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Managing Public Sector Reform:

The Case of Health Care

A Report of Lecture given by
Maureen Mackintosh

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PREFACE

This policy dialogue report summarises the proceedings of a Lecture on " Managing Public Sector Reform: The Case of Health Care" delivered by Maureen Mackintosh of the Open University, UK at the Economic and Social Research Foundation in November, 1996. The Lecture was attended by **ESRF** staff, academics, health professionals, policy researchers, Government health officials and **NGOs** involved in the health sector.

MANAGING PUBLIC SECTOR REFORM:
The Case of Health Care

1.0 Introduction

The lecture , at the outset , set out its structure and content. It then proceeded to cast doubts on the technical coherence and cogency of the 'Public Management Model' by drawing on vast work that has been undertaken on the British public sector in recent years. The lecture delved on two economic models of new public management centred on the economics of regulation and institutional economics and on identifying the conflicts vis a vis these models. The lecture used the institutional model to drive the argument that what emerges from the experience of the new public management reforms, with the specific context of regulating the mixed systems of social provisioning in the in the health sector, is path dependency. In other words, the institutional model postulates that national policy regimes reap from social markets what they have planted. The choice of the health sector for the lecture was driven by the interest in the on going reform and re-organisation that is taking place in that sector in

the industrialised countries where the regulatory framework is posing new challenges for public management.

2.0 The Conventional Wisdom

There is current conventional wisdom about 'leading edge' set of reforms in the management of public services. The maxims used are the 'new public management' and 'managed competition.' These catch words are being actively promoted to reflect the shift towards new and more pragmatic approaches to management of scarce resources. The key elements of this new competitive public management model are summarised as follows:

- centralised cash limited programme budgeting at the centre; tight fiscal constraints and no off-budget expenditures (particularly on social security).
- tight targeting of social spending on primary provision and 'safety net' - style activities.

- decentralisation of management of the use of funds to (sometimes competing) semi-autonomous agencies and cost centres within public services.
- contractual and semi-contractual relations between central funders (purchasers in some fields) and those spending the funds.
- market testing of in-house public provision against external suppliers.
- use of public funds to lever in and charitable funding at agency and project levels.
- allowing financial viable activities to be under-taken by the private sector.

2.1 Advantages of the Model

The advantages of this competitive public management model are the following:

- greater spending control.
- effective cost reduction.

- innovation at local level to produce higher quality and more responsive service.
- higher levels of service provision.

This new public management model is advocated in aid dependent countries through structural adjustment programmes. The pressure from multilateral institutions for control and reduction of public expenditure through the use of cash budget systems on centrally defined and controlled programmes are a new version of the model. Further, the framework for allocation of aid funds takes the form of semi-autonomous or autonomous projects rather than of providing direct support to central government programme budgets.

2.2 Disadvantages of the Model

There is a tendency for decentralised public finance system to be ambiguous and they also tend to subject managers and staff to risk. Other disadvantages includes:

- Increase in transaction processing costs,

including the loss of unpaid exchange.

- Loss of efficient externalities, especially the free flow of information and informal training.
- Loss of economies from team working and scale including loss of efficient risk spreading.
- Perverse incentives for raising of cost and self-seeking behaviour

2.3 Coherence of the Model

The public management model is neither coherent nor is it as widely accepted and as consensual as the model's proponents often postulate. The following are some of the reasons:

- Politically, the model is advocated as one of empowerment when in reality this is not the obvious result.
- The separation of policy making and policy management is very convenient to some politicians who would rather not be associated with

policy failures. They would wish to enjoy the benefit of having to blame those who man age or implement policy.

- the approach which shifts a system of public financial management from the old integrated one to the "new" model is financial decentralisation. Yet under the new modal the accounting system at the centre is unchanged; in other words, it remains that of monitoring spending instead of ensuring the effective management of funds at the decentralised level.
- the movement from budgets to contracts for services changes the role of financial managers because the budget acquires an income side. Thus managers are required to be responsible for both revenue and expenditure management contrary to their conventional role.
- the concern for costs becomes a pertinent issue. Thus to earn a profit issues such as prices,

risk assesment, etc come into therefore. This would demand more management accounting professionalism than the normally availed financial accounting know how.

- the new public management introduces new challenges within public financial management by its introduction of more business-like and market-focused management requirements. It is not an integrated model; rather it tends,to be easily susceptible to fragmentation.

3.0 Two Models of Internal Public Economic and Financial Relations

3.1 Incentive Contracting

The internal relations of government can also be informed by the institutional economics of co-operative behaviour. Allocation of control rights is an enormous problem in the public sphere. And once the problem is resolved , the relationships among contracting parties become important to its resolution: people constantly

need to collaborate in order to resolve unforeseen problems. Further, where transaction processing costs are a problem, reducing the number of variables involved in such transactions, through collaboration, may be the solution. Obviously, norms and culture are critical forces that influence collaborative behaviour.

In accordance with the assurance game, an individual will behave collaboratively if, and only if , he believes that the other person would also collaborate. So the outcome of a transaction depends on expectations of someone else's behaviour. In this context, therefore, the motivations are symmetrical. However, people can also behave in such a manner as to enhance the self-interest phenomenon.

Expectations and behaviour can equally be determined by professional norms; once you have secured the most favourable position, the norms are self reinforcing since the alternatives are not better. Indeed, the professional norms may have emerged precisely because people have worked together for a long time

and have therefore developed expectations which allow them to trust each other to collaborate. Expressive rather than instrumental rationality can also determine professional norms. This is underpinned by behaviour drawn from shared (socialisation) meanings which are constitutive of both the people and the situation.

3.2 Institutional economic and professional norms.

Incentive contracting is rooted in the principal/agent framework. In this context, the framework governing the internal economic relations within the government, as a principal facing decentralised agents, gets restructured. The model characterises the principal as capable of defining the required outputs but unable to achieve them by simple fiat. Instead, the principal has to contract agents whose interests are self-centred and who may not share the aims of the principal. Furthermore, agents tend to know more than the principal about costs and outputs.

In order to align the motivations of the agents as closely as possible

to those of the principal, incentives become imperative. High powered incentives shift risk to the agent, while low powered incentives leave risk with the principal. So performance - related payments are high .powered; so are fixed price contracts. Conversely, salaries and cost-plus contracts are low powered.

The agent will generally minimize risk by withholding adverse information in order to pass losses to the principal. This is the "moral hazard" phenomenon which leads to perverse corrupting behaviour. The total range of possible behaviours by the agent and the principal are best modelled by an "assurance game" in which both cooperate for maximum mutual benefit or behave with self-interest with mutual but reduced benefits or behave diversely and lose or gain depending on the opponent's behaviour. In short, it becomes a game in which one's behaviour is determined by what one believes the opponent's behaviour is likely to be either co-operative or self-interest centred.

Indeed, the model is built strongly on the notion of self-interest

centred agents . It acknowledges that if low powered incentives are the only suitable ones then some other motivation such as career incentives should be put in place. But the model has little to say, in practice, about non-financial incentives.

4.0 Modelling Health Services Decentralisation.

The standard model of health services decentralisation is to provide a district with a clinic, or a hospital, with funds-increasingly called contracts, not budgets, and to agree on outcomes, targets, performance measures of some kind for those units , on behalf of patients and potential patients. The format of the contracts is likely to be "block". In other words, so much for offering a given type of treatment to those requiring it; cost and volume ; so much up to a given maximum, and so much for a case above that ; or cost per case given varying payment losses. This is where the notion of incentives comes in. In addition to the clinical and other staff, there are the patients and other stakeholders in the contract. One of the most difficult tasks is that of

agreeing on performance measures which invariably tend to be subjective.

5.0 Modelling Privatization

The introduction of mixed funding into health services which were previously dominantly public funded, invariably involves some form of privatisation at the level of services provision and payment for services. The Kerala State in India is an interesting model to examine.

5.1 The Case Study of the State of Kerala in India

The State of Kerala has the following characteristics:

- Low incomes and high levels of morbidity .
- Low rate of infant mortality.
- Much longer life expectancy.

This quality of life is widely attributed to the following factors:

- A good primary health care system.
- A high level of female education.
- Involvement of women in the primary health

care system.

- A large number of doctors per capital.
- A good geographical spread of clinics.
- A high literacy rate.

Since the late 1970s, Kerala's health care system, which had been overly state sector dominated, has come under great fiscal pressure. The financial squeeze has been associated with three visible trends. First, a tendency to protect wages and salaries at the expense of supplies to and maintenance of the social sector. Second, a rise in informal payments for services in the public health sector. Third, the inevitable rapid increase in private provision in the health sector. A substantial proportion of Kerala's primary and secondary health care is thus presently privately provided.

What is interesting and necessitates deeper investigation is that the health effects of this shift from public to private sector health provision do not seem to have been negative. There is no evidence in the available indicators showing decline in health status

or rise in mortaliy. This denotes a relatively benign privatisation phenomenon which has not polarised access to health care.

The continued good health record in spite of privatisation could be explained by the following factors:

- Existence of private provision in both rural and urban areas. In other words, the rural areas have not suffered as a result of entry of private health provision.
- High expectations of decent treatment.
- The existence a large number of competing doctors.

These factors together make low quality, casual or exclusionary treatment by doctors much less likely. Further, the previous health care system (prior to privatisation) produced a pattern of "informal regulation" of private health care in Kerala which has limited the emergence of exclusion and instrumental behaviour. Put differently, the informal regulation in terms of local public

pressure, expectations, competition, information and publicity has made the system to function in a co-operative equilibrium rather than in a more polarised and instrumental manner.

6.0 Paths Through Privatisation in Health Care: Some Questions

Path-dependency, that is, the starting point and initial direction of a system, strongly influences its continuing characteristics. To that effect, different patterns of pri-vatisation have different structures of both formal and informal regu tion. For example, it is comonly accepted, at least among health economists, that the single most destructive private health care financing system, in the long-run , is private individual insurance for limited types of hospital care. This is so because of the impact of its second round effects on the system which tends to:

- raise costs sharply.
- produce lots of perverse incentives which escalate costs even further.
- raise medical service income.
- focus hospital provision on those types of care that are funded.

- undermine primary health care provision and gate-keeping .
- create access to medical care as an intensively divisive social issue.
- create political and /or financial lobby against socialising health care risk and uncertainty.

6.1 Current Status of Health Care System in Tanzania

The Tanzania health care system has been a history of declining quality of provision and falling morale of both providers and receivers of health services. This decline has precipitated the need for policy and institutional changes which are now being effected. The picture of the sector mirrors the following features:

- Decentralisation with cost-sharing and privatisa tion.
- Donor funding is critical for prevention and primary health care.
- mission hospitals form a substantial share of

hospital and rural dispensary provision and largely draw on donor funds; some are designated district hospitals, funded by the government to provide district hospital services.

- Non - designated voluntary hospitals charge high fees.
- User fees have now been instituted in the government and designated hospital sector.
- Entry of private for. profit providers has been liberalised.
- A sharp increase in commercial provision has been realised with a concentration in Dar- es-Salaam and in the dispensary sector.

6.2 Public Health Policy

The developments which are taking place in the Tanzania health sector show a healthy mix of public and private - provided as well as funded health care system. If one takes the path-dependency model seriously, then it follows that the next few years should see the emergence of some of the initial condi-

tions which underpin the behaviour of private and public sector health spending. If one thinks of the commercial independent providers and public provisions as two totally independent sectors, then the resulting public policy challenge should be that of providing directly some basic primary and preventative health care leaving the rest to an emerging private sector. Further, public policy is to be seen as a tool for influencing the direction and effectiveness of formal and informal regulation in the health care sector. Nevertheless, the challenge for policy in a liberalising health care system is to try to encourage ethical and professional ways of working and the growth of institutions which would sustain them, piecemeal at first, but with a clear sense of direction overtime.

7.0 General Discussion and Future Areas for Research

During the general discussion, the following questions and comments were noted:

- What do we reform; what do we start with?
- The policy initiators of reform are not Tanzanians but external agencies such as the World Bank; that reforms are likely to fail simply because Tanzanians are not committed to them and do not

own those reforms.

- Reforms in Tanzania mean government abdicating its responsibility and passing it over to the people.
- Government pronounces a 50/50 cost sharing system but it does not fulfil its share of the 50%; the point was underscored in terms of lack of commitment to allocating and releasing funds to meet the health needs of the disadvantaged groups and the very poor.
- Reforms may work well in some sectors, but are likely to fail in education and health.
- How does the Central Government and other actors interface with those under Local Government?
- How will a reformed system take care of the most vulnerable groups -- women and children-- how was it done in Kerala?
- How to target on the poor is a challenge. How

reported to be: "you failed to plan, so we are planning for you now!"

- Information is poorly disseminated, if at all, so reforms fail due to uninformed reform shapers.
- The reform time-frame is inappropriate.
- There is no co-ordination among the reforming sectors.

can one change the behaviour of the poor when there is such a wide variation in the ability to pay?

- Reforms have come at a wrong time!
- Reforms do not address target groups; funding is not assured!
- Reforms are moss - gathering; we keep on creating more reforms.
- Reforms in Tanzania and Britain are not comparable; voluntary in the latter, imposed on the former.
- The imposition of reforms on Tanzania is ideological, not part of "new management".
- What can we do during the transition? Can we do something to influence the reforms?
- In the region, they do no not know what public sector reform is all about.
- We are ill- prepared in policy making and analysis.
- The World Bank's attitude to reforms was