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Towards better stewardship: concepts and critical issues

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TOWARDS BETTER STEWARDSHIP: CONCEPTS AND CRITICAL ISSUES

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I. INTRODUCTION

The *World Health Report 2000* (WHR2000) (*1*) identified four core functions that all health systems carry out in some way, regardless of how they are organized or where they are. They were financing, resource generation, service delivery and stewardship. In order to explain attainment of health system outcomes and efficiency, greater understanding of these four health system functions is required. This paper focuses on the function of stewardship.

The Report broadly defined stewardship as "the careful and responsible management of the well-being of the population", and in the most general terms as "the very essence of good government". Stewardship is the responsibility of government – usually through the health ministry. This does not mean that government needs to fund and provide all interventions. And certain stewardship tasks may themselves be delegated to other actors. Who these are depends on how the health system is organized.

Responsibilities for different aspects of stewardship may be divided (intentionally or otherwise) between central and sub-national health authorities, local government, other ministries such as finance, planning, civil service commissions, audit commissions, parliamentarians, professional associations, ombudsmen, inspectorates, insurance funds, other purchasing agents (sometimes including donors) and even some providers. But a country's government, through its health ministry, remains the "steward of stewards" for the health system, with a responsibility to ensure that they collectively provide effective stewardship.

Stewardship has similarities to the notion of public governance, but as envisaged by WHO is more specifically focused on the state's role in taking responsibility for the health and well-being of the population, and guiding the health system as a whole. It influences the ways other health system functions are undertaken. In addition, it "embeds the health system in wider society" (*2*). In characterizing stewardship, the Report identified three broad "tasks" of health system stewardship: providing vision and direction for the health system, collecting and using intelligence, and exerting influence - through regulation and other means. It asserted that how well or poorly a government executes its stewardship role can influence all health system outcomes.

Many countries are searching for ways to understand and improve different aspects of health system stewardship. Building on previous work with related concepts, work is now under way to develop practical ways to assess stewardship, by analysing different approaches and then exploring the relationships with attainment in the different health system goals. Efforts will be made to develop approaches that allow comparisons between health systems so that relevant lessons can be shared.

This paper reports current WHO work on stewardship. Section 2 reviews related work in health and other sectors. Section 3 presents WHO 's current thinking on "domain / sub-functions" of stewardship. Section 4 discusses WHO's ideas on how to assess stewardship, and outlines future work.

II. CHARACTERIZING STEWARDSHIP: RELATED WORK IN HEALTH AND OTHER SECTORS

What are the essential things stewards should be doing in order to influence the behaviour of health system actors? Although the word itself has not previously been much used in relation to health systems, the importance of many of the activities thought to contribute to effective stewardship has long been written about (*3-5*). As a first step in the current programme of work, related concepts from health and other sectors are being reviewed in detail. Solid evidence is relatively scarce, but there is quite a lot of convergence in prevailing notions of what constitutes "good" stewardship, especially from the fields of public health and work on more general governance. Other recent input into WHO's work on stewardship comes from the Policy-makers Forum (*6*) and the WHO Meeting of Experts on the Stewardship Function in Health Systems held in September 2001 (*2*).

1. Conceptual issues

The ways that stewardship or its related concepts are characterized can be divided broadly into two groups (*7-14*). There are those that characterize *what should be done*, and those concerned with *how things should be done*. In general, the public health literature pays more attention to identifying a wide range of concrete *desirable activities* of ministries of health in "guiding" the system (grouped into broad categories such as policy and planning, regulation, monitoring and evaluation). It also often refers to "how" things should be done: many analysts suggest that, for example, participatory and transparent processes or, put another way, many of the current notions of "good governance", are desirable achievements in themselves.

In WHO's current efforts to develop a coherent framework to assess all four functions, a rigorous attempt is being made to avoid conceptual overlap between functions. For this reason, there are some similarities and distinctions worth making between stewardship as conceptualized in the WHO health system performance assessment framework, the related concept of the "steering role" of ministries of health, and "Core" or "Essential" Public Health Functions (EPHF) (*15;16*). The only real difference between the literature on the "steering role" and stewardship is that the "steering role" documents are specifically devoted to the roles of health ministries in different processes of health sector reform, whereas stewardship is a function of the whole health system, and its assessment involves considering more than ministries of health. With regard to the Essential Public Health Functions, many of them do contain key elements of stewardship. However, the scope of stewardship is broader. It includes ensuring oversight, regulation and accountability of *all actors* involved in any of the four health system functions – including financing and all aspects of resource generation. 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.

The governance literature contains a range of definitions of governance. A number are based on what Armstrong (*17*) refers to as "high order tasks", some of which are similar to the stewardship tasks defined in the WHR2000, such as the capacity to formulate and implement sound policies. But much of the literature puts greater emphasis on more abstract *core characteristics* of good governance which it is desirable to achieve. For example, the Commonwealth's paper on governance (*11*) identifies transparency, accountability and participation as key elements of good governance. Kaufmann et al. (*14*) identify six "aspects" of governance (voice and accountability; political instability and violence; government effectiveness and regulatory burden; rule of law, graft) which

reflect different aspects of the process of government selection, the capacity of the state to implement sound policies, and the respect - for the citizens and the state - for the rules which govern their interactions.

Some people view governance as almost synonymous with the function of stewardship. In part, this depends on which definition of governance is used. But we suggest that there are important distinctions regardless of the definition used. Both stewardship and governance are in part about the way things are done: the principles of "governance" permeate all social systems including health. The "quality" of governance affects the environment within which health systems operate, and the stewards of the health system have a responsibility to ensure the health system operates according to governance principles. But both stewardship and governance are also associated with sets of actions. There are many actions carried out in the name of governance whose primary intent is not to improve health, for example the process by which governments are replaced. By contrast, we argue that the actions of stewardship are all about improving health. It is true that in the course of their work, stewards of the health system may wish to influence aspects of governance that affect the population's health and well-being – much like they might wish to influence education or environmental issues. But stewardship, as one of the core functions of the health system, is a distinct entity.

2. *Approaches to assessment of the stewardship function*

There are also different views on how to articulate the stewardship function for assessment purposes. One is to start by simply describing what is being done in the name of stewardship, and only determine what might be considered "good" by analysing their association with differences in the performance of intermediate goals or outcomes. Those that favour this view do so on the grounds that they believe it is not currently possible to make any reasonable judgement about the content or quality of stewardship activities because inadequate evidence exists.

Another approach is to start by characterizing some core components of stewardship based on current views, propose some notions of "good" performance in these areas – and then investigate whether these are justified, again by examining their association with intermediate goals and outcomes. Those that favour this view do so on the grounds that there IS sufficient experience to justify suggesting which are the key responsibilities and what constitutes good performance in each. And the concern about whether these are the core components of stewardship that matter, and whether stewardship itself "matters", can and will still be "put to the test". This approach does not presuppose that certain instruments are used, simply that certain responsibilities are carried out effectively: there are many, sometimes conflicting and often unproven views about effective instruments, strategies and mechanisms.

Going with this second approach, how much certainty can there be that one has got the core components of stewardship roughly right to start with? What evidence exists that the components of stewardship being proposed, which are largely based on prevailing wisdom, make any difference to outcomes? A more extensive literature review, especially of the political science literature, needs to be carried out, but as a start the work of Dollar and Pritchett (*18*) is informative, because it showed that "good policies" and "good institutions" are important determinants of aid effectiveness. They used various markers of success, for example, GDP per capita growth. They found that in countries with sound policies and institutions, external aid was more effective. How did Dollar and Pritchett decide how to judge what were "good" policies and "good" institutions. Good institutions were judged by governance measures – strength of rule of law; quality of public bureaucracy and pervasiveness of corruption. Good policies were

assessed by examining what were considered to be desirable results: low inflation, small fiscal imbalances and open trade regimes.

III. THE DOMAINS / SUB-FUNCTIONS OF STEWARDSHIP

Based on the above review, WHO is attempting to identify a small number of core domains / 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 (*9*), 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.

Ideally the sub-functions should be defined in a way that avoids any conceptual overlap between them, and that between them cover all aspects of stewardship.

Who are stewards trying to influence, and how? They are aiming at influencing the behaviour of a wide range of players: those involved in provision, financing or generation of other resources; the behaviour of stewards themselves; of users or consumers, and non-health system actors whose actions affect health. The matrix of actors and domains / sub-functions shown in Annex 1 is an aid to thinking about the policy levers and instruments used in the execution of stewardship.

Six domains / sub-functions of stewardship are presented here for discussion. They are constructed from prevailing notions of what together constitute the function of stewardship. Some are primarily concerned with dealing with market failures that are common to health systems, and others are more concerned with addressing potential public sector failure. There may be questions about both the categories and their content, and these domains / sub-functions are expected to further evolve following wide debate. Their definition, their contribution to effective stewardship, the effectiveness of different instruments and approaches within these domains / sub-functions, and the links to intermediate goals and outcomes can all be investigated.

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

What follows is an attempt to describe the core attributes of each domain / sub-function more concretely.

A. Generation of intelligence

This domain / sub-function is justified on the assumption that intelligence contributes to more informed decisions and thus to better health system outcomes.

Which actors require intelligence for effective stewardship? Those with stewardship responsibilities at all levels of the health system.

One could also argue that part of this sub-function of stewardship is to ensure that all health system actors – not just stewards – have access to the information they need to make their contribution to health system outcomes, i.e. including information for

consumers/users of the system; ensuring providers get the information on new products they need, etc. – the production of which would be part of resource generation.

What sort of intelligence is required? Intelligence is broader than information. It implies identifying and interpreting essential knowledge for making decisions from a range of formal and informal sources – routine information, research, the media, opinion polls, pressure groups, etc. Although there is no universal agreement on what is "essential", the areas listed below are commonly cited. Differences remain in the level of detail considered desirable.

What scope of "intelligence" is required? Three broad categories are suggested below.

We propose that stewards should have access to reliable, up-to-date information on:

- *Current and future trends in health and health system performance:* For example, on levels, trends and inequalities in key areas such as national health expenditures; human resources; health system outcomes; health risk factors; vulnerable groups; coverage; provider performance; organizational or institutional challenges in provision, financing, resource generation, stewardship
- *Important contextual factors and actors:* The political, economic and institutional context; the roles and motivation of different actors; user and consumer preferences; opportunities and constraints for change; events and reforms in other sectors with implications for the health sector
- *Possible policy options, based on national and international evidence and experience:* For example, intelligence on different policy tools and instruments for similar problems, on their effects in different settings, and on managing change. It includes information on relatively specific things such as cost-effective interventions, and on possible institutional arrangements for different functions.

Part of the investigation of the relationship between "better" intelligence and better overall stewardship, and between that and better outcomes, may involve trying to more systematically explore which sorts of intelligence really seem to influence and help decision-makers and improve decisions.

B. Formulation of a strategic policy framework

This second sub-function is included on the grounds that the provision of a clear sense of vision and strategic direction for the health system contributes to better stewardship and thus better health system outcomes.

Here, the analysis is not of the technical content of particular policies, which will clearly vary between countries. It is more concerned with ascertaining whether government takes a broad, inclusive view of its responsibilities; the extent to which it is really addressing the health system's major policy issues; has developed a vision of how the system should develop; is monitoring progress and is able to adjust its policies and strategies to new developments (*19*).

The key components to consider in monitoring this domain / sub-function are whether there is:

- *Articulation of health system goals and objectives* (medium and longer term), based on reliable intelligence, and governing values, ethics, principles, etc.
- *Clear definition of roles* of public, private and voluntary sector 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 prioritizing health expenditures,* based on realistic resource and needs assessment; it would include decisions or priorities for major capital investments, and investments in human resource development
- *Outline of arrangements to monitor performance* and effects of change.

One thing to consider further is whether one should look for explicit evidence of certain features which, though implicit in the WHO goals, may deserve special emphasis: attention to addressing inequalities as well as levels of health and responsiveness, protection of consumers, vulnerable groups, and the poor.

When thinking about how to arrive at answers to these questions, it is not sufficient to look merely for the existence of policy documents or plans, as these do not always address major policy issues. The assessment of the policy agenda and direction also comes from assessing statements and debates in parliament, the media, etc.; from asking a range of key players for their understanding of current goals and directions; and from observing how these concerns and intentions are being linked to action – for example, through budget allocations, changes in regulation, etc. This has implications for the design of an assessment instrument and the ways people are selected to be part of that assessment.

Effective policy formulation includes assessment of the feasibility of change – which links back to the sort of intelligence that needs to be generated and making use of it.

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

This third sub-function is justified on the grounds that a key element of stewardship is ensuring the implementation of policies designed to achieve health system goals. One part of that capacity to implement policy has to do with stewards having and exercising the powers to guide the behaviour of different actors. Two other aspects of capacity to implement are addressed in the domains / sub-functions of "coalition building"; and "ensuring a fit between policy and organizational structure and culture".

We present here the argument that good stewardship involves ensuring that stewards have the powers to do their job, and also to ensure that others do theirs. Put more elegantly:

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

By regulatory framework, we refer to a spectrum of rules, procedures, laws, decrees, codes of conduct, standards, etc. that exist to guide a health system.

1. Ensuring stewards' powers are commensurate with responsibilities

In any state, even federal ones, the national government remains the "steward of stewards". However, the division of stewardship responsibilities is dispersed, in different ways, across all states. Local actors generally acquire more stewardship responsibilities with the various forms of decentralization that can occur. Examples of mismatches between responsibilities held and the powers provided to meet them are not uncommon, at any level of the system.

- A central ministry of health may be expected to ensure implementation of the national health policy but have few powers to do so in a situation where health funds go directly from treasury to the local authorities, and another agency hires and fires health staff.
- A law may be passed giving district councils formal responsibility for all local health services, but not giving them any control over either money or staff.
- It may be stated policy to decrease inequalities in health funding between regions, but the existing rules for determining resource allocation give little margin for change.

Questions will need to help identify where there are serious mismatches.

2. Stewards set and enforce rules, incentives and sanctions for other actors

This involves examining whether appropriate tools and rules to influence the behaviour of other actors actually exist, are used, and are contributing towards achieving health system goals.

There are a number of ways to approach whether the mix of rules, incentives and sanctions that exist together constitute an "effective regulatory framework".

One is to consider the common forms of market failure to which health systems are prone, and see whether there are effective safeguards in place against them. For example, what are the mechanisms in place to ensure the provision of pure public goods; to compensate for the common problem of asymmetric information between patient and provider, or provider and payer.

Another is to consider the different health system goals, the available evidence on the biggest perceived problems in terms of aligning the behaviour of actors towards those goals, and look for the regulations and incentives that current evidence suggests are effective in addressing them. For example, considering health inequalities, responsiveness or fairness in financial contribution.

There are a number of challenges to assessing "effective regulation". There can be both "too much" and "too little" regulation. The same instruments can have different effects in different settings. There can also be conflicts and contradictions between sanctions or incentives, and between these and the health system goals they are supposed to support. A key element of any assessment, for which it will be hard to devise measures, is to assess the coherence of effects of the different regulatory instruments.

Things to assess include:

- *The scope of the existing regulatory framework*. In some countries, there are key aspects of the health system that seem to be largely outside the boundaries of current regulation (*20*). For example, are major policy areas such as private providers, drug manufacturers, consumer protection, road safety, tobacco addressed?

- *Enforcement and effects of sanctions and incentives*. A critical issue to assess when trying to "explain" the operation of this domain / sub-function would be the capacity that exists to actually enforce incentives and sanctions. There are many examples where existing laws and regulations are ignored because there are no mechanisms for detection or effective sanctions against evaders. For example, in a supposedly free-at-the-point-of-care system, informal payments may be widespread. Drug quality control rules may exist, but no capacity exists to detect whether these are observed by manufacturers.

Much more work is required to develop appropriate questions, but they might address issues such as whether quality standards for health facilities, individual providers or manufacturers (accreditation, licensing) are enforced; whether codes of conduct for health workers exist and are enforced; whether rules about out-of-pocket payments exist and are observed.

As mentioned earlier, a key element is to assess the coherence of effects of different regulatory instruments. Are these best judged through assessment of other functions or outcomes?

D. Building and sustaining partnerships

This domain / sub-function is justified on the assumption that there are many factors that impact either directly or indirectly on health, over which stewards have little or no formal authority. The steward cannot influence such factors by acting alone, and must involve other actors if positive change is to occur (*21-23*). To be fully effective, therefore, stewards need to build and maintain a wide variety of relationships. This sub-function is thus an important complement to other, more formal, ways of exerting influence through regulation, legislation and similar means as discussed above.

Relationships can be characterized by their type, the parties they involve and the purposes they serve:

- *Types of partnerships* vary along a spectrum of formality from loose affiliations at one extreme to legally binding partnerships at the other. They may also be bilateral or multilateral. Stewards need to be able to form relationships of many different types. In some cases, a relationship may involve little more than communication of key messages or networking among individuals. In others, the steward may need to establish coalitions or alliances with other players within or outside the health sector to achieved desired goals (*24;25*). The amount of time and resources required to establish and maintain relationships will also vary significantly depending on their nature.
- *The parties involved in partnerships* will be determined by the purpose of the relationship. They might include professional associations, patient or consumer groups, other ministries especially ministries of finance and the civil service, private enterprises involved in service delivery, organizations such as medical schools and the pharmaceutical industry that play a role in resource generation, research foundations, politicians in national and local government, insurance funds, NGOs, regulatory bodies, donors and many others. In order to decide who to involve in relationships, the steward should have a good understanding of the main influences on health, and the positions, connections and motivations of the different stakeholders who have (formal or informal) ability to influence them (*26-28*). An effective steward will be versatile and pragmatic in establishing and maintaining relationships, recognizing that many important determinants of health lie outside the health system itself, and that action on a broad front is often needed to achieve sustainable health gains.

- *The purposes for which partnerships need to be established* include specific "one-off" events or issues, regular and repeated tasks, and ongoing activities. Examples of "one-off" tasks might include development of new policy and legislation, a media campaign or a large-scale reform initiative. Regular and repeated tasks could encompass planning or budget setting while possible examples of ongoing activities are routine monitoring of service quality and consumer satisfaction. In all of these areas, relationships might need to be established to ensure success.

In assessing how this sub-function is carried out, it will be important to consider whether the steward has the right relationships with the right players both within and outside the sector. If senior health officials are isolated from, or not respected by, their peers in other ministries, in the wider sector, in key professional bodies, private enterprises, etc., then their ability to exercise effective stewardship may well be compromised.

An essential requirement for building and maintaining relationships is effective communication. Effective communication with the general public and with health sector organizations is a critical part of developing, and developing support for, both popular and unpopular policies and strategies. It can be done in various ways – directly through media campaigns, or more indirectly through representative groups and opinion leaders.

Communication is also fundamental to health promotion activities. Within the WHO framework, however, health promotion is more properly regarded as a form of service provision. Approaches to, and effectiveness of, that particular form of communication should thus be considered alongside other aspects of service delivery.

E. Creating a fit between policy objectives and organizational structure and culture

This is the third of the stewardship domains / sub-functions related to implementation capacity. It is included on the grounds that part of effective stewardship is to ensure that the overall architecture of the health system "fits" with policy objectives, and that there are clear linkages and lines of communication. It involves being able to remove essentially "structural" constraints to equitable and efficient resource use, and assure a supportive management culture.

Lack of organizational congruence may arise for many reasons. For example, it may arise because there has been no recognition of the need to complement separation of functions with organizational change. It may arise from the failure to establish structures that have been approved by law: health boards have been approved in law but not created in practice. It may arise from the creeping duplication that may occur when a new structure is established and an existing one with similar responsibilities is not removed or "retooled". It may arise when districts are expected to deliver care in an integrated way, while vertical programmes continue to employ staff and obtain earmarked funds. It may arise when reporting channels between organizations are not altered to fit new lines of authority and accountability

Assuming that actors have clearly defined functions and responsibilities (this comes under the policy formulation domain / sub-function), and the means to carry them out, one would be interested in the following things:

- The extent to which organizational arrangements minimize overlap, undesirable duplication or fragmentation
- Whether any intended separation or integration of functions and responsibilities is reflected in organizational arrangements.

- Whether clear and operational lines of communication and reporting exist. For example, do organizational linkages facilitate exchange of information and communication, e.g. between people responsible for capital and recurrent budgeting; between people identifying health needs and those planning resources; between people financing and providing services; between programmes?

Part of the effectiveness of stewards will be determined by the management culture within the system and the government's credibility in the eyes of other health actors (*29*). The following are suggested as important contributing factors:

- Policy stability and institutional memory – for example, through staff continuity and records
- A supportive management culture: fostering and communicating successful innovation and experiment, reducing patronage, rewarding good performance
- The quality of bureaucracy – judged by amount of unnecessary "red tape", institutional rigidity, irregular payment, the competence of civil servants
- Resources are available to identify and build stewardship skills and management capacities to carry out responsibilities.

F. Ensuring accountability, responsibility and answerability to the population and "consumer protection"

Accountability is considered a sub-function here on the grounds that it is a stewardship responsibility to ensure that all health system actors (public and private, providers, payers, producers of other resources, stewards) are held accountable for their actions. Accountability to the population is also a means of influence for the population, since it creates a way of balancing the powers accorded directly or indirectly by them to other health system actors.

Accountability helps detect and therefore reduce waste or other misuse of resources, malpractice or negligence. In addition, good stewardship involves ensuring that mechanisms for accountability are fair and do not exclude particular groups.

One could examine the extent to which

- other health system actors are held *accountable to stewards* as proxies or representatives of the population (or are accountable directly to the public)
- stewards are themselves held *accountable to the population* for which they are responsible.

1. Ensuring accountability: the instruments

A wide variety of potential instruments, channels and mechanisms exist – political, bureaucratic, technical, financial, the media. Government as a whole is the ultimate steward, and much health system accountability will be dependent on the general government mechanisms that exist: for reducing corruption, for ensuring transparency in the execution of different social system functions, and for allowing public scrutiny of government actions. However, it is possible to envisage differences in the extent to which different ministries facilitate or enforce these general principles of good governance in their own sector.

There are also health system specific procedures and mechanisms for accountability which may be able to operate even in an unfavourable wider climate – for example, disciplinary procedures for doctors.

2. ***What are commonly cited markers of strong-weak accountability?***

- Existence of rules about publishing plans, reports, codes of conduct, financial accounts, fee schedules, etc.
- Their actual publication, availability, and wide dissemination – in comprehensible form
- Existence of independent "watch dog" committees – political or administrative – with oversight powers: facility boards, health authority committees, e.g. ombudsman, audit commissions, parliamentary committees
- Access to political representatives
- Operation of self-audit, e.g. professional bodies
- Operation of other sorts of NGOs, representing different interest groups (both users and producers or providers)
- Through free popular and scientific press.

Given the multitude of instruments – all of which may vary in effectiveness – questions will need to be devised which capture the desirable attributes and execution of the "sub-function" independently of the organization(s) involved.

IV. PROPOSED STRATEGY FOR MONITORING STEWARDSHIP

A. Methodological options and challenges

Analyses of health policies and systems are done using many different methodological approaches. They cover a spectrum from descriptive case studies to measurement. All have value, and limitations. The case study approach uses largely qualitative information and aims at comparison by using a common framework for analysis (*29-31*). Comparative case studies can be valuable in investigating what exists, and also how and why, which helps when considering the relevance of findings to other settings. However, the number of case studies conducted are usually small, and this limits investigations of causality. The lack of rigorously standardized approaches and measurement also limits the comparability of results.

There is an increasing body of work to measure governance, in which quantitative data on different attributes of policies, systems and institutions have been gathered, usually through surveys. Subject to the usual limitations of survey techniques in different national and cultural settings, such approaches can potentially offer more comparable data. Information from other sources is likely to be needed to interpret findings.

B. Existing tools

Because it is a new construct, there are no tools for looking at all aspects of stewardship. Attempts to assess components of stewardship have been made from several disciplinary perspectives. An extensive review of literature is under way.

Within the health field, the most recent and comprehensive is the "Essential Public Health Functions" (EPHF) instrument (*15*). The instrument, which was developed as part

of a wider programme of work examining the "steering" role of health ministries, presents a comprehensive list of questions and indicators for eleven "essential public health functions" carried out by the "National Health Authority", some of which are aspects of 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, organizational entity, etc.) in the country concerned. Such answers are then scored 1 or 0 respectively. For each of the 11 EPHFs a composite measure is obtained by adding the scores for all relevant questions (all are weighted equally). Function-specific scores are expressed as percentages of the maximum possible. The resulting set of 11 percentages (one for each EPHF) are then displayed graphically to provide a profile of perceived strengths and weaknesses in the country's performance of the EPHFs. So far this instrument has been applied in 20 countries. The respondents are groups of key actors that span the whole public health spectrum, who meet for a three-day workshop. Feedback on the instrument has been widely solicited from public health specialists and other users, but psychometric testing to establish the validity and reliability of the instrument has not yet been conducted. It was not designed for cross-population comparability. To the extent that there is overlap between the EPHFs and the elements of stewardship identified in this paper, this approach can be seen to represent one way of assessing health system stewardship.

Outside the health sector, the World Bank's recent work analysing governance in different countries (*14*) is informative. Kaufmann et al. analysed more than 300 governance indicators compiled from a variety of sources (polls of experts and surveys) for over 150 countries. These were used to examine three elements of governance: the process of government selection, the ability to formulate and implement sound policies, and the respect of citizens and the state for institutions which govern interactions. Six aggregate measures of governance were constructed. The relationships of each of these aggregate indicators to three development outcomes (per capita incomes, infant mortality and adult literacy) were then tested statistically.

Over the last year, WHO has itself been exploring which aspects of governance appear to be associated with WHO's two measures of health system efficiency (*32*). Two of the six indices of governance published by Kaufmann et al. were considered in detail. The analysis showed that both the health and overall efficiency measures are strongly positively correlated with the "index of government effectiveness". There is also a positive but less strong correlation between a second index, the index of voice and accountability, and the two health system efficiency measures.

C. WHO's recent work on health and responsiveness

WHO's experience with the definition and measurement of health and responsiveness has stimulated debate about whether these approaches could also be adapted to the assessment of stewardship.

As part of the programme of work on stewardship, WHO proposes to develop a generic survey instrument that would include questions under each of the domains / sub-functions of stewardship. Such an instrument could be administered to selected key actors involved in different health systems functions. There are also some aspects of stewardship where the perceptions of households would be important.

The intention is to phrase questions in a way that they can be answered using ordered categorical response scales, for example, from "never" to "always" or "very strong" to "very weak", or using a continuous "thermometer" scale (*14*).

There is some relevant experience with surveys of governance. A preliminary overview of governance tools reviewed by the World Bank suggests ways of asking questions. For example, the quarterly country risk assessments produced by Standard and Poor's DRI/McGraw-Hill (*14*) ask respondents questions such as: "rate from 1 to 10 any changes in environmental regulations that reduce investment".

An instrument developed by the European Bank for Reconstruction and Development was used to survey local public officials, private firms, academics, lawyers and other experts. In the box is a sample question on effectiveness of regulation.

The effectiveness of legal rules on banking

Score definition

1. Legal rules governing financial institutions and markets are usually very unclear and often contradictory. The regulatory support of the laws is rudimentary. Supervisory mechanisms are either non-existent or poor. There are no meaningful procedures I place to make financial laws and regulations fully operational.
2. Legal rules are somewhat unclear and contradictory: Supervision of banking activities exists on an ad hoc basis. But there are few if any meaningful procedures in place to enforce the law.
3. Although legal rules governing banking are reasonably clear, regulatory and supervisory support of the law may be inconsistent so as to create a degree of uncertainty. Although the regulator may have engaged in corrective actions against failing banks, enforcement problems still exist.
4. Legal rules governing banking activities are easily ascertainable. Banking laws are generally well supported administratively and judicially, particularly regarding the efficient functioning of enforcement measures against failing institutions and illegal practices. For example, the regulator has taken corrective action against individuals, but could still benefit from more systematic and rigorous enforcement. Courts have the authority to review enforcement decisions.
5. Regulators possess comprehensive enforcement powers and exercise authority to take corrective action on a regular basis. Examination of securities intermediaries and licensing is frequent, as is the use of corrective action, such as prosecution for insider dealing, revocation of licenses and liquidation of insolvent banks.

Any list of questions is likely to be long in the first instance. One important aspect of the development of any instrument will be to make it as short as possible by going through a process of systematic item reduction once it has been field tested. Further work to more thoroughly define domains / sub-functions is of course required in the first instance. There will also be a more extensive review of existing survey tools and experts collecting information on related concepts.

One of the key challenges in the analysis and interpretation of survey data across populations is the comparability of answers to questions that use ordered categorical response scales. This is because of differences in the ways individuals understand and use available responses for a given question. If one imagines a continuous scale of possible responses, different individuals will make the transition from one categorical response (for example from "never" to "rarely") at different "cut points".

WHO has developed the concept of vignettes as a component of survey instruments for health and responsiveness, that allows adjustment for response category cutpoint differences in ordinal self-reported data in order to improve the comparability of data (*33*). A vignette is a description or "story" of an experience that respondents are asked to

evaluate using a categorical response scale. A vignette is always related to one of the main questions about personal experience (for example, state of health or experience with responsiveness) in a survey, which the respondent has also been asked to answer.

Examples of a vignette

Vignette 1: [Rob] is able to walk distances of up to 200 metres without any problems but feels breathless after walking one kilometre or climbing more than one flight of stairs. He has no problems with day-to-day physical activities, such as carrying food from the market.

Vignette 4: [Margaret] feels chest pain and gets breathless after walking distances of up to 200 metres, but is able to do so without assistance. Bending and lifting objects such as groceries produces pain.

For each vignette, the respondent is asked the corresponding main question in the survey: in the above example this is "How much difficulty did Rob have moving around?" and the response categories are the same as those used for the self reports, from (1) extreme difficulty, (2) severe, (3) moderate, (4) mild, (5) no difficulty.

In summary, there is much work to be done in the area of stewardship. There is further conceptual work to more rigorously characterize stewardship and delineate its sub-functions. There is the development of tools and methods to assess it. There is analytic work required to explore the links between the organization and operation of the stewardship function and different health system outcomes in different settings. And there is a need to identify effective ways to strengthen the stewardship function in different national health systems, and ways for WHO to contribute effectively to this process.

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ANNEX 1 – STEWARDSHIP: DOMAINS / SUB-FUNCTIONS AND ACTORS

ACTORS Influencing whose behaviour?	Stewards	Providers	Generators of other resources	Financing agents	Consumers / users
WHAT IS DONE: KEY SUB-FUNCTIONS /DOMAINS/ RESPONSIBILITIES OF STEWARDSHIP					
Generation of intelligence					
Formulating strategic policy direction					
Ensuring (formal) tools for implementation: powers, incentives and sanction					
Building relationships					
Ensuring a fit between policy objectives and organizational structure and culture					
Ensuring accountability					