REVIEW OF LEADERSHIP FUNCTION AND REFORM TOWARDS ENHANCING PRIMARY HEALTH CARE SERVICES IN SELECTED COUNTRIES

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ABSTRACT

Background: Leadership reform was one of the primary health care (PHC) reforms proposed by the World Health Organization (WHO) in response to the failures of the ‘health for all’ goals by the Declaration of Alma Ata. WHO had recommended a leadership approach that was interpreted as the persuasive democratic leadership style. The aim of this manuscript was to analyse leadership styles and functions of different countries, as well as to study the strategies by other countries in achieving leadership reform.

Materials and Methods: Roemer’s model was used to analyse leadership styles and functions between countries. Articles, reports and related publications from online databases such as PubMed, CINAHL and Google Scholar were used for the review.

Result and Discussion: Malaysia, Indonesia, Nigeria and Australia are practising the persuasive democratic leadership style in the PHC system. This is shown by the prominent government role in PHC policy making, management and the financing mechanism to ensure universal health coverage. Element of democracy can be seen by the participation of various stakeholders from different levels of the countries’ PHC system in the negotiation of the PHC services and resources allocation in order to meet the local needs in these four countries. However, government domination became one of the challenges identified as it leads to lack of decentralisation. Several countries had found the solutions towards PHC reform, much of it by the reform in leadership through implementing policy level interventions, aligning bottom-up and top-down interventions, and distributed leadership concept among others.

Conclusion: Different countries have different styles of leadership in its PHC reform, facing different types of challenges with its own set of solutions, approaches that many countries could learn from in enhancing their PHC services.

Keywords: leadership reform, primary health care, Roemer’s model
1.0 Introduction

1.1 History of Primary Health Care Leadership Reform

The ideas about primary health care (PHC) only started to emerge in the 1960s and 1970s; a period when many developing countries had just newly won their independence from former colonial powers, and wanted to provide high standard of health care to their people (Hall & Taylor, 2003). At that time the morbidity and mortality for rural communities was not improving (Bennet, 1979). In consequence several countries had started to develop successful programmes to deliver basic but comprehensive health care services to cover their poor rural populations in which concept was undertaken by the World Health Organization (WHO) and United Nations Children’s Fund or UNICEF (Hall & Taylor, 2003). The 30th World Health Assembly in May 1977 adopted the resolution that the main social target of government and of WHO in the coming decades should be the attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life by the year 2000 or also known as ‘Health for all by the year 2000’ resolution (WHO, 1981). In September 1978, the Declaration of Alma Ata formally adopted the primary health care concept as the means to provide comprehensive, universal, equitable and affordable health care services for all countries (WHO, 1981). During the 32nd World Health Assembly in 1979 the Global Strategy for Health for All was launched when it endorsed the Alma Ata Report and invited Member States to act individually in formulating national strategies and collectively in formulating regional and global strategies (WHO, 1981).

Evaluation of the Global Strategy for Health for All by the year 2000 that was carried out in 1997 has shown significant improvements both in health status and access to health care (WHO, 1998). However, there was concern about resources for health due to the growing costs of health services especially when only few countries were found to have satisfactory distribution of financial resources between promotive and curative services in addition to the problems associated with provisions of human resource (WHO, 1998). In 2008, on the 30th anniversary of Alma-Ata Declaration, WHO came to produce The World Health Report 2008 to revisit the ambitious vision of PHC as a set of values and principles for guiding the development of health systems (WHO, 2008). It was observed that the progress of health had been unequal and there was a growth in health inequalities within countries as a result of several trends in health system. Among the worrisome trends is the health system that focused on narrow offer of specialised curative care, a command-and-control to disease control that focused on short term results, fragmenting service delivery, and hands-off or laissez faire approach to governance that led to unregulated commercialisation to grow (WHO, 2008). There are four major avenues that have been identified in order to narrow the gaps between aspirations and implementation in the health system worldwide. These avenues were defined as four sets of reforms which are universal coverage reforms, service delivery reforms, public policy reforms and leadership reforms (WHO, 2008).

Leadership reforms had been proposed by WHO because the current leadership practices in various countries do not contribute to the goals of health for all. It was also observed that the laissez-faire approach to governance in health systems have dominated in many countries and led to unregulated commercialisation of health to flourish (WHO, 2008). Therefore, it was recommended that an inclusive, participatory and negotiation–based leadership in the health system should replace the disproportionate reliance on command and control as well as the laissez-faire leadership (WHO, 2008). It was strongly recommended for countries to have a
more effective public sector stewardship on health in order to achieve greater efficiency and equity (WHO, 2008). Based on the complexity of health system, it was also proposed for an effective policy dialogue in order to encourage discussion on resource allocation among stakeholders for service delivery to accelerate PHC reforms (WHO, 2008). The recommendation of the leadership style made by the WHO mimics the persuasive democratic leadership style. In this leadership style, group discussion and participation are encouraged in order to come to a consensus in any decision making. However, the leader will also try to influence the followers to favour his idea by diminishing other possible ideas and the final decision is still made by the leaders despite the discussion (Barker, Johnson & Lavalette, 2001).

In Malaysia, the system that is currently in use was inherited from the British upon the country’s independence in 1957 (MOH, 2013). Pre-independence the system concentrated more on the urban areas due to the economics and political importance to the colonial masters (MOH, 2013). Health care services started to be given more attention post-independence with priority given to rural health services, taking more of a population based approach and focusing on the economically disadvantaged (Jaafar, Suhaili, Mohd Noh, Zainal Ehsan & Lee, 2007). The Rural Health Services Scheme was successfully developed in 1966 with the establishment of a three-tier rural health unit and subsequently replaced by the two-tier system in 1970 (MOH, 2013). The system had expanded tremendously over the years with the growth of the private sector resulting in a dichotomous health care system for Malaysia. The private sectors caters for the personal care of individuals while the government led public sector provides for both personal care and public health services towards overall population health (MOH, 2009). Up till the end of 2015, over 7000 private healthcare facilities (including hospitals and medical clinics) had been registered but most are concentrated in the urban areas whereas only about 3000 government healthcare facilities (including hospitals, health clinics and community clinics but excludes 1Malaysia clinics) had been built particularly to reach people in under-served rural areas (MOH, 2016). Nevertheless, in terms of leadership, the MOH remains as the main provider and financer of the whole system of health care in Malaysia (MOH, 2009).

Leadership functions are understood as actions that should be carried out by leaders, however the degree to which it is performed in various national situations may vary greatly (WHO, 1986). This article is aimed to analyse in detail the leadership functions and style in PHC for various countries; Malaysia, Indonesia, Nigeria and Australia in relations to WHO recommendations and to identify the challenges related to leadership reform in PHC. It is also aimed to identify strategies to improve the leadership functions in PHC based on the experience of leadership reforms from other countries; United Kingdom, Spain, South Korea and Thailand.

2.0 Methodology

Roemer’s model was used to analyse the leadership functions in PHC of selected countries namely Malaysia, Indonesia, Nigeria and Australia. These countries were chosen to represent countries of different income level based on the World Bank’s classification and the availability of complete literatures on the subject. The Roemer’s model comprises of the organisation of programs and their management, the production of resources that support the
system, the sources of economic support, and how services are delivered (Wegman, 1992). Roemer’s model was used to analyse the leadership function due to its comprehensive matrices in the healthcare system which provide useful tool for detailed analysis. Figure 1 showed relationship between various components of health services as explained by the model. Leadership reform in PHC for United Kingdom, Spain, South Korea and Thailand was then analysed and these countries were selected based on their efforts in PHC reform and again according to the availability of documents and records. Articles, journals, reports and related publications from online databases such as PubMed, CINAHL and Google Scholar were used for this review and no inclusion or exclusion criteria was specified in this study. The keywords were leadership reform, primary health care and Roemer’s model. Information was synthesized according to literature review.

![Figure 1: Health System: components, functions and their interdependence as seen in Roemer’s Model (Source: Wegman, 1992)](image)

### 3.0 Results and Discussion

#### 3.1 Overview

In this section, leadership styles and functions in PHC for Malaysia, Indonesia, Nigeria and Australia were identified (Table 1). Their similarities and differences were analysed and compared with the WHO recommendation towards leadership reform in PHC. As a consequence, a list of challenges was recorded and subsequently several countries were analysed namely United Kingdom, Spain, South Korea and Thailand to look at their strategies in achieving leadership reform.
3.2 Leadership Functions in PHC for Malaysia, Indonesia, Nigeria and Australia

Table 1: Country comparison on leadership styles and function in PHC

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Malaysia</th>
<th>Indonesia</th>
<th>Nigeria</th>
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<tr>
<td></td>
<td>- MOH administers the public health sector services via central, state and district offices. Other government departments such as Ministry of Higher Education, Ministry of Defence also provide health services (MOH, 2013).</td>
<td>- The government health care system has three main levels which are the Minister of National Health, Provincial Level Health Office and District Level Health Office.</td>
<td>- Public Sector-Federal, state and local level.</td>
<td>- Australian Government Department of Health at all level.</td>
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<td></td>
<td>- Non-governmental organisations (NGO) are involved with the provision of PHC.</td>
<td>- Private sectors, foreign aid, NGOs and religious organisations.</td>
<td>- Private sector-Private for profit organisations.</td>
<td>- Private sectors including the general practitioners, private hospitals and pharmacies.</td>
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<td></td>
<td>- Private health sector provides health services mainly in urban areas.</td>
<td>(Ministry of Health Republic of Indonesia, 2014 &amp; Rokx et al., 2010).</td>
<td>- Non-governmental organisations (NGOs), Community based organisations, faith based organisations and traditional care providers.</td>
<td>- Voluntary and community organisations.</td>
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<td>Management</td>
<td>- Policies and programs are formulated, administered and funded centrally, no decentralisation of the public sector health care system, including staffing (MOH, 2013).</td>
<td>- Ministry of National Health is responsible for national health policy (decentralisation policy) and management of the health system.</td>
<td>-The federal ministry of health is responsible for policy and technical support to the overall health system, the national health management information system and the provision of health services.</td>
<td>(Australian Institute of Health and Welfare (AIHW), 2014)</td>
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<td></td>
<td>- Health facilities would</td>
<td>- Both provincial and district level</td>
<td>-Overall coordination of the public health system</td>
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<td>Malaysia</td>
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<td>receive a fixed annual budget based on performance indicators and targets (MOH, 2013).</td>
<td>governments have authority to manage and regulate their financial system, including their health care system, workforces, and spending.</td>
<td>- The state ministry of health are responsible for secondary hospitals and for the regulation and technical support of primary health care</td>
<td>is the responsibility of all Australian health ministers, that is, the Commonwealth and state and territory ministers.</td>
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<tr>
<td>- Mainly is a top-down exercise but the MOH requires its staff to conduct situational analysis in their areas, then the technical working groups will study the issues and proposed goals, plans of action and performance indicators (MOH, 2013).</td>
<td>- Districts have independence and responsibility to manage employment, deployment, and payments of health care professionals (Rokx et al., 2010).</td>
<td>- The local government is responsible for the PHC.</td>
<td>- Health minister and health department in each jurisdiction is responsible to manage the individual Commonwealth, and state and territory health systems.</td>
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<td>- MOH is the main regulatory actor as major employer of health professionals and provider of health care services. It has only weak regulatory powers over the private sectors especially in terms of enforcement of legislations but there are ongoing proposals to strengthen it (MOH, 2013).</td>
<td></td>
<td>- The private sector: The private sector in Nigeria is believed to provide the major share of health services in Nigeria. (Kombe et al., 2009)</td>
<td>- At local level, Primary Health Networks are expected to align more closely with state and territory health network arrangements. (AIHW, 2014).</td>
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<td>Economic Support</td>
<td>Health expenditure is at 4.2% of GDP in 2014, below the average for upper middle income countries (The World</td>
<td>Health expenditure is at 3% of GDP in 2012. - 39.6% of THE came</td>
<td>Health expenditure is at 4.3% of GDP in 2006. - 65.9% of THE comes</td>
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<td>Health expenditure is at 4.3% of GDP in 2012. - 39.6% of THE came</td>
<td>Health expenditure is at 9.5% of GDP.</td>
<td>-70% of THE in</td>
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<td>Malaysia</td>
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<td>from the government (38% was from social health insurance, 16% from indirect taxes and 22% from direct taxes and 24% other revenue including multilateral loans and grants).</td>
<td>- National health insurance program, under a single social security agency - Social Security Management Agency for the Health Sector (BPJS Kesehatan) since 2014. 60.4% of THE came from private sector (45.3% from OOP) 1% of THE from donor financing and 2% from private insurance.</td>
<td>from OOP payments. 26.1% from the government (federal 12.4%, state 7.4% and local government 6.4%). -Firms (6.1%) and development partners (1.8%). -Health insurance (social and community) (Kombe et al., 2009)</td>
<td>Australia is funded by the government. The federal government contributes two-third of this and the state, territory and local government contribute another one-third. - The two major national subsidy schemes are Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). - Non-government sources (individuals, private health insurance and other non-government sources) funded 30% of THE in Australia. (AIHW, 2014).</td>
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<td>-Health physicians to</td>
<td>-Number of primary care and</td>
<td>-The main categories in</td>
<td>-Nurses and midwives are</td>
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<tr>
<td>-Resource</td>
<td>-Number of primary care and</td>
<td>-The main categories in</td>
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(Trisnantoro, Marthias, & Harbianto, 2014 & The Intelligence Economist Unit, 2015). (Kombe et al., 2009)
Production

- MOH is also gradually converting its facilities from paper-based to electronic system.
- The number of health professionals especially specialists still remain below the requirements despite the increase in the number of training places. Malaysia has 0.9 physicians per 1000 population, 2.73 nurses and midwifery personnel per 1000 population, and 0.14 dentists per 1000 populations (MOH, 2013).

People ratio ranged between 10.36 per 100,000 population to 53.89 per 100,000 which indicate misdistribution of health workforce, with higher number in the urban compared to the rural area.
- In contrary, number of midwives is higher in the rural area compared to the urban area. The average ratio of midwives to people ratio is 37 per 100000 population.
- The physicians and the midwives are allowed to carry out dual practice where they provide private services during non-public hours. (WHO, 2016 & Rokx et al., 2010).

Delivery of Services

- MOH offers services including health promotion,
- Public sectors with three tier systems providing
- The delivery of PHC is the responsibility of the
- General practitioners are the main PHC services

**Malaysia**

dental clinics has increased in both public and private sectors.

**Indonesia**

people ratio ranged between 10.36 per 100,000 population to 53.89 per 100,000 which indicate misdistribution of health workforce, with higher number in the urban compared to the rural area.

- The densities of nurses, midwives and doctors that is still too low to effectively deliver essential health services (1.95 per 1,000).

**Nigeria**

the Nigerian health care system are doctors, nurses and the community health workers.

- Drug procurement in the public sector is decentralised and fragmented. A drug fund was widely established as an integral part of PHC implementation in the 1990s to ensure an interrupted supply of essential drugs (Kombe et al., 2009, Labiran et al., 2008 & WHO, 2016).

**Australia**

the largest group in health workforce, followed by the medical practitioners.

- Workforce shortages – highly significant in the case of nurses (109,000 or 27%) and doctors (2,700 or 3% for doctors overall).

- Australian Commission for e-Health was proposed to establish interoperable infrastructure to support communication across the health care system.

- Rural health innovation as a strategy to retain rural physicians.

### Malaysia
- Disease prevention, curative and rehabilitative care through its clinics and hospitals, while special institutions provide long term care. Health-related services also provided by other governmental ministries (MOH, 2013).
- Private sector offer mainly curative health services (primary and secondary ambulatory care) and focused in urban areas. There are also diagnostic laboratories and ambulance services run by private companies (MOH, 2013).
- MOH health clinics provide basic emergency services managed by paramedics and 90% of clinics are equipped with ambulances (MOH, 2013).
- The healthcare provider payment method is mainly by salary.

### Indonesia
- The preventive and curative services mostly in the rural areas, such as primary health centers, named as Pusat Kesehatan Masyarakat (PUSKESMAS).
- Private providers, such as the private general practitioners and private hospitals.
- The main healthcare provider payment method is from capitation.
- (Ministry of Health Republic of Indonesia, 2014, Rokx et al., 2010 & The Intelligence Economist Unit, 2015)

### Nigeria
- Local government with support from the state ministries of health. These facilities include health centres, clinics, dispensaries, and health posts. They provide general preventive, curative, promotive, and pre-referral care to the population.
- Private sector: providers include physician practices, maternity homes, clinics, and hospitals. It provides curative, preventive and health promotion services.
- The main provider payment method is from fee-for-services (FFS) via the OOP expenses.
- (Abdulraheem, Olapipo & Amodu, 2012 & Kombe et al., 2009).

### Australia
- Other private health providers include the private hospitals and pharmacies.
- Other governmental programmes for PHC services that are targeted to improve special group of population, include the Aboriginal and Community Controlled Health Services, community health centres and allied health services, as well as within the community.
- The main healthcare provider payment method is from FFS via the MBS and OOP expenses.
- (AIHW, 2014).

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It can be seen that for the organisational component of the PHC, there is more than a single sector involved in all the four countries; Malaysia, Indonesia, Nigeria and Australia. There is public sector, such as the Ministry of Health as well as the private sector that fuelled up the organisation of the PHC in all these countries. Besides that, there are also NGOs and community organisations that form part of the organisations in the PHC of the countries. However, there is a slight difference observed in Malaysia as there are a number of ministries, such as Ministry of Defence and Ministry of Higher Education that is involved in the PHC organisation compared to Indonesia, Nigeria and Australia (MOH, 2013). Nevertheless, the top-down decision-making practice within the country resulted in strong collaborations between those different ministries in the organisation of PHC in Malaysia.

The management of the PHC that involves with the planning, administrating, regulating and legislation of these four countries can be seen as being dominated by the federal government. All the decision-making process, including planning and policy making is made by the federal government. The decision-making process is mostly top-down practice. The centralised practice is predominant in Malaysia and Nigeria but the practice in Australia and Indonesia are somehow different. In Indonesia, there has been a strong policy enacted on the decentralisation of primary healthcare that enables the provincial and district levels to have the power in managing and regulating their health care system, including the financial system and workforces in meeting the local needs (Rokx et al., 2010). This decentralisation policy committed by the Indonesian government showed a prominent leadership reform in ensuring universal health coverage. Similarly, even though the Australians health policy is decided at the federal level as stated by the Australian Institute of Health and Welfare (AIHW), the states are responsible at managing individual’s state and territory health systems (AIHW, 2014). Moreover, there is Primary Health Networks at local level that are expected to align more closely with state and territory health network arrangements in the delivery of services in order to meet the local needs and reduce duplication of effort in the primary care (AIHW, 2014). This different approach could be attributed by the collaborative leadership style adopted by Australia following the establishment of Council of Australian Governments’ (COAG) National Health Reform Agreement in 2011 (Horvath, 2014).

For the economic support of the PHC, there is a similar pattern observed where the government is the primary funder of the PHC in Malaysia and Australia. This is mainly from general revenue and taxation collected by the government. The public sector funded 55% of the total Malaysian health expenditure compared to 70% of total health expenditure by the Australian government (The World Bank, 2016 & AIHW, 2014). This discrepancy could be influenced by the difference in health financing system of the two countries. The Australian government had introduced the Medicare, a universal public health insurance scheme since 1984 to provide free or subsidised treatment by health professionals (AIHW, 2014). This commitment by the government of Australia indicates the important role of the federal government in leading the role of decision maker in PHC to ensure equitable access to the population. On the other hand, it was found that 60.4% of the total health expenditure in Indonesia came from the private sources; 45.3% from the out-of-pockets while another 39.6% came from the government (Trisnantoro, Marthias, & Harbianto, 2014). Similarly, it was found that 65.9% of the total health expenditure in Nigeria came from out-of-pocket payment and only 26.1% funded by the government (Kombe et al., 2009). Even though the Indonesian government only contributed 39.6% of the total health expenditure, they do have a national health insurance program under a single social security agency that is initiated by the leaders
of the country as a measure to ensure universal health coverage (The Intelligence Economist Unit, 2015).

In terms of the resource production of the PHC, it can be seen that there is shortage of human workforce including the doctors, nurses and midwives in the PHC of the four countries (WHO, 2016 & MOH, 2013). However, there is ongoing effort in producing more health workforces through training as well as sustaining them. There is slight difference in the strategy used in sustaining the health workforce between these countries. For Australia, in order to sustain the health workforce in the critical area to ensure PHC accessibility to the marginalised population such as the rural population in Australia, rural health innovation had been introduced (Snowdon & Cohen, 2011). It is a strategy to retain the rural physicians by creating infrastructures that enable them to manage the patients in the community as well as offering a flexible working system (Snowdon & Cohen, 2011). There is also a commitment to improve the health system communication network through e-Health establishment in order to support the rural health workers in the PHC management (Commonwealth Fund, 2016). Such innovations could be made as a result of strong steering role by the government in decision making and policy development. In Indonesia, the health physicians and the midwives are allowed to do dual practice that enables them to provide private services after the public working hours as a measure to retain the health workers in the rural areas (Rokx et al., 2010). There is also an initiative on assigning non-permanent health personnel to the very remote areas in Indonesia with higher payment being offered (Ministry of Health Republic of Indonesia, 2014 & Indonesian Academy of Sciences, 2013). In contrast, there is a regulation in Malaysia that requires medical practitioners to serve the public a compulsory service period as a strategy to retain them in the public sector. This results in more doctors made available in the public sector leading to a better access and health care for the population.

The combination of the organization, management, economic support and resource production of the PHC will contribute to the delivery of the PHC services. It can be seen that the public sector is the main provider in the delivery of PHC services in Malaysia and Nigeria (MOH, 2013 & Abdulraheem, Olapipo & Amudu, 2012). This would mirror the health financing system and the centralized decision making of the government in both countries. Similarly, the main primary health providers in Indonesia are the public sectors and this also reflects the leadership role of the government in moving towards improving the national healthcare services provision. On the other hand, private general practitioners are the main primary health care providers in Australia. This could be driven by the financing system in Australia that allows the general practitioners to get reimbursement from Medicare, the public health insurance scheme funded by the government which reflects the leadership role in the PHC system of the country.

From this analysis, it was found that Malaysia, Indonesia, Nigeria and Australia are practising the persuasive democratic leadership style in the PHC system. This is shown by the prominent government role in PHC policy making, management and the financing mechanism to ensure universal health coverage. Element of democracy can be seen by the participation of various stakeholders from the different levels of the countries’ PHC system in the negotiation of the PHC services and resources allocation in order to meet the local needs in these four countries.
3.3 Challenges Identified towards Leadership Reform in PHC

Based on the analysis carried out, there are a number of problems and challenges related to the leadership functions in PHC that had been identified. One of the obvious problems is the nature of the PHC organisation that is mostly controlled by the government in these four countries. Secondly, it was also found out that there is a challenge in decentralising the management of the PHC. Even with decentralisation policy in place, there is lack of coordination and local capacity in managing the PHC at the local level. It is also observed that there is suboptimal resource production in PHC across all countries and that the sustainability of the health financing scheme is still a great concern.

3.4 Review of Leadership Reform in Various Countries

Based on the recommendations by the WHO towards achieving leadership reform, health authorities should approach reforms in PHC according to lessons from other countries’ past successes and failures (WHO, 2008). Four countries, namely United Kingdom, Spain, South Korea and Thailand had been reviewed on strategies that were taken toward reforming leadership in enhancing PHC.

3.4.1 United Kingdom

The National Health Service (NHS) is United Kingdom’s national healthcare system that is funded primarily through taxation. However, after nearly 70 years in existence, the organisation has entered into its most challenging era when it was asked to make a cultural shift; to increase quality and decrease costs (Edwards, Penlington, Kalidasan & Kelly, 2014). Several recommendations and evidences had been outlined for the NHS, with all of it coming to the same conclusion which is to embrace change and incorporate a collaborative leadership. In one of its examples, the author had described the types of problems that an organization might face as a wicked problem, which in general comprised of interwoven strands of problems that cannot be understood if in isolation (Edwards, et al., 2014). Leadership is a critical aspect in wicked problems in order to find a way forward because its answers are probably not self-evident and will require collaborative process for it to make progress thus the leader mainly needs to know what question to ask rather than knowing the answer to a question (Edwards, et al., 2014). This would mean that a top-down management will not be effective in solving their problems. In this collaborative process, they need to engage with the workforce while taking into account the various organizations and teams making up the NHS (Edwards, et al., 2014).

In support of this is the argument that the improvement of the safety culture in the development of NHS towards a learning organization will not be achieved by being a top-down manager who sets rules, incentives and regulations mechanistically (Edwards, et al., 2014; Berwick, 2013). Their focus should also be more of patient-centered rather than indicator-centered or target-centered and their quality improvement agendas should involve their entire workforce (Edwards, et al., 2014). This all translated into the fact that their workforce has an important role to play in shaping the future of NHS. Thus, to bring about this cultural change amidst the complexity of modern healthcare, it required an evolvement in the approach to the workforce and the styles of leadership within the NHS itself (Edwards, et al., 2014).
3.4.2 Spain

Due to the increasing financial, demographic, epidemiological and clinical pressures on health care systems around the world, Basque Country in Spain had taken the initiative to meet these pressures through system wide transformation of the health care system to become more proactive and collaborative rather than reactive or fragmented (Bengoa, 2013). The reform process was applied to four broad lines of work which is by developing a favourable policy environment, stimulating ‘system’ thinking with new models of care, aligning bottom-up and top-down integrators and promoting a distributed leadership approach (Bengoa, 2013).

Developing a favourable policy environment is quite straightforward in the sense that an agreeable policy is needed before any reform is implemented to ensure that the available policy will not hamper in the process of change. This policy-level-intervention provides the health sector with clear policies that is in-line with the agenda for a more proactive and collaborative care (Bengoa, 2013). Secondly, in stimulating ‘system’ thinking with new models of care, those new models helped to create local system of care (Bengoa, 2013). It also stimulates ‘system’ thinking and concurrently opening the door to a population health perspective (Bengoa, 2013). According to the author, the whole population of Basque Country was stratified according to their risk of future hospitalisations thus it became more possible to address and target interventions on those more vulnerable patients.

Bottom-up interventions aimed to engage clinical and nursing leadership in the change process towards a greater involvement of health care professionals in an effective performance of the health care system (Bengoa, 2013). Top-down interventions are towards the standardisation across the entire health care system including efforts to finance defragmentation such as by giving bundled payments across primary care and hospitals to encourage coordinated work at provider level (Bengoa, 2013). In aligning bottom-up and top-down integrators, the care management processes must be developed to ensure that it has the potential to reinforce integration of care (Bengoa, 2013). Encouraging a distributed leadership approach can be achieved through several ways. Participation of health care professionals and staff engagement had been known to improve outcomes in terms of quality and management (Bengoa, 2013). Another approach is by giving the autonomy for different groups to find different solutions locally to improve their care processes and lastly, this bottom-up process also reinforced future continuity of projects throughout any political turnovers or instabilities (Bengoa, 2013).

3.4.3 South Korea

South Korea maintains a universal healthcare system that is rated as the fourth most efficient healthcare system out of the 55 nations rated in 2016 after Hong Kong, Singapore and Spain (Wei, 2016). South Korea introduced three major health care reforms; in financing in 1999, pharmaceuticals in 2000, and provider payment in 2001. Under these three reforms, several changes were seen such as new government policies that merged more than 350 health insurance societies into a single payer, separate drug prescribing by physicians while dispensing by pharmacists, and attempted to introduce a new prospective payment system (Kwon and Reich, 2005). Within the time span of 12 years, South Korea managed to achieve government-mandated universal health insurance (Lee, 2003). This remarkable achievement started modestly in 1977 when the government mandated medical insurance for employees and their dependents in large firms with more than 500 employees (Lee, 2003). Since then,
coverage has gradually broadened to embrace businesses with fewer employees of 300 or more in 1979, and gradually to smaller number of employees of 5 or more in 1988. Health insurance was also expanded to include the rural self-employed in 1988. By 1989, health insurance coverage was available to the entire population, including the urban self-employed (Joeng, 2011). The single insurance system is efficient as it has a greater risk-pooling capacity and can better use its financial leverage in bargaining with providers (Kwon, 2011). This national health insurance system enables universal health coverage and equity to be achieved as everybody can access the same benefits with the same contribution mechanism.

The change of government, the president’s keen interest in health policy, and democratisation in the public policy process toward a more pluralist context opened a policy window for these reforms. Political interest together with civic groups influences in the design of the health reform, created opportunities for a significant health policy change. Change in the policy process from an authoritarian, elite-led, top-down approach to a democratic, participatory, bottom-up approach contributed to the success of healthcare reform (Kwon & Reich, 2005). Therefore, it can be seen that leadership plays a crucial role in the PHC reform in South Korea.

3.4.4 Thailand

The implementation of Universal Coverage Scheme (UCS) for 47 million (75%) of its population has helped Thailand in achieving universal health coverage since 2002 (Limwattananon, Tangcharoensathien, Tisayaticom, Boonyapaisarncharoen & Prakongsai, 2012). Their pro-poor health financing system has been contributed to three factors which is improved access to health services provided by the district health system for the poor, very low level of out-of-pocket payment and significant governmental financial commitment (Limwattananon, et al., 2012). Firstly, the improved access to health services by their district health system is due to the geographical proximity or also known as ‘close-to-client services’ in which their indirect cost of travelling and access is low (Limwattananon, et al., 2012). This is also supported by a satisfactory resource allocation where budget support is good, and there are a three years mandatory rural health services by newly graduated doctors, nurses, dentists, pharmacists and other paramedics (Limwattananon, et al., 2012). The availability of private health clinics for the rich also reduces overcrowding in the public facilities.

Secondly, the low level of out-of-pocket payment (8.5% of total health expenditure in 2012) is due to the comprehensive benefit package for all UCS members which cover medicines, high cost care such as chemo and radiotherapy, preventive medicine and health promotion services (Limwattananon, et al., 2012). Their flat rate co-payment had also been terminated in 2006. Lastly, the government’s financial commitment towards health was quite significant (Limwattananon, et al., 2012). The general government expenditure on health had increased from 50% in 2001 to 85% in 2012 of total health expenditure while total health expenditure as percentage of gross domestic product (GDP) has increased from 3.3% in 2001 to 6.2% in 2012 (Limwattananon, et al., 2012). Thus the good design of UCS and its public health insurance package had resulted in equity outcome that is in favour of the poor.
4.0 Conclusion

Different countries have different styles of leadership though most are in line with WHO’s recommendation towards leadership reform in PHC. Nevertheless challenges faced were many in the path towards reform, though some countries had demonstrated that it could be overcome with different strategy approach for other countries to learn from.

Author’s contribution

Author 1 : information gathering, preparation and editing of manuscript
Author 2 : information gathering, preparation and editing of manuscript
Author 3 : information gathering and preparation of manuscript
Author 4 : initiation of idea and final review of manuscript

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