

National preventive plan: putting stewardship into practice

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ABSTRACT

According to the WHO-European region Tallin-Charter, Stewardship (S) is on the health agenda of many European countries and in particular of those involved in the devolution of powers, as is the case of Italy. Many observers agree that, in such cases, both the configuration and the application of state authority in the health sector should be realigned so as to achieve desired policy objectives.

We present an experience of what could be meant by S in practice, applied to the field of planning preventive interventions.

The Italian National Preventive Plan 2010-2012 is a comprehensive Plan dealing with many areas of prevention. For all these areas, the main health objectives, the specific regional goals and the intervention - called "central" actions- that the Ministry of Health (MoH) is in charge of carrying out in order to support regional preventive programs, are stated in this Plan. In order to carry out its task, the MoH has referred to the model of stewardship and has reconsidered its role. Therefore, the MoH has matched the sub-functions of S according to the model outlined by Travis et al, and the prior actions that have been proposed by local and national governments, as the main aspects of how to deal with the governance of prevention. Overall, we experienced that the S framework is a suitable and helpful tool to tackle what the challenge of national planning, in the scenario of devolution, is. In doing so, we have learnt some practical lessons about the running of the system and about how to plan according to stewardship, in particular.

Among these, given that the steward's most specific responsibility in planning is to assure stewardship, a sound capacity building is needed as a cornerstone in evolving the culture of the NHS. Furthermore, in order to put this effectively into practice, the Steward must be able to measure S functions, and putting in practice a S model needs international comparison and cultural growth.

Key words: Stewardship, Prevention, Health systems, Planning

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INTRODUCTION

Italy has a National Health Service (NHS) providing universal health care coverage. From the 1990s until 2001, the NHS decentralized health service management from the central to the regional level of government. This process was finalized in 2001 with a modification of Italian Constitution.

As a result, today, the central government, and the Ministry of Health (MoH) in particular, is responsible for ensuring the general objectives and fundamental principles of the NHS; while the regional governments, through their regional health departments, are responsible for ensuring the delivery of a nationally-defined benefit package (or LEA) through a network of public and private service providers (clinics and hospitals).

The benefit package is financed primarily by earmarked central and regional taxes. The Regions may choose to provide additional health care services to their own resources as well.

According to the general architecture of the health system, planning is a shared process that involves the national and the regional governments; to finalize any Plan, a statement from the Conferenza Stato Regioni (State-Regions Conference), which is the highest level decision body on this matter (apart, of course, of the Parliament), is requested.

In this paper we present an experience of what the role of MoH in dealing with the issue of governance arising from the scenario of devolution could mean, particularly discussing the use of S framework in practice and namely in the field of planning preventive interventions, as is the case of The National Preventive Plan (NPP).

The National Preventive Plan and the issue of governance

The NPP 2010-2012 is a comprehensive Plan dealing with all aspects of prevention and namely: predictive (individual) medicine; illness prevention for general population (vaccination, healthy lifestyle, etc); prevention for specific groups at risk (cancer, diabetes, cardiovascular diseases etc); prevention of relapses.

For all these areas, the main health objectives have been stated and the specific regional goals for each of these have been articulated.

The main innovation has been to list all the interventions - called "central" actions- that the MoH is charged with carrying out in order to support regional preventive programs. According to this framework, the MoH and the Regions have to put in practice coordinated interventions in order to achieve the health goals and to practice their own responsibility in guaranteeing the population's health.

At the end, the Plan listed 20 topics and 103 "central" actions for which the MoH is in charge (1).

Of course, such a huge number of actions to put in place, and their wide heterogeneity, deserved a systematic approach by the MoH. Such an approach could only be defined by re-considering the MoH's role in the scenario of devolution.

In recent scientific literature, considerable attention has been focused on the role that the state plays within the health sector.

The ongoing debate covers a wide variety

of technical and political dimensions, ranging from policy formulation to implementation, from entrepreneurial innovation to regulatory restrictions, from financial efficiency to social equity, and from public to private ownership of institutions (2). However the most challenging aspect that has been focused on is the need to make changes in state behavior in order to produce better health-related outcomes.

That said, one must acknowledge that the previous rules of governance, based upon a more "vertical" relationship, are basically insufficient in the new scenario.

In fact, nearly all observers agree that both the configuration and the application of state authority within the health sector should be realigned so as to achieve desired policy objectives. And that was exactly the core-need required with Italian devolution, a need shared with most other European countries.

To help Countries in dealing with such an issue, the WHO, in one of its most seminal annual reports, introduced the concept of stewardship (S) to the health sector, identifying it as one of the four major functions of health systems worldwide (3), and even more important than the other functions such as: delivering health services, financing the system, and creation of resources.

The WHO defined S as the "careful and responsible management of the well-being of the population". Subsequently, a series of reports and articles further expanded the concept and defined its conceptual framework. Travis et al's framework for stewardship (4) is arguably the most referenced and comprehensive of these in the health system literature.

Following these efforts, S has been on the health agenda of many countries worldwide.

Most notably, in June of 2008, it was included in the Tallinn Charter, which was adopted at the

WHO European Ministerial Conference on Health Systems and endorsed by all 53 Member States in the WHO European Region (5, 6), Italy included. As such, these States have committed to catalyzing the implementation of health system stewardship as a function, one can argue, of governments responsible for the welfare of populations and of 'those' concerned about the trust and legitimacy with which its activities are viewed by the general public (2).

If this is the case of the whole health system, S also has some added value for the field of prevention. In fact, all the main international policies (like Gaining Health and Health in all polices for instance) point out the important

role that many different stakeholders have in determining health outcomes, very often these stakeholders not belonging directly to the NHS as in the case of the role that individuals themselves play in determining their own health. Yet again, they focus on S as a model of governance to refer to.

In conclusion, on occasion of the implementation of the NPP, the MoH reconsidered its own role in the scenario of devolution, and reviewed how its role may be implemented. It also chose the model of S (1) that it had previously accepted when signing the Tallin Charter.

Learning stewardship and providing tools

The leap to a stewardship model of making health policy is a complicated exercise in State leadership (2).

Supported by a conceptual foundation (Travis et al.) and Charter, today, European countries have begun to understand the practical means of S.

However, they have little empirical evidence to support or guide its implementation. Moreover, they lack relevant data and information for its proper measurement. The reason for this is two-fold: (i) stewardship is a fairly new concept to health systems, and (ii) its theory has not reached an operational level. For example, concerning Travis et al.'s stewardship framework, its empirical application leaves substantial room for interpretation by the authors (7). This makes it less robust for cross-country analysis and more difficult to understand the effects of the implementation of stewardship (8). Nevertheless this frame can be a useful and practical tool, as it has been shown in a case study of Italian screening programs (8).

A pro-active use of this conceptual framework is exactly what is proposed by the MoH in order to carry out the actions which it is in charge about according to the NPP. In the following section, the process of the definition of these actions and their contents will be shown.

This process started with the 103 actions that, as cited above, the NPP recommended be carried out by the MoH and determined the practical use of the Travis framework in order to realign the actions' strategic value. The main point that emerged when discussing with regions was to set up some priorities, the key factor being to tackle the weaknesses of the system (ie: governance) as a whole.

Therefore the main outputs of this shared approach were:

- About the process: on this field, given that an agreement was reached regarding putting into practice a S framework, we experienced the way of refining and articulating both the analysis and the operational level. One thing should be kept in mind is that this process carries the need of some kind of rationalizing what has already established.
- About the contents: in Table 1 the actions we considered dealing with some most important issues are illustrated (Prior central Actions - PCAs) (9).

To make an example of what prioritizing and refining can mean, we can take a look at the PCA 1.2 (Table 1). In this case we are dealing with one of the most important and challenging issue: to generate intelligence in order to achieve effectiveness. The NPP paid a great and widespread attention to "evidence" as the basis to planning an intervention (evidence based prevention) but also to monitor interventions and, finally, to evaluate effectiveness. According to this, the NPP enlisted many "central" actions related to the "generation of intelligence". A further and deeper evaluation by the MoH and Regions has highlighted the need to have a sounder strategic approach in order to be more systemic and efficient. Therefore, we realigned our approach and the PCA 1.2 has been set up which deals with the rules, procedures and organization of all the information systems, surveillances and registries already active and those possibly needed. In this case a very important sub-function (generation of intelligence) has been "postponed" after the more important governance aspect of "Ensuring a fit between policy objectives and organizational structure and culture" had been finalized. In summary, we have an example of the interaction between S strategic approach and NPP contents and namely a "strategic realignment" of actions already decided.

But we can have further examples of this interaction, and a quick overview is provided in the following.

The sub-function "Formulating a strategic policy framework" refers to a key role played by the steward of the NHS and, in our case, the NPP. Under it, the steward should articulate a vision for the programs, as well as define goals and

TABLE 1

ITALIAN NATIONAL PREVENTIVE PLAN 2010-2012. THE PRIORITY CENTRAL ACTIONS (PCA) THE MoH IS IN CHARGE OF		
STEWARDSHIP SUB-FUNCTIONS (4)*	VALUE	PRIOR CENTRAL ACTIONS PCAs
Ensure a fit between policy objectives and organizational structure and culture	Important for the successful implementation of the health system, the steward is responsible for guaranteeing the overall architecture of the health system and its coherence with the social and cultural values of the country. As such, it should work to minimize overlapping roles, undesirable duplication of services and fragmentation within the system	1.1. Upgrade of some specific National laws (on the topics of privacy and information system, evidence-based prevention etc)
		1.2. Stato-Regioni Conference agreement on the architecture and rationalizing of preventive information system& registries & surveillance
		1.3. National GP contract in order to improve the support to NPP objectives
		1.4 Stato-Regioni Conference agreement on criteria for defining Plans
		1.5 Inter-institutional formal agreement in supporting Gaining Health
Ensure tools for implementation	It regards making sure that the appropriate tools and rules are employed for all actors of the system. As such, it is the steward's duty to ensure that its powers are coherent with their responsibilities. It must also do this for the other health system stakeholders, making certain that, while aligned for each stakeholder, the powers and responsibilities should be minimally overlapping among stakeholders. In addition to aligned powers, the steward should ensure that the system's stakeholders have at least access to the tools they need for implementation	2.1 Public Health Genomics Plan
		2.2 Support to regional governments (capacity building)
		2.3 Institutional positioning of the National Center of screening monitoring
Build coalitions and partnerships	Factors outside the main steward's realm impact on health and, so, it is prudent to build and maintain effective coalitions and partnerships, especially in a decentralized system. Compacts with health system stakeholders will help the steward promote changes in the system	3.1 Define a national framework for making alliances for central and regional NHS governments
Ensure accountability	Ensuring that system actors can be held accountable for their actions is a core value of a NHS.. In a decentralized health system, this generally means making certain that the central government is accountable to the sub-central governments as well as to the entire country's population for performing its role and responsibilities to their fullest. At the same time, the sub-central governments should also be held accountable to both the central government and to their constituents (the populations of their territories). Moreover, physicians and other health personnel are also accountable to their sub-central governments as well as their population catchments	4.1 Set up a protocol for communication in prevention
Generate intelligence	Generating intelligence for a health system is essential for creating an evidence base for decision making. When put to effective and good use, intelligence can even improve health outcomes	5.1 Survey of services' resources and processes in delivering prevention
		5.2 Study of citizens joined needs of social welfare and health services

*Note: the sixth sub-function "Formulating a strategic policy framework" is considered accomplished by the National Preventive Plan *per sé*

objectives for the short- to long-term.

Steward should clearly define the roles of the public, private and voluntary health sectors for the programs. It should also outline feasible strategies, guide the prioritization of health expenditures, and monitor the performance of sub-centrally run health services. Most of these issues are dealt with by the general structure of the NHS; the others are stated by the NPP.

So, assuming that the NPP per sé formulates, along with other institutional pillars of the NHS, the strategic policy framework for prevention in Italy, we can examine the main aspects of the remaining sub-functions.

1) Ensuring a fit between policy objectives and organizational structure and culture

This sub-function could be considered as very close to the former old vertical approach to governance because it deals with some issues related to the structure of the NHS, even to laws (like abolishing some old-fashioned, non-evidence-based rules; or smoothing the privacy regulation in order to facilitate the gathering of personal data). Nevertheless the horizontal approach has been assured, for instance, in managing some more general agreements (like GPs national contract in order to enhance their participation in prevention programs) in a joint way or in agreeing the procedures to set up further national plans, or in sharing methodologies and tools for signing inter-institution agreements in order to sustain Gaining Health.

2) Ensuring tools for implementation

It regards making sure that the appropriate tools and rules are employed regarding all actors of the system. As such, it is the steward's duty to ensure that health system stakeholders' powers are coherent with responsibilities and aligned in order to make the system more efficient.

The steward should ensure that the system's stakeholders have at least access to the tools they need for implementation, too.

The PCAs considered as belonging to this sub-function are really heterogenic, but the aim was to tackle the current most important needs of governance, not a systematic and comprehensive approach to the governance issues. So, this sub-function first of all testifies the MoH's and Regions' awareness of the most urgent issues to deal with. Secondly, we here have an example of how different the needs related to different aspects of governance could be, in terms of "state of the art".

The first action worth mentioning is the Public Health Genomics Plan. In this case the rationale is to bridge the gulf between what is already ongoing about the use of genetic tests and the lack of any governance nor strategic or operational decisions related to it. In this case, the tool to implement the NPP objectives related to genomics must be to "build the system" (technical body, criteria and standard for lab accreditation and for quality monitoring, guidelines, coordination of research, information and evaluation system etc).

In the middle of the range there are three other actions that aim to build capacity at the regional level namely the field of programming, managing and evaluating interventions and the availability of scientific basis for decision-making.

At the other edge of the range we find the action related to the National center for screening monitoring. This center is a network of the best performing regional centers in epidemiological research and service delivering related to cancer screening programs. It is also responsible, among other things, for the management of the national screening information/evaluation system, the coordination of regional screening programs, and the professionals' training. In this case, most of the technical aspects and roles have already been defined, and the challenge was to strengthen the positive roles and actions by working on the institutional positioning of the Center in order to better and more effectively embed it into governance. A quite interesting point is that, when dealing with a network, the action doesn't belong to that of making partnerships but rather to making tools for implementation available, and may thus be considered as a "brick" of the system, in this way giving an "institutional" value to a "weak" organization.

3) Building coalitions/building partnerships

Factors outside the main steward's realm impact on health and, so, it is prudent to build and maintain effective coalitions and partnerships, especially in a decentralized system.

Such partnerships or coalitions may vary on a relationship continuum that stretches from loose affiliations to legally binding relationships. The importance of involving stakeholders is even greater in the field of prevention (as mentioned above) and deserves a comprehensive approach. On this base we have enlisted some formal agreements (in the sub-function 1) with other institutions and administrative /political bodies. However, there

still remains a big number of stakeholders and a wide field of possible partnerships to manage, among these scientific societies of NHS professionals and citizens/patients associations. In order to obtain an added value, we decided to use less formal agreement at the national level (mainly for sharing principles and identifying common objectives in the frame of NPP) and to set procedures to articulate these agreements at the regional level, with the aim of guaranteeing the same opportunities all over the Country.

4) Ensuring accountability

Ensuring that system actors can be held accountable for their actions is a core value of a NHS. The culture of accountability sustains all the S model and the selected PCA as well. But we recognized a major priority to communication, given the specificity of dealing with lifestyle of population at risk and, in particular, the need for having a “communication code for prevention” to be entrusted to all the institutions possibly involved. The aim is to assure that communication can be evidence-based, of good-quality, supporting the NPP objectives, unifying the country even with some differences related to local specific contexts.

5) Generating intelligence

Generating intelligence for a health system is essential for creating evidence base decision-making. When put to effective and good use, intelligence can even improve health outcomes. Intelligence is much more than just information and a specific role of S is to identify the “needs of evidence”. The NPP, as above mentioned, pays great attention to information and the generation of intelligence related to all its macro-areas and topics. Therefore it's interesting to notice what has been focused on in setting priorities: a survey of the delivery of resources and a study of social welfare needs.

The first survey is aimed at getting evidence on the providers' side given the greater complexity of the planned interventions they face, particularly the involvement of many further subjects (for instance, cardiologists, diabetes specialists, geneticists etc) in comparison to the traditional role that the specialized Department of prevention at the local Health Units level used to play. The second study aims to tackle the complexity of needs when the well-being of citizens depends both on the NHS service and the welfare system (for instance, poorest population, severely disabled people or chronically affected

patients etc). In this case, the steward must be willing to take care of the population well-being as a whole.

CONCLUSIONS

In our opinion, in order to put S in practice several lessons can be drawn from this experience.

Firstly, the steward's most specific responsibility in planning is to assure stewardship. The usual current way to plan deals with the contents (for instance in fighting against cancer) and, at best, is aimed at applying an evidence-based decision-making and at using a sound methodological approach (internal structure and coherence of the program or project). On the basis of experts' advice, comprehensiveness is a goal frequently considered as a hallmark of quality. Nevertheless, at a national (government) level “running the system” is the very trademark of effectively governing. This is what being a good steward means. Therefore, applying all the suggested sub-functions is exactly an added value to planning, and a value based on its responsibility. Thus, we've learnt that acting along multiple strategic lines allows the whole system to better face the great complexity of prevention.

Secondly, to apply the S framework, a sound capacity building is needed and this is a cornerstone for evolving the culture of the NHS. The main barrier in acting out S is the culture of officers which is obviously conditioned by the “old” model of vertical control oriented relationships (Agency model) (2). A core aspect of this old model is considering, essentially, the content of a given intervention whilst the strategic meaning is, by default, assured by the hierarchical relationship. In the new scenario, the officers must learn how to deal with the complexity, and in particular with the possible multi-level strategic meaning, of the actions they are expected to put in practice.

Furthermore, a capacity building program is essential for generating consent. This, apparently, can tackle the basic question, highlighted by Saltman et al (2), of making the transition to ethically oriented stewardship among civil servants in state offices run in accordance with economically oriented governing. On the other side, sub-national governments very often refer to the previously dominant “vertical” model, too. Therefore the need to change culture is shared with all the stakeholders too. That means that the

system as a whole needs to improve awareness of the new frontiers that have appeared, and the availability of specific skills and tools required to move towards these new boundaries.

Thirdly, in order to effectively put into practice S, we must be able to measure it. The need for evidence is essential not only for continuing the process of implementation, but also for making S understandable. A very specific and important piece of evidence is to describe what governance actually is at the central (national) level and at the regional level as well, and what possibly it should become. The lack of specific monitoring instruments has motivated the MoH to fund/commit to the setup of such a tool.

Fourthly, putting into practice the S model needs international comparison and cultural growth. Going ahead on the basis of the shared model of S, according to the Tallin Charter, not only will make S more operational, but will also allow countries to better compare their Plans and policies. Making them more comparable scientifically will contribute to building a kind of common European culture towards public health,

which is a core aspect of the politics and well-being of different societies.

Fifthly, the room for interpretation is an opportunity. From a more theoretical point of view, putting sub-functions in place gave us an added value. The "room of interpretation" (7, 8), which can obviously be a weakness, has been an opportunity for a deeper understanding of the strategic meaning of the central actions proposed by the NPP, leading us to discuss and evaluate what we, as a system, needed and eventually have chosen.

Finally, we should be aware that we have not still a magic bullet about the governance, whilst we have to face a hard task, to manage difficult relationship with tough stakeholders, to look for innovation, to learn how to share vision and achieve common objectives. Nevertheless, the case of NPP can give us some practical cues and make us confident that S can be put in practice. From this point of view more experiences should be published in order to boost international confrontation and learning.

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