



WORLD HEALTH ORGANIZATION

Meeting on the Stewardship Function in Health Systems
Geneva, Switzerland, 10-11 September 2001

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**REPORT ON WHO MEETING OF EXPERTS
ON THE STEWARDSHIP FUNCTION IN HEALTH SYSTEMS**

Introduction: This report is a summary of major conclusions and recommendations of a meeting of experts on the Stewardship Function in Health Systems. The *World Health Report 2000* proposes a comprehensive framework for health systems' performance assessment that identifies goals of health systems and four main functions that contribute to their attainment. These four main functions are provision, resource generation, health financing and stewardship. The Director-General's introduction to the report defines stewardship as "the careful and responsible management of the well-being of the population" and describes it as "the very essence of good government". The Report also claims that stewardship is "arguably the most important" of the four health systems functions considered and states that "it ranks above and differs from the others." (Page 119). Nevertheless, it has been difficult to arrive at a detailed, operational definition of stewardship that can be used in identifying how countries might strengthen stewardship and thus improve health system performance. The report identified three principal components of stewardship: formulating health policy, exerting influence, and collecting and using intelligence (Page 122).

The technical consultations on Stewardship in Health Systems was organized by WHO and held in Geneva, Switzerland on 10-11 September 2001. A list of participants and their affiliations, as well as details of the agenda, can be found in Annexes 1 & 2 respectively.

Objectives and Agenda: The consultation was part of a broader programme of such meetings being undertaken following publication of the *World Health Report 2000*. There were two objectives of the meeting. The first was to obtain the opinions of a group of recognized international experts on refining the WHR 2000's definition of stewardship and decomposing stewardship to more tangible elements for better assessment of stewardship in a particular country. The second was to obtain their advice and suggestions for a WHO work program in this area so we can better support and advise countries.

The meeting began with an update on work at WHO regarding stewardship. Several experts also presented a variety of perspectives on stewardship including views from business management, studies of social capital, control of corruption, and health system design. The rest of the agenda involved specific working groups as well as open discussions on how WHO can move ahead with a relevant program of work on the stewardship of health systems.

Main Conclusions and Recommendations: This section summarizes the conclusions and key discussion surrounding the issues.

1) Refining the definition of Stewardship

Efforts to come to a consensus on the definition of Stewardship focused on its relationship with "governance" and its normative content.

There was general agreement that stewardship incorporates much of what is described as (public) governance. Participants generally appeared to consider that stewardship differed from governance more in its style or approach to particular tasks than in its scope. More specifically, stewardship was variously described as "good", "ethical", "inclusive" or "proactive" governance (recognising that such terms might have culturally-specific interpretations). In describing stewardship, participants referred to it metaphorically as combining three elements: "glue" that holds the elements of the health system together, "oil" that keeps it running smoothly, and "energy" that gives it (ethical) direction and momentum.

In addition to its ethical content and relationship to governance, stewardship was also seen as the function that 'embeds' the health system in wider society. Thus the stewardship function needs both to internalise and reflect the cultural and political context and broader societal norms and to reach out to address the interactions between the health system and other aspects of society. Thus, the scope of effective stewardship needs to extend beyond the boundaries of the health sector as conventionally defined.

Despite the key role of stewardship at the heart of effective health systems it was noted that stewardship does not equate to centralised control. A key element of stewardship is fostering a culture of self-determination and self-direction among individuals and organisations in the system within an overall framework of agreed norms and values.

Several participants commented that the term 'stewardship' does not translate well into languages other than English (and previous translations by WHO have not accurately reflected the concept). It was

suggested that efforts should be made to identify another, more universally recognisable title for the function.

2) Decomposing the elements of Stewardship

Participants agreed that some form of descriptive characterisation (or classification) of approaches to stewardship would be useful. Initially, this might be based on a fairly simple listing of specific stewardship tasks. By identifying which tasks are carried out in individual countries (and possibly how and by whom they are carried out), it should be possible to describe different countries' approaches to the stewardship function. It may then also be feasible to distinguish 'clusters' of stewardship tasks that broadly define 'styles' of stewardship.

In small group discussions, participants generated a list of possible stewardship tasks, most of which fit into the three-part classification noted earlier. Namely:

Formulating Health Policy	Exerting influence	Collecting and using intelligence
<ul style="list-style-type: none"> ● Policy analysis ● Policy formulation with involvement from stakeholders and civil society groups ● Development of an overarching national health plan ● Defining a vision for health ● High-level investment and resource allocation decisions ● Establishing shared values and the ethical base for health action ● Policy evaluation and correction 	<ul style="list-style-type: none"> ● Consensus building inside and outside the health sector ● Synchronisation of health players ● Strategic institution building ● Regulation and enforcement ● Promulgation of an overarching national health plan ● Promoting a vision for health ● Promoting and strengthening shared values and the ethical base for health action ● Creating incentives ● Consumer education ● Establishing and institutionalising transparency in management ● Advocating for healthy public policies in other sectors 	<ul style="list-style-type: none"> ● Intelligence gathering ● Monitoring and evaluation of public health ● Encouraging dialogue between communities and the health system ● Communication

This provisional list needs to be revised in light of further research and empirical investigations at country level to develop a list that is both comprehensive and appropriate in multiple cultural settings. Furthermore, appropriate boundaries between stewardship and other functions needed to be clarified (e.g. Does "Health education" belong in stewardship or is it more appropriately seen as part of the service provision function? Should "Management and development of human resources" be considered as an element of the resource generation function?).

Other ways of classifying the stewardship tasks were considered. One proposal focused on domains such as: stewardship of health system functions, strategic management of the health system, and stewardship of factors in the broader social, political, and economic environment within which the health system operates.

3) Assessing the effectiveness of stewardship at the country level

Participants generally agreed that that effective stewardship should have a broad focus, a long-term view, be ethically driven, and diverse. Stewardship needs a *broad focus* because it is not simply about managing a central ministry of health. Nor is its scope limited to those services that are directly funded, managed or delivered by the state. Effective stewardship also involves influencing other players, in the private sector and in fields other than health, to bring about positive change. Stewardship needs a *long-term view* because it is not limited to addressing the challenges of today, but also seeks to develop lasting solutions, to build the capacity to solve the problems of the future, and to foster continuous improvement. Stewardship needs to be *ethically driven* because it requires that the interests of citizens be placed above those of people or organisations in positions of power. Furthermore, a good steward behaves as a servant, not a master, of the citizenry. Finally, stewardship is *diverse* since it can involve a wide range of different interventions and actions. In some cases, stewardship might involve direct delivery of services to end-users (i.e. citizens or health service consumers). In other cases, it can involve indirect forms of action such as advocacy, regulation setting or communication.

Participants were asked to propose indicators and measures of good stewardship. Proposals were largely qualitative in nature (e.g. "Transparency and effective communication", "Free of corruption" or "Even-handedness and respect for democratic and legal processes"), although some were more immediately measurable (such as "stability of institutions, personnel and policy settings" as proposed by Veenstra and Lomas).

The need to consider broader societal context in any assessment of stewardship effectiveness was also raised. Is it possible to have effective stewardship in an environment of poor public governance at national level?

4) Possible Approaches to Future Work

The overall objective of future work in this area is to help countries improve the performance of their health systems by means of more effective stewardship. To do so, it will first be necessary to develop a clearer understanding of the relationships between different approaches to stewardship, the resultant effectiveness of the stewardship function and the performance of health systems.

The meeting emphasised the need for empirical research into stewardship and governance in health, including in particular descriptive studies of stewardship tasks, approaches and styles. There was disagreement over the degree to which such research could be comparative given the large differences in country-specific contexts. However, the value of comparative research was acknowledged so long as it is carried out in a participatory manner and in a way that encourages the sharing of experience among countries. Involvement of both academics and health officials from the countries concerned has proven effective in other, similar, exercises and could be valuable in this context.

Any approach to assessing stewardship and stewardship effectiveness should be both practical and multiculturally acceptable. In order not to over-burden governments, it should be as simple as possible and aim for direct relevance to decision-making at country level.

Concerns were expressed at the prospect of WHO seeking simply to 'measure' stewardship or stewardship effectiveness in countries. Relevance at the country level was seen as a prerequisite for success. In order to achieve relevance, however, it may be necessary to adopt different approaches that are 'fine-tuned' to the needs and situations of individual countries. There are also opportunities to learn from work that has already been carried out by WHO and other international organisations in the fields of stewardship and/or good governance, as well as from experience in other sectors.

ANNEX 1

AGENDA FOR WHO MEETING OF SEPERTS HELD IN GENEVA, SWITZERLAND
10-11, SEPTEMBER 2001

Session	Topic
Monday, 10 September 2001	
09.30 – 11.00	Welcome – Dr CJL Murray, Executive Director, WHO Introductions Overview of stewardship - Presentation (P Davies, WHO)
11.00 – 11.30	<i>Coffee break</i>
11.30 – 13.00	Views on stewardship – Plenary discussion Observations on the stewardship function – Presentation (R Saltman)
13.00 – 13.45	<i>Lunch break</i>
13.45 – 15.00	Scope of stewardship – Plenary discussion
15.00 – 15.30	<i>Coffee break</i>
15.30 – 17.00	Stewardship tasks – Group work
Tuesday, 11 September 2001	
08.30 – 09.00	Review of Day 1
09.00 – 10.30	Governance and social capital (G Veenstra) Recognising good and bad stewardship – Plenary discussion
10.30 – 11.00	<i>Coffee break</i>
11.00 – 12.30	Stewardship theory (L Donaldson) Pre-conditions for effective stewardship – Group work
12.30 – 13.30	<i>Lunch break</i>
13.30 – 15.00	Corruption in health: a failure of stewardship? (A Martiny) Benchmarks for good and bad stewardship – Plenary discussion
15.00 – 15.30	<i>Coffee break</i>
15.30 – 16.45	Personal reflections on issues discussed at the meeting (S Nitayarumphong & F Aboulhassani) Next steps: Suggestions for a programme of work – Group discussion
16.45 – 17.00	Wrap-up & close

ANNEX 2**Participants**

The following people participated in the meeting:-

Name	Affiliation
Dr Farid Aboulhassani	Ministry of Health & Medical Education, Tehran, Islamic Republic of Iran
Dr Luis Bohigas	Ministerio de Sanidad y Consumo, Madrid, Spain
Prof. Lex Donaldson	Australian Graduate School of Management, Universities of New South Wales and Sydney, Australia
Dr Gillian Durham	Ministry of Health, Wellington, New Zealand
Prof. Lucy Gilson	University of the Witwatersrand, Johannesburg, South Africa; and London School of Hygiene & Tropical Medicine, UK
Prof. Yoshinori Hiroi	Chiba University, Japan
Dr Kimmo Leppo	Ministry of Social Affairs & Health, Helsinki, Finland
Dr Anke Martiny	Transparency International (Deutschland), Munich, Germany
Dr Fernando Munoz	Latin American Centre for Health Systems Research, Santiago, Chile
Dr Sanguan Nitayarumphong	Ministry of Public Health, Nonthaburi, Thailand
Dr Claes Örtendahl	Senior Health Systems Analyst, Karolinska Institute, Sweden
Prof. Richard B Saltman	Emory University, Atlanta, GA, USA and European Observatory on Health Care Systems, Copenhagen, Denmark
Dr Rubèn Torres	Fundacion Isalud, Buenos Aires, Republica Argentina
Prof. Gerry Veenstra	The University of British Columbia, Vancouver, BC, Canada

WHO Regional Office representatives

Dr Miguel Kiasekoka	WHO -DSD, AFRO
Dr Daniel Lopez Acuña	WHO – AMRO/PAHO
Dr Myint Htwe	WHO – SEARO
Mr. Graham Harrison	WHO – WPRO

WHO Headquarters personnel

Dr Chris Murray	EXD EIP
Dr Abdelhay Mechbal	Director HFS/EIP
Ms. Kei Kawabata	Co-ordinator, FAR/HFS/EIP
Dr Dominique Egger	Co-ordinator, SPM/HFS/EIP
Dr William Savedoff	Senior Health Economist, FAR/HFS/EIP
Ms. Geneviève Pinet	Health Lawyer, FAR/HFS/EIP

Name

Affiliation

Ms. Anneli Milen

Senior Expert in Health, SPM/HFS/EIP

Mr. Philip Davies

Senior Health Economist, FAR/HFS/EIP

Facilitator

Ms. Liz Ollier

Facilitator