

Stewardship of health systems: review of the literature

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STEWARDSHIP OF HEALTH SYSTEMS: REVIEW OF THE LITERATURE

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Introduction

A multicenter study in seven French speaking countries of the South (Burkina Faso, Haiti, Mali, Morocco, Central African Republic, Democratic Republic of Congo, Tunisia) was launched by ITM at the start of 2002.

The study is focussed on capacity building strategies of the stewardship function in health systems. In a meeting in Rabat (2-7 april 2002) the following categories of capacity building strategies were formulated:

1. Strategies contributing to the stewardship function:

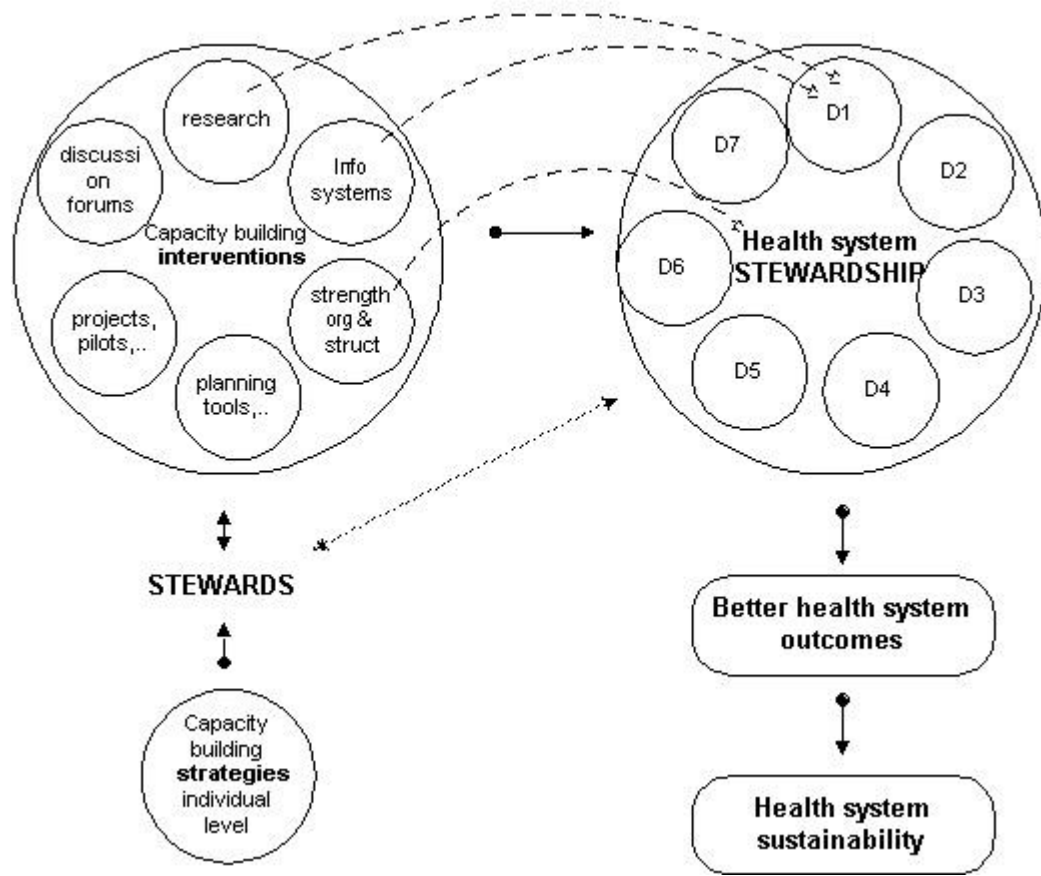
1. Health information systems (reform), needs assessments
2. Discussion and concertation forums (partners, civil society)
3. Research
4. Projets, programs & pilot experiments
5. Organisational and structural strengthening ad hoc
6. Implementation of tools and exercices in planning

2. Strategies contributing to the stewardship function:

1. Professional education
2. Education and training abroad
3. Continuing medical education (CME)
4. Mentorship, coaching, (facilitating) network building, ...

The research questions are

- The efficacy, efficiency and the coverage of strategies contributing to (i) seven domains of the stewardship function, and (ii) (as a possible by-product) the capacity of the system for exertion of the stewardship function.
- The efficacy and efficiency of implicit and explicit, formal and informal strategies contributing or meant to be contributing to the generation and development of a critical mass of competent and performant stewards.



Materials and methods

Seven WHO documents on stewardship are reviewed (1-7). The most relevant in this study is a recent paper by Travis et al in which the domains or subfunctions of stewardship are described. Some documents cited in the WHO documents are also reviewed. Articles citing the article on stewardship theory of management were looked for in ISI web of science (8)

The concept of stewardship was presented to a wide audience in the WHR (World Health Report) 2000, figuring in a framework developed for assessment of the health system performance. The framework, performance assessment and stewardship were described and discussed in several WHO publications, preceding and following the WHR 2000.

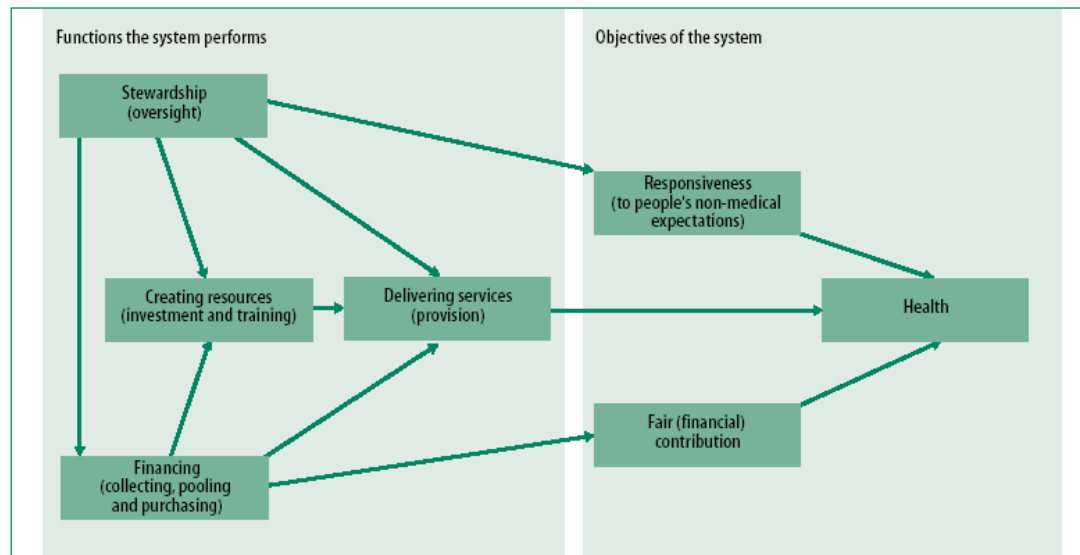
While there was a debate on the WHR 2000 (see <http://www.fiocruz.br/cict/dis/vering.htm>), the concept of stewardship itself received little attention outside the WHO: no references on the WHO use of stewardship were retrieved in Medline, Psychlit and Sociological Abstracts.

The stewardship function of ministries of health in the context of health care reform was discussed by experts from the PAHO on a conference in Malaga, Spain, in february 2002 (9). The conference used the case method to share experiences in a problem-solving framework.

Results

WHO Framework for Health System Performance Assessment

Stewardship is a major concept in the WHO framework to advance the understanding of health system performance. The concern is that health systems vary widely in performance, and countries with similar levels of income, education and health expenditure differ in their ability to attain key health goals.



The boundaries of the health system are based on the concept of health action: any set of activities whose primary intent is to improve or maintain health. Within these boundaries, the concept of performance is centered around three fundamental goals:

1. improving health,
2. enhancing responsiveness to the expectations of the population, and
3. assuring fairness of financial contribution.

Improving health means both increasing the average health status and reducing health inequalities.

Responsiveness includes two major components:

- (a) respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health); and
- (b) client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of provider).

Fairness of financial contribution means that every household pays a fair share of the total health bill for a country (which may mean that very poor households pay nothing at all). This implies that everyone is protected from financial risks due to health care.

The measurement of performance relates goal attainment to the resources available.

Variation in performance is a function of the way in which the health system organizes four key functions:

1. stewardship (**a broader concept than regulation**);
2. financing (including revenue collection, fund pooling and purchasing);
3. service provision (for personal and non-personal health services); and
4. resource generation (including personnel, facilities and knowledge).

By investigating these four functions and how they combine, it is possible not only to understand the proximate determinants of health system performance, but also to contemplate major policy challenges.

Measuring health system quality

Three intrinsic goals of the health system	Level of attainment QUALITY	Distribution of attainment EQUITY
1. Optimal health for all	X	X
2. Responsiveness	X	X
3. Fair financing		X

Intrinsic or major goals are goals for which increasing attainment is desirable in itself, holding all other goals constant. Access is not an intrinsic goal, it is not desirable by itself. It is an instrumental goal. Efficiency is an instrumental goal: ensuring that the best outcomes are achieved for the available sources.

Five indicators were used for a composite index of goal attainment relating to quality, these are the levels of health and responsiveness.

Attainment in terms of the level of population health was calculated using healthy life expectancy. Responsiveness was measured by key informant interviews in which the respondents were asked the extent to which their systems were responsive to people's legitimate non-health-related expectations (seven dimensions).

The composite index of goal attainment in WHR 2000 was the weighted sum of scores for five indicators. The weights were obtained from a web-based survey.

The sum of the weights adds to 1 :

1. Level of population health was valued at 0.25
2. Level of responsiveness was valued at 0.125
3. Inequalities in health outcomes was valued at 0.25
4. Inequalities in responsiveness was valued at 0.125
5. Fairness of financial contributions was valued at 0.25

In the quality index the level of population health was valued at 0.67 and the level of responsiveness was valued at 0.33. Health expenditures per capita are considered as health system inputs and average years of schooling of the adult population as non-health system inputs.

The WHO framework and the results of the performance measurement presented in the WHR 2000 received a lot of comments. The main points of criticism are the following.

There is no evidence that a nation's health system is the most important engineer of national health outcome. The WHO framework implies medicalization of the concept of health.

A ranking of countries' levels of health should not be used to indicate relative effectiveness of health care. Can health care systems be compared using a single measure of performance?

The compound index does not measure whether the population has its health needs met, since it fails to include any indicator of health services utilization. Thus a country can show a good performance as measured by the index, while displaying marked inequalities in the utilization and quality of health services.

There are no clear policy implications: which elements of a health system explain the position of a country is not deducible.

Also the quality of data put into the model is worrying.

Background of the stewardship idea

Dealing with market failures common to health systems and addressing public sector failure are the two concerns explaining the WHO focus on stewardship for Travis et al.

To explain the efforts in applying the role of authority in religious and environmental spheres to government, Saltman refers to the collapse of the Soviet Union and the collapse of governments in several states following civil war and the rise of globalization and the semi-sovereign roles of private transnational corporations. In order to define the role of the state in the health sector, stewardship has a potential for encouraging state decision-making that is both normatively based and economically efficient.

In the discussion paper on stewardship and public service, the central argument of Armstrong is that public service reforms of the last two decades were necessary and had positive results, but the underlying market theory is not robust enough to embrace the full range of public sector activities such as governance and guarding public interest. Market driven reforms have touched mainly delivery of public services, focussing on technique and strategy, without attention to the impact on public interest (10).

What is stewardship?

In the WHR 2000 stewardship is defined as **‘the careful and responsible management of the well-being of the population’**.

Stewardship is the responsibility of the government, usually through the Ministry of Health.

Certain stewardship tasks may be delegated to other actors than Ministry of Health.

Responsibilities for different aspects of stewardship may be divided between central and sub-national health authorities, local government, other Ministries, civil service commissions, parliamentarians, professional associations, But a country's government, through its Ministry of Health, remains the “steward of stewards” for the health system.

– Stewardship and governance

Depending on what definition of governance is used, governance is almost synonymous with stewardship. The stewards of a health system have a responsibility to ensure the health system operates according to governance principles. The actions of stewardship are *all* about improving health in contrast to many governance actions. For example, the primary intent of changing the process by which governments are replaced is not to improve health.

Definitions of governance stress ‘higher order tasks’ (e.g. Armstrong) while others (Commonwealth) put more emphasis on key characteristics of good governance as transparency, accountability and participation. Reference is made to Kaufmann, Kraay and Zoido-Lobaton who provided new empirical evidence on a strong causal relationship between better governance and better development outcomes such as per capita incomes, infant mortality and literacy. They constructed six aggregate indicators corresponding to six basic governance concepts: voice and accountability, political instability and violence, government effectiveness, regulatory burden, rule of law, and graft. As measured by these indicators, governance matters for development outcomes.

Because there does not appear to be a single accepted definition of governance. Kaufmann et al use a working definition of governance as *the traditions and institutions by which authority in a country is exercised*. This includes

- 1) the process by which governments are selected, monitored and replaced,
- 2) the capacity of the government to effectively formulate and implement sound policies, and
- 3) the respect of citizens and the state for the institutions that govern economic and social interactions among them.

– EPHF

Travis et al compare stewardship with EPHF. Eleven EPHF were identified as critical for public health practice and included in the performance measurement instrument developed by PAHO/AMRO in collaboration with the Centers for Disease Control (CDC) and the Latin American Center for Health Systems Research (CLAISS).

Essential Public Health Functions (EPHF)

1. Health Situation Monitoring and Analysis
2. Public Health Surveillance, Research, and Control of Risks and Damages in Public Health
3. Health Promotion
4. Social Participation and Empowerment of Citizens in Health
5. Development of Policy, Planning, and Managerial Capacity to Support Efforts in Public Health and the Steering Role of the National Health Authority (NHA)
6. Public Health Regulation and Enforcement
7. Evaluation and Promotion of Equitable Access to Necessary Health Services
8. Human Resources Development and Training in Public Health
9. Ensuring the Quality of Personal and Population-based Health Services
10. Research, Development, and Implementation of Innovative Public Health Solutions
11. Reducing the Impact of Emergencies and Disasters on Health

The EPHF have been defined as conditions (capacities) that permit better public health practice. For each EPHF indicators and standards were defined.

The scope of stewardship is broader than the one of Essential Public Health Functions because it includes ensuring oversight, regulation, accountability of *all* actors involved in any of the four health system functions.

Stewardship also excludes those aspects of Essential Public Health Functions which more appropriately come under provision or resource generation, for example human resource development and training in public health.

Characteristics of stewardship

In a WHO meeting in 2001 several experts presented views on stewardship from business management, studies of social capital, control of corruption and health system design.

There was general agreement that stewardship incorporates much of what is described as (public) governance. Participants generally appeared to consider that stewardship differed from governance more in its style or approach to particular tasks than in its scope.

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

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

The concept stewardship and its development is explored by Saltman. The Western concept of stewardship has religious roots. In the concept of ecological stewardship the notion of accountability to God is replaced by that of a intergenerational responsibility. The term stewardship as it relates to the state has been defined in various related ways, all reflecting similar concerns as the WHO which views stewardship as “**the effective trusteeship of national health**”. They all imply stewardship to be a function of governments responsible for the welfare of populations and concerned about the trust and legitimacy with which its activities are viewed by the general public.

Stewardship, an explicitly ethically based, outcome-oriented policy approach, is substantially more interventionist than the economically driven agency approach.

Links with agency theory

In a discussion paper Armstrong applies the stewardship approach to the public sector as an alternative to the market oriented approach (10). In their stewardship theory of management, Davis, Schoorman and Donaldson identify three specific differences in motivation, identification and power (8).

Agency theory is related to extrinsic rewards while stewardship theory focuses on intrinsic motivators as opportunities for growth, achievement, affiliation and self-actualisation.

Stewards tend to engage in cooperative, altruistic activities. They are more committed to the organisation, its longevity and values over a longer period of time, and have broader value bases and a belief in the goals of the organisation. Agents see no economic utility in relating to the goals of the organisation. Associated with the agent is organisational power by virtue of position while associated with the steward is personal power, an inherent part of the individual, not affected by position, including respect and expert power, and built on relationships .

Davis, Schoorman and Donaldson look at stewardship and agency theory from various situational factors. A high-commitment, involving, inner-controlled approach which is characterised as participative, open, trusting and comprehensive is a fit for stewards and is more effective in unstable, non-routine, uncertain environments. A control oriented approach which typically believes that thinking/controlling and doing the work should be separated. This approach is best for stable, routine environments with less trust in workers and where an aversion to vulnerability exists.

Stewardship is not useful in every situation. Both the organisation and its stakeholders must agree upon which model will be pursued. Performance is maximised where all parties choose to operate in a stewardship relationship, costs are minimised if all parties choose to operate as agencies. An organisation mixing approaches leads to a situation where stewards are betrayed by opportunistic agents, which results in an inevitable progression toward an agency model.

Stewardship-like solutions include:

- Placing emphasis on the higher-order tasks of governance. A major weakness of governance is its neglect of the longer term.
- Deepening policy reflection and improving central minds of governments. Requires constant learning, the avoidance of group think, better links between policy thinkers and citizens.
- Empowering people with understanding, societal learning.
- Rebuilding trust in governments.
- Replacing state-centered with a more global humanity-centered focus.
- Focusing on and restructuring inter-governance relations, as more forms of collective action are required to deal with emerging issues.

Concentrating on higher-order tasks can be achieved in an involvement-oriented management model which is in agreement with a stewardship model. From a HRM point of view these models have major implications on job design, performance expectations, management organisation, compensation policies, employment assurances, employee voice policies and labourmanagement relations.

There are five essential dimensions to the public sector's capacity to renew in which "learning" is a key issue:

- redefining and restating the mission of government
- selecting and designing policy instruments
- opening up civil service to development
- educating people about government and
- building a strategic capacity to change public institutions.

In addition to skills and expertise in the areas of technique and strategy for service delivery and policy process management, a stewardship-like public service needs an ability to speak truth to power, within and outside of the bureaucracy. In other words, to survive the system needs to institutionalise and nurture independent thinking, foster new ideas and new ways to apply learning as it is able to objectively analyse ideas coming from other sources.

Furthermore, learning organisations require unique types of leadership appropriate to learning organizations.

Stewardship organisations are people-building rather than people-using. They require a culture of trust. They encourage team problem solving across vertical lines and with partners outside the organisation, particularly the development of networks, links and information gathering with the people the organisation is intended to serve.

Openness is another prerequisite of stewardship. The closed character of bureaucratic processes invites suspicion, particularly in the light of the new order of open government and public discourse, as well as limiting learning and thinking ability.

Saltman sees various structural and organizational issues to be resolved before stewardship can be perceived as a suitable model for state decisions in the health sector. One basic question concerns the transition to ethically oriented stewardship among civil servants in state offices run in accordance with economically oriented agency theory:

- How should it be introduced into an administrative structure?
- What type of pressure should civil servants receive?
- When does a steward become a nanny? Or is intruding into personal lives?
- Capacity of different type of state to adopt a stewardship model?
- How sovereign are states to implement a stewardship strategy?
- There are no operational examples (except maybe the welfare states of Northern Europe).

Evolution in the WHO descriptions of stewardship

In a WHO paper by Murray and Frenk (1999) three key aspects of stewardship are described:

1. setting, implementing and monitoring the rules for the health system;
2. assuring a level playing field among all actors in the system (particularly purchasers, providers and patients); and
3. defining strategic directions for the health system as a whole.

In order to deal with these aspects, stewardship can be subdivided into six sub-functions:

1. Overall system design
Overall system design has to do with policy formulation at the broadest level. It involves the way in which all the other health system functions are put together. In this respect, stewardship can be thought of as a “meta-function,” insofar as it deals with the organization of all the other functions of a health system.
2. Performance assessment
An essential ingredient to provide strategic direction and assure a level playing field is to assess the performance of institutions involved in revenue collection, purchasing, provision and resource development. This is another “meta-function.”
3. Priority setting
Designing criteria for setting priorities and conducting a consensus building process around them are major elements of stewardship. This involves both a technical and a political aspect.
4. Intersectoral advocacy
Intersectoral advocacy is the promotion of policies in other social systems that will advance health goals. As mentioned earlier, social and economic determinants of health status, such as female education, are not themselves part of the health system. However, advocating progress on those determinants with the purpose of improving health clearly fits our definition of a health action and therefore falls within the boundaries of the health system.
5. Regulation
Strictly speaking, regulation means setting rules of the game. In the health system there are two main types: sanitary regulation of goods and services, and health-care regulation.
Sanitary regulation refers to the conventional efforts by sanitary authorities to minimize the health hazards that might be generated by the goods and services provided throughout the economy, especially those are directly consumed by humans, such as foodstuffs.
Health care regulation is applied to organizations charged with the financial, provision and resource development functions of the health system. In this respect, regulation is again a “meta-function” directed to institutions charged with other functions, through instruments such as accreditation, certification, rate setting and others.
6. Consumer protection
Both the insurance and the health care markets are characterized by information and power asymmetries between consumers and producers. Therefore, achieving a level playing field among

the actors of the health system requires explicit efforts at consumer protection as part of the stewardship function.

The mix of these six sub-functions of stewardship is the key issue regarding its *strategic design*. With respect to *structural arrangements*, the main policy consideration refers to the locus of responsibility. While stewardship generally entails a set of core public functions, there is variation on the allocation of responsibility to different branches (executive versus legislative) and levels (national versus local) of government. Finally, a key *implementation management* issue affecting performance refers to the actual skills to carry out stewardship functions. In particular, the reorientation of most ministries of health from their traditional function as providers of services to the new challenges of stewardship involves major organizational reengineering for which the skill mix may not be adequate.

In the WHR 2000 the basic tasks of stewardship are identified as about **vision, intelligence and influence**:

1. formulating health policy: defining the vision and direction;
2. concerning implementation of policy: exerting influence, approaches to regulation;
3. collecting and using intelligence.

In formulating a vision, the potential of SWAPS is stressed. SWAPs are perceived as capable of strengthening government's ability to oversee the entire health system, develop policies and engage with stakeholders beyond the public sector. But most important, SWAPs depend on vision and leadership by national government. All providers of services should be recognized and their future contribution outlined. Strategies to reduce dependence on out-of-pocket payments and to increase prepayment should be identified. Roles of the principal financing organizations, private and public, domestic and external, and of households should be recognized and their future directions determined.

In setting the rules and ensuring compliance a lot of attention is paid to encompassment of private players in provision and financing of health actions. Regulatory oversight and contractual strategies entail high transaction costs. Awareness of these costs accompanied the moves to separate the roles of purchasers and providers. Government capacity building in contracting skills and regulatory oversight is critically needed. Rules might be enforced by investing in the knowledge and skills of regulatory staff, supporting professional self-regulation and implementing policies ensuring private actors work on behalf of the public good. A dialogue between public policy makers and private sector players is critical in making regulations work.

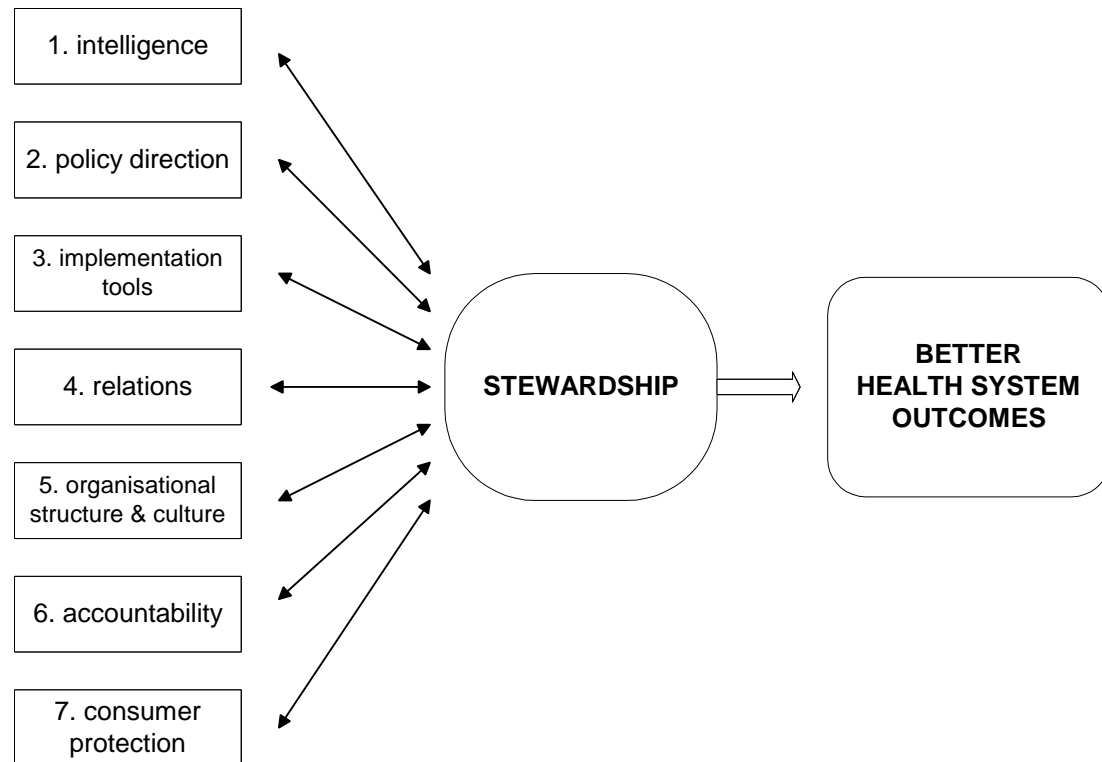
Of great importance for stewardship are missing pieces of information and analysis. Few low and middle income countries today have reliable information on the levels and sources of non-government finance or provision in the health system. Little is known in most countries about peoples' expectations of the health system or about the structure of complex non-government provider markets. The MOH has several advantages as a resource for intelligence. Information dissemination allows the ministry to build a constituency of public support for health policy, and thus a defence against incompetent or corrupt practice by interest groups in the health system. It helps to achieve a public debate on policy directions that is based on reliable evidence. Information dissemination aims both to inform and to consult.

In the WHR 2000 communication and alliances are stressed in the implementation of stewardship. The skills and strategies which have traditionally controlled public bureaucracies are inadequate for stewardship of contemporary health systems. Entrepreneurial, analytical and negotiating skills are needed to steward such systems. Better stewardship requires an emphasis on coordination, consultation and evidence-based communication processes. A full picture of what is happening is needed. The identity of all health actors should be known to the MOH and regular lines of communication established. The MOH also needs communication capacity and strategies for ensuring that the media are aware of the health system's goals and progress or obstacles. Consultation is often a widely neglected part of the policy process, both in policy formulation and in implementation. A massive investment in management information systems will not, of itself, bring about better stewardship. Advocacy strategies are needed to influence other branches of government and non-government health system players. The scope of regulation has to be broader, bringing in and giving voice to consumers, private providers, professional associations, and external assistance agencies.

Domains or subfunctions of stewardship

Travis et al present WHO attempts to identify a small number of core domains or sub-functions that collectively are thought to constitute effective health system stewardship that leads to better outcomes. It builds on the definition of stewardship presented in the WHR2000, and the work of Moran (1999) who identified three core elements of a concept he calls 'governing in health': making authoritative decisions; creating the means to put those into effect, and creating support for them.

Travis et al describe six domains. An additional seventh domain was created on "consumer protection" which is included in the sixth domain in the paper of Travis et al.



1. Generation of intelligence

Stewards should have access and ensure that all health system actors have access, to reliable and up-to-date information. Three broad categories are suggested:

- Current and future trends in health and health system performance
- Important contextual factors and actors
- Possible policy options, based on national and international evidence and experience.

2. Formulating strategic policy direction

Key components are whether there is :

- Articulation of health system goals and objectives
- Clear definition of roles of public, private and voluntary actors in financing, provision, resource generation and stewardship functions
- Identification of policy instruments and institutional arrangements required to achieve improvements in financing, provision, resource generation, stewardship and thus health system goals
- Outline of feasible strategies for making required changes
- Guidance for prioritising health expenditures, based on realistic resource and needs assessment ; including decisions or priorities for major capital investments and investments in HRD
- Outline of arrangements to monitor performance

3. Ensuring (formal) tools for implementation : powers, incentives and sanctions

This part of the capacity to implement policy has to do with having and exercising the powers to guide the behaviours of different actors.

- Stewards have powers commensurate with their responsibilities and they are used properly
- Stewards set and enforce rules, incentives and sanctions for actors involved in provision, financing and resource generation
- They ensure that the rights and responsibilities of users and consumers are defined and mechanisms to protect consumers are fairly exercised.

4. Building and sustaining relationships (coalitions, partnerships)

This is the second domain related to implementation capacity. The relationships can be characterised by their type, parties involved and purposes they serve.

Types of partnerships vary along a spectrum of formality from loose affiliations to legally binding partnerships. They may be bilateral or multilateral.

The parties involved might include professional associations, patient and consumer groups, other Ministries, private enterprises involved in service delivery, organisations playing a role in resource generation like medical schools and the pharmaceutical industry, research foundations, national and local politicians, insurance funds, NGOs,

The purposes they serve include specific 'on-off' events or issues, regular and repeated tasks and ongoing activities.

An essential requirement is effective communication in various ways, directly through media campaigns or indirectly through representative groups or opinion leaders.

5. Ensuring a fit between policy objectives and organisational structure and culture

This is the third domain related to implementation capacity.

Components to consider are:

- The extent to which organisational arrangements minimise overlap, undesirable duplication and fragmentation
- Whether intended separation or integration of functions is reflected in organisational arrangements
- Whether clear and operational lines of communication and reporting exists.

The management culture within the system and the government's credibility in the eyes of other health actors will determine the effectiveness of stewards. Contributing factors to are:

- Policy stability and institutional memory
- A supportive management culture (fostering and communicating successful innovation and experiment, reducing patronage, rewarding good performance)
- The quality of bureaucracy, institutional rigidity, irregular payment, competence of civil servants
- Resources available to identify and built stewardship skills and management capacities to carry out responsibilities.

6. Ensuring accountability (responsibility, answerability to the population, consumer protection)

It is stewardship responsibility to ensure that all health system actors are held accountable for their actions.

One could examine the extent to which

- Other health system actors are held accountable to stewards as representatives of the population
- Stewards themselves are held accountable to the population

A wide variety of instruments, channels and mechanisms exist: political, bureaucratic, technical, financial, the media.

How to assess the stewardship function?

According to Travis et al some notions on good stewardship performance do exist. They refer to the work of Dollar and Pritchett who showed that good policies and good institutions are important determinants of aid effectiveness (11). Travis et al propose to investigate whether these notions and components of stewardship are justified, by analysing their association with intermediate goals and outcomes.

They express themselves very carefully stating that “WHO is attempting to identify a small number of core domains or subfunctions that collectively are thought to constitute effective health system stewardship that leads to better outcomes”.

Ideally there is no overlap between the subfunctions and they cover all aspects of stewardship. Stewards are trying to influence the behavior of a wide range of actors: those involved in the provision, financing and generation of resources, the behavior of stewards themselves, users or consumers and non health system actors whose actions affect health. A matrix of actors and domains is added to the document of Travis et al as an aid to thinking about the policy instruments used in the execution of stewardship.

Travis et al announce an extensive review of literature of attempts to assess components of stewardship from several disciplinary perspectives. Today there are no tools for looking at all aspects of stewardship. WHO has itself been exploring which aspects of governance appear to be associated with WHO’s two measures of health system efficiency. Relevant experience with surveys of governance is discussed. The EPHFs instrument can be seen as one way of assessing health system stewardship. There are 48 indicators, plus around 120 measures leading to almost 700 specific questions. Most questions are answered on a simple yes/no basis to indicate the presence or absence of a particular feature (resource, practice, organisational entity etc) in the country concerned.

One of the issues in health system performance assessment is the appropriate choice between acceptable standards and optimum standards. For example, should the standard be related to the average reality of countries or to a definition of the minimum necessary for exercising a function? Should optimum standards be used as a goal for policy even if they are not achievable in the short run? Measurement of the degree to which the stewardship function and EPHF are being fulfilled is not just an interesting methodological exercise but should lead to an improvement in public health practice, establishing good operating standards and reference points for continuous quality improvement. The process also promotes greater transparency in public health practice and services, while lending greater clarity to the generation of knowledge and evidence-based public health practice. Finally, measurement should lay the foundations for better and greater allocation of resources for public health actions.

The WHO meeting of experts emphasised the need for empirical research, in particular for descriptive studies of stewardship tasks, approaches and styles. There was disagreement over the degree to which such research could be comparative given the large differences in country-specific contexts. However, the value of comparative research was acknowledged so long as it is carried out in a participatory manner and in a way that encourages the sharing of experience among countries. Involvement of both academics and health officials from the countries concerned has proven effective in other, similar, exercises and could be valuable in this context. Relevance at the country level was seen as a prerequisite for success of measuring stewardship or stewardship effectiveness in countries. In order to achieve relevance, however, it may be necessary to adopt different approaches that are fine-tuned to the needs and situations of individual countries. Participants of the expert meeting were asked to propose indicators and measures of good stewardship. Proposals were largely qualitative in nature (e.g. "Transparency and effective communication", "Free of corruption" or "Even-handedness and respect for democratic and legal processes"), although some were more immediately measurable (such as "stability of institutions, personnel and policy settings"). The need to consider broader societal context in any assessment of stewardship effectiveness was also raised. Is it possible to have effective stewardship in an environment of poor public governance at national level?

Conclusions

- The WHO framework for Health System Performance Assessment and the Overall Health System Performance Index was criticised a lot but the concept of stewardship received little attention in grey publications and in peer reviewed journals.
- Failures of market approaches to health systems and the need to redefine the role of the state, the government, the public sector in health systems led to the emergence of the stewardship model.
- The concept of stewardship overlaps with governance. Stewards of a health system have a responsibility to ensure that the health system operates according to governance principles.
- The overlap with EPHF could be useful to assess stewardship since work have been done on the assessment of the EPHF.
- The scope of stewardship is broad, it includes all actors (i.e. private health actors) involved in the health system and the links of the health system with society.
- The stewardship model is a management model, fostering an involvement-oriented management approach.
- The model of stewardship and capacity building share a common rethoric of (process) characteristics as fostering a culture of communication and consulting, empowering people, learning, transparency, accountability and participation (i.e. governance), .. among individuals and organisations.
- Both concepts overlap with more traditional concepts as HRM and strategic management. Both concepts stress the relation between individual, organisational, system performance and the broader environment.
- The feasibility of implementation of the stewardship model in the public sector and public bureaucracies is questioned. Capacities for health system stewardship needs to be build on both individual and organisational levels.
- There is a wide agreement that much work remains to be done in the area of stewardship. Travis et al point at the conceptual work of stewardship and its subfunctions, the development of assessment tools and methods, analytic work to explore the links between the organisation and operation of the stewardship function and different health system outcomes in different settings, identification of effective ways to strengthen the stewardship function in different national health systems.

Discussion

Armstrong and Travis address different levels of government and mixed criteria to judge government.

	Micro	Meso
Staff	Civil servants	Politicians
Output	Public service delivery	Policy
Organisation	e.g. private-public partnerships	e.g. federal constitution

Armstrong mainly takes a managerial point of view on public services, considered as the level of micro-performance of government, and argues for new techniques for HRM. No difference is made between public administration and service delivery. The political dimension is presented as the principal-agent problem.¹ Other political aspects are largely ignored. For instance, that a negative government image is believed to have an impact on the recruitment capabilities of government and consequently on the quality of public employees. The professional identity of human resources in health service delivery is ignored by Armstrong.

Travis et al look at government at the policy (macro-performance) level. Stewardship is almost ‘good governance’, or governance of health systems (Leppo) i.e. formulating and implementing sound policies (stewardship), or transparency, accountability and participation (good governance). Of course both have common concerns, i.e. the reduction of the concept of citizen (societal context ; citizens have substantial rights) to the concept of client (market approach ; consumers have procedural rights).

¹ *The principal-agent theory is built around the structural consequences of an information asymmetry in principal-agent relations (Pratt and Zeckhauser 1991). Administrations should be responsive to both politicians (those who give orders) and citizens (clients), while politicians are responsive to citizens. This can create incompatibilities. The existence of such relation asymmetry or, in this case, the advantage bureaucrats have because of their expertise, might hinder the development of collaborative administration-citizen relations.*

Five of the six domains reflect essential steps in strategic management (vision, planning, implementation). Only the sixth domain « Ensuring accountability” does not fit in the functional cycle of effective and efficient performance. It is related to the principles of democracy (responsive to the needs of the people) and the legitimacy of the system (persons, goals and deeds of government bodies are acceptable for citizens).

In both frameworks performance of government is a criterium together with other criteria (justice, possibilities for discretion in policy, representativity, receptiveness, distribution of values,...).

Defining government-citizen relations on public health in terms of stewardship and trusteeship, in contrast to ownership, fits well in the NPC (new political culture). Cfr the Belgian Copernicus reform initiative wants to stimulate awareness that the administration is rotating around the citizen, and not, as had been the case in the past, that the citizen rotates around the administration.

- Mix of different (micro-macro levels) or absence of explicit levels of capacity in the public sector, for instance as formulated by Hilderbrandt and Grindle.
- Capacity building strategies are NOT related to outputs, outcomes and impacts on different levels.

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