (HSRM) platform.

Goverance remains difficult to assess

The past decade has seen a proliferation of frameworks for understanding governance for health systems. These have differing perspectives (e.g., policymaker or donor), focus (e.g., health sector or broader), uses (checklist or normative program versus diagnostic tool), and components. As a result, there is no single concept of health system governance with a unanimously accepted framework. Thus, assessing governance, even in normal times, remains elusive, making it even more difficult to evaluate health systems steering in times of crisis. Furthermore, many governance frameworks were not developed with emergency response or broader resilience as a goal. In many cases they are focused on constraining political power rather than enabling and directing its use, which is not always helpful in emergency situations. They also emphasise efficiency and transparency rather than creativity and inclusiveness. For that reason, we should look at governance, like so much else, with different eyes after the pandemic.
Box 2: Key governance strategies for a resilient response to the pandemic

1. Setting out a clear and timely COVID-19 response strategy backed by appropriate laws and regulations
2. Having well-functioning monitoring, surveillance, and early warning systems
3. Drawing on the best available evidence supported by effective knowledge-transfer between research and policy
4. Coordinating effectively within the government and across sectors and jurisdictions (horizontally) and across levels of government (vertically)
5. Ensuring transparency, legitimacy and accountability in policy decision-making and implementation
6. Communicating clearly and transparently with the population and relevant stakeholders
7. Involving non-governmental stakeholders including health workforce, communities, and civil society

Source: 2

1. Existing response plans and emergency legislation supported a clear and timely COVID-19 response strategy

Having a clear and timely response strategy has been key to steering the overall response. While some countries sought to eliminate the novel virus, most countries assumed that—as with pandemic flu—widespread community transmission was inevitable. Irrespective of the chosen approach, deciding on a clear strategic direction allowed stakeholders to make concrete plans for action, although this was not always a pre-ordained path and required adaptations and sometimes more radical policy U-turns. This was supported by drawing on or quickly developing or amending response plans and emergency legislation to give the government special powers to impose restrictions or release emergency funds. Even if the existing emergency plans had limited applicability, the process of planning that preceded their development was nevertheless useful as it forced its participants to interact and, through this, better understand other perspectives which they would otherwise only encounter in a crisis.

2. Monitoring, surveillance, and early warning systems were crucial for early detection and ongoing management

These systems allow countries to develop effective and timely public health containment measures, strategies for health care delivery, and policy actions that may be needed outside health, such as social support measures. They cover not only epidemiological indicators but also other areas such as the availability and distribution of financial, human, and physical resources, and indicators measuring barriers to accessing services, among others. In many countries, existing disease surveillance and monitoring systems have been enhanced to inform the pandemic response and were often supported by extensive coordination across a range of actors and the use of digital health tools. Despite these improvements, critical knowledge gaps and other weaknesses, such as a lack of ‘one health’ approach, remain in most countries. The pandemic has also exposed weaknesses in the national, EU-level, and multilateral early warning systems and key gaps in information about the health workforce.

3. Effective knowledge-transfer between research and policy helped bring the best available evidence to light

Given how little was initially known about the virus, the ability to generate and/or access evidence across multiple disciplines has been pivotal in developing effective evidence-informed response strategies. Evidence on COVID-19 was generated at an astounding speed; all countries could benefit from open-source information provided by international agencies, journals and other data sources. Yet, information on the new virus, and later on its variants, was never complete and critical political decisions had to be made under conditions of uncertainty. In many cases, the accumulation and use of epidemiological, clinical, and virological knowledge outpaced that of social science on issues such as public adherence to mandates, the challenges of vaccination, or the operation of labour markets.

Deficiencies in the use of social science knowledge contributed to problems in the adoption, implementation, and operation of public health and vaccination measures. With a virus that exhibits exponential growth, delaying decisions can have a big cost. Given the pace with which this information has been developed and the vast amount of evidence, those in charge of crafting policy responses have in most cases taken steps to develop formal mechanisms to enable scientists and experts to guide them, although the composition of these advisory groups has raised concerns in some countries. Close links between scientific experts and policymakers have raised some questions over the transparency, rigour, objectivity, and independence of scientific advice, highlighting the important role of independent knowledge-brokers such as the World Health Organization (WHO), the European Commission (EC) or the European Observatory on Health Systems and Policies. One of the surprises of the current pandemic is how frequently public health agencies were not granted much of a role in advising governments.

4. Horizontal and vertical coordination was necessary for aligning policymaking and implementation

The scale of the pandemic has required coordination of efforts across many different parts of government, as well as NGOs. For the health sector, this meant horizontal (with other ministries, with relevant non-governmental actors and across jurisdictions and borders) and vertical (spanning central, regional, and municipal levels) coordination of decision-making. Centralisation of executive power has often been used to enhance
coordination of the response across sectors, at least initially (see article by Greer et al.), with special committees and other mechanisms often created to support coordination. Over time, as national lockdowns for regional outbreaks were increasingly seen as unnecessarily restrictive, there has been a shift to a more localised approach but with an important role for central governments to ensure coordination. Coordination among stakeholders was often supported by leveraging pre-existing structures and tools, such as medical associations, or by establishing new accountability mechanisms, such as those dictated by the crisis preparedness plans and emergency legislation. In practice, after a short period of centralisation in spring and summer 2020, most governments decentralised authority again, with irregular efforts to centralise during new waves (e.g. in winter 2020–21).

5. Political decision-making and implementation did not always safeguard transparency, legitimacy, and accountability

Transparency, legitimacy, and public accountability have not always been easy to maintain during the pandemic response, as governments had to act quickly and flexibly. This is a problem because emergency interventions (e.g. PPE acquisition) are always a time of extreme vulnerability to corruption. For example, many governments have loosened their procurement checks and balances. Leading transparency and anti-corruption organisations have supported ensuring transparency, preventing corruption, and strengthening whistle-blower protection during the state of emergency; yet corruption and fraud were rife in many countries. Having dedicated committees to ensure parliamentary scrutiny has helped strengthen oversight and ensure that peoples’ needs were represented, particularly when participation and engagement of the public and key stakeholders were restricted. Detailed presentation of response measures and performance indicators have been used to support accountability of decision-making, but proactive communication of such measures was often lacking.

6. Ongoing communication with the population and relevant stakeholders was often neglected

Despite the crucial need for effective communication coordinated across channels and actors, it has been often neglected during the COVID-19 response. For example, while various traditional communication channels (i.e. TV, radio) and newer ones (i.e. social media platforms) have been used to communicate with the public, national communication strategies were lacking in many countries. Moreover, targeted communication to address specific groups, e.g., those not speaking the country’s official language, was generally underutilised. Communicating transparently about uncertainty and tackling misinformation and disinformation has remained a major challenge throughout the response and has undermined public health measures, including vaccination efforts. The WHO and the EC have played a key role in combatting misinformation, but in most cases reinforcing national efforts has also been necessary.

7. Non-governmental stakeholder involvement could be improved

Participation of non-state actors including citizens and communities, health workers, civil society, and the private sector, can provide insights into how the crisis is affecting various communities. This enables the formulation of informed, real-time policy responses and adjustments, which can enhance the chance of effective implementation. In particular, engagement with civil society can allow governments to understand risks in vulnerable populations and win more adherence to public health measures and vaccines by working with trusted groups. Yet, many countries had limited inclusion of civil society and community groups (see article by Rajan et al.).

8. International coordination of the COVID-19 response has been fragmented

Despite longstanding cooperation in communicable diseases control, the global response to COVID-19 has been highly fragmented, with effective enforcement mechanisms largely lacking. Nevertheless, the WHO played an important role in drawing attention to, and coordinating global efforts against, COVID-19. Within a relatively short period of time the EU managed to organise a range of support measures, such as coordinating repatriation of stranded citizens; sharing and building up epidemiological knowledge; stockpiling key supplies; reopening borders for medical and critical goods; initiating joint procurement processes (for example for PPE); deploying health personnel; releasing funds for urgent health care spending, vaccine development strategy and acceleration of pharmaceutical strategy, among other things. In South-east Asia, regional cooperation through the Association of Southeast Asian Nations (ASEAN) has supported countries in containing the pandemic early on. The region’s prior experience with pandemics such as SARS and MERS has allowed ASEAN Member States to develop their own lessons and priorities which proved highly applicable to the emerging coronavirus (see article by Nitzan et al.).

Discussion

Analysing factors that enhance health systems resilience is vital for strengthening health systems to better prepare for future shocks. As seen during the pandemic, public health capacity—the specific, designated public functions relevant to public health such as surveillance, epidemic intelligence and local service delivery—can be a critical enabler of a resilient response. For example, countries such as Vietnam that invested in developing their public health capacities in the aftermath of SARS and MERS epidemics were able to quickly implement effective contact tracing.
strategies – something that many countries have struggled with well into 2020 (and some continue to grapple with until today). But as demonstrated by the experiences of countries that topped the Global Health Security Index (GHSI) during the COVID-19 pandemic, public health capacity is not a sufficient condition for a resilient response.

State capacity and political leadership are critical enablers of a resilient response

State capacity refers to a state’s ability to make and effectively implement policy decisions in health and other sectors. This requires competent multifunctional local and/or regional governments and administrative and bureaucratic institutions, professional civil service (e.g., to implement the necessary legislative and regulatory changes), and other specialised services such as the police. During the pandemic, state capacity could often substitute for weak public health capacity, which could enable a response even in countries with limited public health capacity. However, the reverse was not true, and COVID-19 has been particularly challenging for countries that have underinvested in state and in public sector capacity more broadly. Shrinking of the state under the dogma of new public management (NPM), which gained popularity in the 1980s, has led – in many countries – to an erosion of public-sector capacity and capabilities to handle emergencies (see article by Greer et al.). The pandemic may result in calls to rebuild state capacity to enable governments to respond to health and other future crises and pressures, particularly the ‘wicked problems’ such as climate change. But these are not necessarily calling for ‘more state’ but instead for a different type of state – one with the right capacities and capabilities. While the capacities described above might be the necessary conditions for a resilient response because they are required to implement policy, political leadership capacity is needed to activate them. Having good political leaders is, however, not something that can be taken as a given and the advice “have better leaders” falls flat during a crisis.

The challenge is how those seeking to protect health can be most effective in doing so with the leaders they have. One approach is to try to steer attention of leaders towards issues where they may be motivated to support. This may be helped by intelligent use of data: numbers of COVID-19 cases and deaths can be tracked in almost real time, making it possible for politicians to be held to account for their (in)ability to protect the health of their populations. But as we have seen during COVID-19 this may not always work. Another approach is to diminish the importance of any one person by distributing leadership, i.e., by reducing centralisation and sharing the responsibility and decision-making across bureaucratic hierarchies. In particular, countries with highly centralised leadership or leaders that do not seek cross-party consensus may be more likely to be paralysed in a crisis, for example, if the leader becomes sick, and their policies might suffer if the leader resists taking necessary actions.

The judicial system can also play an important role, ensuring that public health officials act within the existing laws and help hold governments to account. Further, building ‘flat, fast and flexible’ structures that are open and adaptive to finding solutions to new problems and working across hierarchical boundaries can be helpful in crises that, like the COVID-19 pandemic, require a ‘whole-of-society’ response. This may benefit from commitment over time and investment in development of leadership capacities, which ultimately depends on strong political support. But it can also be developed during a crisis, with Liberia’s Incident Management System set up in 2014 to manage the Ebola crisis being one example where this approach has been implemented successfully. However, such an approach may not be appropriate in all contexts and there is no consensus on whether a centralised or decentralised approach is the best. Thus, while it may not always be possible to have the right leaders in a crisis, effective governance could potentially provide some defence against those that are especially bad. Strong governance that enables good health policy “works in the absence of especially good leaders, and is a defence against especially bad leaders” because it determines the extent to what is possible for the politicians. Governance can therefore enhance resilience against pandemics as well as political crises.

Community engagement is important during times of crisis, but is often neglected

How far the voice and needs of the population have been brought into the emergency response has also been shown to be an important element of a resilient response. The more community-oriented governments are, the more responsive emergency measures can be, with higher policy adherence and buy-in. For example, countries with institutionalised mechanisms for government-community dialogue were able to easily adapt COVID-19 communication to the needs of hard-to-reach population groups. When public health authorities have the tradition and ability to work side by side with communities, they are able to better address the inequities exposed by the pandemic through their insight and understanding of people’s context. The more people-focused and bottom-up political leadership is or is perceived to be the less likely it will face opposition for far-reaching restrictions of basic liberties which can support sustained compliance with these measures. In some cases, communities can step up to compensate for the deficiencies in the government’s response.

Community engagement is seen as critical to many health initiatives. Previous experiences show that it has been central in prevention and control of past epidemics, such as Ebola, Zika, and H1N1 outbreaks, where it has been mostly used for social and behavioural change.
communication and risk communication, surveillance and contact tracing, although rarely as part of organised response programmes. Effectively responding to a pathogen that spreads through community transmission requires devising contextually appropriate strategies that consider the ways people interact and live with each other and how this and people’s needs are affected by the outbreak. Some of the newest health systems resilience frameworks that draw on the COVID-19 experience have recognised that community engagement is core to building resilience and that resilience must be developed with and according to the needs of the communities it is meant to serve. However, meaningful community engagement work is often ‘poorly understood, left until too late and clumsily executed.’ While community engagement can be improved during a crisis, high-quality coproduction is hard to establish rapidly. Community co-production under the COVID-19 pandemic has also been challenging and national responses, at least initially, have largely been top-down, with community involvement being seen more as an additional burden, rather than a fundamental element of a successful, sustainable response. But the importance of community-sensitive approaches has grown over time, reflecting the key role of communities in reaching marginalised populations, increasing adherence to nonpharmaceutical interventions and improving vaccination take-up, among others.

**Conclusion**

Governance has been a key determinant of an effective response to the COVID-19 pandemic. The effectiveness of governance at multiple levels – the health system functions, the health system overall and beyond the health system – enables a resilient response and can provide a buffer against ineffective political leadership. While changes to crisis governance can be made during the pandemic, these cannot be created from nothing and must recognise existing opportunities and barriers, including where power lies both formally and informally. New adaptive approaches to governance surfaced during the pandemic, with more actors, including actors at the community level, providing support to the government in response to the pandemic. Mechanisms to ensure community engagement have been essential for effective disaster response and can improve preparedness for and response to future emergencies, especially infectious disease outbreaks that spread through community transmission and require community-sensitive responses. These community voices should be incorporated to co-create both better pandemic response and better health services. Looking forward, as health governance continues to evolve, community engagement should be firmly built into crisis responses as well as governance and resilience frameworks.

**References**

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**COVID-19 responses in Europe – towards better governance**