In this month's *Bulletin*

How good is your health system?

Many countries, rich and poor, are struggling to assess how well their health systems are performing and how to make them perform better. But health systems are complex and have to a large extent defied precise evaluation. Murray & Frenk (pp. 717–731) present a conceptual framework that provides a road map to the essential components of a health system and should make the task of measuring its performance less daunting. The framework starts by marking out the system's boundaries, that are based on its defining activity, i.e. actions (*health actions*) primarily intended to improve or maintain health. It then identifies the system's main goals: better health, responsiveness to the population's expectations and fair financing. Underpinning the entire workings of the system are four key functions – "stewardship" (see next paragraph), financing, provision of services and generation of resources. The framework is still evolving but its potential as a policy-making tool is already illustrated in an analysis of the performance of the health systems of all 191 WHO member states and published for the first time in WHO's *World Health Report 2000*.

Wanted – trusty steward

A new buzzword is going the rounds of health and development circles – *stewardship*. Its meaning is not clear, though. On an ethical ladder, with management on the bottom rung and administration and governance on the next two rungs above it, stewardship would be at the top. Saltman & Ferroussier-Davis (pp. 732–739) explore the history of the concept – from the selfless servant of Biblical times who managed his master's assets to the Muhtasib who regulated medical practice in pre-colonial Arab societies to the present-day Scandinavian model of the welfare state – and suggest that the term, which denotes a mix of pragmatism, efficiency, accountability, trust and regulation, could define a new role for the state in running a country's health system. By extension, WHO believes stewardship could apply to international organizations acting as "good agents" for national governments.

The woes of wealth

Life is not always a bed of roses for the healthy and wealthy. Hurst (pp. 751–760) looks at some of the problems facing health policy-makers in the 29 countries of the Organisation for Economic Co-operation and Development: an ageing population that makes disproportionately heavy demands on the health system; affluence that often goes hand-in-hand with an unhealthy lifestyle; high-tech medicine that can perform "miracles" but is costly and raises popular expectations that governments cannot always fulfil. Moreover, OECD countries cover a wide range of wealth and health status, from Mexico and Turkey with a below-average health expenditure and an above-average infant mortality rate, to the United States, the top spender on health, but not necessarily with the best performing health system. Some observers predict that with an expected further wave of high-tech medicine coming over the horizon, many OECD governments will not be able to afford their publicly funded health care systems much longer. However, there is no sign that any countries with universal health insurance cover are about to abandon that prize. Everything points to a need for greater efficiency.

Managed chaos

In the United States nine out of ten employees are enrolled in a managed health care plan – a system whereby an insurer contracts with health providers (physicians, hospitals, etc.) to deliver to members a defined set of health care services at an agreed price. Introduced in the 1980s and 1990s to stem escalating health costs and to put some order into a fragmented health delivery scene, managed care has in recent years provoked criticism that it has not produced a fall in costs but rather in the quality of care provided. Sekhri (pp. 830–844) analyses the intricate web of managed care systems operating today in the United States and shows that managed care *has* slowed the growth of health care spending *without* lowering quality of care. Other countries, particularly those coping with a possibly unmanageable mix of public and private health delivery, might see in the United States' experience elements they could apply to their own attempts at health reform.

Time to bring out-patients in from the "cold"

In developing countries, most people seeking health care turn to personal ambulatory services, most out-of-pocket spending goes on ambulatory care and most of the conditions responsible for the bulk of the disease burden, such as childhood diarrhoea, lower respiratory infection, tuberculosis, sexually transmitted diseases and acute malaria, are treated through ambulatory care. Yet, the care provided is often costly and substandard. One of the main reasons, Berman (pp. 791–802) argues, is that in many poor countries public policy ignores the need to organize ambulatory care, which is delivered through a poorly explored, largely neglected market of diverse, competitive providers. For decades governments in these countries have concentrated only on providing services directly in the hope that this would remove the problem. Instead, they should seek innovative ways of improving the provision of both public and nongovernmental ambulatory services, particularly through better financing, regulation and information.

Fresh *Perspectives*

With a lecture on "Evaluating physician competence," given in 1976 by United States public health observer Avedis Donabedian, the *Bulletin* inaugurates a new section called *Perspectives* (pp. 857–860). Frenk, in a commentary, sees this text as "a visionary contribution" that offers a glimpse "into the creative mind of one of the true giants of this field". The *Bulletin* welcomes for its *Perspectives* section viewpoints, hypotheses, commentaries on public health issues (850 words).