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Stewardship/Governance of health systems in the WHO European Region

The WHO Regional Office for Europe held a European ministerial conference on health systems in Tallinn, Estonia in June 2008, to highlight the impact of health systems on health status and economic growth and to assess recent evidence on effective strategies to improve health system performance.

The Tallinn Charter: Health Systems for Health and Wealth, was adopted by 53 countries during the Conference. The Conference launched a broad policy dialogue to explore the social well-being that lies at the centre of the triangle of interactions between health systems, health and wealth. One of the keys to this dialogue was the provision of evidence on how well-performing health systems improve people's lives and thus contribute to the well-being of nations.

Stewardship/governance is a core function of health systems which requires specific attention. Increased transparency and accountability are driving forces behind better health system performance, which health system "stewards" strive to achieve by carrying out a number of subsidiary functions: formulating strategies and policies to ensure the attainment of health system goals; gathering and applying intelligence; exerting influence through coordination with partners and other sectors and advocating for better health; ensuring good governance in support of the attainment of health system goals; ensuring that the system can adapt to meet changing needs; and mobilizing legal, regulatory and policy instruments to steer health system performance.

The Regional Committee discussions on stewardship/governance of health systems are expected to focus on: facilitating the exchange of knowledge and experience; strengthening national capacity to improve health system performance through better stewardship; and advocating for investment in better health and health system stewardship as an entry point to strengthening health systems. The Regional Committee discussions are also expected to link to the Tallinn Charter, which enshrines the commitment to strengthen the Region's health systems and make them more accountable and more responsive to people's needs, especially those of poor and vulnerable groups.

A draft resolution setting out key policy directions on the issue is attached, for consideration by the Regional Committee.

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Stewardship and health system performance

1. The health situation in the WHO European Region is characterized by an overall improvement in health status over the past fifteen years, as expressed by main health indicators such as life expectancy at birth or disability-adjusted life expectancy (WHO Regional Office for Europe, 2007). But this improvement coexists with serious concerns such as the high prevalence of noncommunicable diseases in most countries in the European Region, inter- and intracountry inequalities in access to health services and health outcomes, a mismatch between health, human resources and the health needs of the people, and rising expenditures in health and health care. These concerns are just some of the factors threatening people's confidence in their health systems (European Commission, 1998).

2. Member States in the WHO European Region are therefore facing difficult challenges. In some cases, the above concerns have persisted in spite of decades of efforts in a number of areas. More specifically, there is a pressure on governments to improve health system performance and value for money. This is even more acute since the link between health and social well-being is becoming clearer. For instance, a recent study found that between 1970 and 2003, the welfare increase from life expectancy gains in western European countries was equivalent to 29–38% of gross domestic product (GDP) when valued in monetary terms. Variations between selected eastern European countries for the period 1990–2003 were great: some experienced declines in life expectancy, with an equivalent welfare loss valued at 16–31%, while life expectancy gains in other countries provided a welfare benefit valued at between 12–31% of GDP (Suhrcke et al., 2008). Governments are faced with difficult choices and trade-offs to improve health system performance, trying to involve all stakeholders and reconcile principles such as equity and efficiency. In this context, the state and the private sector have been involved in complex health system reforms. With the media and the public calling for more transparency and accountability, the stewardship function of health ministries and governments has received more and more attention, with the aim of achieving better health system performance and ultimately of “the attainment by all peoples of the highest possible level of health” (WHO, 2007a) while taking the interests, opinions and expectations of stakeholders properly into account and, in particular, making health systems more responsive to the free voice and choice of citizens and to the knowledge of health professionals.

3. Changes that have occurred in recent years in the world economy, the environment and health systems have prompted a reconsideration of the relative influence of the factors influencing health. On the one hand, it is clear that part of the improvements in health have been due to socioeconomic development, improved education and nutrition, better housing and a number of factors not directly related to health care. On the other hand, recent research has demonstrated that effective health services have a bigger influence on health outcomes than was previously expected. McKee and Nolte (2004) have shown that the relative role of health systems in reducing mortality at a certain level is more important than originally thought. Their findings provide evidence that improvements in access to effective health care (combined with other factors) have had a clear impact (up to 23% of total mortality under the age of 75 for males and 32% among females for countries with the highest levels of amenable mortality, including Finland, Ireland, Portugal and the United Kingdom) in many countries of the European Region during the 1980s and 1990s, in particular through reductions of mortality due to diseases amenable to health care in several age groups. In another study, Arah et al. (2006) found that health care performance indicators could explain between 44% and 57% of the variance in life expectancy as a measure of health, the rest being accounted for by nonmedical determinants of health.

4. The role of governments in using all policy instruments and tools at their disposal to steer health systems towards better health outcomes has been reaffirmed in the WHO European Region, despite substantial differences in the way health systems are organized and run. Health ministries and governments are moving from a managerial role, directly involved in the delivery of services, to a role of strategic overviewer making increasing use of incentives and various policy tools to steer the health system towards better performance. The importance of the health and health system stewardship role is also a consequence of the lessons learned from other countries inside and outside Europe (Perlin, 2006) and from the successes of different industries and public administrations (“new public management”).

The literature on strategic management in the private sector has reaffirmed principles such as the need consistently to translate performance expectations into incentives and accountability schemes in strategy-led organizations (Kaplan and Norton, 2003) and to adopt renewed and simplified organizational forms (Nohria et al., 2003). However, private companies and public systems alike have experienced that no single concept can be applied in all contexts and all sectors of the health system (Khaleghian and Das Gupta, 2004; Kirby, 2005).

5. The health system stewardship function implies 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 (WHO Regional Office for Europe, 2005a). Stewardship is fundamentally about designing and steering health systems towards the most effective arrangements in order to secure better health outcomes. A key function in doing so is for the health system steward to build an environment in which well-informed citizens are able to take decisions and responsibilities regarding their own health. Furthermore, health system stewardship does not necessarily mean that all stewardship roles have to be carried out by the health ministry or national government alone. Rather, configurations of health systems exist in which other actors (decentralized levels such as regions or provinces, government agencies, health insurance funds, providers, patients, health care professionals and other health organizations) play active roles in fulfilling the stewardship functions.

6. Overall, ascertaining the relative influence of factors affecting the performance of the health system and determining the best possible ways to exercise effective stewardship seem to be important preconditions to improving health outcomes. It is known (Preston, 1980) that the positive correlation between GDP and health under given conditions of education and health technology is linked to governance/stewardship. The impact of wealth on health systems, health and equity in aggregate terms (as expressed in the significantly positive correlation between GNP per person and life expectancy) has been shown to work mainly through the impact of GNP on the incomes of the poor in particular and on public expenditure, especially in health care, both aspects that are closely linked to governance/stewardship (Anand and Ravallion, 1993). Also the different health outcomes at comparable income levels – including some striking exceptions to the positive correlation between GDP per person and life expectancy (Sen, 1999) – are directly correlated with social values and governance of the health system. As demonstrated by the WHO-sponsored Commission on Macroeconomics and Health (WHO, 2001), stewardship includes important economic aspects.

7. In this context, the WHO European Ministerial Conference on Health Systems (organized pursuant to resolution EUR/RC55/R8, adopted by the WHO Regional Committee for Europe in 2005) was held in Tallinn, Estonia on 25–27 June 2008. Among other topics, the Conference reviewed the impact of health systems on people's health, welfare and wealth, while taking stock of recent strategies to improve health system performance. From this perspective, strengthening health system stewardship seems to be a critical endeavour. The Tallinn Charter: Health Systems for Health and Wealth has as its purpose to foster general political commitment and action, acknowledging the diversity of health systems, cultural and policy contexts and economic conditions that exist in the Region. It also tackles the health system stewardship function as one of its key components. This background paper and its discussion by representatives of Member States at the Regional Committee are another opportunity to present the critical challenges faced by governments in steering their health systems towards better performance. The role of the WHO Regional Office for Europe in helping Member States overcome these challenges, as set out in its mission statement (“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 for public health”) will also be discussed.

8. This background paper aims to (1) clarify the definitions, roles and underpinning values of health system stewardship in the WHO European Region, (2) propose a framework designed to help analysis and assessment of the health system stewardship function, (3) present some of the tools and instruments of health system stewardship, and (4) discuss the critical challenges of health system stewardship. It draws upon the experience of different countries inside and outside the WHO European Region in order

to propose, in the attached draft resolution, a course of action linked to the Tallinn Charter: Health Systems for Health and Wealth. This background paper is based on the guidance provided by the Standing Committee of the Regional Committee and on the conclusions of the pre-conference meetings that took place over the past two years and of the WHO European Ministerial Conference itself. The contributions of partner organizations are explicitly incorporated. It is supported by a glossary of terms (see Annex 1).

Concepts and definitions

9. Health systems are defined as “comprising all the organizations, institutions and resources that are devoted to producing actions primarily aimed at improving, maintaining or restoring health” (WHO, 2000). Health systems strive to attain certain goals, the first one of which is to improve health (by achieving both the best possible average level and the smallest feasible differences between individuals and groups). Other goals are to ensure responsiveness to people’s expectations, to protect against the catastrophic financial risks of disease, to distribute the burden of funding fairly and to improve efficiency (WHO, 2007b). Health system stewardship is one of the four health system functions outlined in *The world health report 2000* (WHO, 2000) and is defined as a “function of government responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry”. Fundamentally, stewardship is “about the role of the Government in health and its relation to other stakeholders whose activities impact on health” (WHO, 2007b). The concept has incorporated the various elements required to form a basis for this function (e.g. governance, leadership) and there have been debates around its application in a number of professional environments. Furthermore, the concepts of stewardship and governance have often been confused. Governance can be defined as “the exercise of political, economic and administrative authority in the management of a country’s affairs at all levels” (WHO, 2000). More specifically, governance is not only a context in which the steward operates as part of the broader public sector but also an ensemble of health system-related mechanisms (such as those related to accountability and transparency) that can be adjusted or changed in order to align the behaviour of system stakeholders with the goals pursued by the health system. It should be acknowledged that the word “stewardship” is difficult to translate in different languages: in German, for instance, the English term is often used (WHO Regional Office for Europe, 2002). Therefore, although governance and stewardship are not the same, in the health field the two terms are often taken as being synonymous.

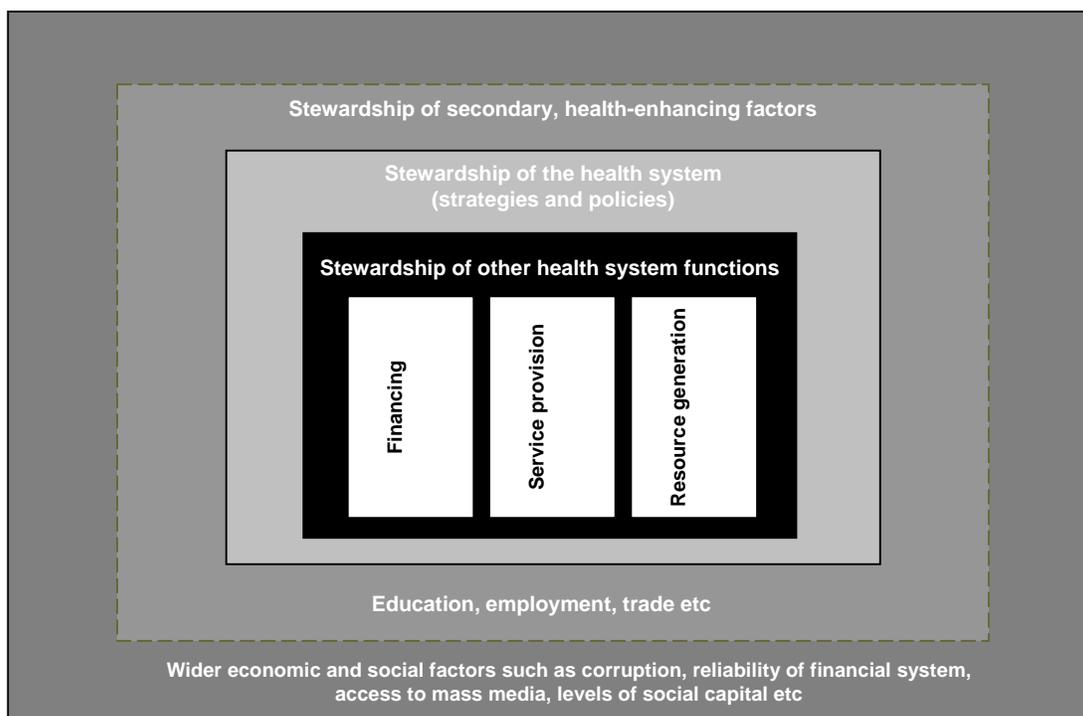
10. Different positions have been adopted concerning the precise objectives, roles and instruments of a health system steward, but overall the health system stewardship function goes beyond leadership and includes the ability to “formulate strategic policy direction, to ensure good regulation and the tools for implementing it, and to provide the necessary intelligence on health system performance in order to ensure accountability and transparency” (WHO Regional Office for Europe, 2005a). The core roles of a health system steward are consequently to: define the vision and the strategy to achieve that vision; to apply intelligence when defining the vision and evaluating outcomes; to govern the health system in a way that is values-based, ethical and conducive to the attainment of health system goals; to mobilize its legal and regulatory powers to attain health system goals; to ensure that the health system is designed in such a way that it can adapt to changing needs; and to exert influence across other sectors than health and advocate for better health. Importantly, though stewardship is fundamentally a public responsibility, the scope of stewardship includes the private sector and its governance. Hence, for example, achieving universal coverage is a public policy objective but it does not *a priori* imply that service provision and financing must be wholly public. Private insurers and providers can and often do play important roles in achieving this objective within a context of coherent governance and regulation.

11. One of the areas under discussion has been the question of whether stewardship of the health system and health stewardship are different and if so, by whom and at which levels of government each is exercised. In a way, it is arguable that since a health system is the ensemble of all resources, organisations and institutions primarily intended to improve, restore or promote health, then by definition it includes all services as well as intersectoral action for health. A slightly different point of view sees within

government two levels for the stewardship function: the government is responsible for health stewardship in broad terms, while the ministry of health is responsible for the health system in the strict sense. In that perspective, the health stewardship of governments translates into actions on so-called secondary health-enhancing factors (see Fig. 1), for which responsibilities may be exercised by other ministries (but influenced by or coordinated with the health ministry), or actions on tertiary factors such as wider socioeconomic factors or levels of social capital, which are usually dealt with by the head of the government (prime minister) and the entire government. A multilateral illustration of the importance of governments' health stewardship is the declaration adopted by representatives of the 27 European Union Member States at the conclusion of the Conference on "Health in All Policies: Achievements and Challenges" (Rome, 18 December 2007) in which they state their commitment to "strengthening multisectoral approaches and processes at European, national, regional and local levels by which public health impacts can be effectively taken into account in all policies". Increasingly, the health stewardship function of governments can also be exercised at transnational level through leadership in global health issues or through assistance to other states in need (Gostin and Archer, 2007).

12. The function of stewardship of health systems is undertaken by health ministries, who exercise it by influencing the other health system functions – personal and population service delivery, resource generation and health system financing. Health system stewardship entails striking a balance between the individual and the State (in terms of patients' rights, for instance) and includes a number of actions such as: orienting personal health care (delivered in primary health care settings and hospitals) towards quality, effectiveness and health gain; ensuring the relevance and cost-effectiveness of population services (health education, disease prevention, etc.); influencing planning of the future workforce to meet health needs within an ethical framework; and ensuring the availability of funds. It is worth noting that the health system stewardship function does not run parallel to the other functions but rather subsumes them. Health system stewardship includes providing leadership and advocacy to influence and coordinate action with other branches of government (finance, trade, transport, agriculture, etc.) at central and regional or local levels (for decentralized systems), and with the private sector and other stakeholders, in order to secure the presence of health in all policies as well as proper attention to the social determinants of health (Figueras, et al., 2008). The above efforts require not only episodic actions but also the building of robust social institutions capable of exerting continued influence in society. Health system stewards therefore have to find a balance between the medium-term outcomes necessary to respect the pace of political life and the long-term actions required to promote better health.

Fig. 1. Stewardship of different factors influencing health



Source: Adapted from Davies, 2001

13. While a country's government, through its health ministry, remains responsible for providing effective stewardship, these responsibilities may be divided with other ministries or bodies such as finance, planning, civil service commissions, audit commissions, parliamentarians, professional associations, ombudsmen, inspectorates, insurance funds, other purchasing agents (including donors) and even some providers (Travis et al., 2003). It is important to recognize that national contexts determine different configurations in which the stewardship function is carried out. The health system stewardship function can be exercised centrally, at national level alone, or it may be exercised jointly at subnational level, depending on the degree of decentralization of the country. However, only in the most decentralized systems can true stewardship be exercised at subnational level, because a broad array of policy powers and tools would have to be used.

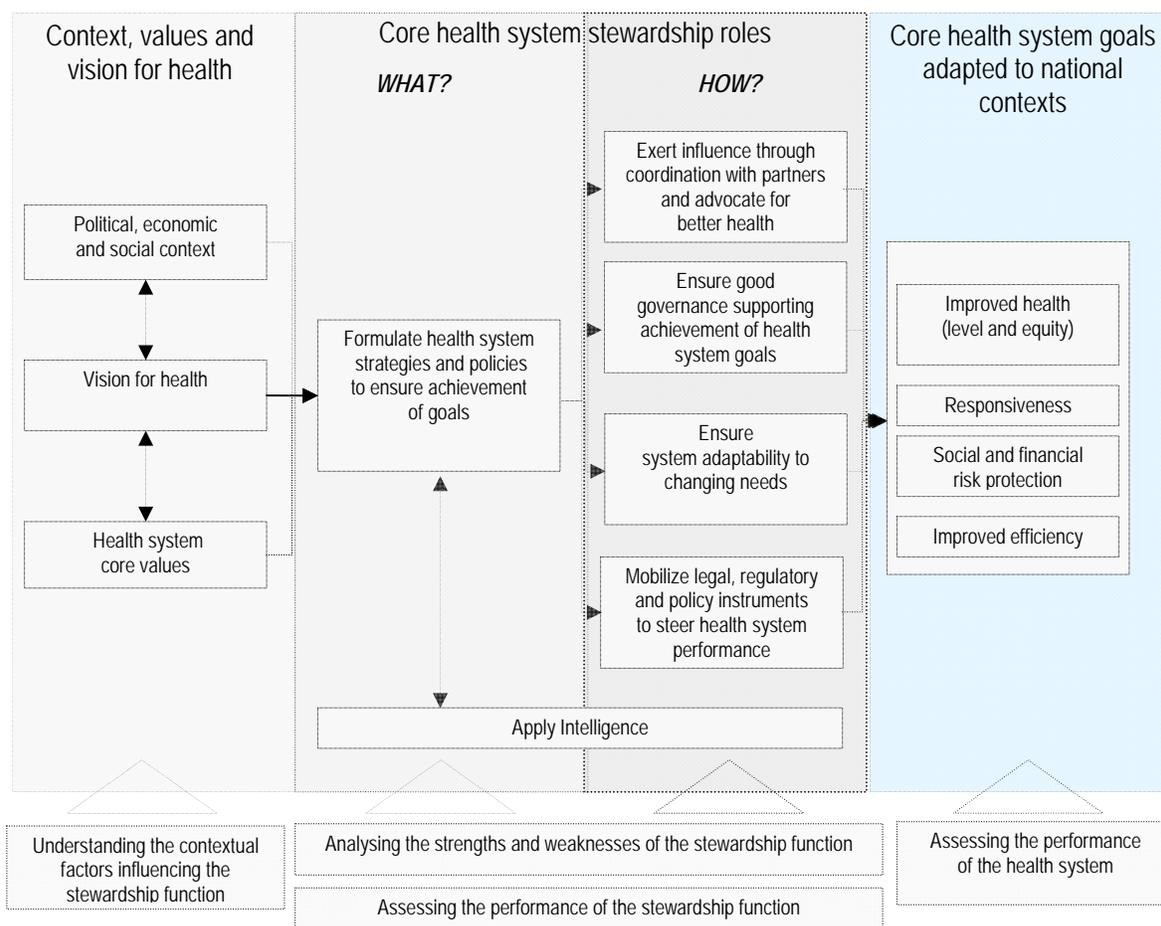
14. Providing ethical governance – for example, by establishing shared values for health, promoting system-wide accountability and clarity in the roles and responsibilities of health system actors, and making consumer protection a priority – is also a key element in stewardship. In the WHO European Region, this is in line with the Ljubljana Charter developed in 1996 (WHO Regional Office for Europe, 1996), which laid down the principles for reforming health systems in the Region by stating that health systems need to be: (i) driven by values of human dignity, equity, solidarity and professional ethics; (ii) targeted on health; (iii) centred on people; (iv) focused on quality; (v) based on sound financing, and (vi) oriented towards primary health care. The 2005 update of the Health for All policy framework for the WHO European Region also states that “across the European Region, certain common values play a central role in health decision-making” (WHO Regional Office for Europe, 2005b). Even if these values are put in practice in different ways in various Member States, they form a strong basis for carrying out the health system stewardship function, since they contribute to defining the vision for health in the country within its own particular political, economic and social context. As defined in the Health for All policy framework, these values are solidarity between individuals and within the entire society, equity (in process and outcomes), involvement of patients and citizens in health decision-making and ethical, values-based governance of the health system (for definitions, see Annex 1).

Improving the stewardship of health systems in the WHO European Region: methods, tools and techniques

15. As noted above, the configuration of the health system stewardship function can vary, depending on the economic, political and social context and on the core values embedded in a national culture. For example, the role of the private sector in delivering health services or the degree of decentralization to decision-making authorities at subnational level will vary, depending on a country's national context, culture and history. The conjunction of a specific mix of values and the political, economic and social context is an important variable which influences the way in which the health system stewardship function is carried out. Ensuring consistency between the health system objectives pursued, the core stewardship roles it performs and the national context in which it operates is a crucial activity of the health system steward. Fig. 2 tries to represent such relationships while outlining three questions ("lenses") that may yield a better understanding of health system stewardship: (i) what are the contextual factors that help explain the specific configuration of the stewardship function in the country? (ii) what are the key roles in the health system stewardship function? and (iii) against which performance criteria can the stewardship function be measured? Such lenses could help countries analyse the strengths and weaknesses of their stewardship function and decide how to carry it out most effectively in order to achieve health system goals.

16. As the ultimate goal of a good steward is to achieve health system goals adapted to its national context, performance of the stewardship function ultimately links to overall health system performance. The steward needs not only to put the appropriate processes in place and make sure that they are right but also to ensure that they have an impact in terms of health system performance. The first task is therefore to formulate strategies and policies to ensure that health system goals are attained. This can be done by: (i) defining a vision for health; (ii) steering the process of drawing up the strategy and coordinated policies and defining the health investment priorities to attain the desired goals (for instance through an overarching national health plan), and (iii) specifying the roles of public, private and voluntary stakeholders and civil society. To focus on a commitment to health, rather than simply to health care, is ambitious and challenging, as this is a long-term task involving time-consuming alliance-building among many potentially competing interests. National strategy formulation is both a technical and a political process of transforming broad goals into country-specific, measurable objectives and ensuring that health system policies are aligned with these objectives, taking account of other political processes and the plans of other ministries and local government. Crucially, the involvement of stakeholders from relevant areas of work within and outside government must be secured. Emphasis should be placed on the relationship between economic development and health through targeted investments, so that policy-makers in both sectors fully understand the implications of public policy and resource allocation decisions. The national health plan of Portugal (2004–2010), for example, is an attempt to integrate medium-term targets related to specific health system objectives and goals while involving stakeholders through numerous participation channels (Portuguese Ministry of Health, 2004).

Fig. 2. A diagrammatic representation of the health system stewardship function



17. Another role of the health system steward is to apply intelligence, which can be achieved by: (i) ensuring the generation, analysis and use of high-level information (“intelligence”) about the attainment or lack of attainment of health system goals through health system performance assessment, and (ii) building evidence-informed decision-making processes, including the active use of epidemiological, economic and performance information (Nutbeam, 2004). Besides encouraging evidence-based policy, it is important for a health system steward to adopt national evidence-based clinical guidelines and protocols for all health care professionals. The Russian Federation, for example, has announced the development and adoption of clinical standards and protocols as one of its major priorities in health policy. The intention is to make the clinical process more cost-effective across regions and medical organizations (Figueras, Jakubowski and Robinson, 2005). Making progress towards health also requires that the steward build strong alliances with the stakeholders concerned, which is an essentially political process. Such a process calls for effective advocacy, exerting influence and employing strong negotiation tools and techniques (Mizrahi and Rosenthal, 2001), which in turn requires staff able and willing to use the above-mentioned intelligence (see Box 1).

Box 1. Strengthening institutional capacity for policy analysis in Kyrgyzstan

The WHO Health Policy Analysis Project was launched in Kyrgyzstan in 2000. It was designed to support the government's Manas Health Care Reform Programme, whose goal was to improve the sustainability, efficiency and quality of the Kyrgyz health system. The project had four types of activities: policy analysis; linking evidence to policy; capacity-building for policy analysis and evidence-based policy design; and dissemination of results. Capacity-building in monitoring and evaluation of health system performance, and in policy analysis more broadly has been carried out in four ways. There were frequent interactions with senior policy-makers to present findings and implications of studies, to demonstrate their political usefulness and stimulate demand. Round-table discussions on key health policy topics were a way to inject technical input and build political consensus. The Ministry of Health (MOH) health management courses targeted at managers of primary care and inpatient facilities were a crucial way to inform and engage health care managers in health policy issues. The health policy courses for central Asia and the Caucasus, in collaboration with the World Bank Institute and the WHO European Region, allowed cross-country learning for a large number of Kyrgyz policy makers. Lastly, a group of young health policy analysts have been mentored through the six years to become independent researchers providing continuous support to the Ministry of Health. These core activities have now been institutionalized through the creation of a Department of Strategic Planning and Reform Implementation within the Ministry, which has taken on core health system performance monitoring, and a Centre for Health System Development, which is an autonomous public entity created by the Ministry to support policy development and implementation through knowledge generation and training. Support to these two young institutions will continue until at least 2010 (WHO, 2007b).

18. A good steward should also aim to strike the appropriate balance among the legal, regulatory and policy instruments needed to improve health system performance. This mostly means: (i) ensuring that legislation and regulations are fairly enforced (in an even manner for all actors operating in the health system); (ii) getting the right mix of powers, incentives, guidelines, best practices and sanctions with which to steer stakeholders in the chosen direction (Figueras, Saltman and Busse, 2002), and (iii) aligning health system incentives to make sure that they support attainment of the policy goals being pursued by government. Many countries in the WHO European Region have promoted different combinations of legislation, regulations and incentives intended to strengthen quality and safety policies. In France, for example, a law was voted by Parliament in 1996 to set up a mandatory process of accreditation for public and private hospitals. Regulations were also developed to enhance requirements for minimum volumes of services (e.g. minimum thresholds for hospitals to be authorized to carry out normal deliveries) or to enhance staff qualifications and norms (e.g. further requirements for qualified staff in order for hospitals to be authorized to run resuscitation departments). Incentives were set up (such as the inclusion of quality indicators in contracts between hospitals and regional hospitalization agencies) and professional guidelines and evaluation of professional practices were promoted (through the Haute Autorité en Santé, HAS). Another example is seen in how governments, health ministries and/or health insurance funds oversee the development and functioning of the private sector, and how the "playing field" for private sector actors is levelled through accreditation, quality control mechanisms, incentives, etc. Getting the right balance and mix of policy tools adapted to the policy goals being pursued and ensuring that system incentives support attainment of these goals provide health ministries and governments at large with important leverage points for carrying out their stewardship function. Ensuring the alignment of incentives in complex health systems can be a less onerous but still powerful way for governments to achieve their policy goals.

19. Stewardship also has to do with ensuring a health system design that can adapt to changing needs, thereby reducing duplication and fragmentation. This means for example augmenting the system's capacities in response to changing health needs, enhancing its ability to adjust strategies to take account of changing priorities, ensuring a good fit between strategy and structure, or ensuring that evaluation is built into policy instruments to facilitate continuous performance improvement. Assessing the

performance of the health system means appraising the balance of roles performed by the health system steward to achieve specific policy objectives in the given national or subnational context. It is also important to see whether the processes put in place are relevant and proportionate. Doing so is never an easy task, since the different stewardship actions largely depend on the context in which the system operates and on the specific balance of health system goals the country is aiming at. Building performance improvement processes in general, and feedback loops in particular, into the assessment process is a way to keep the stewardship function focused on achieving better performance through better health system outcomes (Smith, Mossialos and Papanicolas, 2008). Another way to ensure that the health system adapts to changing needs is continuously to question the adequacy between the health system's needs and health investments. The use of private industry techniques such as portfolio management allows health ministries to consider if the mix of investments in health is optimal to reach expected outcomes.

20. A good steward also has to ensure that good (ethical and values-based) governance is in place and supports achievement of the health system's goals, by: (i) establishing shared values and an ethical base for health improvement; (ii) ensuring system-wide accountability and transparency, as well as clarity in the roles and responsibilities of health system actors; (iii) ensuring a fit between strategy and structure and reducing duplication and fragmentation, and (iv) making consumer protection a priority. Improved health system governance can be achieved, for example, by involving citizens more fully in decision-making. In the United Kingdom, the white paper *Choosing health* posed wide-ranging questions on how the country might tackle preventable problems such as obesity and smoking. This document formed the basis for a nationwide consultation exercise with hundreds of events and individuals, the industry, non-profit-making organizations and the government as participants. In the white paper, the government also gave a commitment to building health into all future legislation, by including it as a component in regulatory impact assessment (RIA) (WHO, 2005a; Department of Health, 2004). Increased accountability and transparency are also important objectives and make sure that providers and agencies acting on behalf of the state focus on improved health system outcomes. A variety of techniques such as performance contracts and incentives have proved to be powerful ways of aligning the behaviour of governments' agents with health system-specific goals.

21. Finally, health system stewards have to advocate for health and exert influence through coordination with partners by: (i) collaborating and building coalitions across sectors in government and with actors outside government to attain health system goals; (ii) promoting initiatives aimed at improving health or addressing the social determinants of health, and (iii) advocating the incorporation of health issues in all policies. The use of health impact assessments in Finland and Slovenia to evaluate the likely health impact of policies outside the health sector offers promising examples of coordination, intersectoral action and advocacy for better health, as reflected in the European Union Declaration on Health in All Policies.

Box 2. Intersectoral actions for health

It is widely accepted that socioeconomic factors have a great impact on health. In this regard, the health system steward needs to take a leadership role and ensure intersectoral actions to tackle the social determinants of health. In Sweden, the health sector initiated multidisciplinary research into health determinants and facilitated the active participation of all political parties, the public and other stakeholders in the process of formulating public health goals. This led to the approval of the Public Health Objectives Act (2003) which is one of the world's first formalized health strategies employing a health determinants approach. The 11 goals and their specific, measurable targets are monitored and evaluated on behalf of a steering committee of ministers from different sectors, chaired by the Minister of Public Health. In the United Kingdom, the national policy that explicitly addresses health equity has identified intersectoral action as a key strategy. The establishment of "health action zones" is designed to organize area-based and intersectoral action around the social determinants of health. Health equity auditing has also been introduced to ensure that local community plans for health and development prioritize those with greatest need. In Slovenia, the Ministry of Health started to implement health impact assessment at national level by applying the technique to food and agriculture policies related to accession to the European Union. The process resulted in better cooperation between the agriculture and health sectors, leading to the inclusion of a food security "pillar" in the national food and nutrition action plan. Finally, Norway adopted a phased approach to reducing social inequalities in health by first establishing a competence unit in the Directorate for Health and Social Affairs, in order to increase knowledge and strengthen work on health impact assessment. The government then submitted a report to the National Assembly presenting its strategy over 10 years including guidelines for the government and central administration (Stahl et al., 2006; Bonnefoy et al., 2007; Public Health Agency of Canada, 2007).

22. Although the arsenal of stewardship is perhaps equipped with as many intentions as well-tested instruments, a number of tools and techniques exist to carry out an effective stewardship function (e.g. health sector policies and medium-term expenditure frameworks; standardized benefit packages; resource allocation formulae, and performance-based contracts). These tools are linked to specific subfunctions of health system stewardship such as presented in Fig. 2. Even if further research and evaluation is required in order to ensure that these tools are effective in different contexts, some of them already seem to be relevant for improving health system stewardship and are considered below.

- From the point of view of strategy development, strategic and operational planning should be revisited and more focused use made of epidemiological and economic analysis. Medium-term expenditure frameworks, national health accounts, and target- and priority-setting techniques (such as health technology assessment or WHO-CHOICE¹) are useful tools in that perspective.
- In order to support strategy implementation, health framework laws and tools such as incentives or pay-for-performance techniques are useful for adjusting performance to the expectations set out in the health system strategy.
- Intersectoral collaboration can be supported by techniques such as health impact assessment and health needs assessment (Wright et al., 1998), as well as sector-wide approaches (SWAPs) (WHO, 2000).
- Accountability may be strengthened through performance-based contracts for providers or by releasing performance information to providers and the public (as has been done in the United Kingdom).
- Citizens may be involved in public decision-making through innovative mechanisms such as consensus conferences (United Kingdom, France, Denmark) or national health forums (United Kingdom, France).

¹ WHO-CHOICE: the WHO project on Choosing Interventions that are Cost-Effective

- Finally, innovative techniques such as long-range scenario planning in the Netherlands have made it possible to model different future scenarios for health services, thus enhancing the steward's capacity to anticipate changes and adapt to changing needs.

It should be noted, however, that no single country is able to provide solutions to all the dilemmas posed by effective implementation of the stewardship function.

Assessing the health system stewardship function

23. A better understanding of the roles and competencies required for health system stewardship may help governments analyse how efficiently the stewardship function is carried out. The roles and responsibilities of the actors need to be well defined and consistent with the goals being pursued, namely of assessing whether accountability is being exercised and whether the decision-making processes sufficiently involve the different stakeholders, including the private sector, patients and citizens. Looking at the use of legal powers poses questions related to the rule of law in the country and the alignment of incentives to achieve health system goals. System design issues can also be raised, to see whether and to what extent the system is able to adapt to changing needs. Finally, the influence/advocacy component can be analysed by reviewing processes for achieving health gain put in place across and outside government. Methods that will enable the health system steward to analyse its different roles must of course be further adapted to national contexts and policy goals.

24. Robust performance of the stewardship function should ultimately be linked to satisfactory health outcomes. One of the difficulties in this regard is to find the appropriate mix of performance indicators that can validly and reliably reflect progress in health system reform (in other words, those that a government would see as a sign of strong performance) and which are amenable to action. The time lag between policy interventions and their impact on health status, as well as the difficulties of attributing an impact to specific policy interventions, usually encourage governments to favour process indicators over outcome indicators. Other approaches have been adopted, such as using composite indicators with different weights or indicators of people's "confidence in the health system" as an ultimate measure of success; these techniques demonstrate the importance – and the difficulties – of linking the stewardship function with performance of the health system in a meaningful way. Overall, policy-makers need to ensure that the whole approach to performance measurement is embedded in governance systems (Smith, Mossialos and Papanicolas, 2008).

25. Furthermore, benchmarking efforts are starting to show their value, in examples not only from private industry but also and increasingly from the public sector, and they can help to foster continuity and share best practices for performance improvement. Initiatives such as the Commission on a High Performance Health System in the United States have shown the value of benchmarking between countries (a number of them European) and between sub-federal levels in the United States (Commonwealth Fund Commission on a High Performance Health System, 2006; Davis, 2007; Cantor et al., 2007). Other lessons can be learned from different types of health care organizations, as well as from federal governments that have started using the balanced scorecard system to link key performance indicators to their overall strategy and measure their overall organizational performance (Zelman, Pink and Matthias, 2003). The Netherlands has applied an OECD performance framework to assess broad health care quality indicators that each stakeholder in the system can use to evaluate its performance (Tawfik-Shukor, Klazinga and Arah, 2007).

Box 3. Benchmarking for better health system performance: the example of the Commonwealth Fund in the United States

The Commonwealth Fund is a private foundation that aims to promote a high performing health care system in the United States by supporting independent research on health care issues and by stimulating innovative policies and practices in the United States and other industrialized countries. In 2005 it established the Commission on a High Performance Health System, a group of experts and leaders representing every sector of health care, as well as professional societies, the business sector, academia and state and federal governments.

The Commission has analysed best practices from several countries and concluded, based on the lessons learned, that the United States system could achieve universal coverage and better health outcomes at a dramatically reduced cost per capita. Its benchmarking against a number of European countries showed that, in terms of public satisfaction with the health system, Denmark performs better than any other country in Europe. It is also rated as one of the best countries for primary health care (as measured by high levels of first contact accessibility, patient-focused care over time, a comprehensive package of services and coordination of services when services have to be provided elsewhere), and it continues to have lower health care expenditures than many other countries. Germany is a leader in national hospital quality benchmarking, with quality information on all German hospitals based on over 300 quality indicators. The Netherlands and the United Kingdom stand out for their leadership on transparency in reporting quality data (Davis, 2007). Within the United States the Commission has also benchmarked states against each other. After establishing a national scorecard on United States health system performance in 2006, the Commission assessed state variations across five key dimensions of health system performance (access, quality, avoidable hospital use and costs, equity, and healthy lives) with the state scorecard (Commonwealth Fund Commission on a High Performance Health System, 2006). Overall rankings and ranks on each dimension were calculated and specific, practical implications for policy-makers were suggested. The results, which are publicly available, are intended to help states identify opportunities to better meet the population's health needs and learn from the best performing states (Cantor et al., 2007).

26. Private company boards usually apply performance indicators to assess their success in carrying out their governance function or benchmark against successful boards of other industries. Such a practice could be promising for health system stewards, who could develop indicators to measure their performance and benchmark their performance, either against other stewards pursuing comparable health system goals or even against other complex organizations. Although this practice has rarely been used in health, it could help build continuity and share best practices for performance improvement. An interesting attempt in this direction has been the methodological framework to assess stewardship/governance in health developed by the WHO Regional Office for the Eastern Mediterranean (2008). Adapted from the United Nations Development Programme principles and themes of governance, the analytical framework is based on the following principles: strategic vision; participation and consensus orientation; rule of law; transparency; responsiveness; equity and inclusiveness; effectiveness and efficiency; accountability; information and intelligence; and ethics (see Annex 2 for more details). For each principle, three levels of assessment (national; health policy formulation; and policy implementation) are defined and a set of broad and specific questions proposed. The framework was externally peer reviewed and then applied in nine countries of the WHO Eastern Mediterranean Region, which were able to identify strengths and weaknesses in the governance/stewardship of their health systems.

Critical challenges and priorities for health system stewardship in the WHO European Region

27. Member States of WHO in the European Region are striving to design or adapt their health systems to their values and sociopolitical circumstances. Despite their differences, all countries are trying, to the utmost extent possible, given their means, to reflect their underlying shared values by pursuing the goals of health systems: improvement in overall health status and equity in health outcomes, greater protection against the financial risks of using health care, more equitable distribution of the burden of funding the system, and improved responsiveness. For this they need to ensure that their health systems have a strategic direction with regard to health problems and their determinants; that policy decisions are informed by appropriate intelligence on the cost-effectiveness of available interventions; that “healthy public policy” is promoted across all aspects of government in order to maximize health gain; and that the relationships between all health stakeholders are regulated in a context of transparency and accountability. Some countries, however, have found difficulties in adapting their approaches and structures to a modern health system stewardship function. Four possible reasons for this are: (i) the relatively short average lengths of time health ministers are in office (in contrast with the long time lag between a policy intervention and its impact on health outcomes); (ii) an insufficiently clear framework for aligning their stewardship function, coupled with political pressures on them to carry-out short-term tasks at the expense of medium- and long-term action; (iii) difficulties with health ministry staff modifying their skills and competences in order to carry out health system stewardship (as opposed to traditional administration), especially if the ministry remains heavily involved in direct health services management and provision, and (iv), a scarcity of valid and reliable performance information and evidence for decision-making.

28. WHO’s global priorities in the field of stewardship (WHO, 2007b) are to support Member States for them to: (i) develop health sector policies and frameworks that fit with broader national development policies and resource frameworks; (ii) design, implement and monitor health-related laws, regulations and standards supporting the achievement of clearly defined goals; (iii) support greater accountability in the health system through an assessment of health system performance and accountability mechanisms; (iv) generate and interpret intelligence and research on policy options; (v) build coalitions across government ministries, with the private sector and with communities to act on key determinants of health, ensuring that the health needs of the most vulnerable are properly addressed, and (vi) work with external partners and stakeholders to promote greater harmonization and alignment with national health policies. However, the various health system functions are interconnected, and improving performance demands a coherent approach involving coordinated action on all functions. Actions on stewardship as a single function is unlikely to lead to substantial progress or the desired results.

The role of the WHO Regional Office for Europe

29. In response to the above challenges and limitations, and in line with its mission statement, the WHO Regional Office for Europe will continue to support Member States in developing their own health policies, health systems and public health programmes by setting priorities intended to strengthen health system stewardship. The Regional Office will continue to play its normative and technical roles, working closely with many partners such as the World Bank, the United Nations Children’s Fund, the International Organization for Migration, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Council of Europe, the European Commission and related institutions, and the European Investment Bank. Such work will build specifically on the Health Systems Charter that was signed during the WHO European Ministerial Conference on Health Systems, Health and Wealth in Tallinn. It will also benefit from the two books, nine policy briefs and three background documents developed specifically for the Conference. The subjects of those publications were identified by Member States and discussed at four preparatory events: in Brussels, Belgium, in March 2007 (assessing health systems performance); in Belgrade, Serbia, in September 2007 (health workforce policies); in Bled, Slovenia, in November 2007 (improving the performance of health service delivery) and Rome, Italy, in April 2008 (health systems stewardship).

Draft resolution

30. The WHO Regional Office for Europe will support Member States in developing their roles and competences, as well as tools and frameworks, regarding the health and health system stewardship function. These priorities are included in the draft resolution attached to this paper. The key issues in the draft resolution build on the discussions at the pre-Conference event on health system stewardship and at the Ministerial Conference itself, the Charter signed during the Ministerial Conference, and on the discussions to be held during the fifty-eighth session of the Regional Committee.

Annex 1

Glossary of terms

Access is a measure of the extent to which a population can reach the health services it needs. It relates to the presence (or absence) of economic, physical, cultural or other barriers that people might face in using health services.

Accountability, on the part of both governors and managers, is the process of being held responsible. It includes evaluating how well the organization's actions serve to achieve the desired and measured outcomes. (Sinclair, Rochon and Leatt, 2005).

Equity refers to fairness in the allocation of resources or the treatment of outcomes among different individuals or groups. The two commonly used notions of equity are horizontal and vertical equity. Horizontal equity is commonly referred to as "equal treatment of equal need." For example, horizontal equity in access to health care means equal access for all individuals irrespective of factors such as location, ethnicity, or age. Vertical equity is concerned with the extent to which individuals with different characteristics should be treated differently. For example, the financing of health care through a social health insurance system may require that individuals with higher income pay a higher insurance contribution than individuals with lower income.

Efficiency refers to obtaining the best possible value for the resources used (or using the least resources to obtain a certain outcome). The two commonly used notions of efficiency are allocative and technical efficiency. Allocative efficiency means allocating resources in a way that ensures obtaining the maximum possible overall benefit. Technical efficiency (also referred to as productive efficiency) means producing the maximum possible sustained outputs from a given set of inputs.

Governance is defined as the exercise of political, economic and administrative authority in the management of a country's affairs at all levels (WHO, 2000). In the health field, it is sometimes used as a synonym for stewardship, particularly by those who find trouble with the word and its translation.

Health impact assessment is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population (European Centre for Health Policy, 1999).

Stewardship is "about the role of the government in health and its relation to others whose activities impact on health" (WHO, 2007b). *Health system stewardship* implies for some 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 (WHO, 2000; WHO, 2007b; WHO Regional Office for Europe, 2005a). For some, *Health stewardship* then focuses specifically on actions on secondary health-enhancing factors, such as education, or actions on tertiary factors such as wider socioeconomic factors. Health stewardship is the responsibility of governments as a whole but largely involves health ministries.

Sustainability is the capacity of the system to continue its normal activities well into the future. The two commonly used notions of sustainability are financial and institutional sustainability. Financial sustainability is the capacity of the health system to maintain an adequate level of funding to continue its activities. Institutional sustainability refers to the capacity of the system, if suitably financed, to assemble and manage the necessary non-financial resources to successfully carry on its normal activities in the future.

Annex 2

**Principles for assessing health system governance (stewardship)
(WHO Regional Office for the Eastern Mediterranean, 2008)**

<i>Governance principle</i>	<i>Explanation</i>
<i>Strategic vision</i>	Leaders have a broad and long-term perspective on health and human development, along with a sense of strategic directions for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.
<i>Participation and consensus orientation</i>	All men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures.
<i>Rule of law</i>	Legal frameworks pertaining to health should be fair and enforced impartially, particularly the laws on human rights related to health.
<i>Transparency</i>	Transparency is built on the free flow of information for all health matters. Processes, institutions and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters.
<i>Responsiveness</i>	Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users.
<i>Equity and inclusiveness</i>	All men and women should have opportunities to improve or maintain their health and well-being.
<i>Effectiveness and efficiency</i>	Processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources.
<i>Accountability</i>	Decision-makers in government, the private sector and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization.
<i>Intelligence and information</i>	Intelligence and information are essential for a good understanding of health system, without which it is not possible to provide evidence for informed decisions that influences the behaviour of different interest groups that support, or at least do not conflict with, the strategic vision for health.
<i>Ethics</i>	The commonly accepted principles of health care ethics include respect for autonomy, non maleficence, beneficence and justice. Health care ethics, which includes ethics in health research, is important to safeguard the interest and the rights of the patients.

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