Performance management in health systems and services: Studies on its development and use at international, national/jurisdictional, and hospital levels
Veillard, J.H.M.
Chapter 2
Health system stewardship of national health ministries in the WHO European region: Concepts, functions, and assessment framework
Abstract

Objectives. To propose an operational framework for assessing the completeness and consistency of the stewardship function of national health ministries.

Methods. The authors carried out a purposive and multi-disciplinary review of the literature and derived an operational framework through iterative discussions and participatory methods. The results of the literature review were compared to the authors’ observations of stewardship in action and key functions were matched with case examples from Europe and North America.

Results. The operational framework relates six functions of stewardship with national contexts, values, and ultimate goals pursued by health systems: to define the vision for health and strategy to achieve better health; to exert influence across all sectors for better health; to govern the health system in a way that is consistent with prevailing values; to ensure that system design is aligned with health system goals; to better leverage available legal and regulatory instruments; and to compile, disseminate, and apply intelligence.

Conclusions. Challenges in the implementation of stewardship relate to limitations to the role of health ministries, and to governance, operational, and change implementation issues. The framework proposed seems flexible enough to help assess the health system stewardship function; however it should be further tested in practice.
Introduction

Health in the 53 Member States of the World Health Organization (WHO) European Region has improved over the past 15 years, as reflected by improvements in key indicators such as life expectancy at birth, disability-adjusted life expectancy, or mortality amenable to health care [1,2]. However, this improvement coexists with continued concerns, such as the increasing prevalence of chronic diseases, inequalities between and within countries in both access to care and health outcomes, variations in the quality and safety of care, a mismatch between human resources and health needs, and between rising health care expenditures and changing public expectations [1]. The recent financial and economic crisis has amplified concerns over health system performance, sustainability, and value for money [3]. In particular, the crisis highlighted the importance of well-functioning health systems and of the role of governments in safeguarding social solidarity, targeting improvements in health, and stimulating efficiency gains [4].

In the WHO European Region, the need to reconstitute previously socialist states after the collapse of the Soviet Union and the recent financial and economic crisis have reaffirmed the importance of well-functioning states in the achievement of economic and social objectives [1,5]. A number of studies point to the importance of government—whether embodied in ministries of health or other agencies—in ensuring improvements in health as well as well-functioning health systems [5–7].

The World Health Report 2000 proposed that stewardship—which in its traditional definition points to the ethical use of common resources in pursuit of financially efficient outcomes [5]—is the appropriate basis on which to reconfigure the governing role of the state in the health sector [8]. This report pointed to the potential of the health system stewardship function of national health ministries to encourage decision-making in the public sector that is ethical, fair, and economically efficient and defined stewardship as “being ultimately responsible for the careful management of the well-being of the population” [8]. Saltman and Ferroussier-Davis define stewardship as 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” [5]. In both definitions, the values of trust, ethical behaviour, and sound decision-making are underpinning this concept [9].

Health system stewardship has drawn an increasing interest from national health ministries in Europe and elsewhere on the promise that it could incorporate concerns about efficiency into a more socially responsible, normative framework reinvigorating the broader social contract on which the state is based [5]. After the 2008 financial and economic crisis, this promise seems particularly relevant in a fiscal context calling for an efficient use of available or diminishing resources to deliver better outcomes expected by citizens.
However, it has been often pointed out that the stewardship concept is difficult to grasp, risky to implement, that its boundaries are unclear, that the term stewardship itself does not translate well to other languages than the English language, and that it has been challenging for countries to implement [5,6,10,11]. Indeed, stewardship involves a wide range of issues that have been addressed by scholars in numerous disciplines, in particular philosophy (the relationship between the individual and the state), political science (the role of government), law (the role of legislation), organizational theory (intersectoral action), management science (stewardship theory of management), and other disciplines such as complexity theory [5–7,9,12]. In addition, implementing health system stewardship is challenging, risky for governments if they fail to deliver on health outcomes, and may not be adapted to all contexts. In fact, the existing literature reveals only limited operational research on the concept and little evaluation of its implementation [11,13]. If there are on-going discussions of the range of tools available to national health ministries pursuing stewardship (such as health system performance assessment and health impact assessment), these discussions are neither comprehensive nor sufficient to guide governments wishing to pursue a stewardship model in the health sector. Still, the continued interest for this model (based on the promise that it could help deliver better outcomes more efficiently and in a socially responsible manner) calls for an identification of the key consistent elements of the concept so that governments desiring to pursue health system stewardship understand its scope, can assess their effectiveness in engaging in this model, and can address the challenges related to its implementation [11].

This research paper attempts to clarify the concept and boundaries of the health system stewardship function; derives core health system stewardship functions from a review of the literature and matches them with case examples from countries in Europe and North America; proposes a set of guiding evaluation questions as well as an operational framework for policy-makers to assess the completeness and consistency of their health system stewardship functions in their particular context; and discusses the challenges of implementing the health system stewardship model in different national contexts in the WHO European Region.

**Methods**

This research paper was developed through a purposive and multi-disciplinary review of the scientific and grey literature that focused on both the concept of stewardship in general, and its implementation in the health sector in particular. We could identify one prior review of the literature on stewardship applied to the health sector; however this review was not systematic and was based on a limited number of references, extracted mainly from the health sector [14]. In contrast, we considered various disciplines interested in stewardship: philosophy, political science, law, organizational
theory, management theory, public management and administration, and systems thinking. We mapped various definitions of stewardship in general and applied to the health sector, and identified common elements. We used the same approach to define the different functions of health system stewardship. We discussed iteratively different versions of the conceptual framework, based on the review of the literature and on our relevant professional experiences and observations of health system stewardship in action, working for the WHO, the World Bank, the Organisation for Economic Co-operation and Development (OECD) and national health ministries in Europe and Canada. An initial version of the operational framework was presented for discussion to 53 country representatives at the 58th Regional Committee of the WHO European Region [15]. This discussion was an important contribution to the development of the framework proposed in this paper.

On the basis of the methods presented above, we developed a set of key questions, which can support policy-makers in assessing the completeness and the consistency of the health system stewardship function; derived an operational framework for health system stewardship; and identified challenges related to the implementation of the stewardship model in Europe.

Finally, we defined and ordered the six functions of stewardship applied to the health sector so that they would be consistent with the values stated by the Member States of the WHO European Region and conducive to the achievement of health system ultimate goals such as defined by the WHO and others: improved health (level and equity), health system responsiveness, social and financial risk protection, and improved efficiency [8,24].

Results

Definition and boundaries of health system stewardship

The review of the literature carried out allowed identifying a number of common characteristics from the different definitions of stewardship:

- It is a function of governments—specifically health ministries—responsible for the well-being of the population and for protecting the public interest [5,8,9].
- It takes place within an overall framework of agreed norms and values [7,9].
- It is ethically driven, in turn implying an element of trust on behalf of the population [5,6,8,9].
- It involves a focus on health system outcomes and on the well-being of the population [5,8,9].
- It requires effective decision-making based on accountability and transparency [5,6,9].
- It implies giving due attention to system design [11,12].
Consequently, the boundaries of stewardship in the health sector cover not only the stewardship of health system functions and of the health system as a whole, but also the stewardship of secondary, health-enhancing factors (such as education, employment, transportation policies, etc.) as well as the wider economic and social factors influencing health [16–18]. Figure 1 presents the boundaries of the stewardship function applied to the health sector. It was adapted from Davies by clarifying that the stewardship of the health system covers both strategies (strategic management) and policies related to the health system [19].

**Figure 1. Boundaries of the health system stewardship function of national health ministries**

Further, we discussed iteratively the findings of the literature review and confronted them to our experience and observations of health system stewardship in action to derive six generic stewardship functions applied to the health sector:

- Strategy formulation and policy development [8].
- Intersectoral collaboration and action [21].
- Health system governance and accountability [5,7,22,23].
- Attention to system design [11,12,24,25,26].
- Health system regulation [22,23].
- Intelligence (data and analysis) generation [23].
Finally, we defined and ordered the six functions of stewardship applied to the health sector so that they would be consistent with the values stated by the Member States of the WHO European Region and conducive to the achievement of health system ultimate goals such as defined by the WHO and others: improved health (level and equity), health system responsiveness, social and financial risk protection, and improved efficiency [8,24].

The six health system stewardship functions proposed are to:

• Define the vision for health and strategies and policies to achieve better health.
• Exert influence across all sectors and advocate for better health.
• Ensure good governance supporting the achievement of health system goals.
• Ensure the alignment of system design with health system goals.
• Make use of legal, regulatory, and policy instruments to steer health system performance.
• Compile, disseminate, and apply appropriate health information and research evidence.

The functions of health system stewardship presented above depart from a narrow perception of the role of government in the health sector concentrated on its regulatory and policy development role. Differentiating factors from the traditional role of government in the health sector are: a focus on the achievement of health system ultimate goals (defined as improved health (level and equity), responsiveness to individual needs and preferences of patients, financial protection, and improved efficiency [24]); the importance of good governance and sound decision-making; the necessity to engage and advocate across all sectors to achieve better health; and the importance of understanding the complexity of health systems and of ensuring that system design aligns with health system goals [5,6,9,12].

Definition and illustration of the functions of health system stewardship

The WHO argues that the first task of a health system steward is to **define the strategy for achieving better population health**. This can be done by defining a vision for health, drawing up the strategy and coordinated policies, and defining and mobilizing the resources required to attain the desired goals [20]. Key questions for ministries within this function, as identified through the review, included defining the role of citizens in maintaining good health and specifying the roles and responsibilities of public, private, and voluntary stakeholders in implementing the strategy [6]. National policy and strategy formulation is both a technical and a political process of transforming broad health system goals into linked sets of actions and specific, measurable objectives [27–29]. Strategy and policy formulation is however complicated by the challenge of ensuring alignment of health system actions and goals with other government policy agendas. These include, for example, the overall national economic, social,
and political developmental goals, and national values and existing governance structures and political processes [20,27]. In order to do this, it is important that health system strategies specify health system goals and define boundaries within which actors operate [24]. An evaluation of the 2004–2010 national health plan of Portugal [30,31] showed that the plan had been successful in gaining continuous support from health system stakeholders for a small number of priorities focused on health gains despite several contextual changes. However, the evaluation also found that the stewardship function of the ministry of health was fragmented and that there was a lack of alignment at central level between strategy, decision-making, and implementation [31]. Similarly, an evaluation of the stewardship function of the Ministry of Health in Spain after the 2001 decentralization reform of health care management to autonomous communities showed progress in formulating a strategic policy framework but also the lack of an appropriate authority for the Ministry of Health to efficiently coordinate the health system and ensure that autonomous communities implement policies that are in line with the overall health system objectives [32].

A second function of health ministries is to **exert influence across all sectors through intersectoral collaboration and action**, in order to promote better health. From that perspective, national health ministries can play various roles to influence secondary and tertiary health enhancing factors. This involves: building coalitions across sectors in government, and with actors outside government, to attain health system goals [33,34]; promoting initiatives aimed at improving health or addressing the social determinants of health [18]; and advocating for the incorporation of health issues in all policies [35]. Focusing on a commitment to better health, rather than simply to more effective health care, is ambitious and challenging, and is a long-term approach involving alliance-building among many potentially competing interests. It is a political process and calls for effective advocacy supported by strong information systems and negotiation tools [36]. The use of health impact assessments in Finland and Slovenia to evaluate the health impact of policies outside the health sector provides some promising examples of intersectoral coordination and advocacy for better health [35]. A broader reflection of this same trend is the European Union Declaration on Health in All Policies [37]. In Sweden, the Ministry of Public Health initiated multidisciplinary research into health determinants and facilitated the active participation of all political parties, the public, and other stakeholders in the process of formulating public health goals. This led to the approval of the Public Health Objectives Act, which is one of the world’s first formalized health strategies employing a health determinants approach [38]. The 11 goals and their specific, measurable targets are monitored and evaluated by a steering committee of ministers from different sectors, chaired by the Minister of Public Health. In Turkey, after the ratification of the WHO Framework Convention on Tobacco Control in 2004, a National Tobacco Control Committee was created, with high-level representation of key ministries and civil-society organizations. In line with
this, the government continually increased taxation on tobacco products to reach a compound tax rate of 73–87%, one of the highest rates in the world. This was followed by an amended law in 2008 expanding smoke-free environments to cover all indoor areas. Despite initial objections on cultural grounds, recent polls show that more than 85% of the population now favours the legislation [39].

A third health system stewardship function is **governance and accountability**. It consists of ensuring that national health ministries govern the health sector in a way that is fair, ethical, and conducive to the attainment of health system goals. Governance is reflected in the relationship between the state and citizens, in the structural reporting relationships in the health system, and in the contractual and other instruments that health system actors—including health ministries—can use to ensure goal attainment and the broader alignment of the behaviours of system stakeholders with health system goals. This involves establishing shared values and an ethical base for health improvement; enhancing clarity in roles and responsibilities of health system actors and reducing duplication and fragmentation; and ensuring mutual accountability and transparency [6]. Enhanced health system governance can be achieved, for example, by engaging citizens more fully in policy development and decision-making through diverse engagement techniques such as citizen juries, consensus conferences, or town halls [40]; by promoting shared clinical decision-making [41]; or by strengthening health system accountability and transparency through the public reporting of performance measures linked to accountability and strategy at various levels of the health system [42]. In the United Kingdom, the 2004 White Paper *Choosing Health* posed wide-ranging questions on how the country could tackle preventable health problems such as obesity and smoking [33]. This document formed the basis for a nationwide consultation exercise with hundreds of events and included industry, non-profit organizations, and the government. In the 2004 White Paper, the government also gave a commitment to building health into all future legislation, by including it as a component of regulatory impact assessments. In 2010, the White Paper *Equity and Excellence: Liberating the NHS* focused on putting the patients and the public first by promoting shared decision-making at clinical and policy levels [41].

A fourth function is **ensuring that health system design is aligned with health system goals** and that there are structures and processes in place to manage health system performance. It requires first that health ministries ensure a fit between strategy and institutional and organizational structure, and that there are efforts in place to reduce system duplication and fragmentation. It also implies that the health system has the capacity to adapt its strategies and policies to take into account changing priorities and health needs [20]. Second, performance assessment and evaluation are important tools facilitating health system performance management and continuous performance improvement [43]. An example of this is the health
system performance management framework adopted within the Ontario Ministry of Health and Long-Term Care (Canada), which links strategy, performance measurement, resource allocation, accountability, and system improvement through an integrated performance management framework [42]. Similarly, in order to stimulate health system performance improvement, the health system performance measurement framework adopted in the Netherlands links a managerial framework for health care system performance (based on the balanced scorecard model) with a public health approach focused on health gains [17].

A fifth health system stewardship function is regulation, or the effective and appropriate use of legal, regulatory, and policy instruments to implement health system strengthening strategies. For example, legislation and regulations can be used to ensure a fair playing field for all system actors, public and private. However, the achievement of an effective and comprehensive mix and allocation of powers, incentives, guidelines, best practices, and sanctions with which to steer stakeholders is a challenge [44], particularly in terms of aligning health system incentives to make sure that they support the attainment of policy goals [45,46]. Not surprisingly, there is considerable variation in the use of legislation, regulations, and incentives to achieve stewardship goals. An example is in how governments, health ministries, and/or health insurance funds oversee the role of the private sector while protecting the public interest through accreditation, quality control mechanisms, and incentives, as in the Netherlands or other countries [44,47].

The sixth and final health system stewardship function is to ensure the collection, dissemination, and application of appropriate health information and research evidence. This function supports the other health system stewardship functions. This includes the combined use of epidemiological, economic, and performance data and research evidence [24,48]. The regular assessment of health system performance in an increasing number of countries [24], and recent benchmarking and international comparative initiatives [49,50] are useful examples of efforts to build more strategically oriented performance information into decision-making. Generating this type of information requires that health ministries invest in strengthening their health information infrastructures and in standardizing data collection (extraction, coding, and audit) practices in order to support benchmarking of performance across different levels (intra-jurisdictional, international, longitudinal) of the system [51]. There is increasing evidence from the private and public sector that a strong intelligence generation function (and capacities to use this information systematically for decision-making) is a key determinant of performance [52]. A commitment to improved health evidence built up over time can facilitate evidence-informed decision-making and thus contribute to the attainment of health system goals.
In Table 1 key questions are presented that could guide health ministries in reviewing how they are carrying out their stewardship function; and/or scope out the changes they are considering in implementing a new stewardship approach. These questions are complemented by selected examples from countries from the WHO European Region. The set of questions is intentionally limited and is intended to be more indicative than exhaustive. Health ministries could derive their own comprehensive list of assessment questions based on this table.

Table 1. Key questions to assess the completeness and consistency of health system stewardship

<table>
<thead>
<tr>
<th>Health System Stewardship functions</th>
<th>Key questions to assess the completeness and consistency of health system stewardship</th>
<th>Selected examples from European countries</th>
</tr>
</thead>
</table>
| Define vision for health and strategy and policies to achieve better health | i. Has the ministry of health defined a vision for health?  
ii. To what extent are the vision for health and related goals consistent with the overall societal and developmental goals of the country?  
iii. Is there a health system strengthening strategy and coordinated policies in place to implement this vision, and are resources allocated in a consistent way to attain the desired goals?  
iv. Are the roles and responsibilities of the public, private and voluntary sectors and of civil society specified in implementing the strategy? | National Health Plan of Portugal [30,31]  
Evaluation of stewardship function of Ministry of Health in Spain [32] |
| Exert influence across all sectors and advocate for better health | i. Is there a strategy in place to collaborate and build coalitions across all sectors in government, and with actors outside government, to attain health system goals?  
ii. Are there initiatives in place aimed at addressing the broader social determinants of health?  
iii. Is the ministry of health advocating the incorporation of health issues in all policies? | Health Impact Assessment in Slovenia and Finland [35]  
Sweden Public Health Objectives Act [38]  
Turkey policy on tobacco control [39]  
2007 Getting Healthier strategy in Italy [53] |
| Ensure good governance supporting achievement of health system goals | i. To what extent was the formulation process for the vision for health and health system strengthening strategy inclusive of main stakeholders for national consensus and ownership?  
ii. Are common values shared across the health sector and is an ethical base for health improvement established?  
iii. Are health system-wide accountability and transparency ensured?  
iv. Are there strategies in place to engage and involve patients and citizens in shared decision-making and priority setting? | England 2004 White Paper Choosing Health [33]  
England 2010 White Paper Equity and Excellence: Liberating the NHS [41] |
Table 1. Key questions to assess the completeness and consistency of health system stewardship (continued)

<table>
<thead>
<tr>
<th>Health System Stewardship functions</th>
<th>Key questions to assess the completeness and consistency of health system stewardship</th>
<th>Selected examples from European countries</th>
</tr>
</thead>
</table>
| Ensure alignment of system design with health system goals | i. Is there a fit between strategy and health system institutional and organizational design and are there efforts in place to reduce duplication and fragmentation?  
ii. Is the health system able to adapt its strategy and policies to take account of changing priorities and health needs?  
iii. Are there processes in place to manage health system performance? | Netherlands health system performance assessment and management framework [17] |
| Make use of legal, regulatory and policy instruments to steer health system performance | i. Does the ministry of health ensure that legislation and regulations are fairly enforced?  
ii. Is the right mix of powers, incentives, guidelines, best practices and sanctions used to steer stakeholders in the chosen direction?  
iii. Are health system incentives aligned to make sure that they support the attainment of policy goals? | Netherlands health care regulatory framework [44] |
| Compile, disseminate and apply appropriate health information and research evidence | i. Does the health ministry ensure that strategy-based information, research evidence and other important data is generated, analysed and used for decision-making by policy makers, clinicians, other health system actors and the public?  
ii. Are research evidence and strategy-based performance information (including health system performance assessment) built into ministry policy development and decision-making processes? | Various European countries health system performance assessments [24]  
Netherlands health outcomes benchmarking study [50] |

An operational framework to assess the completeness and consistency of the stewardship function

The six functions of stewardship applied to the health sector in the context of the WHO European Region are all important. But the extent to which these functions should be carried out to achieve health system goals depends largely on contextual factors. Thus, to ensure clear alignment with their context, health ministries should quantify the goals pursued, starting with the overarching goal of improved health. This is critical to the proportionate alignment of all the stewardship functions and resources towards these goals. Health system stewards thus need to not only put appropriate structures and processes in place to effectively steer the health system, but also to ensure that they have an impact on its performance [24,42].

We propose with Figure 2 an operational framework relating the six functions of stewardship applied to the health sector in the context of the national values and socio-economic constraints within which the stewardship role of national health
ministries takes place; and the ultimate goals of health systems such as defined by the WHO. This framework aims to clarify the scope of functions that can be exercised by national health ministries to achieve health system ultimate goals within the boundaries of stewardship presented in Figure 1. The extent of use of these functions will then depend on both context and goals such as stated in the national strategies and policies. Furthermore, the framework proposes strategies to evaluate the completeness and consistency of the stewardship of national health ministries, in relation to the goals set and within the context the steward operates; and health system performance assessment as a tool to measure the achievement of health system ultimate goals [24].

**Figure 2. An operational framework for assessing the completeness and consistency of the health system stewardship function of health ministries**

<table>
<thead>
<tr>
<th>Context and values for health</th>
<th>Health system stewardship functions</th>
<th>Generic health system goals to be adapted to national contexts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political, economic and social context</td>
<td>Exert influence across all sectors and advocate for better health</td>
<td>Improved health (level and equity)</td>
</tr>
<tr>
<td>Health and health system prevailing values</td>
<td>Ensure good governance supporting achievement of health system goals</td>
<td>Responsiveness</td>
</tr>
<tr>
<td>Define vision for health and strategy and policies to achieve better health</td>
<td>Ensure alignment of system design with health system goals</td>
<td>Social and financial risk protection</td>
</tr>
<tr>
<td></td>
<td>Make use of legal, regulatory and policy instruments to steer health system performance</td>
<td>Improved Efficiency</td>
</tr>
<tr>
<td></td>
<td>Compile, disseminate and use appropriate health information and research evidence</td>
<td></td>
</tr>
</tbody>
</table>

Understanding the contextual factors influencing the health system stewardship function

Assessing the completeness and consistency of the health system stewardship function

Assessing the performance of the health system
Discussion

The operational framework proposed here (Figure 2) aims to bring greater clarity about the concept of stewardship applied to the health sector and its implementation. The value of this framework is to propose an operational approach scoping out the different health system stewardship functions and relating them in practice to national contexts and various health system goals.

However, there are a number of practical challenges related to the implementation of the stewardship concept in the health sector. A first obvious challenge relates to the lack of evidence about the institutional settings favouring the level of trustworthiness, ethical behavior, and good decision-making on the side of the government and public administration that the stewardship approach has to rely on [5]. In addition, if all 53 Member States of the WHO European Region endorsed in principle values underpinning the stewardship concept, these values are far from being implemented in practice in all countries. This raises the question of knowing whether the stewardship concept can be adapted to other models than democratic states. Davis et al. [7] argue that greater resistance to implement stewardship will be met in societies less eager to accept an involvement-oriented approach, as opposed to a control-oriented approach. They suggest that the transition towards a stewardship model should take into consideration the challenge of implementing stated values in practice across society. From that perspective, the operational framework proposed could be used as a starting point to assess the degree of consistency between the stewardship model and national values in various countries.

The second challenge relates to possible limitations in the ability of national health ministries to implement strategies and policies, depending on the national context. The recent financial and economic crises have since 2008 often reduced the capacities of governments to develop health system policies, which is an obvious challenge to the implementation of health system stewardship. The decentralization of a number of health systems is also bringing difficulties for central ministries of health often missing the appropriate authority to ensure an alignment between health system objectives and those of sub-levels of government [32,53]. The limited power of the state in a number of post-socialist transitional countries in the WHO European Region is an additional challenge. Furthermore, the capacity of health ministries to gather important information for decision-making (in support of their stewardship role) through the collection of data varies widely. Finally, health ministries in some countries may not have the influence across government to define a vision for health that would underpin in practice government policies. The operational framework proposed allows analysing whether national health ministries have the power, influence, and policy tools to implement strategies and policies in practice.

A third challenge relates to the difficulty of implementing change within national health ministries. Four possible reasons for this are the relatively short
average lengths of time health ministers are in office, in contrast with the long time lag between a policy intervention and its impact on health outcomes; an insufficiently clear framework for aligning their stewardship function, coupled with political pressures to carry out short-term tasks at the expense of medium- and long-term action; gaps between available skills and competences of ministry staff and those necessary for implementing stewardship, especially if the ministry remains heavily involved in direct health services management and provision; and a scarcity of valid and reliable performance information and evidence for decision-making. This difficulty to implement change is particularly problematic in countries having a long-established culture of command-and-control in government and subject to path dependency.

Some of the limitations of this research paper relate to the difficulty of developing an operational framework that would be useful to countries with different values and governance contexts; to the limited amount of operational research on health system stewardship despite recent evaluation efforts [31,32]; and the fact that there are very few countries in practice which have fully implemented all aspects of the stewardship function [3]. The approach proposed is a first step to develop a broader operational research agenda on the topic. In the meantime, this framework requires a formative evaluation of its implementation over time and in different national health system contexts in order to assess the validity of its content and construct [54]. Comparative case studies of health system stewardship would be a useful approach to test this framework in various national health system contexts across the WHO European Region [13]. Challenges to the development of appropriate evaluation methods relate to the difficulty of assessing with a high degree of validity interrelated health system stewardship sub-functions whose implementation is highly dependent on national contexts and values. In democratic states, this context may change during the evaluation, requiring an even more nuanced approach to evaluation.

Other potential areas for empirical research include the applicability of the stewardship model in non-democratic states; a review of the institutional settings supporting the successful implementation of health system stewardship in different contexts; lessons learned from its implementation in decentralized and centralized countries; a review of the effectiveness of the policy tools and levers most appropriate to support different health system stewardship sub-functions and of their effectiveness; what are the challenges, such as capacity building and talent retention, that health ministries face in implementing health system stewardship and how these can be overcome; and how to use health system performance assessment, international comparisons and benchmarking for overall health system performance management. Stewardship remains a concept in evolution and is likely to do so until further research articulates its effectiveness in national health goal attainment in various contexts. This paper hopefully provides greater conceptual clarity for the continued application of stewardship in different countries, along with the articulation of specific stewardship functions and of an initial evaluation framework.
Chapter 2

References


