Stewardship for health systems

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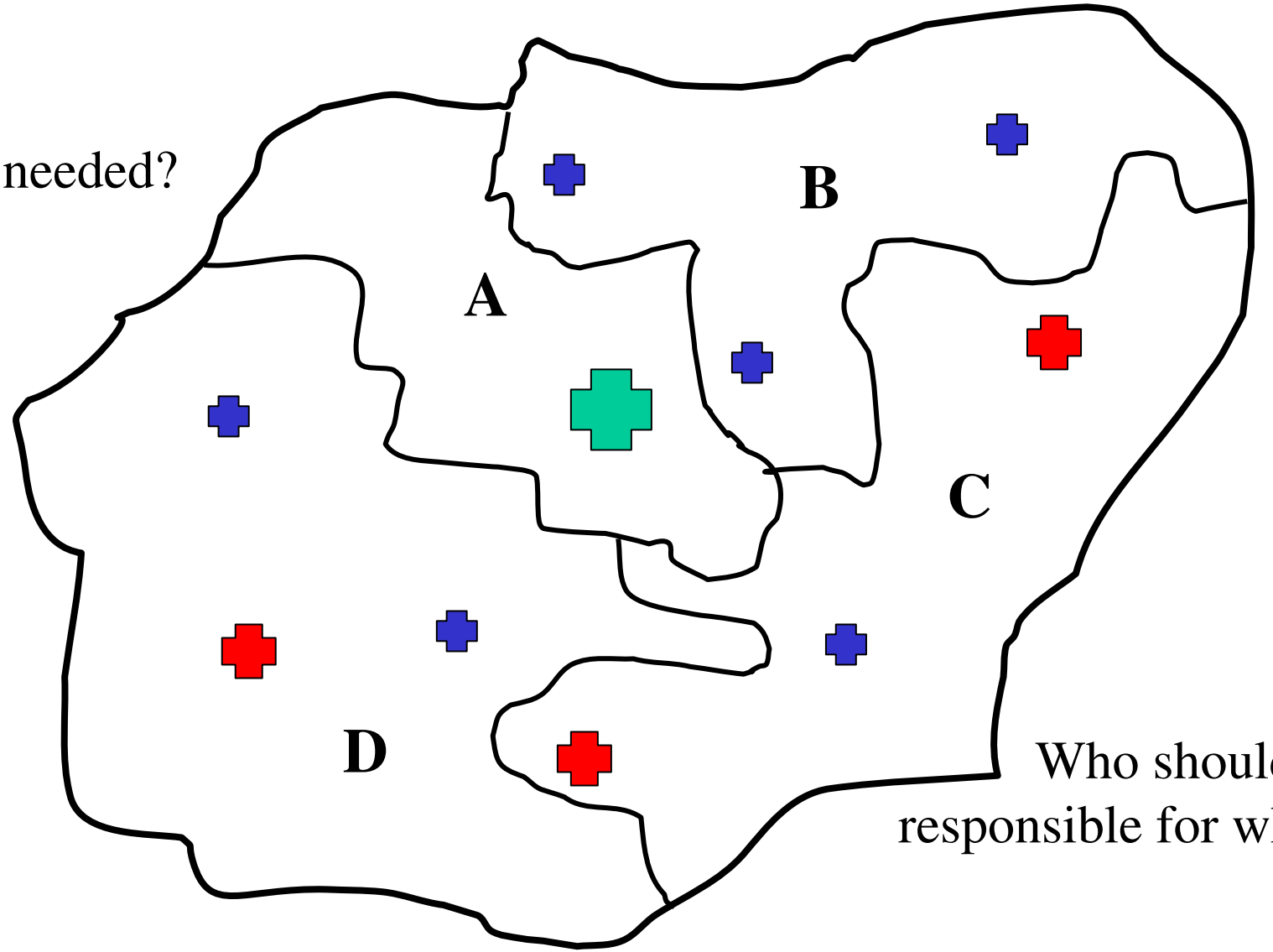
How should countries A, B, C and D develop their hospital systems?

Who is needed?



Who should be responsible for what?

What (information etc.) is neded?

Components of Stewardship (WHR 2000)

- *Health policy formulation* – defining the vision and direction for the health system
- *Regulation* – setting fair rules of the game with a level playing field
- *Intelligence* – assessing performance and sharing information

TOWARDS BETTER STEWARDSHIP: CONCEPTS AND CRITICAL ISSUES

P Travis, D Egger, P Davies, A Mechbal

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.

III. THE DOMAINS / SUB-FUNCTIONS OF STEWARDSHIP

- 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

Generation of intelligence

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.

Formulating strategic policy direction

- *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.

Ensuring tools for implementation

- 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.

Building coalitions/ 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.

Ensuring a fit between policy objectives and organizational structure and culture

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?

Ensuring accountability

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.

Fig. 1. **Comparison of agency theory and stewardship theory**

Characteristic	Agency theory	Stewardship theory
1. Model of man	Economic man	Self-actualizing man
Behaviour	Self-serving	Collective serving
2. Psychological mechanisms		
Motivation	Lower order/economic needs (physiological, security, economic)	Higher order needs (growth, achievement, self-actualization)
Social comparison	Extrinsic	Intrinsic
Identification	Other managers	Stakeholders
Power	Low value commitment	High value commitment
	Institutional (legitimate, coercive, reward)	Personal (expert, referent)
3. Situation mechanisms	Control-oriented	Involvement-oriented
4. Management philosophy	Control mechanisms	Trust
Risk orientation	Short-term	Long-term
Time frame	Cost control	Performance enhancement
Objective	Individualism	Collectivism
5. Cultural differences	High-power distance	Low-power distance

Source: Armstrong (*13*), adapted from Davis, Donaldson and Schoorman (*17*).

Table 1.1 Social and economic policy objectives

- *Equity and justice*: to provide equitable and needs-based access to health care for the whole population, including poor, rural, elderly, disabled and other vulnerable groups
- *Social cohesion*: to provide health care through a national health care service or to install a social health insurance system
- *Economic efficiency*: to contain aggregate health expenditures within financially sustainable boundaries
- *Health and safety*: to protect workers, to ensure water safety and to monitor food hygiene
- *Informed and educated citizens*: to educate citizens about clinical services, pharmaceuticals and healthy behaviour
- *Individual choice*: to ensure choice of provider, and in some cases insurer, as much as possible within the limits of the other objectives

Table 1.2 Health sector management mechanisms

- *Regulating quality and effectiveness*: assessing cost-effectiveness of clinical interventions; training health professionals; accrediting providers
- *Regulating patient access*: gate-keeping; co-payments; general practitioner lists; rules for subscriber choice among third-party payers; tax policy; tax subsidies
- *Regulating provider behaviour*: transforming hospitals into public firms; regulating capital borrowing by hospitals; rationalizing hospital and primary care/home care interactions
- *Regulating payers*: setting rules for contracting; constructing planned markets for hospital services; developing prices for public-sector health care services; introducing case-based provider payment systems (e.g. diagnostic-related groups); regulating reserve requirements and capital investment patterns of private insurance companies; retrospective risk-based adjustment of sickness fund revenues
- *Regulating pharmaceuticals*: generic substitution; reference prices; profit controls; basket-based pricing; positive and negative lists
- *Regulating physicians*: setting salary and reimbursement levels; licensing requirements; setting malpractice insurance coverage

Table 1.11 Rules of the regulatory road

Regulate strategically

- Regulation is part of strategic planning
- Regulation is a means rather than an end
- Regulation should further core social and economic policy objectives
- Regulation is long-term not short-term

Regulate complexly

- Regulation involves multiple issues simultaneously
- Regulation can combine mechanisms from competing disciplines
- Regulation requires an integrated approach that coordinates multiple mechanisms
- Regulation should fit contingencies of each health system
- Regulation requires flexible public management

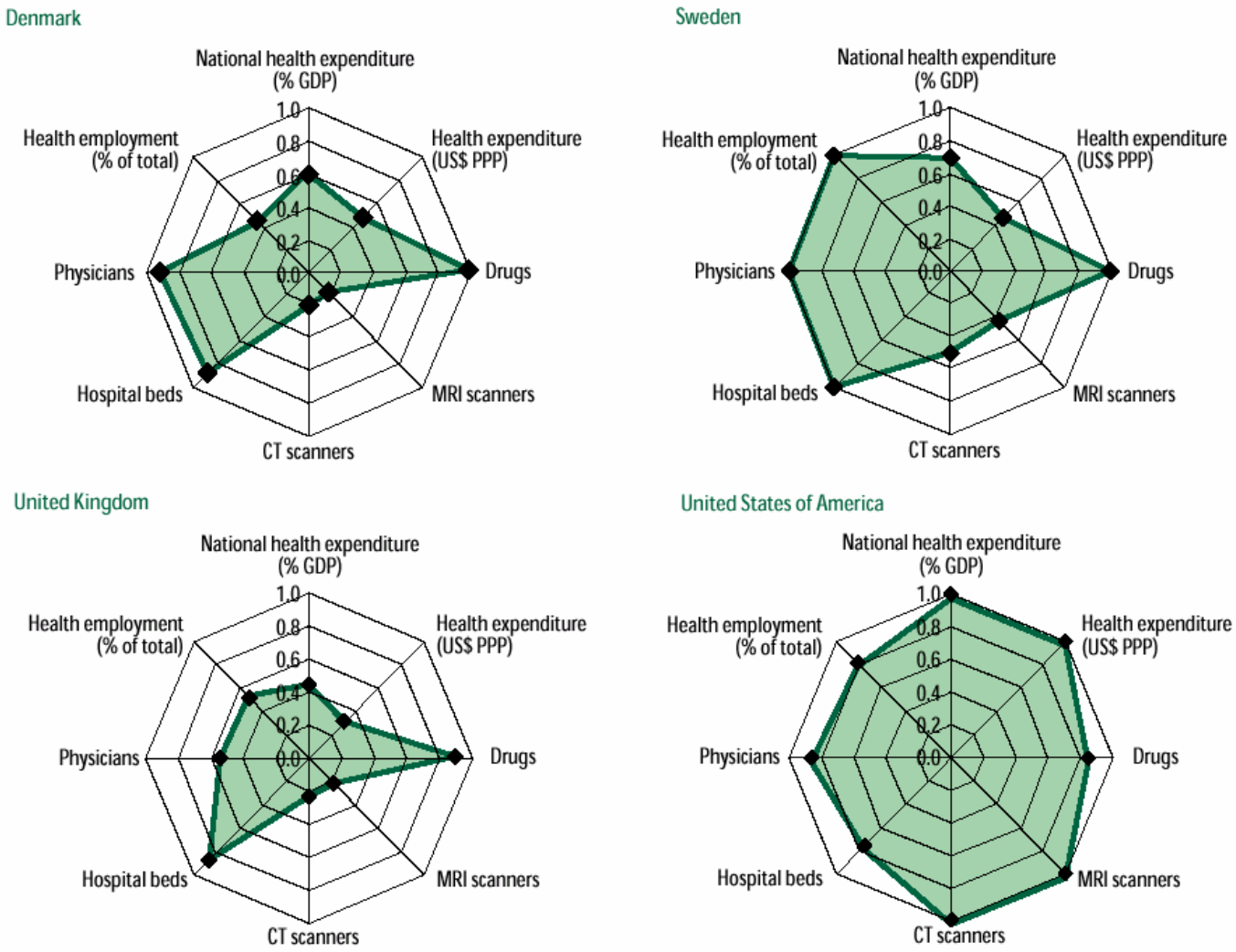
No deregulation without re-regulation

- Deregulation requires a new set of regulatory rules
- Re-regulate before you deregulate

Trust but verify

- Regulation requires systematic monitoring and enforcement
- Self-regulation requires systematic external monitoring and enforcement

Figure 4.2 Health systems input mix: comparison of four high income countries, around 1997



Note: Data are presented as fractions of the maximum value (among the four countries shown) for each individual indicator: these maximum values define the 'frontier' inside which all the data lie. All indicators are per capita except for total national health expenditure and health employment.
PPP = purchasing power parity. MRI = magnetic resonance imaging. CT = computered tomography.
Source: OECD health database 2000