

## VI. STEWARDSHIP FUNCTION

### 1. WHR 2000

WHR 2000 introduced the concept of stewardship as one of the four essential functions of the health system: *service provision, resource generation, financing* and *stewardship*. In the Introductory chapter, the Director-General highlighted this new concept noting that the function involves “setting and enforcing the rules of the game and providing strategic direction for all the different actors involved”. The concept was developed further in chapter six.

Here stewardship was defined as “the careful and responsible management of the well-being of the population, the very essence of good government”. The text continued “This does not, of course, mean that the government needs to fund and provide all health interventions. It needs, however, to set the direction for both public and private sectors and ensure that the health system contributes to the socially desired intrinsic goals. How well or poorly a government executes its stewardship role can influence all aspects of health system performance”. It also stated that ultimate responsibility for the overall performance of a country’s health system lies with government, which in turn should involve all sectors of society in its stewardship. Within government, Ministries of Health must take on a large part of the stewardship of health systems and should direct/coordinate intersectoral action for health.

### 2. Main commentaries and criticisms

Although various individuals and groups had commented extensively on aspects of the WHR 2000, there was little published comment on stewardship. Only two articles have been identified. Saltman and Ferroussier-Davis (2000) discuss the concept of stewardship in health policy as proposed in WHR 2000, and conclude that the concept “holds substantial promise if adequately developed and effectively implemented”. An editorial in the European Journal of Public Health (McKee 2001a) also discusses the potentially major implications of the concept of ‘stewardship’ of health systems, both for countries and for WHO as it seeks to strengthen its role as a credible advocate for global health.

The Regional Consultations on health-system performance assessment did discuss stewardship. In addition to statements about the importance of the notion of stewardship, it featured in general discussions on the need to better map all the health system functions, their linkages with each other, and their relation to outcomes. Participants in the EMRO consultation observed the need for better definition of each of the components of stewardship (WHO Regional Office for the Eastern Mediterranean 2001). In AFRO and SEARO,

participants recommended that in future work on performance assessment, WHO and Member States should pay special attention to developing methods for assessing the stewardship function of health systems (WHO Regional Office for Africa 2001; WHO Regional Office for South-East Asia 2001). In the EURO consultation, it was stressed that assessment should not be seen as an isolated exercise, but explicitly linked to efforts to strengthen stewardship (WHO Regional Office for Europe 2001). More general comments were also made on the need to develop complementary and qualitative measures of functions, not just pursue quantitative dimensions of analysis. PAHO/AMRO proposed the use of a 'dashboard' approach to assessing functions (WHO Regional Office for the Americas 2001). In the WPRO consultation, the participants commented on WHO's own stewardship role in the international health arena (WHO Regional Office for the Western Pacific 2001).

The most extensive debate on stewardship has been the international technical consultation on stewardship in September 2001 at which the participants reviewed the definition of the term and discussed its relation to governance (World Health Organization 2001). They also noted the difficulty in preserving the idea when translating the term into other languages. Participants referred to it metaphorically as combining three elements ("the 'glue' that holds the health system together; the 'oil' that keeps it running smoothly, and the 'energy' that gives it ethical direction and momentum"). They generated a list of possible stewardship tasks that fitted within the three-part classification that WHR 2000 set out:

- formulating health policy;
- exerting influence; and
- collecting and using intelligence.

Participants agreed that some form of descriptive characterization of approaches to stewardship would be useful, and counselled against measurement of stewardship as an isolated exercise. They emphasized that a clearer understanding is needed of relationships between approaches to stewardship, the resultant effectiveness of the stewardship function, and the performance of health systems.

The few comments on assessment of stewardship have noted that this will be an important yet challenging task. Some have commented on the importance of ensuring that any assessment is useful in the first instance to nationals in their own efforts to improve stewardship.

### **3. WHO responses and proposals**

#### ***Stewardship: conceptual issues***

Building on the work of other organizations as well as the recommendations of the meeting on the stewardship function held in September 2001, WHO staff prepared a paper in November 2001 that further developed the concept (Travis et al. 2002). The paper tentatively identifies a number of essential ingredients or “core domains” that appear to constitute good stewardship. Domains are conceived as relatively well defined, distinct areas of responsibility that collectively constitute effective stewardship. The six domains or sub-functions that constitute effective health system stewardship, i.e., that lead to better outcomes to achieve the goals of health systems are referred to as:

- Generation of intelligence
- Formulating strategic policy direction
- Ensuring tools for implementation: powers, incentives and sanctions
- Coalition building / Building partnerships
- Ensuring a fit between policy objectives and organizational structure and culture
- Ensuring accountability

The paper states that it is desirable to increase capacity within the health systems of Member States with regard to each of these domains. The assumption is that, collectively, the better these sub-functions are carried out, the more effective health system stewardship will be and the higher attainment of intrinsic goals. These domains, attributes and relationships are based on prevailing notions of effective stewardship, and the paper emphasizes that all should be considered “testable hypotheses”. The concept of stewardship has evolved in the course of the consultations and analyses (see table below):

Three Classifications of Tasks for Stewardship

<b>WHR 2000</b>	<b>Consultation</b>	<b>Travis et al. (2002)</b>
Collecting and using information	Collecting and using intelligence	Generation of intelligence
Defining the vision and direction of health policy	Formulating health policy	Formulating strategic policy direction
Exerting influence through regulation and advocacy	Exerting influence	Ensuring tools for implementation: powers, incentives and sanctions
		Coalition building / Building partnerships
		Ensuring a fit between policy objectives and organizational structure and culture
		Ensuring accountability

The scope and core attributes of each domain are outlined briefly here and described in more detail in the background paper.

### **Generation of intelligence**

This domain responds to the concern "to what extent do health system actors have useful intelligence at their disposal?"; and do key actors have reliable, up-to-date information on current and future trends in health and different aspects of health system performance, important contextual factors and actors, possible policy options based on national and international experience?

### **Formulating strategic policy direction**

This domain responds to the concern "to what extent is there a clear sense of vision and strategic direction for the health system?":

- Is there clear articulation of health system objectives?
- Is there a clear definition of roles and responsibilities of public and private actors in all four functions?
- Has there been a clear identification of policy instruments and institutional arrangements required to achieve improvements?
- Have the authorities developed strategies for making the required changes? and
- Have they provided guidance for prioritizing health expenditures based on realistic resource and needs assessment, and for monitoring effects of changes on performance?

### **Ensuring tools for implementation: powers, incentives and sanctions**

This domain addresses the concern "to what extent is there a regulatory framework that facilitates implementation of health policy, i.e., steers different actors in the desired direction?". "Regulatory framework" refers to the spectrum of rules, procedures, laws, codes of conduct, standards, etc., that exist. This will involve looking at the scope of existing regulation, conflicts or contradictions between stated policy and the regulatory framework (whether powers and responsibilities are matched); and the extent to which they are enforced.

### **Coalition building/Building partnerships**

This domain addresses the concern "to what extent does capacity exist to create alliances of individuals, groups or organizations for joint action around strategic health and health system priorities?"

### **Ensuring a fit between policy objectives and organizational structure and culture**

This domain addresses two questions: "To what extent do organizational structures and management systems fit with policy objectives so that they help rather than hinder policy implementation"; and "to what extent have conditions been created by government that allow stewards themselves to be effective?".

### **Ensuring accountability**

This is considered a separate domain at present on the grounds that it is a stewardship responsibility to ensure that all health system actors are held accountable for their actions. This will also contribute to consumer protection.

### ***Assessing stewardship***

WHO states that the objective of its work is to support health systems' performance improvement at country level by providing evidence-based advice on the relationships between stewardship and health system outcomes. Travis et al. (2002) rightly point out that whilst the importance of many of the activities thought to contribute to effective stewardship have long been written about, as a whole it is a new construct in health systems and there are no tools for looking at all its different aspects. They referred to studies in other areas which have attempted to measure some of the elements of stewardship. In particular, they noted the work done on governance, and work to define an instrument for measuring 'Essential Public Health Functions' (Pan American Health Organization et al. 2001) that may assess selected aspects of stewardship. WHO proposes to explore this and other approaches in the development of credible stewardship assessment tools. Based on WHO's recent experience with measuring responsiveness, one approach that is being considered is to develop a survey instrument that would include questions on all domains of stewardship, accompanied by vignettes, that could be administered to all main groups of health system actors, including households if appropriate.

### **Development of an instrument to assess stewardship**

Descriptive and analytical approaches will require qualitative and quantitative assessments. The analyses required, audience and intended use will guide the selection of approaches. Therefore, rather than one single instrument, a set of assessment approaches will be developed and tested.

WHO has developed a provisional programme of work to further develop the concept of stewardship and its assessment based on the comments thus far received.

### **Proposed outputs by December 2003**

- Revised conceptual paper and broad-based consensus on domains and assessment indicators.
- Tools for assessing stewardship developed and used in around 15 interested countries.
- Series of country reports on key findings of the stewardship assessment for in-country discussions and policy dialogue.
- Valid and meaningful approach to analyses, for in-country, regional and cross-national use.
- Set of training modules for capacity building on stewardship related to health systems' performance.

- Dissemination and public access to information and linking various research results across functions and goals.

#### 4. SPRG comments and recommendations

##### *Conceptual issues*

##### • **What is the value of this new concept?**

Several commentators (McKee 2001b) see it as an important development. "WHO has clearly stated that governments have a responsibility for their health systems. Stewardship implies a much more active involvement in promoting health than most governments have previously assumed" (McKee 2001a). Not all commentators have seen it as such a departure. In the discussions of SPRG, it was observed that WHO as a technical and political organization has long had an obligation to produce reliable evidence on health or health system issues, and to 'speak up' and publicize that evidence. One WHO Regional Office commentator pointed out that it builds on previous efforts by WHO to strengthen ministries of health and their 'leadership' role. Another noted that there are many examples of current market or political failures arising from the lack of stewardship within ministries of health. Some commentators have requested that WHO provides examples of effective stewardship when different actors in public and private settings have conflicting goals or interests, as a means to illustrate good stewardship more concretely (Saltman and Ferroussier-Davis 2000).

##### • **The definition of stewardship**

SPRG consider that the concept is well defined. They considered whilst it is not that distinct from governance, the word stewardship may better reflect the element of directing a health system. In the Technical Consultation, the ethical foundation of the concept was stressed (World Health Organization 2001). One commentator observed that it is the 'moral' aspect of stewardship that distinguishes it most from governance, which is seen as more procedural notion. Another distinction has been drawn between stewardship as an 'intelligent' function and governance as a more structural one – a set of activities that have to happen.

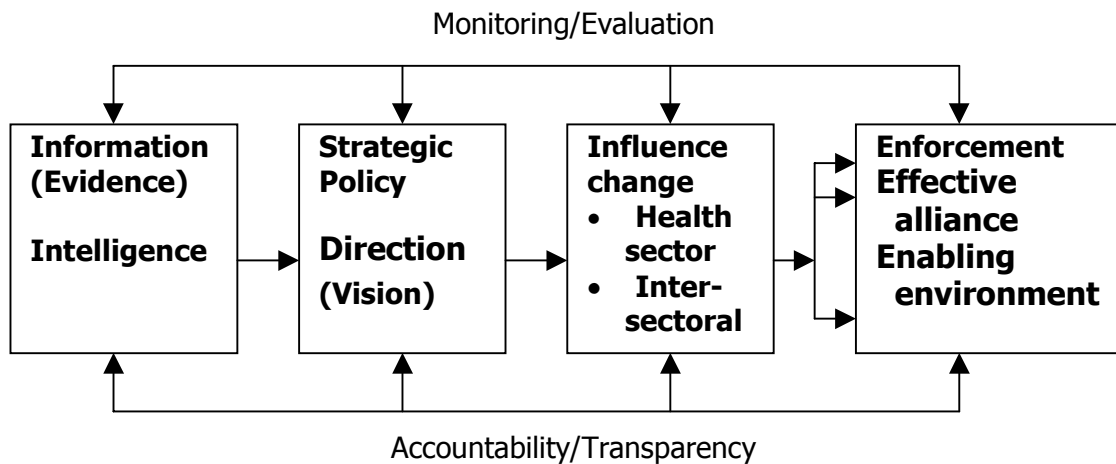
##### • **Who is responsible for stewardship?**

Governments have the primary responsibility for discharging the stewardship function of the health system. The expectation is that each governments will ensure that it meets the legitimate health needs and expectations of the population in the context of available resources. This does not imply that the government will be solely responsible for performing all the essential tasks. In discharging its stewardship role, the government develops partnerships,

works with civil society and with the private sector but such linkages cannot dilute the fact that governments are primarily responsible for discharging the function of stewardship. Active participation by the civil society can be of great value in developing national goals and in ensuring good stewardship by government. The active involvement of the civil society and the contributions of the private sector are vital components of the health system but the people have the right to hold their governments accountable for the operation of the health system as a whole. Responsibility refers who must ensure that justifiable expectations are met and it identifies who must take the blame when things go wrong.

***The proposed domains/sub-functions of stewardship***

SPRG supports the six elements of stewardship and proposes an interconnected framework for these six elements:



More work is required to characterize each domain more clearly. Aspects of stewardship that are currently insufficiently addressed or unclear include:

- The need for a clearer link between the generation and use of intelligence.
- The need to be clear that stewardship is not only about central control.
- The early warning / detection function of stewardship – for example of harmful practices.
- The refereeing function - detection and dealing with conflicts of interest.

***Assessment issues***

In the SPRG discussion, WHO emphasized that the work being proposed was mainly aimed at improving understanding of the different components of stewardship, so that action could be taken by countries. Qualitative as well as quantitative approaches are likely to be needed.

On the question about the use of surveys to measure stewardship, SPRG raised several issues:

- Who should be surveyed – key informants, households, or a mix?
- Who should carry out such surveys?
- Would assessment from household surveys be useful to governments who may have to make unpopular decisions?

The reliability, validity and comparability of any survey approach were viewed as key issues in ensuring acceptability and use of results. A note of caution was provided by SPRG that whatever aspects of stewardship are selected for assessment, these will automatically be assumed to be important or desirable, when there is still little evidence.

SPRG commends the Secretariat's initiative to measure the level of stewardship. The Group suggests that in addition to subjective measurements, some objective indicators should also be developed. The key stakeholders who will be the respondents should be clearly defined and identified and conflict of interests avoided. A composite index on stewardship may be developed. However, as this is quite a sensitive area involving the function and responsibility of national health leaders, great care should be accorded to the methodology, the measurements, and the publication.

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