CHAPTER SIX

How is the Public Interest Protected?

Governments should be the "stewards" of their national resources, maintaining and improving them for the benefit of their populations. In health, this means being ultimately responsible for the careful management of their citizens' well-being. Stewardship in health is the very essence of good government. For every country it means establishing the best and fairest health system possible. The health of the people must always be a national priority: government responsibility for it is continuous and permanent. Ministries of health must take on a large part of the stewardship of health systems.

Health policy and strategies need to cover the private provision of services and private financing, as well as state funding and activities. Only in this way can health systems as a whole be oriented towards achieving goals that are in the public interest. Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. At the international level, stewardship means influencing global research and production to meet health goals. It also means providing an evidence base to guide countries' efforts to improve the performance of their health systems.

6

How is the Public Interest Protected?

Governments as stewards of health resources

Stewardship is the last of the four health systems functions examined in this report, and it is arguably the most important. It ranks above and differs from the others – service delivery, input production, and financing – for one outstanding reason: the ultimate responsibility for the overall performance of a country's health system must always lie with government. Stewardship not only influences the other functions, it makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution. The government must ensure that stewardship percolates through all levels of the health system in order to maximize that attainment.

Stewardship has recently been defined as a "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry" *(1)*. It requires vision, intelligence and influence, primarily by the health ministry, which must oversee and guide the working and development of the nation's health actions on the government's behalf. Much of this chapter, therefore, addresses the ministry's role.

Some aspects of stewardship in health must be assumed by government as a whole. Affecting the behaviour of health actors in other sectors of the economy, or ensuring the right size and skill mix of the human resources produced for the health system, may be beyond the ministry's reach. The government ought to ensure coherence and consistency across departments and sectors, where necessary by an overall reform of public administration.

Outside of government, stewardship is also a responsibility for purchasers and providers of health services who must ensure that as much health as possible results from their spending. And stewardship in health has an international dimension, relating to external assistance.

But government remains the prime mover. Today in most countries the role of the state in relation to health is changing. People's expectations of health systems are greater than ever before, yet limits exist on what governments can finance and on what services they can deliver. Governments cannot stand still in the face of rising demands. They face complex dilemmas in deciding in which direction to move: they cannot do everything. But in terms of effective stewardship, their key role is one of oversight and trusteeship – to follow the advice of "row less and steer more" *(2, 3)*.

Stewardship has major shortcomings everywhere. This chapter examines some of them, then discusses important stewardship tasks. It considers the main protagonists involved, and strategies for implementing stewardship in different national settings. Finally, it brings together some of the messages from preceding chapters on policy directions for better-functioning health systems.

What is wrong with stewardship today?

"Ministries of health in low and middle income countries have a reputation for being among the most bureaucratic and least effectively managed institutions in the public sector. Designed and initiated in the early 20th century and given wide responsibility for financing and operating extensive public hospital and primary care systems in the post-war period, they became large centralized and hierarchical public bureaucracies, with cumbersome and detailed administrative rules and a permanent staff with secure civil service protections. The ministries were fragmented by many vertical programmes which were often run as virtual fiefdoms, dependent on uncertain international donor funding" *(4)*.

The problems described above are familiar, in greater or lesser degree, in many countries today. The consequences are easy to see, but it is not always easy to see why the problems occur or how to solve them. Often that is because the stewards of health suffer specific visual impairments.

Health ministries often suffer from myopia. Because they are seriously short-sighted, ministries sometimes lose sight of their most important target: the population at large. Patients and consumers may only come into view when rising public dissatisfaction forces them to the ministry's attention. In addition, myopic ministries recognize only the closest actors in the health field, but not necessarily the most important ones, who may be in the middle or far distance.

Ministries deal extensively with a multitude of public sector individuals and organizations providing health services, many of which may be directly funded by the ministry itself. Often, this involvement means intensive professional supervision and guidance. But sometimes just beyond their field of vision lie at least two other groups with a major role to play in the health system: nongovernmental providers, and health actors in sectors other than health.

In their size and potential impact on achieving health goals, these little recognized individuals and organizations may be more important than the public resources directed through the health ministry. Yet information about them may be scant, and a policy approach towards them is often lacking. In Myanmar, Nigeria *(5)*, or Viet Nam, for example, privately financed and provided medical care is three or four times as big, in expenditure terms, as spending on public services. But the many different types of private providers in these countries are barely recognized in legislation and regulation.

Some large health insurance schemes in India currently have no legal status *(6)*. In Europe and the Americas, road traffic accidents rank fourth in the total burden of disease. Yet the main involvement of the health ministry is often as a steward of accident and emergency services, not as a force for prevention. Services funded from public sources are obviously the responsibility of government. But private finance and the provision of *all* health actions clearly need to be within the focus of government as overall steward of the public interest.

Ministries are also myopic in the sense that their vision does not extend far enough into the future. Investment decisions – new buildings, equipment and vehicles – frequently

occupy the foreground, while the severe and chronic need to improve the balance between investment and recurrent funding fades into the hazy distance.

Tunnel vision in stewardship takes the form of an exclusive focus on legislation and the issuing of regulations, decrees, and public orders as means of health policy. Explicit, written rules have an important role to play in the performance of the stewardship function. But formulating regulations is relatively easy and inexpensive. It is also often ineffective, with ministries lacking the capacity to monitor compliance: there are seldom enough public health inspectors to visit all food shops and eating places or enough occupational safety inspectors to visit all factories regularly. On the rare occasions when sanctions are invoked they are too mild to discourage illegal practices or to affect widespread disregard of regulations.

Good stewardship needs the support of *several* strategies to influence the behaviour of the different stakeholders in the health system. Among these are a better information base, the ability to build coalitions of support from different groups, and the ability to set incentives, either directly or in organizational design. As authority becomes devolved, delegated and decentralized to a wide range of stakeholders in the health system, the repertoire of stewardship strategies needs to move away from dependence on "command and control" systems towards ensuring a cohesive framework of incentives.

Health ministries sometimes turn a blind eye to the evasion of regulations which they themselves have created or are supposed to implement in the public interest. A widespread example is the condoning of illicit fee collecting by public employees, euphemistically known as "informal charging". A recent study in Bangladesh found that unofficial fee payments were 12 times greater than official payment *(7)*. Paying bribes for treatment in Poland is cited as a common infringement of patients' rights *(8)*. Though such corruption materially benefits a number of health workers, it deters poor people from using services they need, making health financing more unfair, and it distorts overall health priorities.

In turning a blind eye, stewardship is subverted; trusteeship is abandoned and institutional corruption sets in. A blind eye is often turned when the public interest is threatened in other ways. For instance, doctors can remain silent through misplaced professional loyalty in the face of incompetent and unsafe medical practice by colleagues. A 1999 US study commented "whether care is preventive, acute or chronic, it frequently does not meet pro-

Box 6.1 Trends in national health policy: from plans to frameworks

National health policy documents have a long history, predating but stimulated by international concern for promoting primary health care. In many centrally planned and developing economies, health policies were part of a national development plan, with a focus on investment needs. Some health policy documents were only a collection of project or programme-specific plans. They ignored the private sector and often took inadequate account of financial realities and people's preferences. Implementation problems were common.

By no means all countries have formal national health policies: France, Switzerland, and the United States do not; Tunisia has no formal single national policy document; the UK produced its first formal document in the 1990s, Portugal in 1998. The lifespan of a policy depends on whether there are fundamental changes to the agenda: India is still using its 1983 plan; Mongolia, in economic transition, revised its 1991 policy in 1996 and again in 1998.

A shift is now occurring towards more inclusive – but less detailed – policy frameworks mapping the direction but not spelling out the operational detail, as in Ghana and Kenya.

A national health policy framework:[1]

- identifies objectives and addresses major policy issues;
- defines respective roles of the public and private sectors in financing and provision;
- identifies policy instruments and organizational arrangements required in both the public and private sectors to meet system objectives;
- sets the agenda for capacity building and organizational development;
- provides guidance for prioritizing expenditure, thus linking analysis of problems to decisions about resource allocation.

[1] Cassels A. *A guide to sector-wide approaches for health development*. Geneva, World Health Organization/DANIDA/DFID/European Commission, 1997 (unpublished document WHO/ARA/97.12).

fessional standards" *(9)*. Ensuring probity in decisions on capital projects and other large purchasing decisions (equipment, pharmaceutical orders), where corruption may be particularly lucrative, is another frequent challenge to good stewardship.

Some recent developments create opportunities for better vision and more innovative stewardship. Greater autonomy in decisions relating to purchasing and service provision, for example, shifts some responsibility away from central or local government. But it creates new tasks for government in overseeing that both purchasing and provision are carried out in accordance with overall policy. Accumulated experience of practices such as contracting is now available *(10)* and rapid technological advances enable the fast, inexpensive handling of huge amounts of information, thus making it easier in principle for stewards to visualize the whole health system.

The notion of stewardship over all health actors and actions deserves renewed emphasis. Much conceptual and practical discussion is needed to improve the definition and measurement of how well stewardship is actually implemented in different settings. But several basic tasks can already be identified:

- formulating health policy – defining the vision and direction;
- exerting influence – approaches to regulation;
- collecting and using intelligence.

These tasks are discussed below.

Health policy – vision for the future

An explicit health policy achieves several things: it defines a vision for the future which in turn helps establish benchmarks for the short and medium term. It outlines priorities and the expected roles of different groups. It builds consensus and informs people, and in doing so fulfils an important role of governance. The tasks of formulating and implementing health policy clearly fall to the health ministry.

Some countries appear to have issued no national health policy statement in the last decade; in others, policy exists in the form of documents which gather dust and are never translated into action. Too often, health policy and strategic planning have envisaged unre-

Box 6.2 Ghana's medium-term health policy framework

In Ghana, after an extensive process of consultation, the following strategies were identified as providing the means to better performance in health.

- Re-prioritization of health services to ensure that primary health care services (i.e. services with maximum benefits in terms of morbidity and mortality reduction) receive more emphasis in resource allocation.
- The strengthening and decentralization of management within the context of a national health service.
- Forging linkages between private and public providers of health care to ensure consensus and that all resources are focused on a common strategy.
- Expansion and rehabilitation of health infrastructure to increase coverage and improve quality.
- Strengthening human resource planning, management and training as a means of providing and retaining adequate numbers of good quality and well-motivated health teams to provide the services.
- Provision and management of adequate logistics such as drugs and other consumables, equipment, and vehicles at all levels of the health system.
- Strengthening the monitoring and regulatory systems within the health service to ensure more effective implementation of programmes.
- Empowering households and communities to take more responsibility for their health.
- Improving the financing of health care by ensuring the efficient and effective use of all available resources from government, nongovernmental organizations, and private, mission and donor sources. Ways of mobilizing additional resources with a view to making the services more accessible and affordable will also be explored.
- Promoting intersectoral action for health development, particularly in the areas of food and nutrition, employment, education, water and sanitation.

Source: *Medium-term health strategy: towards vision 2020 Republic of Ghana.* Accra, Ministry of Health, 1995.

alistic expansion of the publicly funded health care system, sometimes well in excess of national economic growth. Eventually, the policy and planning document is seen as infeasible and is ignored. Box 6.1 sketches how comprehensive health planning has given way to a more flexible 'framework' approach. Ghana's 1995 medium-term health strategy identified ten ways in which the health system would contribute towards better health (see Box 6.2).

Public consultation occurs in some countries at the beginning of the policy formulation process. A "rolling" framework is sometimes used, and periodically updated and amended. In countries where external assistance forms an important part of the health system's resources, an important expansion of this approach to policy-making and implementation is represented by sector-wide approaches (SWAPs). The essence of SWAPs is that, under government leadership, a partnership of funding agencies agrees to work together in support of a clear set of policy directions, often sharing many of the implementation procedures, such as supervision, monitoring, reporting, accounting, and purchasing. Box 6.3 summarizes the development of SWAPs. Health planning thus shows signs of moving beyond investment programming and towards consensus statements on broad lines of policy and system development.

A policy framework should recognize all three health system goals and identify strategies to improve the attainment of each. Few countries have explicit policies on the overall goodness and fairness of the health system. Yet the need to combine these two values in governance can be traced far back in history *(1)*. Box 6.4 describes the ancient *Hisba* system of stewardship in Islamic countries, highlighting both its ethical and economic purposes. Public statements about the desired balance among health outcomes, system responsiveness and fairness in financing are yet to be made anywhere. Policy should (and in partial

Box 6.3 SWAPs: are they good for stewardship?

A sector-wide approach (SWAP) is a method of working that brings together governments, donors, and other stakeholders within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy dialogue; developing a single sector policy (that addresses private and public sector issues) and a common, realistic expenditure programme; common monitoring arrangements; and more coordinated procedures for funding and procurement. Being engaged in a SWAP implies commitment to this direction of change, rather than the comprehensive attainment of all these different elements from the start. It implies changes to the ways in which both governments and donor agencies operate, and in their required staff skills and systems.

This approach has begun to take root primarily in some of the most highly aid-dependent countries. It has been driven by both government and donor concerns about the results of historical approaches to development assistance, which have often involved a combination of 'social sector-blind' macroeconomic adjustment policies and 'sector-fragmenting' projects. Many of the countries are in Africa, for example, Burkina Faso, Ethiopia, Ghana, Mali, Mozambique, Senegal, Uganda, the United Republic of Tanzania, and Zambia. The other cluster of countries discussing or actively engaging in a SWAP is in Asia: Bangladesh, Cambodia, and Viet Nam are examples.

The evolution of a SWAP takes time. In Ghana, before the Ministry of Health single sector programme was endorsed by donors, the country had already gone through 10 years of institutional development, 4 years of major policy/strategy work, 3 years of strengthening core management functions, 2 years of negotiations, planning and design, and 1 year of slippage and delays.[1]

Cambodia and Viet Nam are at the earliest stage of discussing sector policy with donors. In other countries, progress has been mostly towards developing and agreeing to operate within a single sector policy and medium-term expenditure framework. Joint review missions have become a feature in some countries. Least progress has been made towards common financing and procurement arrangements.

SWAPs have the potential to support good stewardship. Walt and colleagues argue that SWAPs are perceived as capable of strengthening governments' ability to oversee the entire health system, develop policies and engage with stakeholders beyond the public sector.[2] But, most importantly, SWAPs depend on vision and leadership by national government.

[1] Smithson P. Cited in Foster M. *Lessons of experience from sector-wide approaches in health*. Geneva, World Health Organization, Strategies for Cooperation and Partnership, 1999 (unpublished paper).

[2] Walt G et al. Managing external resources in the health sector: are there lessons for SWAPs? *Health Policy and Planning*, 1999, 14(3): 273–284.

ways sometimes does) address the way in which the system's key functions are to be improved.

With respect to the provision of services, all providers should be recognized and their future contribution – greater in some cases, less in others – should be outlined. On financing, strategies to reduce dependence on out-of-pocket payments and to increase prepayment should be identified. Roles of the principal financing organizations – private and public, domestic and external – and of households should be recognized and their future directions determined. The machinery of stewardship, designed to regulate and monitor how these functions change in accordance with policy, should also be made explicit. This is likely to involve opportunities for consumer representatives to balance provider interests.

Danger exists when particular lines of policy, or whole reform strategies, become associated with a specific political party or minister of health. Regardless of whether the policy is good or bad, it becomes highly vulnerable. When that minister or party leaves office the policy dies, usually before it has either succeeded or failed, because the next minister or administration is seldom willing to work under the predecessor's banner. Rapid turnover of senior policy officials, and a politically charged environment, are both hazards to good stewardship *(11)*. Establishing good stewardship can reduce exposure to "personality capture" of particular policy directions, by creating an informed constituency of stakeholder support, and ensuring that the interests, skills and knowledge needed to maintain a particular policy direction are widely distributed.

All remaining stewardship tasks concern the implementation of policy, as distinct from its formulation and promotion.

Setting the rules, ensuring compliance

Regulation is a widely recognized responsibility of health ministries and, in some countries, of social security agencies. It covers both the framing of the rules to govern the behaviour of actors in the health system, and ensuring compliance with them. In keeping with

Box 6.4 Stewardship: the Hisba system in Islamic countries

The institution of Hisba was developed to carry out the function of stewardship in Islamic countries more than 1400 years ago. The *Hisba* system is a moral as well as a socioeconomic institution, whose raison d'être is to ordain good and forbid evil. The functions of the *muhtasib* (the head of *Hisba* system) can be classified into three categories: those relating to (the rights of) God; those relating to (the rights of) people; and those relating to both.

The second and third categories are related to community affairs and municipal administration. The main foundation of *Hisba* was to promote new social norms and develop the required system to ensure the adherence of various sectors of society to these norms.

The first *muhtasib* in Islam was a woman called Al Shifa, appointed in Medina, the capital of the Islamic state, by the second calif, Omar ibn Al Khattab, almost 1450 years ago, and given authority to control the markets. Another woman called Samra bint Nuhayk was given a similar authority in Mecca, the second city, by the same calif.

The *muhtasib* could appoint technically qualified staff to investigate the conduct of different crafts, trades and public services, including health services. The *muhtasib* received complaints from the public but could also order an investigation on his or her own initiative.

Medical services were also regulated by the Hisba system. Physicians and other health specialists had to pass professional examinations and possess the necessary equipment before being licensed. The *muhtasib* had to ensure compliance of practising physicians to moral and ethical norms, including equitable provision of services and protection of the public interest. In the field of pharmaceutical services, technical publications were prepared, including monographs describing standards and specifications for various drugs as well as methods of quality assurance. The system also included inspections and enforcement mechanisms.

Like many other institutions, the Hisba system underwent drastic modification with the advent of western colonization: its functions were transformed into a number of secular departments and its moral content reduced.

Contributed by the World Health Organization Regional Office for the Eastern Mediterranean.
Source: Al-Shaykh al-Imam Ibn Taymiya. *Public duties in Islam: the institution of the Hisba.* Markfield, UK, The Islamic Foundation, 1985.

the policy-making and intelligence tasks, regulation has to encompass all health actions and actors, and not just those of the health ministry or the public sector. While the public health care system is often replete with regulations, few countries (with either high or low income) have developed adequate strategies to regulate the private financing and provision of health services. The rethinking of a consistent set of regulatory approaches to private providers and sources of finance, in line with national goals and priorities, is a top priority task in most countries.

Regulation can either promote or restrict. Since the private sector comprises many different players, national policy needs to distinguish carefully where to promote and where to restrict. A single position on the private sector is unlikely to be appropriate. In promotive terms, explicit incentives may be provided for private practice such as the sale of public assets, preferential loans, or donations of land. Tax incentives may be offered to promote private provision, with no or very little government regulation of providers' market behaviour. China re-legalized private practice in the 1980s and promoted joint public/private ventures in hospital ownership. Thailand's finance ministry offers tax incentives to private hospital investors.

At the other extreme, significant barriers to market entry have sometimes been created, such as a legal ban on private practice. This is still the case in Cuba and was previously in Ethiopia, Greece (for hospitals), Mozambique, the United Republic of Tanzania and several other countries. Between these extremes are policies that allow relatively free market entry, provide modest incentives, or have limited prerequisites for those wishing to enter the private market, including some standards for market behaviour and some level of oversight and enforcement.

Incentives for greater private sector opportunities in health are often sought by government agencies other than the health ministry, and by private investors themselves. Finance, trade, and development ministries often advocate greater private investment in health in line with overall economic liberalization strategies.

Promotive policies seem to work, contributing to growth in private finance and provision *(12, 13)*. But they have also had serious side-effects: rising inequities, uneven quality of care, and inefficiency. The health ministry needs to know in advance what conditions it will require for such investments to contribute to the efficiency, quality, or equity goals of the health system, and how to defend the view that health is *not* just like all other sectors.

The harm caused by market abuses is difficult to remedy after the fact. The United States is probably the best-documented case of regulators trying to catch up with private health insurers *(14)*. State governments have extensive laws, regulations and enforcement authority over private insurers in the USA to ensure fair competition, assure quality and generally protect consumers from fraudulent marketing. This regulatory framework took many years to develop and is still far from perfect: it does not guarantee insurance for everyone. Recent regulatory changes have improved access to, but not the affordability of, private insurance by small employers and individuals. Private employers have devised various ways of avoiding the rules, so as to come under the looser federal regulations. But the system prevents many of the worst abuses – financially unsound or unscrupulous insurers – and helps to ameliorate many market failures. Chile and South Africa have similar experiences in regulating private health insurance practice. South Africa has recently changed earlier regulations governing medical schemes to reduce risk selection and increase risk pooling (see Box 6.5).

Chile has been unable to establish explicit contractual obligations for private insurers or prohibit risk selection by these private companies, due to the political influence of insurers

and their clients. If there is a long delay between market entry and the enforcement of rules regarding market behaviour, experience suggests that the task of instituting those rules will become politically very difficult *(15, 16)*.

A more moderate form of incentives for private sector involvement are represented by contracts between public purchasers and private providers. In Lebanon, for example, 90% of hospital beds are in the private sector and nongovernmental organizations provide ambulatory care to about 10–15% of the population, particularly to the poor. Out of necessity, the Ministry of Health contracts with almost all private hospitals for a predetermined number of beds to serve public patients *(17)*. But the government does not use this regulatory tool to its advantage. Reimbursement policies allow unnecessary hospitalizations and overuse of services, which result in cost escalation; and private hospitals operate in a largely unregulated environment, which leads to uncontrolled investment. This in turn can lead to pressure for sustained public financial support, which will appear to justify further investment. Stewardship needs to ensure consistency in the incentive messages sent out by different levels of public policy.

Regulation requires resources. Regulatory oversight and contractual strategies entail high transaction costs for both government and providers or insurers, which may reduce the potential cost savings of these strategies. High levels of awareness of these costs accompanied the moves to separate the roles of purchasers and providers in the United Kingdom and New Zealand *(18)*. Often, lack of commitment and funds hamper government capacity to carry out regulatory responsibilities, old as well as new. This suggests that capacity building in contracting skills and regulatory oversight is critically needed both via recruitment of skilled staff and through training and technical aid to existing staff.

Box 6.5 South Africa: regulating the private insurance market to increase risk pooling

The government which came to power in 1994 after South Africa's first democratic elections found itself with a health sector which mirrored the inequalities existing in the wider society. A long-established and well-developed private health care industry accounted for 61% of health care financial resources, while providing for the needs of only the affluent 20% of the population. The vast majority of the population had to rely upon poorly distributed, underfunded and fragmented public services. Cost escalation in the private sector typically exceeded inflation during most of the late 1980s and 1990s. The private sector responded to this by limiting benefits, increasing co-payments and accelerating the exclusion of high-risk members from cover, thereby heightening the problem of inequality.

The new government's response to these challenges was to enact new legislation for medical schemes to offer a minimum benefits package and increased risk pooling. The fundamental principles and objectives at the core of the Act are as follows.

- *Community rating.* For a given product or option, the only grounds on which premiums may be varied are family size and income. Risk or age rating are prohibited.
- *Guaranteed access.* No-one who can afford the community rated premium may be excluded on grounds of age or health status.
- *Increased risk pooling.* Caps on the permissible contributions and accumulations through individual medical savings accounts will ensure that a greater proportion of contributions flows into the common risk pool.
- *Promoting lifetime coverage.* Community rating and guaranteed access will be combined with premium penalties for those who choose only to take out cover later in life, to provide powerful incentives for affordable lifetime membership.
- *Prescribed minimum benefits.* Every medical scheme must guarantee to cover in full the cost of treating a specified list of conditions and procedures in public facilities, thus greatly decreasing the impact of "dumping" patients onto the state.

A committee of inquiry was appointed by the health minister during 1995. It set up a small technical team to prepare new regulations for medical schemes. The team produced its first discussion document in 1996, and consulted widely with key stakeholders on its proposals. Discussion and debate continued until mid-1997, when a formal policy paper resulted.[1] After a period of intense, open debate during the legislative process, the new Medical Schemes Act and its accompanying Regulations came into force on 1 January 2000, three and a half years after the committee was formed. One important group will benefit immediately: HIV-positive members of medical schemes now have access to subsidized care, including drugs for opportunistic infections, whereas previously they were excluded or their entitlement was limited to very low benefit levels.

Contributed by T. Patrick Masobe, Department of Health, South Africa.

[1] *Reforming private health financing in South Africa: the quest for greater equity and efficiency*. Pretoria, Department of Health, 1997.

Shortcomings in staff skills or resources are often cited as the cause of outdated regulatory frameworks, or those which are not adequately enforced *(4)*. Lack of legislative authority, too, is sometimes at fault. For example, in the late 1970s, Sri Lanka deregulated private practice by government doctors and liberalized the economy in general, which increased availability of capital *(19)*. However, the health ministry failed to register effectively the growing number of private providers. It had no regulatory strategy, no staff responsible for private sector relations, and it lacked adequate legislative authority to take on many tasks. The only law on the books required registration of nursing homes, but not private clinics or doctors. A law has been pending since 1997 but has not yet been implemented. However, a new Ministry of Health unit for development and regulation of the private sector was set up in 1998.

In Egypt, most physicians work simultaneously for the government and in private practice. As a result, much of their work escapes oversight and regulation. Similar practice is widespread in Latin America. In India, mechanisms for monitoring, let alone regulating, the private sector have not kept pace with its expansion, despite concerns about quality of care. Health professionals are aware of practice-related laws but know that enforcement is weak or non-existent and that professional associations, which are nominally responsible for self-regulation, are also ineffective.

When public providers illegally use public facilities to provide special care to private patients, the public sector ends up subsidizing unofficial private practice. It is nearly impossible to completely prohibit private practice by health workers on the public payroll, but several steps can be taken to ensure that private practitioners compete on a fair basis and do not flourish by "moonlighting" at public expense *(20, 21)*. Ensuring that patients, the public, and the media, as well as providers, know the rules is an important factor in regulating the public–private mix.

Effective public services themselves can be a regulatory tool. Developing effective public provision and financing systems becomes even more important if government policy seeks to restrict the development of a private health market, or when it lacks the resources to prevent undesirable market failures. The public sector must then respond to the changing needs of consumers, to the introduction of new medical technologies, and to reasonable expectations of health professionals. A strong public sector may even be a very good strategy for regulating private provision and for consumer protection, if it helps to keep the private sector more competitive in price and quality of service.

Too often, however, it is the public sector which is seen as uncompetitive in terms of quality and responsiveness, in spite of its free or subsidized services. If the public system deteriorates or does not continually improve, an unhealthy amount of resources and attention will be siphoned off trying to catch offenders in the "black market", and growing under-the-table payments will undermine equity goals.

Rules rarely enforced are invitations for abuse. Stricter oversight and regulation of private sector providers and insurers is now on the policy agenda of many countries. But progress is slow if not impossible. This suggests that countries must not only consider the impact of the private sector on the public sector and develop the regulatory framework to limit deleterious effects, but must make a continuing commitment to enforce the rules by investing in the knowledge and skills of regulatory staff. A study in Sri Lanka concluded, "the slow response in the 1980s makes the regulatory task in the 1990s more difficult: uncoordinated and unmonitored private sector growth has created a market context which is bigger, more complex, and with more established provider and user interests" *(19)*.

Professional self-regulation, as distinct from personal self-interest, supports good practice. In establishing a professional organization, health workers assume several of the basic tasks of stewardship – identifying and certifying members, sharing experience, and sometimes offering in-service training. Small amounts of financial support to such organizations can ensure that basic information needed on non-government providers, particularly in ambulatory care settings, is available to the ministry of health. In several East African countries where religious groups are important providers of health services, central, nongovernmental coordinating bodies already perform this role. National medical associations are common; associations of traditional practitioners also exist.

Recent reforms in the Netherlands demonstrate the difficult balancing act between stronger regulation to protect consumers and increase equity, and looser rules to allow more competition (see Box 6.6).

Developing countries have also implemented policies which help ensure that private actors work on behalf of the larger public good. In addition to the South African example in Box 6.5, Bangladesh's National Drug Policy, adopted in 1982, prohibits importation and sale of all non-essential drugs. As a result, about 1666 products that were judged ineffective or harmful were banned, while about 300 were approved for marketing. The government also oversees production quality of all manufacturers and provides training to drug retailers on rational drug use. "Through a combination of public sector oversight and private initiative, essential drugs have been placed within reach of large numbers of the population, [and there are] reasonable and stable drug prices for products … produced locally" *(22)*.

Regulation requires dialogue. In countries with stronger oversight of the private sector, governments for the most part place their regulatory structure at arms-length from the regulated private players. If they do not, the private sector can subvert the system through "regulatory capture", i.e. coopting regulators to make the regulations more favourable to them. But "arms-length" does not mean no communication. Dialogue between public policymakers or regulators and private sector players is a critical factor in making such regulations work. Governments must not only see well for good stewardship, they must also listen. Groups that have both public and private representation provide valuable input into policy development and rule-writing by assessing how private sector players can contribute to public policy goals without compromising their ability to succeed in the market. The drawback of such processes is that they may slow the pace of reform. And even with strong oversight and regulation, private sector players can weaken the regulatory apparatus through political pressure.

In conclusion, the following important lessons for the development of regulatory frameworks for private health markets are clear.

Box 6.6 Opening up the health insurance system in the Netherlands

The Netherlands' new health insurance system, authorized in 1990, for the first time required all private insurers to provide a comprehensive uniform benefits package. But it promoted competition by giving individuals a subsidy to help them buy compulsory health insurance from competing insurers. Insurers receive risk-adjusted per capita payments by the government and a separate flat rate premium from each insured person. The more efficient the insurer, the lower the premium paid by the insured. Insurers were also allowed to negotiate lower fees than officially approved provider fees, which was previously prohibited. As a result, private health insurers entered the market for the first time since 1941, and both insurers and providers became involved in quality improvement efforts, which became the focus for competition among insurers rather than competition only on price.[1] But the new system made the goal of reducing health-related inequalities more difficult, as better-off individuals can prepay for more inclusive benefit packages.[2]

[1] Van de Ven W, Schut F. Should catastrophic risks be included in a regulated competitive insurance market? *Social Science and Medicine,* 1994, 39(1): 1459–1472.
[2] Saltman RB, Figueras J, Sakellarides C, eds. *Critical challenges for health care reform in Europe*. Buckingham, UK, Open University Press, 1998.

- Frameworks should be instituted *prior* to any significant planned expansion through economic incentives and forcefully implemented as soon as the private market starts to respond to incentives.
- Regulatory policies must be continually reviewed to ensure consistency with changing political scenes.
- Improving quality, increasing access to care, and promoting efficiency each require different regulatory tools.
- Regulators must strike a balance between avoiding regulatory capture by private interests and maintaining productive dialogue with them to ensure that regulatory frameworks are realistic.
- Where governments choose to restrict the activities of the private sector, they must ensure that the public sector responds effectively to the needs of consumers.

Governments must make a continuing commitment to enforce regulations and rules by investing in the knowledge and skills of regulatory staff to keep pace with market developments.

Exercising intelligence, sharing knowledge

Stewardship is about vision, intelligence and influence. Without a good understanding of what is happening in the entire health system, it is impossible for the ministry of health to develop strategies to influence the behaviour of the different interest groups in ways that support, or at least do not conflict with, the overall aims of health policy.

A good intelligence system in the sense of both information and understanding needs to be selective in the information it generates for decision-making at the top. But it must be drawn from grass-roots knowledge. Who are the principal service deliverers, and what challenges do they pose to health policy goals? Where are the main imbalances or bottlenecks in input production, and what policy options appear most suitable? Where are the major financing sources and what strategies will achieve greater and more equitable prepayment? What are the main uses of financing and what policies will ensure more efficient resource allocation?

Most health systems collect huge amounts of information that can clog the works. Such information may include accounts, personnel records, inventories, vehicle log books, activity reports (daily, by programme, department, ward, prescription and patient) at each health facility, and patient records. In many ministries of health, thousands of clerical hours each month are wasted in compiling information that is never used. As a general management rule, the amount of information passed up the system should be greatly reduced for each level.

For stewardship purposes, only periodic summaries, showing geographical or temporal variation, may be required. Information on the distribution and activity of public sector health inputs and on budgetary allocations may reveal important and unjustified variations. But of greater importance for stewardship are the missing pieces of information and analysis. Few low and middle income countries today have reliable information on the levels and sources of non-government finance or provision in the health system. As the national health accounts indicators in Annex Table 8 show, these are typically dominant in such countries. Little is known in most countries about peoples' expectations of the health system or about the structure of complex non-government provider markets. Without these data, assessments of responsiveness and fairness in financing, or of intermediate measures

such as service quality and accessibility, are impossible. Without the full picture, good stewardship cannot be practised.

Intelligence requires resources. Stewardship requires a different type of information and understanding from that required in the daily management of service delivery. Should the ministry of health collect it? There is no reason to assume that the resource and skill cost of stewardship intelligence is greater than that of traditional health management systems. Of course, new skills in the area of regulation, coordination and communication are needed. But the ministry of health may already have several advantages.

First, the dispersed national network of public sector health workers and managers provides skilled people for undertaking inventory or survey work. District level health workers can rapidly compile an initial register of non-government providers. Second, the ministry of health has the moral authority to license and accredit providers, so it can engage its staff in the assessment process. Third, health workers have frequent contact with the population and are well placed to ask people about public goals and personal expectations. So the ministry of health can be a formidable potential resource for better stewardship, beginning with its engagement for better intelligence on the entire system.

However, not all of the intelligence gathering, or sharing, will be best done by the ministry. Research institutes, university departments, nongovernmental organizations *(23, 24)* and local or international consulting firms may be able to undertake inventory and survey work more speedily and accurately. To manage them, the ministry will need to draw on skills in contract setting and oversight.

Stewardship also requires information for influencing behaviour and events. Information dissemination provides support, for instance, to both policy-making and regulation. It also allows the ministry to build a constituency of public support for health policy, and thus a defence against incompetent or corrupt practice by interest groups in the health system. It helps to achieve a public debate on policy directions that is based on reliable evidence. A strategy for disseminating technical information can also form part of a capacity-building

Box 6.7 Responsiveness to patients' rights

Since the end of the 1970s there has been a slowly growing recognition of the rights of patients, such as respect for the dignity of the individual and for autonomy.

Rapid advances in medical and health sciences and in technology have hastened increases in patients' expectations: better-informed patients have begun to assert their rights in their dealings with professionals. To a growing extent, patients' rights are incorporated into statutory regulations: in laws on specific subjects, or in citizens' rights covering sectors broader than health care. Regulation may give patients direct legal rights in their relationships with health care providers, or may help to improve their position through administrative health laws and hospital certification, for example. Self-regulation – voluntary arrangements in the form of professional codes or model contracts worked out in cooperation between consumers and health care providers' organizations – also have a role to play. Legislation opens new domains for self-regulation: framework laws on privacy and confidentiality, for example, may oblige institutions to elaborate their own guidelines for the protection of patients' data.

Three types of approaches can be distinguished in national legislation on patients' rights. Some countries have enacted a single comprehensive Law (e.g. San Marino in 1989, Finland and Uruguay in 1992, the Netherlands in 1994, Israel and Lithuania in 1996, Argentina and Iceland in 1997, Denmark in 1998, and Norway in 1999). Other countries have integrated patients' rights into legislation regulating the health care system or into several health laws (e.g. Canada (New Brunswick) and Greece in 1992, France in 1992–94, Austria in 1993, Hong Kong in 1995, Belarus and Canada (Ontario) in 1996, Georgia and Guinea in 1997, and the USA in 1999). Charters on the rights of patients, which have varying status as national policy or are often embodied in the regulations of health care establishments, have been found more appropriate to the legal traditions of some countries, such as France (1974–95), Ireland (1991), the United Kingdom (1991–95) and Portugal (1997).

Informed consent, access to medical records, and the confidentiality of data are the classic rights of patients. New rules for the protection of personal data in medical data banks or automated hospital information systems are also being developed. In recent years the right to privacy has given rise to new individual concerns such as the right to be notified when personal data are first recorded in a data bank, the right to have inexact or incorrect data corrected or destroyed, and the right to be informed about the disclosure of information to third parties.

programme within the health system, and particularly within the ministry of health.

Information dissemination should focus on getting the most difficult tasks of stewardship into the open, both to inform and to consult. Priority setting in health, discussed in Chapter 3, has only recently been conducted as a public debate in a small number of countries. The debate is often noisy and confused because it lacks rules. The ministry's role is to clarify the rules: priority setting should take into account the burden of illness, the cost-effectiveness of available interventions, and the scale of existing action to address the problem. And it can listen to expressed preferences regarding the value basis of priority setting, as occurred in Sweden and Oregon, USA *(25)*. The rights and obligations of different players can be clarified through dissemination strategy in ways which reinforce the concerns of policy. For example, in situations with prevalent informal charging for care, providers may at least be required to display publicly the full costs of procedures, and patients invited to register complaints where additional charging occurs.

Many countries have already taken steps to safeguard the rights of patients, as shown in Box 6.7. Even without legislation, the notion of patients' rights and providers' obligations can be promoted and given substance by active stewardship. Where particular practices and procedures are widely practised and known to be harmful, the ministry as a steward has a clear responsibility to combat these with public information. Pharmaceutical sales by unregistered sellers, the dangers of excessive antibiotic prescription and of non-compliance with recommended dosages should all be objects of public stewardship, with active support from information campaigns targeted at different actors – patients, the providers in question, and local health authorities. Box 6.8 illustrates how for one key input – pharmaceuticals – actions at different levels are needed.

Box 6.8 Towards good stewardship – the case of pharmaceuticals

Most curative and many preventive health actions depend on medicines. However, medicines also involve powerful economic interests. In poor countries over 50% of household expenditure on health is spent on medicines: within government health budgets pharmaceuticals are usually the second largest item after wages. In industrialized countries drug costs are increasing by 8–12% per year, much faster than consumer prices. Many stakeholders are concerned with pharmaceuticals: manufacturers (both research-based and generic), consumer groups, professional associations, service providers of all types, donor agencies, and different departments of government.

The health system must make essential drugs available and affordable to all who need them, ensure that drugs are of good quality, and that they are used in a therapeutically sound and cost-effective way. The following are the core roles of central government to achieve these objectives:

- ensuring the quality of medicines through effective regulation including systems for market approval, quality assurance, licensing of professionals and inspection of facilities;
- ensuring the affordability and adequate financing of essential drugs for the poor and disadvantaged;
- procuring essential drugs for public sector providers, or establishing central tendering with prime vendor or delivery contracts for regional and lower levels;
- developing and supporting a national programme to promote rational and cost-effective drug use by health workers and the public;
- coordinating the activities of all stakeholders through the development, implementation and monitoring of a national policy.

Good stewardship at the international level includes supporting governments in fulfilling these core roles. External support may also be useful in the following areas:

- nongovernmental organizations, professional and consumer networks, religious bodies, universities, and private providers need information support and management training;
- national pharmaceuticals manufacturers need training, support and supervision in good manufacturing practice;
- regulations, training programmes and financial incentives are needed to encourage rational drugs use in the private sector.

The international community must ensure that the overwhelming health problems of the world's poorest countries feature on the agenda of drug manufacturers; mechanisms such as the Global Alliance on Vaccine Initiatives and the Medicines for Malaria Venture are intended to do this.

In the technically and politically complex field of pharmaceuticals, external agencies may need guidance on the best types of support to give developing countries. For example, guidelines for good drug donation practice[1] are available to maximize the value of donated pharmaceuticals.

[1] *Guidelines for drug donations, 2nd ed*. Geneva, World Health Organization, 1999 (document WHO/EDM/PAR/99.4).

Broader information allowing comparisons of per capita health resources, and of health goal attainment by geographical area, are a way of spreading the stewards' concern about avoidable variations by creating public awareness. Without such awareness based on reliable information, government lacks an effective bulwark against incompetence and corruption in the form of personal or professional capture.

A recent study analysing initiatives in India, by the state governments of Delhi, Punjab and Rajasthan, to attract private investors into joint hospital ventures illustrates how the tasks of stewardship matter *(26)*. All three schemes failed: no joint venture resulted. Different factors came into play in each situation, but the report identifies failure in each of the above tasks of stewardship in the overall explanation. It specifically identifies:

- inadequate policy on the role of the private sector by each state;
- insufficient consultation with relevant stakeholders, and absence of mechanisms for coordination among the parties concerned;
- absent, weak or inappropriate regulation machinery related to private providers;
- ineffective performance monitoring and information sharing arrangements, making public–private partnerships vulnerable to inefficiency and high cost.

Requisite skills for carrying out these tasks were found to be lacking in the health departments of all three states.

Strategies, roles and resources: who should do what?

The previous sections discussed three basic tasks of stewardship and the principal role of the ministry of health in ensuring their implementation. This section considers *how* those tasks can be implemented, and what are the potential contributions of other groups and agencies to overall stewardship.

"Virtual" health systems, as described in Chapter 3, comprise many autonomous and semi-autonomous actors in different sectors of the economy, as well as those directly under the full authority of the ministry. The skills and strategies which have traditionally controlled public bureaucracies are inadequate for stewardship of contemporary health systems. Entrepreneurial, analytical and negotiating skills are needed to steward such systems. "Virtual" systems are held together by a shared policy vision and information, and by a variety of regulatory and incentive systems designed to reward goal achievement and punish capture, incompetence and fraud. An informed population of consumers helps in holding such a health system together.

Better stewardship requires an emphasis on *coordination, consultation and evidence-based communication* processes. For the ministry of health to understand the principal challenges to better performance it must have a full picture of what is happening. Initial engagement of other departments (education, finance, transport) may most effectively be done through government as a whole, rather than in bilateral approaches by the ministry of health, but the latter will need to provide evidence and continue the dialogue. Ministries of health can learn much from changing practice in other parts of government, where public roles have already greatly altered. And relevant international experience provides a major source of potential learning.

Ministries need to listen to a wider range of voices and to put the public case on health priorities and strategies forcefully and imaginatively. To ensure that the tasks of steward-

ship are carried out and delegated, the identity of all health actors should be known to the ministry of health, and regular lines of communication established. Special studies have sometimes been necessary *(26)* to assess the scale and content of private practice in health.

The ministry of health also needs communication capacity and strategies for ensuring that the media are aware of the health system's goals and progress or obstacles. Some ministries of health have offices responsible for private sector, media, and cross-sector liaison with other health players, and for consumer and public relations. In Thailand's experience, for example, skilful use of national media ensures that the Ministry of Public Health can amplify its own influence by judicious use of support (see Box 6.9).

Consultation is often a widely neglected part of the policy process, both in policy formulation and in implementation. A lack of consultation led to a public campaign of opposition by the British Medical Association to the reforms in Britain's national health service, introduced by the Thatcher administration in 1989 *(27)*.

Kenya introduced its cost-sharing policy with substantial increases in user fees in December 1989. The press featured a number of hardship stories as a result of cost-sharing. The following August, a presidential announcement was made abandoning the policy. Fee policy was subsequently re-introduced in a phased way, beginning at specialist hospitals, with a much greater emphasis on staff training and familiarizing the public *(28)*. Health system reforms in the United Republic of Tanzania and Zambia benefited from the Kenyan experience. They made great efforts to ensure that the reform programme was debated publicly, and that health workers were also involved in decisions about the reform process *(29)*. Finland's system of democratically elected municipal health boards is cited as a good example of how to ensure citizens' participation and empowerment in health *(30)*.

In many settings a sensible strategy to improve information for stewardship would be to begin with a review of key information needs for performance monitoring; develop strate-

Box 6.9 Thailand: the role of the media in health system stewardship

Thailand is becoming a more open and responsive society. The 1997 Constitution foresees full democratic participation by the individual, community and civic society. The Public Organization Act (1999) grants government units autonomy, in close collaboration with civic society. Several public hospitals are being given autonomous status. Remaining public hospitals are setting up boards consisting of local lay members.

The Public Information Act (1998) further promotes transparency and social accountability through guaranteed citizen rights to government information. Amidst these reforms the media have played an important role in reflecting the public needs, and have helped in shaping several key health policies. A Council of Journalists sets standards for ethical conduct and fosters balanced public information in the media. Regular public opinion polls help serve as an effective interface between the public and policy-makers.

The Ministry of Public Health has a long history of engaging support from many stakeholders, including the press and broadcasting media. Recent efforts have mobilized medical bodies and nongovernmental organizations to put sustained and public pressure on the government to promulgate two important laws, the Tobacco Products Control Act (1992) and the Non-smoker Health Protection Act (1992). This legal framework aims towards eventually achieving a smoke-free Thai society.

Traffic accidents are Thailand's leading cause of death. Intensive messages by radio and television during the highest traffic peaks have significantly reduced deaths and injuries in recent years. Other health activities such as physical fitness, healthy diet, and traditional medicines have been covered by radio channels providing evidence-based and balanced information. The media and nongovernmental organizations have set up HIV/AIDS counselling, and the Ministry of Public Health has set up a help line to provide counselling on stress and suicide prevention, as well as a telephone hot line aiming at consumer protection.

The media reflect public dissatisfaction with both public and private hospital care. At the same time the Health Systems Research Institute (HSRI) coordinates a national forum on hospital quality improvement and accreditation and is pressing for an independent hospital accreditation body. HSRI also has a programme to guide journalists wanting to specialize in the health field.

Thus, Thailand's media play an important role in health system stewardship, as information providers and change agents, linking the general public, consumer groups, civic society, the research community, professional organizations and the government in improving health of the people in a participatory way.

Contributed by Viroj Tangcharoensathian, Health Systems Research Institute, Bangkok, Thailand.

gies for improving data collecting; review the core policy vision and messages; review existing organizational and incentive arrangements; and establish coordination and communication processes. A massive investment in management information systems will not, of itself, bring about better stewardship. Advocacy strategies, too, are needed to influence other branches of government and non-government health system players. The scope of regulation has to be broader, bringing in and giving voice to consumers, private providers, professional associations, and external assistance agencies.

An improved information base for policy creates a major strength for communication. On occasions this may require a higher profile by the ministry of health – in its dealings with the ministry of finance, or with donors, for instance. But the health ministry may get its messages across more forcefully when it uses other channels, such as the press, television and radio, academic institutions, and professional or consumer groups, to put its case. The ministry of health has to recognize all those primarily motivated by health gain – whether they are in the public or private sector – as its partners in the health system. Regular communication is one of the fibres which holds the system together.

The wide range of partners involved in a health system gives rise to an important question: who should do what?

Much of the preceding has been concerned with the role of the ministry of health. But the local context and particular issue determine who the stakeholders are – who stands to win or lose by a line of policy. Seeking the support of stakeholders is an important task for the ministry of health. The political feasibility of policy depends on: the power of the players; their position; the intensity of their commitment; and their numbers *(31)*. As the agency responsible for formulating policy and steering its implementation, the ministry of health needs to bear this in mind.

Within the public sector, social security organizations and the education system are prominent among bodies whose activities affect health. The ministry of health can influence these either by dealing directly with them, or by working through higher political channels to ensure that health policies are supported, not contradicted by the practice of other parts of the public sector.

Where private sector activities are motivated by health gain, as for example in research and development in pharmaceuticals, medical technology, or motor vehicle safety, health ministries should at least ensure that their information and communication strategies include these partners. Where such inputs are internationally traded, regional and global organizations concerned with health should support the stewardship role of individual ministries of health by bringing governments, industry and consumer representatives together, promoting guidelines for good practice, and providing international information, monitoring and comparison.

Professional organizations can often play a much bigger role in self-regulation. With judicious support, ministries of health can assist professional bodies assume some of the burden of stewardship, such as licensing, credentials checking, and in-service training.

Consumer interests in health are weakly protected in countries at all levels of development. In countries such as Canada, New Zealand and Sweden, however, where public knowledge about health is taken seriously by government, numerically powerful and committed consumer groups have sprung up. Although they may oppose the ministry of health on some issues, on others the position of organized consumers will reinforce that of the ministry in dealings with input suppliers or professional groups. Modern communication strategies allow fast, easy access to health information in presentations suitable for non-

specialists: ministries should be energetic in making these resources available to the public.

External agencies, both public and nongovernmental, have special responsibilities in assisting stewardship. This report is directed to them and their expert advisers as well as to national policy-makers. External agencies have a dual mandate: they are accountable to their domestic chiefs and constituency as well as to governments in the developing countries in which they work. A focus on self-contained projects was a compromise which for many years made this dual mandate workable. Donors found projects an easy way to demonstrate their work to the home audience, and well-chosen projects also met a development priority need for the host country. The shift which began in the 1980s to more systemic support, through programmes and subsequently sector approaches, makes it much easier for external agencies to take a supportive role in government-led stewardship. Some donors now have a voice in the development of policy and strategy, and are abandoning their right to pick individual development projects in exchange for a fuller partnership with aid-receiving governments *(32)*.

With their technical knowledge and resources, external agencies can ensure that the tasks of stewardship are recognized, and that the supporting investments in new skills needed to establish this function can be given priority. For stewardship is the irreducible core of public responsibility: government has to do this job and do it properly. Without stewardship, market failure and the exclusion of poorer consumers from access are ever-present dangers.

Donor agencies have a special responsibility not to make the stewardship role more difficult by acting in a semi-autonomous way. Donors – often numerous and anxious to ensure that their individual concerns are expressed in policy – can too easily find themselves at cross-purposes with each other and with government, compounding the difficulty of setting clear lines of policy *(33)*. In this respect, the concept of sector-wide approaches offers a promising model. It puts government at the helm and establishes a dialogue on priorities, strategy and common implementation plans.

What are the challenges?

Many countries are falling far short of their potential, and most are making inadequate efforts to achieve responsiveness and fairness in financing. There are serious shortcomings in the performance of one or more functions in virtually all countries.

These failings result in very large numbers of preventable deaths and disabilities in each country; in unnecessary suffering; in injustice, inequality and denial of basic rights of individuals. The impact is undoubtedly most severe on the poor, who are driven deeper into poverty by lack of financial protection against ill-health.

Within all systems there are countless highly skilled, dedicated people working at all levels to improve the health of their communities. There is little argument that health systems in general have already contributed enormously to better health for most of the global population during the 20th century. As the new century begins, they have the power and the potential to achieve further extraordinary improvements.

Unfortunately, health systems can also misuse their power and squander their potential. Poorly structured, badly led, inefficiently organized and inadequately funded health systems may do more harm than good.

The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society in its stewardship. The

careful and responsible management of the well-being of the population – stewardship – is the very essence of good government. The health of the people is always a national priority: government responsibility for it is continuous and permanent.

Stricter oversight and regulation of private sector providers and insurers must be placed high on national policy agendas. Good policy needs to differentiate between providers (public or private) who are contributing to health goals, and those who are doing damage or having no effect, and encourage or sanction appropriately. Policies to change the balance between providers' autonomy and accountability need to be monitored closely in terms of their effect on health, responsiveness and the distribution of the financing burden.

Consumers need to be better informed about what is good and bad for their health, why not all of their expectations can be met, but that they still have rights which all providers should respect. But consumer interests in health are weakly protected in countries at all levels of development. The notion of "patients' rights" should be promoted and machinery established to investigate violations quickly and fairly.

The most obvious route to increased prepayment is by raising the level of public finance for health, but this is difficult if not impossible for poor nations. But governments could encourage different forms of prepayment – job-based, community- based, or provider-based – as part of a preparatory process of consolidating small pools into larger ones. Governments need to promote community rating, a common benefit package and portability of benefits among schemes, and to use public funds to pay for the inclusion of poor people in such schemes. Insurance schemes designed to expand membership among the poor are an attractive way to channel external assistance in health, alongside government revenue. Alert stewardship is needed to prevent the capture of such schemes by lower-risk, better-off groups.

Mechanisms are needed in most low and middle income countries to separate revenue collection from payment at the time of service utilization, thus allowing the great majority of finance for health to come through prepayment. More pooling of finance allows cross-subsidies from rich to poor and from healthy to sick. Risk pooling strategies in each country need to be designed to increase such cross-subsidies. Payments to service providers of all types need to be redesigned to encourage providers to focus on achieving health system goals through the provision of cost-effective interventions to people with common conditions amenable to prevention or care.

On an international level, the largely private pharmaceutical and vaccine research and development industry must be encouraged to address global health priorities, and not concentrate on "lifestyle" products for more affluent populations.

Serious simultaneous imbalances exist in many countries in terms of human and physical resources, technology and pharmaceuticals. Many countries have too few qualified health personnel, others have too many. Health system staff in many low income nations are inadequately trained, poorly paid, and work in crumbling, obsolete facilities with chronic shortages of equipment. One result is a "brain drain" of talented but demoralized professionals who either go abroad or move into private practice.

Overall, governments have too little of the necessary information to draw up effective strategies. National health accounts offer an unbiased and comprehensive framework from which overall situation analyses can be made, and trends monitored. They should be much more widely created and used.

How to improve performance

Stewardship is needed to achieve better health system performance. The following conclusions on stewardship apply in many industrialized countries as well as in low and middle income nations.

Stewardship of the health system is a government responsibility. To discharge it requires an inclusive, thought out policy vision which recognizes all principal players and assigns them roles. It uses a realistic resource scenario and focuses on achieving system goals. Intelligence requires a selective information system on key system functions and goal achievement, broken down into important population categories, such as income level, age, sex and ethnicity. Stewardship also calls for the ability to identify the principal policy challenges at any time, and to assess the options for dealing with them. Influence requires regulatory and advocacy strategies consistent with health system goals, and the capacity to implement them cost-effectively.

Service provision. Private provision of health services tends to be larger where countries' income levels are lower. But poorer countries seldom have clear lines of policy towards the private sector. They thus have important steps to take in recognizing the diverse forms of private provision and developing communications with the different groups of private providers.

In order to move towards higher quality care, a better information base on existing provision is commonly required. Local and national risk factors need to be understood. Information on numbers and types of providers is a basic – and often incompletely fulfilled – requirement. An understanding of provider market structure and utilization patterns is also needed, so that policy-makers know why this array of provision exists, as well as where it is growing. Information on the interventions offered and on major constraints on service implementation are also relevant to overall quality improvement.

An explicit, public process of priority setting should be undertaken to identify the contents of a benefit package which should be available to all, including those in private schemes, and which should reflect local disease priorities and cost-effectiveness, among other criteria. Rationing should take the form of excluding certain interventions from the benefit package, not leaving out any people. Supporting mechanisms – clinical protocols, registration, training, licensing and accreditation processes – need to be brought up to date and used. A regulatory strategy which distinguishes between the components of the private sector, and includes the promotion of self-regulation, needs to be developed. Aligning organizational structures and incentives with the overall objectives of policy is a task for stewardship, rather than one left only to service providers.

Monitoring is needed to assess behavioural change associated with decentralizing authority over resources and services, and the effects of different types of contractual relationships with public and private providers. Striking a balance between tight control and the independence needed to motivate providers is a delicate task, for which local – not textbook – solutions must be found. Experimentation and adaptation will be necessary in most settings. A supporting network for exchanging information will be necessary to create a "virtual health system" from a large set of semi-autonomous providers.

In middle income countries, where health service delivery is often segmented into parallel systems, quality-based competition among providers may be encouraged. A combination of public subsidy and regulated private providers, through extended insurance coverage

(Argentina, Colombia), and contracting directly to ministry providers (Brazil) has been implemented with some success. And in the high income economies, better regulation of private providers and greater attention to responsiveness (United Kingdom) and control of wastage due to over-prescribing, overuse of diagnostic technology and excessive interventions (France, Japan, the United States) are often needed.

Resource generation. Stewardship has to monitor several strategic balances and steer them in the right direction when they are out of equilibrium. A system of national health accounts (NHAs) provides the essential information base for monitoring the ratio of capital to recurrent expenditure, or of any one input to the total, and for observing trends. NHAs capture foreign as well as domestic, public as well as private inputs and usefully assemble data on physical quantities (numbers of nurses, CT scanners, district hospitals) as well as their costs. NHAs in some form now exist for most countries, but they are still often rudimentary and are not yet widely used as tools of stewardship.

NHA data allow the ministry of health to think critically about input purchases by all fundholders in the health system. The concept of strategic purchasing, introduced in Chapter 5, does not only apply to the purchase of health care services: it applies equally to the purchase of health system inputs. Where inputs such as trained personnel, diagnostic equipment, and vehicles are purchased directly with public funds the ministry of health has a direct responsibility to ensure that value for money is obtained – not only in terms of good prices, but also in ensuring that effective use is made of the items purchased.

Where health system inputs are purchased by other agencies (such as private insurers, providers, households or other public agencies) the ministry's stewardship role consists of using its regulatory and persuasive influence to ensure that these purchases improve, rather than worsen, the efficiency of the input mix. This does not, however, entail comprehensive central planning and programming. The role of stewardship in systems with a great deal of decentralized spending authority is to set the rules, rather than to adjudicate every decision. In Brazil, rules for allocating funds to states, prices for services, and reviews of major investment decisions have been put into practice *(34)*. The central ministry may have to decide on major capital decisions, such as tertiary hospitals or medical schools. But regional and district health authorities should be entrusted with the larger number of lower-level purchasing decisions, using guidelines, criteria and procedures promoted by central government.

Ensuring a healthy balance between capital and recurrent spending in the health system requires analysis of both public and private spending trends and a consideration of both domestic and foreign funds. The budgetary information usually available to the ministry of health tells only part of the story. A clear policy framework, incentives, regulation and public information need to be brought to bear on important capital decisions in the entire system to counter ad hoc decisions and political influence.

In the field of human resources, similar combinations of strategy have had some success in tackling the geographical imbalances common within countries. In general, the content of training needs to be reassessed in relation to workers' actual job content, and overall supply often needs to be adjusted to meet employment opportunities. In countries such as China where the social return to medical training is negative, training institutions are being considered for privatization or closure. Certainly, public subsidies for training institutions often need to be reconsidered in the light of strategic purchasing. Re-balancing the intake levels of different training facilities is often possible without closure, and might free resources which could be used to retrain clearly surplus health workers (for example, specialist doctors in Egypt) in scarcer skills.

Stewardship of pharmaceuticals and vaccine inputs consists, at international level, of influencing the largely private research and development industry to address global health priorities. At national level the key tasks are to ensure cost-effective purchasing and quality control, rational prescribing, and that consumers are well informed. Health financing strategy also needs to ensure that poor people, in particular, get the drugs they need without financial barriers at the time they are sick.

Major equipment purchases are an easy way for the health system to waste resources, when they are underused, yield little health gain, and use up staff time and recurrent budget. They are also difficult to control. All countries need access to technology assessment information, though they do not necessarily need to produce this themselves. The stewardship role lies in ensuring that criteria for technology purchase in the public sector (which all countries need) are adhered to, and that the private sector does not receive incentives or public subsidy, including the subsidy inherent in being able to sell the services of that equipment to government, for its technology purchases unless these further the aim of national policy.

Providers frequently mobilize public support or subscriptions for technology purchase, and stewardship has to ensure that consumers understand why technology purchases have to be rationed like other services. The public case may be helped by identifying the opportunity cost of additional technology in terms of other needed services.

Health system financing. In all settings, very high levels of fairly distributed prepayment, and strategic purchasing of health interventions are desirable. Implementation strategies, however, are much more specific to each country's situation. Poor countries face the greatest challenge: most payment for health care is made at the time people are sick and using the health system. This is particularly true for the poorest people, who are unlikely to have any prepaid health insurance and who are frequently unable to benefit from subsidized services. Out-of-pocket payment for care, particularly by the poor, should not be relied on as a long-term source of health system finance.

Perhaps the most obvious route to increased prepayment is by raising the level of public finance for health, but two immediate obstacles appear. The poorest countries as a group manage to raise less, in public revenue, as a percentage of national income than middle and upper income countries. Indeed, this lack of institutional capacity is a facet of their poverty. And ministries of finance in poor countries, often aware that the existing health system is performing poorly, are sceptical of its claims on public revenues. Where there is no feasible organizational arrangement to boost prepayment levels, both donors and governments should explore ways of building enabling mechanisms for the development or consolidation of large risk pools. Insurance schemes designed to expand membership among the poor offer a path for government – with external funding partners – to a rapid improvement in the health of the most vulnerable.

In middle income countries substantial mandatory, income and risk-based schemes often coexist. The policy route to a fair prepaid system lies through strengthening such schemes, again ensuring increased public funding for the inclusion of poor people. Expansion of the beneficiary base through subsidies and merger of pre-existing schemes was how national coverage grew from small-scale schemes in Germany, Japan and the Republic of Korea.

Although most industrialized countries already have very high levels of prepayment, some of these strategies are also relevant to them. For its income level, the United States has an unusually high proportion of its population without health insurance protection: a

combination of the above strategies will be necessary if the level and fairness of financial protection is to be substantially improved in the decade ahead.

To ensure that prepaid finance obtains the best possible value for money, strategic purchasing needs to replace much of the traditional machinery linking budget holders to service providers. Budget holders will no longer be passive financial intermediaries. Strategic purchasing means ensuring a coherent set of incentives for providers, whether public or private, to encourage them to offer priority interventions efficiently. Selective contracting and the use of several payment mechanisms are needed to set incentives for better responsiveness and improved health outcomes.

This report has broken new ground in presenting for the first time an overall index of national health systems' attainment, and an index of performance relative to potential. These are based on the fundamental goals of *good health, responsiveness to people's expectations* (where both level and distribution matter for each of these goals), and *fairness of contribution to financing the health system*. Achieving these goals depends on the effectiveness of four main functions: *service provision, resource generation, financing,* and *stewardship*.

The preliminary ranking of countries in terms of their health system performance is revealing. It suggests that, at very low levels of health expenditure, performance is both systematically worse and much more varied than at high spending levels, even when performance is judged relative to a country's human resources and how much is spent on health. Clearly the countries with limited resources and severe health problems present the greatest needs: to understand why health systems do not achieve as much as it seems they might, and to help them attain their potential. The findings reported here also show that while much achievement – particularly for the level of health and some aspects of responsiveness – depends greatly on how much a system spends, it is possible to achieve considerable health equality, respect for persons, and financial fairness even at low resource levels. Some systems achieve much more than others in these important respects.

Much more work lies ahead for all concerned to improve the concepts and generate the data on national health system performance. A widespread refocusing of policy is strongly suggested.

Service delivery, resource mix, health financing and, above all, stewardship all matter greatly. The better performance of these four common functions makes substantial gains in goal achievement possible in countries at all levels of development. The poor will be the principal beneficiaries.

References

1. **Saltman RB, Ferroussier-Davis O.** On the concept of stewardship in health policy. *Bulletin of the World Health Organization*, 2000, **78**(6) (in press).
2. **Osborn D, Gaebler T.** *Reinventing government.* Reading, MA, Addison Wesley, 1993.
3. **Saltman RB, Figueras J, Sakellarides C, eds.** *Critical challenges for health care reform in Europe.* Buckingham, UK, Open University Press, 1998 (State of Health Series).
4. **Bossert T et al.** Transformation of ministries of health in the era of health reform: the case of Colombia. *Health Policy and Planning,* 1998, **13**(1): 59–77.
5. **Ogunbekun I et al.** Private health care in Nigeria: walking the tightrope. *Health Policy and Planning,* 1999, **14**(2): 174–181.
6. **Bennett S et al.** *Health insurance schemes for people outside formal sector employment.* Geneva, World Health Organization,1998 (unpublished document WHO/ARA/CC/98.1).

7. **Killingsworth J et al.** Unofficial fees in Bangladesh: price, equity and institutional issues. *Health Policy and Planning,* 1999, **14**(2): 152–163.
8. **Halik J.** Respecting patients' rights in hospitals in Poland. In: *Health sector reform in Central and Eastern Europe: current trends and priority research: a FICOSSER research meeting, Velingrad, Bulgaria, 2–3 October 1998.* Warsaw, National Centre for Health System Management, 1999.
9. **Schuster M et al.** How good is the quality of good health care in the United States? *The Milbank Quarterly,* 1998, **76**(4): 517–563.
10. **Bennett S, McPake B, Mills A, eds.** *Private health providers in developing countries: serving the public interest?* London, Zed Books, 1996.
11. **Salinas H, Lenz R.** *Las no reformas de salud en Latinoamérica: razones que explican su fracaso* [*Non-reforms of health in Latin America: reasons explaining their failure*]. Santiago de Chile, 1999 (in Spanish).
12. **Nittayaramphong S, Tangcharoensathien V.** Thailand: private health care out of control? Health *Policy and Planning,* 1994, **9**(1):31–40.
13. **Turshen M.** *Privatizing health services in Africa*. New Brunswick, New Jersey, Rutgers University Press, 1999.
14. **Chollet DJ, Lewis M.** Private insurance: principles and practice. In: Schieber G, ed. *Innovations in health care financing*. Washington, DC, The World Bank, 1997 (World Bank Discussion Paper No. 365).
15. **Musgrove P.** *Public and private roles in health: theory and financing patterns*. Washington, DC, The World Bank, 1996 (World Bank Discussion Paper No. 339).
16. **Hsiao WC.** Abnormal economics in the health sector. *Health Policy*, 1995, **32**:125–139.
17. **Van Lerberghe W et al.** Reform follows failure: unregulated private care in Lebanon. *Health Policy and Planning,* 1997, **12**(4): 296–311.
18. **Borren P, Maynard A.** The market reform of the New Zealand health care system: searching for the Holy Grail in the Antipodes. *Health Policy*, 1994, **27**(3): 233–252.
19. **Russel S, Attanayake N.** *Sri Lanka: reforming the health sector. Does government have the capacity?* Birmingham, UK, University of Birmingham, 1997.
20. **Bennet S, Ngalande-Banda E.** *Public and private roles in health. A review and analysis of experience in sub-Saharan Africa*. Geneva, World Health Organization, 1994 (Current Concerns, ARA Paper No. 6, document WHO/ARA/CC/97.6).
21. **Broomberg J.** *Health care markets for export? Lessons for developing countries from European and American experience*. London School of Hygiene and Tropical Medicine, Department of Public Health and Policy, 1994.
22. **WHO Action Programme on Essential Drugs.** *Public–private roles in the pharmaceutical sector.* Geneva, World Health Organization, 1995 (unpublished discussion paper).
23. **Zurita B et al.** *Structural pluralism as a tool for equity, quality and efficiency in healthcare in Mexico: the role of FUNSALUD*. 2000 (unpublished paper).
24. **Smithson P.** Quarts into pint jugs? The financial viability of health sector investment in low income countries. *Health Policy and Planning,* 1995, **10**(Suppl.): 6–16.
25. **Ham C.** Priority setting in health care: learning from international experience. *Health Policy*, 1997, **42**(1): 49–66.
26. **Bhat R.** *Public–private partnerships in the health sector: the Indian experience*. 2000 (unpublished paper).
27. **Robinson R, Le Grand J, eds.** *Evaluating the NHS reforms*. London, King's Fund Institute, 1994.
28. **Quick JD, Musau SN.** *Impact of cost sharing in Kenya: 1989–1993. Effects of the Ministry of Health Facility Improvement Fund on revenue generation, recurrent expenditures, quality of care, and utilization patterns.* Nairobi, Management Sciences for Health, 1994.
29. **Kalumba K.** *Towards an equity-oriented policy of decentralization in health systems under conditions of turbulence: the case of Zambia*. Geneva, World Health Organization, 1997 (document WHO/ARA/97.2).
30. **Calnan M, Halik J, Sabbat J.** Citizen participation and patient choice in health reform. In: Saltman RB, Figueras J, Sakellarides C, eds. *Critical challenges for health care reform in Europe*. Buckingham, UK, Open University Press, 1998 (State of Health Series).
31. **Reich M.** In: *Diagnostic approaches to assessing strategies, weaknesses and change of health systems.* Washington, DC, Economic Development Institute, The World Bank, 1998 (Flagship Module 2).
32. **Hay R.** *International aid: economics and charity*. Oxford, Oxford Policy Institute, 2000 (Oxford Policy Brief No. 1).
33. **Walt G et al.** Health sector development: from aid coordination to resource management. *Health Policy and Planning*, 1999, **14**(3): 207–218.
34. *Brazil: social spending in selected states.* Washington, DC, The World Bank, 1999 (World Bank Report BR-17763: Chapter 3).