Meeting report

Health systems stewardship/governance
Third preparatory meeting for the WHO European Ministerial Conference on Health Systems:
“Health Systems, Health and Wealth”

Rome, Italy 3–4 April 2008
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Opening of the meeting

The third preparatory meeting for the WHO European Ministerial Conference on Health Systems was held in Rome on 3–4 April 2008, hosted by the Ministry of Health of Italy. Representatives of 47 of the 53 Member States in the WHO European Region, as well as European experts in the field of health systems, took part in the meeting.

Dr Donato Greco, Director, Department of Prevention and Communication, Ministry of Health, Italy opened the meeting and welcomed participants to the Ministry’s new headquarters building. His country was particularly interested in the topic of the WHO European Ministerial Conference and was working closely with WHO to obtain the best advice with regard to health systems, health and wealth.

Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe recalled that the mission of the Regional Office is to support Member States in developing their own health policies, health systems and public health programmes, preventing and overcoming threats to health, anticipating future challenges and advocating public health. WHO is deeply convinced that Member States can only benefit from strengthening their health systems, defined as “all organizations, institutions and resources devoted to producing actions primarily aimed at improving, maintaining or restoring health”. The key objectives of the Ministerial Conference are to take stock of recent evidence concerning effective strategies to improve the performance of health systems, and to lead to a better understanding of the impact of health systems on people's health and therefore on economic growth in the WHO European Region. The recent evidence in the field is being brought together for the Ministerial Conference in two major studies, a series of “policy briefs” on health system themes and a number of related publications issued by WHO and other organizations such the World Bank, the Organisation for Economic Co-operation and Development (OECD) and the Council of Europe. A European Charter on Health Systems is being developed and will be presented for adoption at the Ministerial Conference.

Four key themes of the Ministerial Conference were identified by Member States and partner organizations at consultative meetings held in Vienna and Barcelona in August and October 2006, respectively. A pre-Conference meeting was accordingly held on “Assessing health systems performance” (Brussels, Belgium, March 2007); the topic of “Health workforce policies” was addressed under a special agenda item at the fifty-seventh session of the WHO Regional Committee for Europe, (Belgrade, Serbia, September 2007); and a further pre-Conference meeting considered the question of “Improving the performance of health service delivery” (Bled, Slovenia, November 2007). The present meeting was the final full preparatory meeting before the Ministerial Conference itself, although the Charter Drafting Group would meet again to reach final consensus on the wording of the Charter. The specific objectives of the meeting were:

- to review the main concepts related to the stewardship/governance function and the main responsibilities of ministries of health therein;
- to review the available evidence on stewardship/governance strategies in use in the WHO European Region, in order to improve the performance of health systems and to formulate recommendations for the Conference; and
- to discuss experiences in the Region in the field of stewardship/governance concerning the tools for planning, regulating and creating intelligence.

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Session 1. Health and health systems stewardship/governance: an introduction

The position of WHO

With regard to key concepts and definitions, a distinction can be made between stewardship, defined (in the health sphere) as “the careful and responsible management of the well-being of the population”, and governance, seen as "the exercise of political, economic and administrative authority in the management of a country's affairs at all levels". Notwithstanding the possible overlap between these two concepts (and the difficulties encountered in translating the terms into languages other than English), the “autoritas” of a health system rests on three pillars: steering (focusing on the overall vision, rather than on operations or service delivery); governing (being transparent and fair, ensuring good use of resources) and being accountable for outcomes. From this standpoint, it is apparent that stewardship or governance is a fundamentally different notion from that of leadership, since the latter does not entail transparency, fairness or accountability. The health system stewardship/governance function has three main components: the ability to formulate strategic policy direction, to ensure good regulation and the tools for implementing it, and to provide the necessary intelligence on health system performance in order to ensure accountability and transparency. These three components apply equally to personal and non-personal health services, as well as to intersectoral actions.

The scope and content of the stewardship/governance function help to underline its importance and shed light on its relationship with health and wealth. On an individual level, health is determined by a multiplicity of factors, including a person’s social and physical environment, genetic endowment and response. At the same time, it is also determined by the presence of disease, which affects (and is affected by) the delivery of health care. These elements of health and health care in turn have an impact on well-being and prosperity. At the macro level, health aspects have numerous links to a country’s gross domestic product (GDP). The dependency ratio is affected by increases in fertility and mortality rates, resulting in lower GDP per capita, while reduced labour productivity may be a direct result of adult illness and malnutrition or an indirect result of similar conditions in children impacting their cognitive capacity and education uptake. The significantly positive correlation between per capita gross national product (GNP) and life expectancy works mainly through the impact of GNP on the incomes of the poor, in particular, and on public expenditure (especially with regard to health care). In other words, unless economic benefits are targeted towards the poor and the health system (through the exercise of stewardship), they do not result in better health outcomes. That finding may account for the striking exceptions to the generally positive correlation between GDP per head and life expectancy.

Five "instrumental freedoms" have been identified for promoting development: political freedoms, economic facilities, social opportunities, transparency guarantees and protective security. All are related to good governance and stewardship. The Commission on Macroeconomics and Health has postulated that health may be linked to economic development through various pathways such as enterprise capital, technology and human capital, and most importantly through economic policies and institutions, governance and the provision of public goods. Nowadays, stewardship is exercised not in a hierarchical model but rather as a distributed, contingent function that requires attention to be paid to the interests of all stakeholders, because open societies are balanced constellations of interest. Looking beyond the health system, it is equally important to ensure stewardship of secondary, health-enhancing factors such as education, employment or trade, and of broader tertiary factors such the global financial system, the mass media and levels of social capital.

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3 Stewardship [web site]. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/healthsystems/Stewardship/20061004_1, accessed 11 April 2008)
A variety of tools are available for exercising good stewardship. A new approach must be adopted to epidemiological analysis and to strategic and operational planning, in order to set the right priorities and goals. The resulting high-level information must be communicated to stakeholders, and advocacy and negotiation techniques used to build the necessary alliances. Norms and laws may need to be introduced that protect the poor without impeding economic progress; measures should be taken to promote behaviour change and empower citizens in a climate of accountability; arrangements should be made for monitoring and evaluation; and legal instruments may be required in order to enforce sanctions.

It is worth measuring the extent to which good governance and stewardship is exercised in countries. WHO has a framework in place for doing this, building on the findings presented in The world health report 2000 and intended to promote policy actions in Member States. The World Bank is implementing the Worldwide Governance Indicators (WGI) project, and countries themselves are taking a variety of initiatives in the health field, including inspection and audit accompanied by the setting of national targets, benchmarking of services, quality assurance and system performance assessment. In that context, there is a need for a clear conceptual framework, attention must be paid to the detailed design of data sources and individual indicators, and analytical devices (such as risk adjustment) must be carefully developed. A mixture of “top-down” and “bottom-up” approaches should be adopted, incentives should be enhanced to promote local capacity to respond to the findings of performance measurement, and proper evaluation of performance measurement instruments should be put in place.

**The health ministry’s intersectoral role**

Ever since the Declaration of Alma-Ata was adopted in 1976, WHO has paid considerable attention to the importance of ensuring and strengthening the health ministry’s intersectoral role, and it has been repeatedly emphasized in the WHO European Region, notably at the four most recent WHO ministerial conferences (Tobacco-Free Europe 2002; Environment and Health 2004; Mental Health 2005, and Counteracting Obesity 2006). The health ministry’s responsibility for influencing other sectors is a key dimension of its stewardship role. This function encompasses all systematic activities aimed at ensuring that health actions, including intersectoral work, are carried out to maximize health outcomes.

The concept of “Health in All Policies” (HiAP) is now an agreed principle within the health strategy of the European Union (EU). HiAP, which is essentially a way of giving effect to intersectoral action for health, is put into practice by countries according to different modalities: in some, it is a way of working (e.g. a whole-government approach), in others it is a way of adjusting other policies for health (e.g. impact assessment), while in yet others it is a means of regulating for health in other sectors (e.g. tobacco legislation). Equally, a variety of approaches are used, including activities that are targeted, place-based or staged.

The enabling conditions for intersectoral work are that there is a solid argumentation base for health; that the organizations involved have the capacity (mandate, skills and knowledge) to take action; and that the policy sectors concerned have developed a relationship of trust and respect on which to base planned action. Roles and responsibilities must be clear; the planned action must be capable of being implemented and evaluated; and there should be positive media coverage and public support. In playing its intersectoral role, a health ministry can act as a leader, partner, supporter or defender. Barriers to intersectoral action include a lack of sustained political commitment, information tools, institutional arrangements, financial mechanisms, legislation and regulations, and frameworks for ensuring accountability.

In order to play a significant intersectoral role, health systems need to have sufficient capacity in terms of resources, such as personnel with adequate training and appropriate mandates and responsibilities assigned to them. It will also be necessary to secure sustained political commitment, to balance competing objectives and interests, and to account for results. If this is done, the triangular relationships between health systems, health and wealth will indeed result in greater social well-being (or social justice, as represented in much of medieval Italian art).

Members of the discussion panel for the session confirmed that the position or influence of the health ministry varies greatly from one country to another: in some western European countries, the health
sector has achieved equality with other sectors, while in the eastern part of the Region its position is being strengthened as constraints with regard to health system responsiveness and capacity are overcome. In all cases, however, health is recognized as being one of the most complex areas to govern and manage. While the national or central health ministry is a key actor, governance and stewardship of public health, in particular, is frequently exercised at local level. Other special features of the health sector include the fact that it is driven by values and that personal health services are extremely labour- and skills-intensive. One good way of promoting intersectorality is to identify low-cost, practical measures that can be taken by other sectors and which have positive health outcomes (such as lowering the salt content in bread, in order to cut down cardiovascular mortality).

In the subsequent discussion, participants agreed that economic growth does not automatically result in better health without proper policy formulation. One key concept that may be advocated to politicians is that an open society leads to better health. Health can be a very powerful political tool, and joint accountability for decision-making accordingly strengthens the health ministry’s position in government as a whole. In several countries, a task force or interministerial working group has been charged with developing a common position on health policy development or with drawing up plans in the health field that are subsequently translated into legislation. Another approach is to subject all policy documents to interministerial consultation. While implementation by other sectors on the ground may be more difficult, successful examples cited include a smoking ban in public catering establishments and restrictions on alcohol advertising on television. The “proof” of an intersectoral policy is to be found in its implementation: important lessons can be learned from failures, as well as from successes, in giving effect to the values embodied in policy measures.

Session 2. Exercising health stewardship/governance

Setting and implementing health priorities

Many of the concepts in priority-setting are not new: a matrix based on the importance of the problem to be tackled and its “vulnerability” to modification was developed by Donabedian in 1973, while the Dunning Report from 1992 set out various criteria (necessity, effectiveness, efficiency, etc.) for inclusion of services in a basic package. The issue can be restated, however, in terms of the link between the four functions of a health system (including stewardship), on the one hand, and the desired outcomes (health, responsiveness, financial protection and efficiency), on the other, while recognizing that health systems are complex, adaptive and not mechanical structures. In setting priorities, the key question is whether the totality of the health system is able to create and sustain a set of effective policies and strategies to improve the health of the population in a way that is acceptable to most stakeholders. This entails making political choices, placing users at centre stage and changing services accordingly. The example of health workforce migration underlines the need to take account of ethical and international dimensions in policy formulation and implementation.

While the majority of countries in the WHO European Region now have explicit health policies, many of which incorporate not only broad objectives or outcomes but also public service frameworks or agreements (with associated performance rankings and targets), it should be recognized that strategic planning is not about predicting the future, but rather about modelling it. With that caveat, health targets may be used for inspirational (political), managerial (policy) and technical (practice) purposes. The target-based approach to achieving change should focus on outcomes, transparency and accountability; broaden the "territory" of the health sector; concentrate on health priorities; raise public awareness and create commitment; and guide policy development and health planning. Evidence from other sectors shows that a combination of instruments will be needed to attain the targets set. In the case of tobacco use, for instance, the tools applied might include regulation, education, capacity-building, social support, interventions by health professionals, and partnerships.

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A number of problems may be encountered when working towards targets that have been set: they can encourage “gaming” or distortion of actions, diversion of resources away from areas that are not specifically targeted, and the stifling of initiative and innovation. In all cases, successful implementation is (as mentioned above) the key to making the transition from an unsatisfactory present to a desired future situation. This can be achieved by ensuring a good fit between policy objectives, organizational structure and the surrounding “culture”, providing the necessary tools for implementation and ensuring accountability for results. It is essential to evaluate the impact of the policy instruments used, to monitor their impact over time, and to involve targeted groups in decision-making, implementation and feedback.

So far as health ministries are concerned, obstacles to exercising these aspects of stewardship include ministers’ short periods in office (as compared with the time lag between policy interventions and their impact on health outcomes), the pressure to achieve short-term results, the continuing involvement of ministries in service management and delivery, and the scarcity of valid and reliable performance information.

Members of the discussion panel confirmed the existence of those obstacles, while noting that in many cases the current economic and political environment favours a continuing role for health ministries of command and control, rather than stewardship. The Ministerial Conference and, more generally, international assistance should help countries to make a sustained move towards the latter orientation. The increasing vocal demands by patients and citizens for resources to be allocated to certain areas should not outweigh the need to continue to set priorities in terms of the public good. At the same time, it is important to place users at centre stage, in response to the ethically based human right to personal integrity and the highest possible degree of control over their own affairs. In addition to the three pathways for public participation already identified (choice, voice and representation), patients should be actively involved in managing their own health problems by taking part in monitoring and treatment.

In discussion, participants recognized that the link between health and wealth can be a driving force for congruent, whole-government target-setting and action on complex issues. Countries in economic transition may need continuously to adapt their policies to changing circumstances, but it is important to maintain the underlying value system. Ongoing management of health service delivery can be a factor in ensuring continuity and is not necessarily incompatible with the concepts of stewardship and governance.

**Prevention and cure, personal and population services, purchasers and providers**

When a government is considering how to strike the right balance between preventive and curative activities, and between personal and population services, it should recall the eight principles of a good health system:

- analysis of population health needs and provision of access to health care based on need;
- combination of prevention and cure, but focused on multidisciplinary primary care;
- evidence-based and patient-centred;
- inclusive, sensitive and non-discriminatory;
- responsive in emergencies but otherwise persistent in pursuit of prevention and health improvement;
- fiscally progressive funding which favours the poor and avoids catastrophic cost;
- working across government and championing equity and health in all policies; and
- sustainable over time through integration into the wider goals of society.

Evidence from the United Kingdom shows that prevention can be much more cost-effective than cure, especially when targeted at groups with high risk. For instance, each quality-adjusted life year (QALY) gained via a brief and targeted smoking cessation intervention costs around £500, while the cost per QALY of treating patients with advanced cancer is estimated at between £40 000 and $50 000.

Nonetheless, it is not enough to adhere to those principles in order to achieve a good health system: at least three challenges need to be overcome. First, it must be acknowledged that health ministries do not start with a “blank sheet”; they must take account of their existing environment (somewhat like building an aeroplane in mid-flight). Second, principles (or applied values) have to be aligned with incentives.
Principles without incentives just lead to rhetoric, while incentives without principles result in “gaming” (in a health system, this may take the form of wrong coding of diseases or excessive and unnecessary surgical interventions, for instance).

The third challenge is that health services increasingly involve multiple purchasers and a wide array of autonomous, corporate or private health care providers. In addition, various structural forms of decentralization may be implemented, such as devolution, deconcentration, delegation or privatization. Appropriate governance and accountability arrangements and mechanisms need to be put in place to regulate, govern and steer such complicated systems (a task that can likened to herding cats). In terms of planning, the ministry should set the overall policy direction and establish the rules within which regional and local decisions are made. It can hold to account regional and (through them) local purchasers, who assess need and then seek to match it to provision; and it can create and hold to account specialist national agencies where required, who may regulate providers of various types to ensure quality of provision. The resulting “outcomes model” (with a results chain stretching from inputs through processes to short-term, intermediate and high-level outcomes) may entail some elements that are external to the health ministry or even to health itself.

One member of the discussion panel emphasized the growing need for evidence of the economic effects of health gains, both to underpin the view that health is beneficial to society, rather than a cost driver, and to strengthen the case for risk solidarity. In a context of greater competition in the health system, strict public guarantees are needed to protect the vulnerable and the sick. On the other hand, one advantage of introducing market incentives is that some health insurers may find a competitive edge by covering the cost of preventive care. Ultimately, however, prevention is not about earning money but about increasing healthy life years as a foundation of civilized society.

Some countries’ experience with privatization following the break-up of the Soviet Union has taught them that the public interest should still prevail. Similarly, moves towards decentralization need to be balanced by the continued responsibility of the health ministry for health system performance, for the collection, allocation and use of resources, and for accreditation. However, it may be difficult for the health ministry to play its regulatory role in settings where emphasis is increasingly placed on primary care.

Participants recommended that there should be no presumption of the superiority of one form of financing the health system over another. Market-based incentives in health systems can offer value to other sectors of the economy, yet free competition in health care has sometimes had catastrophic results. The humanitarian and ethical aspects of medicine need to remain predominant. A clear distinction should be made between “primary care”, i.e. the level at which certain services are delivered, on the one hand, and “primary health care”, seen as a comprehensive set of preventive, promotive, curative and rehabilitative measures, on the other. Different stewardship and governance arrangements may be needed in each setting. The multisectoral approach is exemplified by one country’s experience with channelling tax revenues on tobacco and alcohol back towards the health system, thus promoting both disease prevention and wealth redistribution. The media should not be overlooked as one of the multitude of stakeholders in the health system.

**Regulating the public-private mix**

The scope of health system regulation may be defined in terms of a number of dimensions: national/local, public/private, curative/preventive, personal/intersectoral, etc. Similarly, the purpose of regulation may extend from attaining social and economic goals to pursuing clinical and medical objectives or those related to health status. A number of regulatory tools are accordingly available. In the context of general industrial regulation, they include measures related to employment (pensions, minimum wage), professional matters (licensure) and financial conditions (minimum operating reserves for insurance functions). “Downstream” health sector regulation covers facilities and areas such as hospitals (patient safety, accreditation), primary care (physician payment formulas, co-payment), nursing homes, mental health and pharmaceuticals. “Upstream” regulation aimed at disease prevention, health promotion and
social development encompasses mechanisms such as health impact assessment, tobacco restrictions and pricing policy, health education and workplace organization.

In order to ensure effective regulation of a broad mix of actors and factors in the public and private sectors, the existing regulatory framework should first be reviewed (and extended if necessary), before decisions are taken about what additional regulation is needed to cover new actors such as hospital trusts, self-managed primary health care centres, and commercial pharmacies, hospitals and insurers. In addition to regulating innovative organizations and practices, as well as the “melting” public/private boundary, the major challenges in this connection include harnessing private market incentives to achieve public sector objectives and steering changes that are driven by the exercise of patient choice.

One key strategy for meeting these challenges is to deregulate restrictive practices that have hitherto favoured public actors. This may entail changing the rules governing health care providers (services offered, personnel employed, etc.) and insurers (commercial operations, co-payments). On the other hand, a second key strategy is to restrain inappropriate competitive behaviour by, for instance, expanding state oversight of private sector initiatives, imposing restrictions on the establishment of private medical schools or establishing clinical evaluatory agencies. In any case, it is essential to re-regulate before innovative organizations start operating, by taking steps such as laying down licensure arrangements, requiring adequate financial reserves, setting operating standards and monitoring performance.

Four main “rules of the regulatory road” may thus be discerned: (a) regulate strategically (as part of long-term strategic planning to attain core social and economic policy objectives); (b) regulate in a complex manner (covering multiple issues simultaneously, combining mechanisms from different disciplines); (c) no deregulation without re-regulation; and (d) trust but verify (self-regulation requires systematic external monitoring and enforcement).

Panellists confirmed the need to bring together and harmonize regulation of the public and private sectors in the health field. In some countries, development of the private sector can also involve a shift in focus from health care towards disease prevention, which will require a different basis for regulation. Novel regulatory approaches will also be needed to tackle the advent of foreign pharmaceutical companies and the practice of paying physicians a commission for the prescriptions they write.

In the ensuing discussion, participants agreed that regulatory measures to promote and restrict competition should be complementary, rather than contradictory, and will entail “trade-offs” between aspects such as efficiency and equity, or solidarity and freedom of action. Due account needs to be taken of the transaction costs of regulatory measures which, in the case of competitive contracting, for instance, may be prohibitive. It is important that the same principles (e.g. concerning the provision of evidence-based care), as well as the same tax regimes, should apply to both public and private bodies. Countries in the eastern part of the WHO European Region that deregulated their health systems in the 1990s in order to foster the growth of the private sector are now placing renewed emphasis on the role of the state in guaranteeing the accessibility and quality of health care, and in enforcing and ensuring compliance with regulatory arrangements.

**Stewardship in practice**

Workable instruments for stewardship are country- and time-specific. Several countries report that their health ministries have been successful in exercising governance or stewardship of the performance of the health sector itself, but it is proving difficult for governments to guide intersectoral or public/private cooperation and to hold other sectors accountable for the health effects of their actions. The situation is even more complex in countries with highly decentralized health care systems and multiple sources of funding. The move from a technocratic to an advocacy role for the health ministry, which can be likened to the difference between rowing and steering a boat, calls for a new set of skills and hence for capacity-building measures. Both domestically and at the international level, steps should be taken to retain the necessary personnel and ensure that the migration of human resources takes place within a proper ethical framework.
Session 3. Stewardship and performance assessment

Governance, performance assessment and accountability: closing the circle

One component of health system stewardship is to collect, analyse and use information, in order to measure not only health outcomes but also the performance of the system itself. No health system can be adequately steered without good performance information. Performance assessment is a public good that will not occur naturally without government action. Its implementation requires the creation of analytical capacity throughout the health system.

Accountability is the interface between targets, standards, politics and markets, on the one hand, and the findings of performance measurement, on the other. The resulting political, managerial and clinical action feeds into the health system and is then reassessed as part of an evaluation cycle. Accountability implies both rendering an account (as a result of inspection or through the submission of a performance report) and attributing responsibility for an action or policy (with consequences expressed through the patient’s choice or citizen’s voice). There are thus a multitude of accountability relationships within the health system, connecting government, citizens, patients, clinicians, professions, and purchaser and provider organizations, all of which require different performance information.

In clinician/patient accountability the role of government is, among other things, to mandate specific outcome measurement instruments, to ensure that appropriate benchmarking and comparison methods are in place and functioning effectively, to design, test and implement appropriate “pay for performance” instruments (incentives), and to make sure that patients are able to use the resulting information. With regard to professional accountability (i.e. the relationship between the clinician and the relevant professional body), government should nurture professional leadership, empower and finance professional surveillance and improvement, and maintain reserve powers to be used if professional accountability fails. Government/citizen accountability is ultimately expressed through the democratic process; in the context of a health system, however, government has the role of assuring data specification, collection and audit; promoting public trust in statistics; encouraging political debate; and engaging with the media and opinion-formers. In some countries, certain accountability relationships (citizen/patient, profession/government) may be relatively underdeveloped.

Governments accordingly have certain stewardship responsibilities with regard to performance measurement. They should develop a clear vision of the purpose of the measurement system and its conceptual framework. They need to exercise “information governance”, as specified above, and to develop analytical devices and capacity to present and help people understand the information generated. They should design incentives to act on performance measures and findings, and carry out proper evaluation of performance measurement instruments. Lastly, they need to manage the related political process, ensuring that specific interest groups do not “capture” the performance information system and encouraging healthy political debate.

Performance assessment in decentralized frameworks: the case of Italy

Within the Italian National Health Service (SSN), a series of agreements have been concluded between the central government and the regions to ensure that SSN budget constraints are respected and that good quality health care services (centrally defined in terms of “essential levels of care” or LEA) are provided to citizens. Three per cent of annual SSN funding is withheld until there is positive central assessment of compliance with the conditions set out in the accords. This assessment looks at both financial management (public expenditure trends and respect of budgeted levels) and performance (quality, appropriateness, safety, efficacy, equity). If the assessment reveals a regional deficit of more than 7% of planned spending, the region can have access to special central financial assistance, provided it commits itself to following a detailed budgetary balance plan. A region in a critical situation is also required to enter into a partnership with a region in budgetary balance.

With 21 health regions and provinces, Italy’s total public expenditure on health amounts to some € 100 billion per year, with € 1.32 million allocated to the National Centre for Disease Prevention and
Control (CCM) for performance assessment in connection with the National Prevention Plan 2006–2008 in areas such as cardiovascular risk, cancer, accidents and immunization. CCM’s role is to provide regions with guidance and support in planning and carrying out projects, as well as to evaluate and certificate their implementation. It accordingly issued guidelines concerning planning and project design in June and October 2005. The planning phase was certificated in June 2006, a first evaluation report on implementation was issued in December 2006, and a second evaluation report was released in June 2007. These evaluation reports (with tables showing the progress made in each region) are available on a public-access website (http://www.ccm-network.it/Pnp_stato_attuazione). Findings to date are that the quality of planning varies between regions and project areas; that many areas of intervention require more standardization, integration and stewardship; and that the timetables in the planning phase are often unrealistic.

As an example of experience at subnational level, the implementation of performance assessment in the region of Umbria was described and a “Document for the evaluation of health determinants and system strategies” (DVSS) was presented. The four volumes of the document concentrate on health status, outcomes, evaluation of the regional health plan 2003–2005, and methodology. Rather than a clinical, pathology-oriented analysis, a population-based approach is adopted for the evaluation of hospitals, districts, general practice, prevention, rehabilitation, etc. Findings with regard to health status include the facts that life expectancy in Umbria is higher than the regional average, as is mortality from certain causes of death (stomach cancers, road accidents); disability is also higher than the national average, but so is a measure of equity (access to specialist physicians). For the purpose of performing outcomes evaluations (in such areas as community care or acute care), one fundamental tool is the DVSS/System for the eValuation of outcomEs (SVE) project for analysis of administrative data. Participants were given details of the dictionary of indicators, data warehouse and statistical analysis (standardization) used in the project, and of findings with regard to stroke and caesarean section in hospitals, diabetes prevalence in districts and prescription of beta blockers after heart failure in general practice. It was concluded that the methodology complies with current international standards and can be effectively used in other regions; that a targeted data warehouse, integrated in an efficient statistical system, may be a strategically important factor in routine evaluation cycles; and that results can be shared and translated into policy decisions only if the system of indicators is well acknowledged by all actors.

In the ensuing discussion, panel members confirmed that performance assessment must be reliable, valid and based on scientific evidence. Factors promoting the process include an environment of public accountability, a desire for quality improvement and the requirement to demonstrate a return on investments. Given the need to assess both the efficiency of the health system and the health outcomes obtained, as well as to take account of short- and long-term trends in health determinants and to carry out horizon scanning or mapping exercises, the information requirements are considerable. Countries may therefore choose to adopt a centralized and incremental approach and to prioritize some aspects over others. It was noted, however, that ownership of information by regional or local entities in decentralized systems (and related difficulties with benchmarking) may create an obstacle to this approach. Outcome-based programme budgeting may be useful in this connection. At the same time, the requirements for reporting information to international organizations should be harmonized.
Session 4. The Health Systems Charter

Update on the third draft of Health Systems Charter

The third draft of the Health Systems Charter (Annex 2) was drawn up following the second meeting of the Charter Drafting Group (Valencia, 8–9 February 2008) and circulated to Member States and partners on 10 March 2008. It was approximately three pages in length and consisted of four parts: a) a preamble and three sections entitled, respectively, b) “From values to action”, c) “The health system” and d) “Commitment to act”. The aim of the session was to highlight the stewardship function in the Charter, to comment on the draft text in preparation for the next meeting of the Drafting Group (Moscow, 12–13 May 2008) and to agree on approaches for securing ministerial engagement and consensus.

The preamble sets the Charter in the context of earlier declarations, agreements and international partnerships concerning health and health systems. In response to Member States’ early comments on third draft, the flow of the argument in the section entitled “From values to action” might need to be made more apparent, with a clear distinction drawn between values and goals, and reference made to the iterative process of tailoring those goals to the specific situation in each country, aligning incentives, carrying out actions, measuring performance and feeding the findings back into revisited policy-making.

The section on “The health system” should perhaps be less “definitional” and contain descriptions of principles or features that the functions of a health system (such as stewardship) should embody. In the “Commitments” section, more attention could to be paid to stakeholders, especially empowering citizens and patients, and to expressing commitments in more concrete terms. Other recommendations that had been made by countries were to retain references to solidarity between countries, to include a convincing statement about the economic benefits of investing in health, to give explicit recognition to subnational levels and to take in the issue of climate change. One open question was whether the Charter should refer directly to the need for income distribution as a means of improving health, or whether it was enough for the link between wealth and health to be made explicit. Lastly, it was suggested that a final consultation with Member States might be needed, after the forthcoming meeting of the Charter Drafting Group in Moscow.

In the ensuing discussion, participants recognized that the current version of the Charter was a substantial improvement on previous drafts. They reiterated the view that the active participation of patients and citizens should occupy a prominent place in the Charter, with emphasis on the individual’s responsibility for his or her own health. In order to recall the purpose of a health system, the “Commitments” section might be structured around the four functions of a health system, reflecting the arrangement of the points made in the previous section. More explicit reference should be made to the issue of human resources for health, due to be discussed in detail by the World Health Assembly in 2009, and to the ethical principles being elaborated with regard to migration of health personnel. It was suggested that the Charter should emphasize the need for health systems to cope with catastrophic expenditure and to embody solidarity, rather than to promote income redistribution. Care should be taken to include carefully chosen, evidence-based wording on that subject.

It was important for the Charter to recognize the diversity of the WHO European Region and to suggest criteria for judging whether a health system was operating successfully, rather than to advocate one particular model. The commitments for WHO and other international organizations should be made more ambitious and specific. Emphasis should be placed on WHO’s role in building and coordinating intercountry alliances that included all stakeholders and nongovernmental organizations, in the framework of existing bodies such as the Commonwealth of Independent States. It would be worth considering whether to rearrange the sequence of sections in the Charter, moving the “Commitments” section to the top of the document.
Conclusions and next steps

Participants welcomed the proposal to hold a final meeting on the Charter in Brussels in early June, kindly hosted by the Belgian government. That event, coordinated with the organization of national consultations, would ensure that Member States really felt “ownership” of the Charter.
**Thursday 3 April 2008**

**Welcome and opening. Objectives of the meeting and Conference preparations**
Dr Donato Greco, Director, Department of Prevention and Communication, Ministry of Health, Italy
Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

**Session 1. Health and health systems stewardship/governance: an introduction**

**Chair:** Dr Josep Figueras, Director, European Observatory on Health Systems and Policies

*Health and health systems stewardship/governance: the position of WHO.* Dr Nata Menabde, WHO Deputy Regional Director for Europe

*Ensuring the intersectoral role of the ministry of health.* Dr Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy

**Panel discussion and debate with participants**

**Panel:** Chair of Session 1, presenters and representatives of Member States (Finland, Italy and The former Yugoslav Republic of Macedonia)

**Session 2. Exercising health stewardship/governance**

**Chair:** Dr Enis Barış, Director, Division of Country Health Systems, WHO Regional Office for Europe

*Setting and implementing health priorities.* Dr Antonio Duran, Adviser, WHO Regional Office for Europe

**Panel discussion and debate with participants**

**Panel:** Chair of Session 2, presenter and representatives of Member States (Denmark and Kyrgyzstan)

*Prevention and cure, personal and population services, purchasers and providers.* Professor Peter Donnelly, Deputy Chief Medical Officer, Scottish Executive Health Department, United Kingdom

**Panel discussion and debate with participants**

**Panel:** Chair of Session 2, presenter and representatives of Member States (Armenia and the Netherlands)

*Regulating the public-private mix.* Professor Richard B. Saltman, Department of Health Policy and Management, Rollins School of Public Health, Emory University, United States of America

**Panel discussion and debate with participants**

**Panel:** Chair of Session 2, presenter and representatives of Member States (France and the Russian Federation)

**Exercising stewardship in practice**

*Improving the stewardship/governance role of the Ministry of Health. What does it take most of all?* Final panel discussion and debate with participants. Conclusions

**Panel:** Chairs of Sessions 1 and 2, presenters and representatives of Member States (Estonia, Germany, Moldova, Tajikistan)
Friday, 4 April 2008

Session 3. Stewardship and performance assessment

Chair: Dr David Evans, Director, Department of Health Financing, WHO headquarters

Governance, performance assessment and accountability: closing the circle. Professor Peter Smith, Director, Centre for Health Economics, University of York, United Kingdom

Performance evaluation in decentralized frameworks; the case of Italy. Dr Donato Greco, Director, Department of Prevention and Communication, Ministry of Health

Dr Filippo Palumbo, Director, Directorate-General for Health Planning, Ministry of Health

Dr Fabrizio Carinci, SIVEAS National Expert, Directorate General for Health Planning, Ministry of Health

Performance assessment in practice

Improving performance assessment in the Ministry of Health. What does it take most of all? Final panel discussion and debate with participants. Conclusions

Panel: Chair of Session 3, presenters and representatives of Member States (Belgium, Ireland, Kazakhstan, Serbia and Spain)

Session 4: The Health Systems Charter

Chair: Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, England

Co-chairs: Dr Ainura Ibraimova, Deputy Minister of Health and Director, Ministry of Health’s Statutory Health Insurance Fund, Kyrgyzstan

Dr Leen Meulenbergs, Head of Service, International Relations Department, FPS Health, Food Chain Safety and Environment, Belgium

Update on the third draft of Health Systems Charter. Dr Fiona Adshead, Deputy Chief Medical Officer and Mr Joseph Kutzin, Regional Adviser, Health Systems Financing, WHO Regional Office for Europe

Panel discussion and debate with participants

Panel: Chair and Co-chairs of Session 4, Dr Nata Menabde, WHO Deputy Regional Director for Europe, Dr Antonio Duran, Adviser, WHO Regional Office for Europe

Conclusions and next steps. Dr Fiona Adshead, Deputy Chief Medical Officer, Department of Health, England

Final remarks and closure

Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

Dr Donato Greco, Director, Department of Prevention and Communication, Ministry of Health, Italy
Preamble

1. The purpose of this Charter is to provide a policy and strategic framework to guide the strengthening of health systems throughout the WHO European Region and to promote a vision of the health system as a means to invest in social welfare. Hence, this Charter is intended to foster political commitment and action, while recognizing the diversity of health systems, policy contexts and economic conditions that exist in this Region.

2. The Charter reflects several main themes:
   - Investment in health is an investment in future human development.
   - Well-functioning health systems are essential for any society to improve health and attain health equity: strengthened health systems save more lives.
   - Health systems involve more than health care.
   - Effective health systems promote both health and wealth.

From values to action

3. We believe that all human beings have the right to enjoy the highest attainable level of health as an intrinsic component of social welfare, and thus improving health status is a defining goal of health systems. Beyond its intrinsic value, we also note the importance of health as an indirect contributor to social welfare through its impact on the creation of wealth and economic development. Wealth creation can be an important supplementary outcome of health system actions; however, it is not the prime rationale for them.

4. The values of equity, solidarity and participation form the underlying principles for action to strengthen health systems. Hence, health systems should strive to achieve the goal of improved health on an equitable basis, through participatory processes that reinforce social cohesion and solidarity. In fact, experience shows that for economic growth to contribute to health, some transfer of resources from those who have to those who have not is required, exemplifying the above values.

5. The design and adaptation (reform) of health systems also affect social welfare in other ways, most notably through financial protection (the extent to which people are at risk of becoming economically impoverished by their need to pay for health care), equity in the burden of funding the health system, and the extent to which people are treated with dignity and respect when they come in contact with the system (responsiveness).

6. Despite their differences, all countries should pursue the goals of health systems – health, equity in health, financial protection, equity in financing, and responsiveness – to the extent possible given their means. This requires making the best use of available resources in the pursuit of these goals (efficiency) as a goal on its own.

7. While the context and choices of countries differ, these shared goals should drive the development and reform of health systems in all countries. The goals can be pursued through intermediate objectives, some of which are also shared across all countries. Examples include matching need with the provision of services by improving coverage and access, improving the quality of care and patient safety, etc.

8. In other words, health system actions are influenced by incentives (financial and non-financial) but should also be underpinned by values, which in turn can be made operational by specifying both broad goals and intermediate objectives, and transforming these into evaluation criteria for health systems. The extent to which these goals and objectives are achieved is dependent on ensuring that the incentives are aligned with them, and thus whether values can be transformed into action.
The health system

9. The signatories acknowledge that the health system is more than health care; in each country, the health system is the ensemble of all organizations, institutions and resources that are devoted to producing actions whose primary intent, in the political and institutional map of the country, is to improve, maintain or restore health.

10. While recognizing that the diversity of approaches to health system organization in Member States reflects cultural, historical, economic, and policy influences, all health systems perform a common set of functions and can be understood in these terms:

- **Delivering personal and population-based health services.** The most visible function of any health system is the delivery of services to individuals and to groups or entire populations. Key issues are the choice of services to be delivered, in what settings, and by what mechanisms. Strengthening primary health care is a particularly important strategy to promote the aims of access, coverage and quality, and provides a natural platform for intersectoral and inter-professional cooperation, for the integration of vertical programmes in existing structures and services (as opposed to their development in parallel structures with its implied inefficiencies), and for health promotion.

- **Financing.** This consists of the collection, accumulation (pooling), and allocation of funds used for the health system. Member States are confronted with difficult choices and complex tradeoffs as they use various approaches in their efforts to promote health system goals within the constraints of available funds.

- **Stewardship.** The ensemble of systematic activities aimed at ensuring that: (i) the health system has a direction, and the other functions are well orchestrated and oriented to promote the goals; (ii) healthy public policy” is promoted in order to maximize health gain by increasing the political “connectivity” between health systems and other policy areas/sectors; and (iii) the relationships between health-related stakeholders are ruled and regulated in a context of evidence-based transparency and accountability, with monitoring and audit functions established to inform them.

- **Resource generation.** Identifying, “creating” and developing the resources – knowledge, staff, medical devices, physical infrastructure, etc. – necessary to produce the above services within the cultural, historical, economic, and political context of the specific country. Investment in human resources for health is particularly critical.

11. Health system functions are inter-connected, and experience suggests that action in one single function or programme alone is unlikely to lead to substantial progress or the desired results. There are no “magic bullets” for improving health systems performance; successful progress towards policy objectives always demands a coherent approach involving multiple system functions.

12. Because health is the outcome of a number of factors, some of which lie outside the health system, health systems encompass not only personal and population-based health services, but also the activities intended to advise, influence and support the actions of other public and private institutions to take health into account in all policies and address the social determinants of health. Analysis of the determinants of health and the potential for affecting these, as well as action to influence those in other sectors to improve health is a fundamental responsibility of the health system steward.
Commitment to act

13. We commit ourselves to producing and refining tools to support inter-country learning and exchange in the implementation of the Charter.

14. We, the Member States hereby make the following commitments:

- To promote our shared values in the development of health system strategies while taking account of our own national specificities, transforming broad goals into country-specific, measurable objectives, ensuring that health system policies are aligned with these objectives and that actions are coordinated across the health system functions.

- To improve the performance of health systems while targeting the production of a robust evidence base to be shared by all. This includes measuring the impact of investments and identifying with greater precision the likelihood that a particular set of actions will contribute to health, wealth and equity in specific country contexts.

- To ensure that health systems are designed to meet crises and humanitarian emergencies, and measures are taken to ensure collaboration between countries whenever needed; this is particularly important in times when potentially devastating public health emergencies of international concern call for the enforcement of the WHO-led International Health Regulations.

- To help finance and economic development policy-makers fully understand the implications of public policy and resource allocation decisions for health and social welfare, and explore in more detail the role of health as a sector of the economy.

- To take the interests, opinions and expectations of stakeholders properly into account (technocratic approaches alone are not sufficient), and to ensure transparent processes and accountability for results.

- To promote accountability by making sure that societies are provided with understandable evidence of the effects of policies or reforms on objectives, and that users are involved in decision making. At a political level, ministers of health should report periodically on progress.

- If deemed appropriate in each country, to translate the Charter in the form of action statements, setting out the ideal situation or goals to be attained, including a specific time frame.

15. WHO will, through its normative and technical roles, continue to support Member States in developing their own health systems and institutions, working with partners towards the objectives of the WHO European Ministerial Conference on Health Systems: “Health Systems, Health and Wealth”. The WHO Regional Office for Europe will develop a technical framework that countries can adapt for periodically reporting their progress on the various dimensions of health systems performance.

16. WHO will also work closely with the European Union (EU) on “Health in All Policy” areas. Intersectoral action will be built on continuous work within the EU to integrate health into all policies. The EU’s work on cross-border health care and other relevant areas will also be considered with a view to transferring the lessons learned to the rest of the WHO.

17. WHO will also work closely with other partners, such as the World Bank (WB), the European Investment Bank (EIB), the Organisation for Economic Cooperation and Development (OECD), the United Nations Children’s Fund (UNICEF), the Council of Europe (CoE), the European Centre for Disease Prevention and Control (ECDC), and others that support the objectives of the Charter to improve the performance of health systems in the European Region.
Annex 3

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