

New Trends in Public Sector Management in Health

Applications in Developed and Developing Countries

R. Paul Shaw

September 2004



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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

New Trends in Public Sector Management in Health Applications In Developed and Developing Countries

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Paper prepared as background study for World Bank Institute Flagship Program on 'Health Sector Reform and Sustainable Financing'

Abstract: This paper begins with a review of the broad *motivations* behind the 'New Public Sector Management' (NPSM), including intrinsic differences between public and private organizations that appear to impact on incentives and performance. The experience in selected OECD countries is reviewed where the financing and delivery of health and other social services is heavily socialized with a strong public sector role, taxpayers have expressed dissatisfaction with traditional modes of public sector management, and NPSM reforms have been hotly debated. Part II of the paper then describes the NPSM paradigm in terms of three ***building blocks*** that influence the performance of public agencies and the behaviors of employees who work for them. It explains how ***leverage points*** within the NPSM paradigm are expected to create ***incentives for improved performance***. It is when all three building blocks of the NPSM paradigm work together that synergies are expected to take place, and that continuous improvements in the performance of public agencies are expected to be generated over time. Part III illustrates five ***organizational strategies*** that can be used to introduce NPSM into public agencies in the national health system. Much of Part III refers to developing country applications. The organizational strategies include (i) increased accountability in personnel performance management, (ii) performance-related budgeting, (iii) autonomous agencies, (iv) managed competition and contracting, and (v) corporatization. In reality, none of these organizational strategies are likely to work in complete isolation of the other. Nor is any pretense made that these five strategies represent an exhaustive list of all NPSM tools available to the policy-maker, or that they must be sequenced in a particular way. Rather, they are featured here because they incorporate or mimic business-like practices that have been observed to increase the effectiveness and efficiency of employees, line managers and senior managers. A concluding section acknowledges that an adequate "enabling environment" must be in place if NPSM reforms are to take hold and be sustainable. This includes a checklist of specific conditions that are pertinent to the enabling environment -- for example, appropriate legislative changes, civil service reform, and the introduction of other facilitating instruments.

Keywords: New public sector management, performance management, competition, contracting, autonomy, corporatization

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FOREWORD

Over the past decade, government health officials have been increasingly challenged to demonstrate that public expenditures yield good ‘value-for-money’, are responsive to the needs of citizens, and can be accounted for in terms of promised outputs and outcomes. Many such challenges originate from taxpayers who acknowledge that government may have the mandate as well as comparative advantage to collect revenues for health (financing), but question the efficiency of government as a manager and provider of health services. Debate over this issue tends to become most heated when claims are made that public officials are somehow of a lower quality than their counterparts in the private sector, and that outright “privatization” of public service provision would help solve the problem. This is what happened in the UK, during the ‘Thatcher era’ when novel approaches were discussed, piloted, reviewed and revised, in efforts to make the National Health Service perform better and be more accountable to citizens.

What has emerged from all this is a “middle road” approach to improving performance of health systems called the New Public Sector Management (NPSM). In a nutshell, NPSM is concerned with injecting *business-like practices* into public agencies with the expectation that efforts to implement change will be easier, more effective, and more permanent as a result. NPSM acknowledges perceived differences in public versus private performance, especially the perception that weak incentive structures undermine performance of public sector managers. A key premise in NPSM is that managing business aspects of a health ministry, department, division, or facility is not so different from managing any other business.

Admittedly, health markets tend to be different from markets for other goods and services in terms of their positive externalities, asymmetries of information between provider and client, societal pressures to subsidize the poor, and complexities involving health insurance markets and catastrophic financial loss. But once these differences are acknowledged, advocates of NPSM maintain that there is no reason to assume that management of health inputs, outputs, and outcomes cannot take place in a business-like environment. Roles and responsibilities must be clear, performance of employees counts, and accountability to clients/patients is important.

This discussion paper introduces the origins of NPSM, a framework to understand its core components, several steps that can be implemented towards improving performance in the public sector, and a variety of examples in developing countries. It provides a valuable companion for three Bank publications on organizational reforms in the health sector: (a) Jakab M., A.S. Preker and A. Harding (2002), *The Introduction of Market Forces in the Public Hospital Sector: From New Public Sector Management to Organizational Reform*; (b) Preker A.S. and A. Harding, Eds., (2003). *Innovations in Health Service Delivery: The Corporatization of Public Hospitals*; (c) Harding A. and A.S. Preker, Eds, 2003, *Private Participation in Health Services*.

Alexander S. Preker

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PART I: ORIGINS

In 1979, Margaret Thatcher and her Conservative Party came to power in the UK, on a wave of promises to reduce the size of government and improve the performance of civil servants. The government was viewed as being too big, inefficient and wasteful. It owned huge proportions of the economy -- utilities, auto companies, and dozens of other nationalized industries -- representing 44% of the country's Gross Domestic Product. Management and provision of government goods and services were also widely perceived to be eroding in quality, public revenues had been stagnating, and public spending was on the rise.

As with most new governments, Thatcher's Party commenced with a classic exercise to purge waste and inefficiencies from publicly financed and provided services. An "Efficiency Unit" conducted more than 200 departmental reviews within three years, leading to the elimination of 12,000 positions and recurrent annual savings of about \$400 US million. This purging exercise paid big dividends, even in a country where a high degree of professionalism and meritocracy were generally praised within the civil service.¹

A fundamental problem with Thatcher's purging exercise, however, is that it was typical of a "one time house cleaning", traditionally practiced by new governments on coming into power. What it lacked were built in mechanisms that would lead to *continuous improvements* in management and performance. As some observers put it, "the purging exercise helped weed the garden, patch by patch, but it did not develop a regimen with built-in mechanisms and incentives to keep the garden weed-free."²

As Thatcher and her party learned more about the systemic problems behind the government's waste and inefficiency, she began to mount a renewed reform effort. Commencing around 1982, this resulted in the development of more than 1,800 performance objectives, most of them focused on cost and efficiency. But, again, the long-term impact was disappointing. The reformers realized that while many valuable performance objectives had been created, that without changing the internal dynamics of government organizations, there had been little effect on the overall behavior and performance of the public sector.

By 1988, a truly ambitious reform initiative was initiated, based on far-reaching recommendations by the government's Efficiency Unit. The Efficiency Unit had documented that there was a shortage of good managers, a budget and finance system that was focused more on controlling spending than on making it effective, and few external pressures on government managers and organizations to improve performance.

To overcome these management shortcomings, the Efficiency Unit recommended an "uncoupling" of government functions that had fundamentally different purposes into different organizations. This "uncoupling" aimed to separate the *policy and regulatory roles* of government on the one hand, from its *service-delivery and compliance roles*, on the other hand. In the UK, delivery of services by the public sector typically includes health, education, and other

¹ This overview of the UK reform process borrows heavily from David Osborne and Peter Plastrik, 1997, *Banishing Bureaucracy*, New York: Addison Wesley.

² Osborne and Plastrik, *ibid.*

social services, whereas compliance roles typically involve the courts, police and tax collection, etc. A fundamental goal of this “uncoupling” was to allow government to centralize and coordinate its policy functions (i.e., determining “the right things to do”), while decentralizing and devolving service-delivery functions to a different group of managers charged with the responsibility of “doing the right things the right way”.

Thatcher accepted the Efficiency Unit’s recommendations and moved quickly to adopt a “Next Steps” program that has since revamped the British public service. Key principles of the Next Steps program were to:

- uncouple the policy functions at Ministerial level from the service-delivery functions of government, with the latter functions being managed by “executive agencies” and staffed by civil servants;
- use a competitive search to find chief executives to manage the executive agencies and pay them whatever it takes to get the talent needed, including performance bonuses of up to 20% of their salaries;
- require the new chief executives to develop 3-5 year corporate plans and one-year business plans for the executive agency they manage;
- negotiate a 3 year framework document between each executive agency and its departmental minister (the policy arm of government), that specifies the results to be achieved by the agency, and the flexibility within which it would operate;
- give the managers of the executive agencies much more control over their budgets, personnel systems, and other management practices;
- deny chief executives the civil service’s normal lifetime tenure and require them to reapply for their jobs every three years, with reappointments based on satisfactory performance.

In health, the Next Steps program established the National Health Service management executive (NHS) as a separate entity. The NHS basically removed management functions from the Ministry to a separate management entity. By early 1991, fifty-one such executive agencies had been created in the UK at a pace that surprised most observers. By late 1996 the process was all but complete with 126 agencies, including the National Health Service. More than 80% of all civil servants now work in Executive Agencies!

By many accounts, the Next Steps program enjoyed considerable success. In November, 1994, Parliament’s Treasury and Civil Service Committee called it “the single most successful Civil Service reform program of recent decades.” While individual Executive Agencies have improved at varying speeds -- some rapidly, some slowly -- they managed to accomplish 75 percent of their performance targets in the early years, and were meeting more than 80 percent by 1995.

Achievements of the Next Steps program has been attributed to a reform strategy that has made use of several new public sector management practices to guarantee continuous improvement. One of those practices, as noted above, involves uncoupling the service delivery organizations from the policy making organizations, so that each organization could focus on its primary mission, and emphasize the kinds of skills needed to carry out that primary mission. An important aim in the UK reforms was to give the service delivery organizations the control over

most of their decisions, thus freeing them from traditional bureaucracy and political influence to innovate and make the necessary business-like changes to improve their operations. This involved trading higher-level (Ministerial) control over these organizations in return for promises that they will deliver agreed outputs and outcomes, and punishments if they don't.

A second notable management practice in the UK reforms lies in creating consequences for the performance of the executive agencies -- their management and workers -- so they have incentives to improve service delivery and compliance functions. These consequences (or incentives) range from termination of employment of underachievers to variations in the level of performance bonuses. Expectations are typically specified in *contracts*, subject to monitoring and evaluation.

A third management practice is to anchor accountability for service delivery in a client-based strategy that emphasizes choice and quality of service. Clients may be consumers who benefit directly from the provision of a service (e.g., health consultations), or intermediary clients who are dependent on intermediary products along a "production chain" (e.g., government distributors responsible for delivering publications to government bookstores). This strategy purports to empower both the intermediate clients (e.g., the bookstores) and the consumers of public services to lobby for improved quality, rather than being passive users of services.³

In the UK, the aforementioned management practices can be roughly construed as the origin of the New Public Sector Management (NPSM). More recently, the principles involved -- as defined and discussed in Part II -- have undergone further scrutiny by the current Bloor government and some revision. In health, emphasis on competition in 'internal markets' has been played down in favor of new economic relationships between public purchasers of health services (e.g., district health authorities) and public and private providers that favored longer-term collaboration.⁴ But emphasis on performance and accountability through purchasing arrangements and contracting remains in force.

Nor is the UK alone in its efforts to reform the performance of its public sector -- to make its services more cost-effective, of higher quality, more sustainable. To varying degrees, modalities of the New Public Sector Management (NPSM) are operating throughout all 24-member states of the Organization for Economic Cooperation and Development.⁵

The motivation behind public sector reforms is not unsimilar in most low and middle-income countries. Governments of such countries often spend more than they collect from tax revenues,

³ To what extent such reforms have actually empowered clients is an item of extensive debate in the UK. For example, Britain's GP fundholding module aims to use consumer choice to drive competition, but several studies suggest that people simply go to the GP closest to their home. People cannot be empowered unless they exercise choice in an informed manner and it often takes time for behavioral changes to occur, particularly in a system of care that has been hierarchically structured in the past.

⁴ Maria Goddard and Russel Mannion, 1998, "From Competition to Co-operation: New Economic Relationships in the National Health Service", *Health Economics*, Vol. 7, p. 105-19.

⁵ By world standards, OECD countries enjoy relatively high per capita incomes, with relatively highly paid civil servants. At the same time, however, rising public expenditures in most OECD countries are being blamed for unsustainable fiscal deficits. Moreover, "government" agencies are often perceived as too big, inefficient and wasteful, with public agencies often performing service delivery functions that the private sector might do better. See, Jan-Erik Lane (Ed.), 1997, *Public Sector Reform: Rationale Trends and Problems*, London: Sage Publications Ltd.

resulting in accumulating deficits and international debt (resulting from crisis borrowing). Voters attribute at least some of the overspending to inefficiencies in public sector management, accountability and performance. Tax revenues are further compromised in many countries by “leakage” and corruption, whereby public authorities have difficulty accounting for large sums of money. Complaints that publicly provided services are delivered badly or not at all are commonplace. A survey conducted for the World Bank’s 1997 World Development Report on the role of the state, found that only 6% of domestic private business managers in fifty-eight developing countries rated public service delivery as efficient, while 36% rated them as very inefficient. Health services scored lowest.⁶ Sixty percent of the business managers rated the efficiency of health services as low, 33% as moderate, and only 7% as high.

To conclude, it is only within the last 10 years that NPSM has been emerged as a major reform strategy, applied in varying degrees to public sector agencies in a growing number of developed and less developed countries. As NPSM reforms forge ahead in countries like the UK, New Zealand, Trinidad and Tobago, and the US, government reformers worldwide have been eager to experiment with similar policies. This is happening in Mongolia, which has passed a law to introduce “big bang” reforms (as in the case of New Zealand), and in Thailand where privatization and corporatization of public agencies is on the agenda. It is also happening in countries like Columbia, Mexico, and Zambia which are introducing different varieties of a purchaser/provider split to enhance public sector performance through the separation of policy and service delivery roles. Moreover, countries like Bolivia, China, Thailand, Malaysia and South Africa are turning increasingly to contracting arrangements and negotiated performance agreements. All of these experiences, and the “renewal excitement” associated with them have generated a growing demand for the dissemination of lessons learned and best practice.

WHY REFORM PUBLIC SECTOR MANAGEMENT?

What are the origins of NPSM? NPSM stems from disenchantment with the performance of traditional public sector bureaucracy, reinforced by claims that the private sector and market

⁶ Public performance and institutional weaknesses in developing countries are exacerbated by a relatively weak tax base, shortages of public funds, low employee incomes, the erosion of professionalism and meritocracy by corruption and favoritism, and political instability. From the perspective of NPSM, however, these familiar problems can only be held partly accountable for the weak track record of public bureaucracy. Equally important is that the approaches to improving public institutions and strengthening capacity have tended to stress the wrong things.

This point is echoed in a recent review of the World Bank’s portfolio of loans for health, nutrition and population (HNP) projects by the Bank’s independent Operations Evaluation Department (OED). According to the OED report, attention to incentives among public sector workers and emphasis on strengthening capacity of public institutions was ranked as “infrequent” in a large majority of Bank funded projects. Moreover, advocacy for public sector reform has seldom been accompanied by sufficient development of the concepts, approaches, and capacity required to translate them into sustainable action. Furthermore, most HNP projects have taken an input-oriented approach to capacity building -- providing training, technical assistance, and equipment to “fix” capacity problems, without defining institutional development objectives with sufficient clarity to enable regular monitoring and tracking of results.

mechanisms tend to be far more efficient. Lackluster performance in the public sector is often associated with the following:⁷

- Control tends to be exercised by political figures who may be more interested in patronage than in performance;
- Managers tend to be protected by civil service regulations that insulate them from performance based incentives;
- Money to provide public services comes from taxation and cost-based budgeting, not from prices consumers are willing (or unwilling) to pay for services, conditional on good quality;
- Customers often have no alternative but to purchase or accept public services due to public monopoly;
- Public measures that understandably prevent managers from accumulating political power often have the undesired side-effect of depriving them of power over personnel and budgets;
- Workers may have more power over their managers than vice versa due to union influences and political commitments, thus further undermining the capacity of managers to bring about change.

As might be expected, such claims have resulted in a ‘tug-of-war’ of competing, and often biased, opinions about the merits of the public versus private sector. Moreover, each perspective tends to be bolstered by different theoretical traditions, dogma, rhetoric and evidence of varying merit. Stakes in the debate tend to become higher, and interest in NPSM stronger, when governments are plagued by fiscal deficits, and when parliamentarians and business leaders call for cost cutting, downsizing, and divestment of government assets.

One positive outcome of the public-versus-private debate is a growing consensus that it is worthwhile, if not imperative, to search for *business-like practices* in the private sector that might be effectively *mimicked* and transferred to public sector agencies. But what is a business-like practice and what would it look like in a public agency where the production and supply of goods and services tends not to be determined by the interaction of market supply, demand, and price? A working definition might read as follows:

A business-like practice is an approach to developing, producing and supplying a good or service that (i) utilizes unit costs when producing the good or service, (ii) links costs with expected outcomes of the good or service in the pursuit of ‘value for money’, (iii) takes stock of client needs, demand, and satisfaction on a regular basis, (iv) holds personnel accountable for performance through explicit terms of reference, (v) demonstrates accountability to “shareholders” (e.g., taxpayers) by rigorously monitoring and evaluating its functions (e.g., MIS systems, auditing), and (vi) makes use of monetary and other incentives to reward performance.

A fundamental premise behind the emergence of NPSM is that public sector managers have been insulated from the same kinds of pressures/incentive structures that prevail in the private sector.

⁷ Adapted from presentation by Marc Roberts, Harvard University, to the World Bank Institute Flagship Program on Health Sector Reform and Sustainable Financing, November 1998, Washington DC.

It is argued that the absence of these private sector pressures has maintained inefficient bureaucratic organizations, has permitted complacency to prevail over dynamic innovation, and has often penalized rather than rewarded entrepreneurial staff in public sector agencies. Advocates of NPSM further argue that lagging public sector performance arises because of the problems of securing appropriate incentives to pursue the public interest, lack of appropriate information to determine what the public interest is, and lack of appropriate monitoring mechanisms to assure that outcomes prevail.⁸

What determines these pressures and incentives that are purported to exist in the private sector but not in the traditional public sector? Table 1 summarizes six structural differences between public and private sector agencies that are often said to act differently on incentives, the drive for results and efficiency.⁹

Table 1: Factors Affecting Managerial Incentives and Accountability

| <i>Public Sector</i> | <i>Private Sector</i> |
|---|---|
| 1. funds raised from taxes | 1. funds raised by venture capital |
| 2. ownership of assets by government | 2. ownership of assets by shareholders |
| 3. costs used to crudely estimate prices | 3. market determined prices |
| 4. clients vote through representation | 4. clients vote with their feet |
| 5. resource allocation based on non-transparent bargaining between interests groups & politicians | 5. resource allocation follows rules of efficiency |
| 6. bounded rationality -- defined below -- more severe in view of monopoly situation of public entity | 6. bounded rationality less severe in view of information/communication associated with "market clearing functions" |

How funds are raised: To produce public goods and services, public sector organizations rely heavily on general revenue sources (taxes) and historically replenished budgets. In many instances, the justification for budgetary increases amounts to little more than a historically determined percentage increase over last year's allotment. Such practices may allow a sense of complacency and dependency on traditional sources of funding. Moreover, were a taxpayer to be informed of, and disagree with how funds are going to be spent, it tends to be difficult if not impossible for that taxpayer to withhold or withdraw his/her funds. This means that the consequences of mismanagement are heavily deflected.

In contrast, when funds are raised in the private sector (e.g., through share offerings), investors seek compelling information that the new venture offers attractive benefits, that costs are

⁸ Peter M. Jackson and Catherine M. Price, 1994, *Privatisation and Regulation: A Review of the Issues*, (London: Longman).

⁹ Thomas Clarke and Christos Pitelis, 1993, *The Political Economy of Privatization*, (London: Routledge).

manageable, and that the use of funds will be strictly monitored. Satisfying venture capitalists requires that private sector agents communicate and document their plans and expectations as thoroughly as possible. This means that private sector entrepreneurs are strongly motivated to research their market, their competitors, and the quality and appeal of their product. Often several independent analysts come into play who will rank each company, its past profit performance, and the financial appeal of new offerings.

Ownership of assets: In public agencies, managers may control how assets are used, but they do not have any ownership claim on them, and are not entitled to sell them. In contrast, the manager of a private enterprise under single ownership can sell his/her firm's property rights and therefore has complete entrepreneurial control. The more completely that ownership of resources falls on the shoulders of managers and their employees, the stronger are the incentives to use, preserve, and maximize the value of those resources efficiently.¹⁰ This wisdom is reflected in commonplace observations that resident owners of dwellings tend to be more motivated to maintain or improve the premises than do renters.

Pricing of Products: In their decisions about what and how much to produce, public agencies are rarely guided by price. Rather, the modus operandi tends to be to (i) produce as many units as possible within a given public budget, (ii) fulfill orders with available supplies in response to requests from a hierarchically structured system, and (iii) provide those units to consumers "free" or at highly subsidized rates. In a worst case scenario, a public agency could be producing and supply a good or service at two to three times the cost that it could be provided by the private sector, but not know it.

In the competitive private sector, on the other hand, firms are continually being pressured to produce more at less cost, in fiercely competitive markets. Pressure is exerted by other competitive firms that try to produce more for less, and appeal to consumers by pricing their products more cheaply. If the firms with overpriced products fail to cut their costs (and prices), then consumers go elsewhere, profits fall, and the firms go out of business. It is the discipline of minimizing costs and estimating prices that construes private sector managers with a sharp competitive edge.

Accountability to Clients: The public and private sector can be sharply distinguished in terms of the speed by which client feedback can affect production, performance, and job tenure. When services are underprovided or of poor quality in the public domain, negative client feedback often takes considerable time, through public opinion polls, media coverage, and eventual changes in political candidates and platforms via the voting process. All of this implies a lagged process whereby public administration officials may be misinformed about client demands for some time.

In contrast, private sector markets can signal dissatisfaction within days through declining demand for products in competitive markets. This forces producers to adjust prices downwards or improve quality. If shareholders become increasingly agitated by falling stock shares, the manager of a firm becomes increasingly vulnerable to being fired, or seeing the company taken over via a merger.

Resource allocation decisions: It is well known that shifting political agendas and lack of transparency can result in prior resource allocation decisions being changed to suit special interest

¹⁰ Some authors note, however, that it is not ownership per se which is crucial for efficiency, but, rather it is the degree of competition which exists in the final product market.

groups, or political whims. When this happens, public managers tend to lose control over the priority setting and resource allocation decisions that may have been based on a well-formulated plan. In contrast, the private sector is relatively immune from such influences, with resource allocations being guided largely by efficiency criteria.

Bounded Rationality: In a public agency where the threat of competition is minimal, managers and employees can afford to be relatively “inward looking” with respect to how they are doing things, including the efficiency of their production processes as well as the range of goods and services they offer. This may result in a kind of bounded rationality -- meaning a reduced (or underutilized) capability of individuals to have and act on information about all alternatives.

In the private sector, however, there is great pressure to be aware of one’s competitors, including the nature of their product, demand, price, and profitability. Though monitoring such external phenomena incurs transaction costs, it can also contribute to the knowledge that one’s competitor may be doing something better and why. To the extent that this results in an “outward looking” mentality and continuous interest in other options, it tends to reduce the effects negative of bounded rationality on competitiveness and performance.

HOW CENTRAL IS PRIVATIZATION?

One reaction to the perceived gap between public and private sector incentives is to recommend privatization of publicly owned and operated agencies as a means of improving performance.¹¹ Any proposal to privatize health, however, must contend with the argument that ‘health markets’ are different from other markets.¹² It is widely believed that the private sector will under provide (i) goods and services of a largely public nature such as information campaigns to prevent AIDS/STDs, (ii) goods and services with positive externalities such immunizations and TB treatments, and (iii) targeted goods and services to poor people who cannot afford them. It is also widely believed that strong informational asymmetries prevail in health care, whereby consumers may be ignorant of treatments and medicines that could harm them, and thus need some form of protection.

In the UK, a strong push for full privatization was clearly what Margaret Thatcher wanted to see in her Next Steps reform agenda. She not only viewed public sector organizations as being inefficient and wasteful, but implied that civil servants tended to be underachievers as well. Fortunately, her experience working with many highly qualified, innovative, and dedicated civil servants, prompted her to modify her views concerning the public service. She also learned that

¹¹ In many low-income countries the private health sector is already dominant, sometimes comprising as much as 80 percent of health care provided to the population. In these countries, the key challenge is not privatization but rather harnessing the private sector for public aims. See Harding A. and A.S. Preker, Eds., 2003, *Private Participation in Health Services, Health, Nutrition, and Population Series*, Washington, World Bank.

¹² Preker A.S. and A. Harding, 2000, *The Economics of Public and Private Roles in Health Care: Insights from Institutional Economics and Organizational Theory*, HNP Discussion Paper, Washington, World Bank; and Musgrove, P, 1996, *Public and Private Roles in Health: Theory and Financing Patterns*, Washington, World Bank.

not all publicly operated agencies or enterprises are inefficient.¹³ Nor were British voters willing to see government relinquish control of key social services, such as education and health, to private agents where pursuit of profits tends to reign supreme and concerns for just and equal treatment of all citizens tends to be secondary.

The privatization question therefore prompted two responses in the UK, which have been closely watched by other countries. On the one hand, the British government was urged to identify those public agencies that were most suitable for privatization on a number of broad criteria. On the other hand, for public agencies that did not appear to be suitable for privatization, the British government recommended another course -- that business-like practices be identified and imported into government policy and service functions. While this latter course explicitly recognizes that "health" *is* different from other sectors (for the reasons noted above), the Thatcher reformers maintained that the process of *managing* health care inputs and desired outcomes in the UK should not be so different as management skills and functions required in other sectors.

While there is no binding, absolute formula regarding public agencies that should or should not be privatized, broad guidelines have emerged as follows:

What Functions should be regarded as candidates for privatization?

- Functions, goods or services that the market can and will spontaneously provide to consumers. This assumes that buyers will pay for them that people who are unwilling to pay can be excluded from enjoying them. Under such conditions, private producers will indeed supply. Alcoholic beverages and private automobiles are examples.
- Functions, goods or services that primarily benefit individuals rather than society as a whole. If so, they can be construed as private goods that individuals are typically willing to pay for. Examples include domestic pets, and plastic surgery for cosmetic reasons.
- Functions, goods or services that the community does not care whether everyone has access to -- meaning there is no societal concern about equity or universal access. Examples include memberships in golf clubs, and a private hospital room, complete with air condition and television.

Examples of formerly public agencies that are good candidates for privatization -- in terms of the criteria above -- include; electric utility companies; gas, coal and water companies; national railways and airlines; national telecommunications; national banks; public housing, hotel, and tourism agencies. These kinds of public agencies have been successfully divested or sold to the private sector in countries like the UK, New Zealand, and Canada.

Voters and taxpayers tend to be satisfied with plans to privatize public agencies as long as a reasonable case can be made that (i) revenues will be generated by the divestment of public assets to the private sector, (ii) the newly divested agencies will perform well in terms of efficiency and potential profitability, (iii) the production and efficiency goals of the newly privatized agencies

¹³ Indeed, studies conducted by Thatcher's Efficiency Unit revealed that one of the most efficient steel companies in the world is the publicly owned and operated Korean Pohang Steel Company, whereas other high-performance public enterprises include the Kenyan Tea Development Authority, the Ethiopian Telecommunications Authority, and the Guma Valley Water Company of Sierra Leone. See Peter M. Jackson and Catherine M. Price, 1994, *ibid.* p. 20.

are unlikely to be compromised or distorted by heavy demands of political accountability for outcomes and “politics”, and (iv) employees can be redeployed or terminated in an acceptable, humane manner.

On the other hand, there are grounds for arguing that selected core public functions or services should be provided solely or largely by government, because the market would not undertake such functions or provide such services appropriately.

What core public functions, goods or services are least likely to be appropriate candidates for privatization?

- National policy and regulatory activities. Government policy determining immigration quotas and procedures is an example, as is government regulation of medical schools and licensing of MDs.
- Major compliance functions like the courts, the police, and tax collection (though private agencies often are involved in managing parts of their functions through subcontracting arrangements).¹⁴
- Goods and services demanded by societies that provide positive externalities, but that private sector won’t provide, such as safe drinking water, immunization.
- Goods and services for the indigent and poor people (though the private sector may well co-finance them and often is involved in providing them).

What the New Public Sector Management is all about, therefore, is identifying various ways to (i) transfer some public agencies into the market where competition and management freedom will contribute more to improved performance and societal welfare, and (ii) inject business-like practices into all other public agencies over which government wishes to continue to exercise considerable control. This is illustrated in Figure 1 with respect to three kinds of hypothetical public agencies.

¹⁴ The private sector is sometimes willing to provide such services, and sometimes does, but at a sub-optimal level from a societal perspective. In such cases, the services in question may not be a core public function, whereas financing of them is.

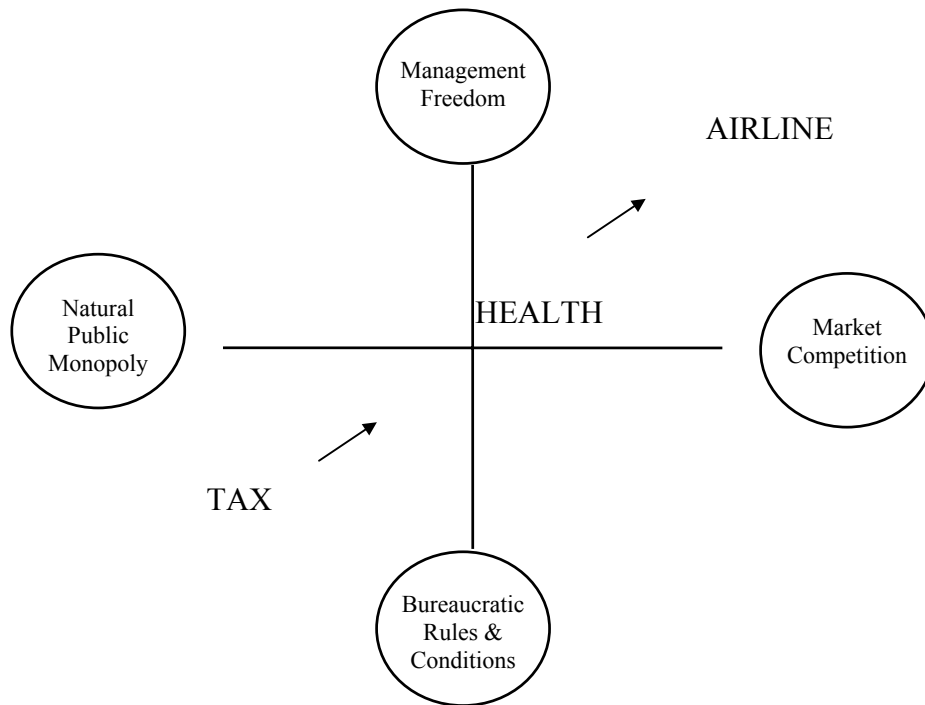
Figure 1: Targeting Public Agencies for Privatization

Imagine you are a Minister of Finance, charged with the responsibility of deciding whether to privatize any or all of the following three kinds of public agencies or organizations. One is a central tax collection agency (TAX), the second is a district health network comprising a large district hospital, linked to several clinics (HEALTH), and the third is a national airline (AIRLINE). These agencies are depicted in the Figure below.

In the case of the TAX agency, government is mandated to collect taxes and to guarantee the protection of revenues in the national treasury. Because TAX is one-of-a-kind and is not involved in competition in the marketplace, it is sometimes referred as a “natural” monopoly and is governed entirely by bureaucratic rules and conditions set by the public sector. In this case, privatization is out of the question, though private companies might be hired to collect taxes or chase down tax dodgers. However, from an NPSM perspective, the TAX agency would be a prime candidate for the injection of proven business-like practices, borrowed and adapted from the private sector.

In the case of HEALTH, government may be mandated to collect revenues to finance health in the country’s Districts (from taxes and other sources). But this does not mean that government must also own and operate *all* health care facilities in the country. Thus, competitors exist in the form of private and NGO providers, and no one can claim that HEALTH is a natural public monopoly. From an NPSM perspective, HEALTH is an appealing candidate for the development of “internal markets” or “managed competition”. If government favors an “internal market” -- as it did in the UK -- contracting would take place only with public providers. If government favors “managed competition”, then contracting would take place with both public and private providers competing for government-financed contracts. In such contexts, government may well continue to play a strong role raising funds for health, specifying national health outcomes, but then contracting with different providers to deliver best value for money.

In the case of AIRLINE, government might be operating a national airline, perhaps on a continent where the majority of airlines are run privately. No claim to a natural public monopoly can be made in this case. Private financing and provision of airline travel is available, paying customers tend to line up for airline tickets -- meaning markets are working, competition between airlines can help to cut costs, and the profit motive will operate to increase performance and quality standards. Demand and supply of airline tickets is determined by ability and willingness to pay. Equity is not a central issue and no national policy is likely to prescribe that all people should have equal access to airplane seats. This is a perfect candidate for full privatization.



DOES NPSM REQUIRE A BIG BANG APPROACH?

As yet, there is no agreement on exactly how NPSM reforms should be sequenced, or the timetable they should follow. Each country that has embarked on NPSM reforms has been a trailblazer insofar as it has introduced NPSM principles and practices with varying degrees of intensity, timing, and political commitment. To some extent, this is good news because policy-makers need not subscribe to only one way of doing things -- such as the government-wide, “big bang” approach adopted by Margaret Thatcher in the UK. A danger this presents, however, is that the virtues of one approach over another have yet to be established, with the implication that policy makers are at risk of introducing initiatives that (i) may not be well orchestrated, (ii) may be hard to defend with empirical data, and (iii) may not generate sufficient political commitment and carry-through.

Appropriate sequencing or phasing of NPSM reforms becomes particularly important when effectiveness of changes in one sector is conditional on broader changes occurring across all sectors -- such as legislative or civil service reform.

The experience of New Zealand provides valuable insights as it represents one of the most ambitious and fast-moving attempts to reinvent government and reform public bureaucracy. The government began with an aggressive NPSM organizational strategies, namely corporatization, as reviewed in Part III. This strategy changes the organizational form of a public agency to be more like that of a private company. Corporatization uses an “uncoupling” strategy, with government continuing to undertake policy and regulatory functions that influence the behavior of the corporatized agency, but with the managers of the corporation focusing on business-like delivery of the services involved. The new public corporation -- called State Owned Enterprises in New Zealand -- are quasi-independent of government, and must meet business tests, such as maximizing profits and earning a return on investment. Examples of corporatization in New Zealand include air traffic control, the postal service, and forestland management.

Corporatization policies in New Zealand were followed by more aggressive policies favoring privatization. And commensurate with the privatization of selected public agencies took place, the government also turned its attention to identifying business-like practices that could be applied to core public services -- those remaining under government control and management. What is significant is that the managerial culture has changed in both the core public agencies affected by the NPSM as well as those that have been corporatized. There is now a greater emphasis on achieving commercial objectives such as cost recovery; measuring performance outputs rather than inputs; improving management information systems, especially financial systems; introducing effective cost control mechanisms; and ensuring that the incentive systems of rewards are compatible with the objectives. The lesson learned thus far is that the design of incentive structures is crucial for economic performance.¹⁵

¹⁵ David Osborne and Ted Gaebler, 1994, *Reinventing Government*, (New York: Addison-Wesley Publishing Co. Inc); David Osborne and Peter Plastrik, 1996, *Banishing Bureaucracy*, (New York: Addison-Wesley Publishing Co. Inc.); Peter M. Jackson and Catherine Price, 1997, “Privatisation and regulation: a review of the issues”, in Peter M Jackson and Catherine M Price, 1994, *Privatisation and Regulation: A Review of the Issues*, (London: Longman); World Bank, 1997, *World Development Report 1997: The State in a Changing World* (Oxford University Press).

Australia, being a close neighbor of New Zealand, watched the situation carefully. It then decided to embark on its own brand of NPSM in a more protracted manner. The trend in Australia has been to insert market-type decision mechanisms into the public sector without resorting to privatization. Emphasis has been placed on shifting from administering to managing within the bureaucracy, and making greater use of commercialization and user charges, decentralization, and reform of the senior public service. Australia has therefore focused initially on core public services. This was followed by financial management reform, then by corporatization and later privatization.

Several parliamentary and official inquiries have reported that productivity and efficiency in Australia have grown in the public service and in the business enterprises of the public sector. The “efficiency dividend” was later claimed to have saved \$60 million annually. According to the Joint Committee of Public Accounts, commercialization and corporatization have produced significant improvements in the efficiency and effectiveness of the provision of goods and services by agencies.¹⁶

In the United States, NPSM reforms were initiated Vice President Al Gore in 1992/93, though they have not involved major structural changes in the form of privatization or corporatization of public services. Rather, they are stressing managerial and administrative reforms within central government agencies. To accomplish this, Vice President Gore established a National Performance Review in 1993 to “create a government that works better and costs less”.¹⁷ The National Performance Review determined that approximately \$108 US billion could be saved over the period 1995-99 through streamlining the bureaucracy (\$40.4 billion); consolidating public agencies and downsizing their workforce (\$36.4 billion); improving procurement practices (\$22.5 billion); consolidating and modernizing information technology (\$5.2 billion); and offering fee-for-service options in lieu of existing administrative costs (\$3.3 billion).

To realize the US goals, the National Performance Review began trying to bring about changes, first in 31 government agencies that involve considerable direct contact with citizens and public customers. After five years of implementation, the U.S. Brookings Institution released a study by Donald Kettl, entitled “Reinventing Government: A Fifth Year Report Card”.¹⁸ According to the Brookings report, the overall report card grade is a “B”, with relatively high marks for “effort”, “procurement reform”, and government “downsizing”, versus relatively low marks for “identifying objectives of government” and “overall effort to develop legislative support”.

Kettl, who has followed Gore’s project from the start, summed it up this way: “Great progress in some areas, little traction in others, some administrative disasters prevented, others not prevented, strong academic complaint, government downsized, but only modest public awareness of the effort, and little voter appreciation of the result.” (More detailed findings are reported in the accompanying Case entitled “Reinvention Report Card”.) Upon reflection, Robert Stone, “Chief

¹⁶ Joint Committee of Public Accounts, 1995, *Public Business in the Public Interest: an Inquiry into Commercialisation in the Commonwealth Public Sector*, Report 336, Canberra: Australian Government Purchasing Service; John Halligan, 1997, “New Public Sector Models: Reform in Australia and New Zealand”, in Jan-Erik Lane (Ed.) *ibid*.

¹⁷ Report of the National Performance Review, 1993, *Creating a Government that Works Better and Costs Less*, Washington DC: US Government.

¹⁸ Donald F. Kettl, 1998, *Reinventing Government: A Fifth Year Report Card*, Washington, DC: The Brookings Institution.

Energizer” of the National Performance Review estimates it will take about 8-10 years for the program to bring about the kinds of managerial and behavioral changes sought within the agencies.

In most developing countries, vestiges of NPSM have only recently been in the spotlight. Some countries, such as Indonesia, Tunisia, and Kenya, have been experimenting with autonomization of public hospitals. This is a key organizational strategy for injecting NPSM elements into public agencies that will be reviewed later. Other countries, such as Argentina, Brazil, Mexico, Columbia, and El Salvador are experimenting with other organizational strategies that incorporate NPSM -- namely managed competition and contracting. Still others, such as Mongolia, China, and Thailand, are considering moving ahead quickly with the corporatization and privatization of public agencies. Graham Scott, architect of the New Zealand reforms, suggests that politicians in less developed countries would rather take the risk and inject NPSM principles into their public systems, rather than await almost certain, further decline in public performance. He is quick to add, however, that the New Public Management is still “...an eclectic field, not a discipline.”

PART II: HOW NPSM WORKS

Thus far, we have described the emergence and contents of NPSM by example, refraining from analysis and description of its most important components and modalities. Our goal has been to convey that public sector reforms are exceptionally active in many countries, and that these initiatives are giving rise to a variety of new management practices. The purpose of this part of the paper is to examine more closely building blocks of NPSM, and the synergistic effects they are expected to have on public sector performance when combined.¹⁹

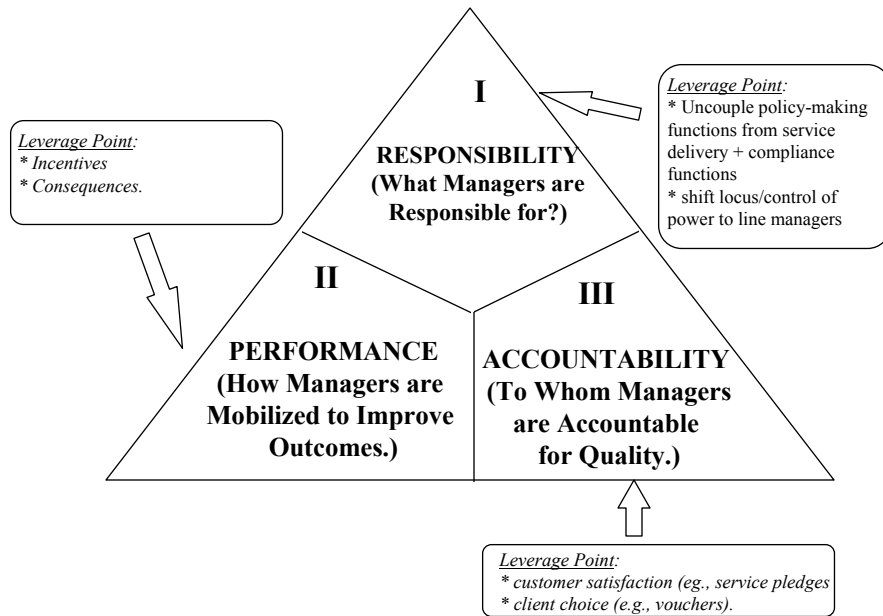
THREE BUILDING BLOCKS OF NPSM

Figure 2 depicts NPSM in terms of three building blocks that can be applied to the reform of public agencies. The first -- RESPONSIBILITY -- asks “what managers and organizations are responsible for”. It is concerned with “uncoupling” government functions into policy and regulation on the one hand, versus service provision and compliance on the other. The second -- ACCOUNTABILITY -- asks “to whom organizations should be held accountable for delivery and quality”. The third building block -- PERFORMANCE -- asks “how managers or departments can be mobilized to improve the delivery of agreed outcomes”. If an acronym is helpful at this juncture, one might employ RAP to capture the three building blocks of NPSM.

Some of the elements in Figure 2 may have a familiar ring. Public sector managers, for example, are likely to receive varying degrees of praise or criticism for their managerial performance. Moreover, the Ministers and managers of most public agencies have rhetorically pledged to improve the well being of the people they serve and respond to voter demands.

¹⁹ This part of the paper follows new public sector management thinking as reflected in citations in footnote 15.

Figure 2: Three Building Blocks of NPSM



What differentiates the components in Figure 2 from traditional interpretations, however, is the explicit introduction of policies **within each building block** that contain great leverage to influence clarity of purpose, agreements, power over decision-making, individual and team performance, and customer accountability. These leverage points are noted in Figure 2 and are discussed further below.

As we shall see, any one of the three building blocks of NPSM can be expected to make an independent contribution to the performance of public sector agencies. However, it is only when all three building blocks are activated that real synergies can be expected to take place in the performance and behaviors of public agencies. Rather than trying to control what people do (from the top-down), the building blocks of NPSM work together to influence what employees want to accomplish. Some advocates of NPSM argue that unless all three building blocks are activated together, it will be impossible to sustain *continuous* performance improvements over time.

Clarifying Responsibility

Imagine the organizational problems faced by the Minister of Health in a low or middle-income country where health services are planned by government, financed by government, and provided by publicly owned and managed health facilities. In this context, the Minister tends to be held responsible for a dizzying array of functions -- policy formulation, budget planning, recruitment and deployment of personnel, procurement functions, service delivery, and regulation. Most important decisions become highly centralized, with public bureaucracy being viewed as remote from people's real concerns. Moreover, government has a mammoth job just trying to keep track of public expenditures on inputs, and formalizing the process of work, let alone accounting for outcomes.

In short, the Minister may enjoy a huge amount of control over the MOH, but tends to be blamed for *not* (i) devoting sufficient time to the concerns of Parliament, formulating wise policy, and assuring quality through state regulatory functions, (ii) demonstrating efficient allocation of scarce resources for health goods and services, and (iii) monitoring and evaluating health outcomes to assure the public is receiving value-for-money.

Imagine also the dilemma of a motivated manager, charged with the responsibility of improving the health status of the population in one of the country's districts. The manager works hard to identify those services that are to be provided, has costed them, and has submitted a district budget to the MOH for approval. Incorporated into the district budget are a number of innovative proposals that would increase value for money. These include reallocating funds from prior budget lines to new priorities, sub-contracting some services that can be provided more effectively and more cheaply by local private agents, amalgamating a few public health units to serve areas where demand is greatest, and reducing staff in some underutilized places while increasing staff in shortage areas. The dilemma arises because she cannot meddle with the line-item budget allocations in her district, sub-contracting is not permitted, nor can she reallocate staff, and she must accept government assigned quotas. Moreover, she is never really informed if and when she will receive the budget allocation she requested but, rather, fears that "pledged" resources may be siphoned off for other government ministries.

The organizational problems described above are a recipe for professional demoralization. The Minister cannot possibly perform adequately in such a centralized, bureaucratic arrangement. The motivated manager risks becoming de-motivated, robbed of the incentive to take action and be held accountable for her proposed results.

Recognizing these familiar problems, the NPSM paradigm places great emphasis on 'uncoupling' traditional functions of government, ministries, and departments, so as to better distinguish roles, responsibilities, and skills needed to perform policy functions versus service delivery functions. This uncoupling is motivated by the premise that policy making and regulatory functions on the one hand, versus compliance and service delivery functions on the other, have different primary missions, thus requiring a different focus, mandate and management skills. This uncoupling is also motivated by the desire to shift the locus of power and control for policy, regulation, compliance and service delivery away from single hierarchical offices -- which cannot possibly do everything -- to other managerial echelons in the organization which are more immediately involved in production and delivery of services.

When the 'uncoupling' takes place, the first building block of NPSM -- clarifying responsibility - - comes into effect in two ways. First, the policy making function of government concentrates on specifying its vision of desired outputs and outcomes, rather than a more traditional emphasis on processes and inputs. That vision, as well as the desired outputs and outcomes, is shaped by (i) political processes (what the political party in power has promised and what voters want), (ii) consultations with expert groups (public health authorities, national medical associations, NGOs), (iii) consultations with other stakeholders, and (iv) feedback from the media and other channels. This part of the first building block therefore addresses "what is to be done by public agencies".

Second, the compliance and service delivery functions concentrate on how best to deliver what is to be done (as prescribed by the policy making function of government). To perform this function efficiently, the service organizations of government must be allowed greater control over their decisions, thus freeing them to innovate and make changes necessary to improve their operations. This involves trading, or at least relaxing, higher-level (Ministerial) control over these organizations in return for enforceable promises that they will deliver agreed outputs and

outcomes. Admittedly, this is likely to be an initial sticking point in launching the first building block of NPSM because traditional, hierarchically oriented managers are very reluctant to let go of control to managers of service organizations. This reluctance to devolve power tends to be reinforced by all sorts of misconceptions and worries about the absence or capacity of such managers.

The clarification of RESPONSIBILITY that is afforded by this uncoupling of functions lies in formal agreements drawn up between the policy functions (organizations) of government and the service delivery functions. It is through these agreements -- often formalized as interagency contracts -- that service delivery functions are held responsible for delivering pre-specified outputs and outcomes. When this is not done as expected, managers of the service delivery units may not have their employment contracts renewed. This presumes, of course, that employment arrangements for top managers of the service delivery functions can be changed from one of life-long tenure and security to relatively short-term performance based, renewable contracts (e.g., 3-5 years). This is the practice in Britain's National Health System, where managers of Executive Agencies and District Health Authorities are given 2-3 year contracts, renewable upon satisfactory performance. To compensate for reduced job security, such contracts typically carry large salaries and benefits. The NHA has had no trouble in attracting top-level executives to manage the District Health Authorities.

Some authors refer to the uncoupling process described above as 'the' core strategy of NPSM.²⁰ It is most concerned with getting higher-level government offices to do those things they are mandated to do better, while devolving control and daily management of service provision functions to others. With this uncoupling in place, our hypothetical Minister of Health focuses her energies on responsibilities that politicians are likely to do best -- assess demands of voters, explain public priorities to other Parliamentarians and citizens, formulate clear policies on the aims and objectives of the nation's health sector, formulate agreements with service organizations to do the job, regulate the work they do, and monitor and evaluate outcomes.

Enhancing Performance

Continuing with our hypothetical scenario, the second building block of NPSM -- enhancing PERFORMANCE -- is largely concerned with the work environment of the district manager who is charged with doing the right things *right*. The uncoupling process has now given her the flexibility to focus her energies on implementing health service agreements, with greater control over resource allocation decisions and business-like practices to implement them. A crucial difference for her District now is that accountability for what she does and how she does it goes from being external (dictated by the Minister) to being built into new organizational arrangements. This is set into motion when she agrees, on behalf of her District employees and public providers, to supply a pre-determined set of services for a pre-determined budget, over a pre-determined time frame. Built into that agreement may be hard budgets, clearly specified outcomes that are to be delivered, district-level reporting on progress, and centrally or district-financed audits and client surveys.

To live up to the new performance expectations, the district manager has recourse to create incentives as well as consequences for the performance of her agency and its employees by utilizing:

²⁰ Osborn & Plastrik, 1997, *ibid*.

- personnel performance management for her own employees
- managed competition and contracting for employees working elsewhere, and
- enterprise management and commercialization.

Personnel Performance Management (PPM) involves written terms of reference that set individual achievement targets, standards, rewards and penalties for each worker or group of workers. On the positive side, PPMs may be introduced relatively quickly, following decisions by senior management to do so. They contribute greatly to clarity of understanding between managers and employees on the nature of work and outcomes expected, with rewards and pay linked explicitly to performance and deliverables. On the negative side, subjective judgments can enter into performance assessments by managers, and reward and penalty structures may be relatively weak. Our hypothetical district manager would use PPMs to convey that performance of the District is a shared responsibility -- with everyone expected to do their part -- rather than her responsibility alone.

It is well established among organizational theorists, however, that change in behaviors is hardest to motivate from *within an* organization, whereas it is easiest to motivate when employees perceive an external threat to the organization. Perception of an external threat tends to motivate a collective behavioral response to do better. An external tool for obtaining leverage over performance involves **managed competition and formal contracting**. On the one hand, this requires public agencies to tender contracts for the provision of goods and services to competing contractees. Contracts can be awarded only to public sector providers (creating an 'internal market'), only to private sector providers (contracting out or out-sourcing), or to either public or private providers (managed markets). Contracts may be competitive or negotiated.

This process of designing and negotiating contracts involves considerable thinking about what is wanted, where, when and for whom, as well as the formulation of tight contractual arrangements whereby contractors promise to deliver. Managed competition -- where contracts are awarded to either public or private providers -- can also be construed as a form of public-private collaboration, whereby the public sector is the source of financing of goods and services, but where private sector entities provide them. This requires potential providers of government services -- both private firms and/or public agencies -- to compete against one another for contracts, based on performance. Our hypothetical district manager would be looking for every opportunity to sub-contract services in order to contain costs -- through competition -- and improve quality.

In the UK's national health system, the aforementioned approach operates when District Health Authorities receive public funds -- in return for promises they will fulfill policy goals -- and then contract with a variety of public and private providers to supply the services. It is the competitive tendering and bidding process that works to increase performance and value for money because both public and private providers, such as hospitals, endeavor to sell their services at a more attractive price than they would were they occupying a monopoly position. Efficient contractees win contracts and enhance their rate of economic return while inefficient contractees fail to win contracts, and are threatened with going out of business.

Use of incentives/consequences as a performance leverage point can lead to continuous improvements because each round of competitive bidding is guided by "memory" of costs associated with prior bids and endeavors to cut those costs or improve services further in the future. Those providers that fail to win contracts receive strong messages that they are not competitive, that they must offer more value for money. Observers note that where public service

agencies use competitive contracting willingly and enthusiastically, they typically save 20-25% in their first round of contracting.²¹

A third tool for obtaining leverage over performance involves *enterprise management and commercialization*. This forces public service delivery organizations to function as a business enterprise with a financial bottom line. They may do so as public agencies with a mandate to charge user fees for some goods and services, or as quasi public agencies -- public corporations -- that focus on business goals, such as maximizing profits and return on investments.

Rather than acquiring their revenues from tax dollars, public enterprises earn some or all of their money by selling goods and services directly to their customers. One may require the public agency to live within a hard budget, thus forcing it to look to paying customers if it wants to expand or sustain services. Another option is to allow public agencies to “market test” the demand for the goods and services they provide -- by charging user fees -- and to modify those goods and services to better reflect demand. Revenues from fees can be used towards rewarding the performance of employees, thus reinforcing incentive structures. If the public producers fail to offer goods and services of adequate quality, or fail to anticipate what customers want, then customers will not come forth and pay for them. This can provide a strong signal to the public providers that they are not appropriately serving their customers, or that they have failed to understand their market. If governments are unwilling to bail out public agencies under enterprise management when they overspend, the results of poor fiscal mismanagement become more painful and immediate, usually manifesting in layoffs.

Client Accountability

Our newly liberated District manager will clearly seek feedback and approval from the government authorities who authorized her service agreement. But what about the approval of the households she serves in the District? What do the citizens think of her performance and how can they be meaningfully involved? Client accountability constitutes the third building block of NPSM. It anchors accountability in a consumer-oriented strategy that emphasizes customer satisfaction and client choice.

An important tool to obtain leverage in this area is for public providers to prepare a charter of consumer rights. This not only helps to establish client-conscious targets, but also provides clients with benchmarks against which judgments can be based. A useful rule of thumb in the interpretation of benchmarks is “What gets measured and reported gets attention.”

In Malaysia, for example, Clients Charters have been developed for over 300 public sector agencies. The Charters are posted at public locations in government offices and distributed in booklets. Agencies are responsible for setting their own service standards, and offer awards to encourage improvements. Charters set out the standards of service, explain how performance will be assessed against those standards, indicate how the public can provide suggestions against those standards, and tell the public how to complain in the event of dissatisfaction.²²

²¹ Osborne & Plastrik, 1997, *ibid*.

²² Hj Hazman Shah Abdullah, 2003, “Client Charters in Malaysia: Moving Beyond Symbolism” (Hong Kong: Paper presented to International Symposium on Service Charters and Customer Satisfaction in Public Services, December 8-9, mimeographed).

In the UK, there are over 40 Charters covering the main public services that set out principles and mechanisms to improve public services and make them more responsive to the needs of users. These include setting, monitoring and publication of explicit rights; providing full, readily available information about services; providing choice where practicable and consultation with service users; promising a courteous and helpful service from accountable public servants; and an apology and swift remedy if things go wrong. For example, the “Patients Charter” of the National Health Service promises:

- When you go to an outpatient clinic you can expect to be given a specific appointment time and be seen within 30 minutes of that time.
- If you call an emergency ambulance, you can expect it to arrive within 14 minutes in an urban area, or 19 minutes in a rural area.
- If you go to an accident and emergency department, you can expect to be seen immediately and have your need for treatment assessed. If you are admitted, you will be given a hospital bed within two hours.

Some elements of the Patients Charter have given rise to harsh criticism of the National Health Service -- particularly the failure of health providers to reduce waiting times for hospital admission. This has served customers insofar as their dissatisfaction prompted a review of the supply and cost of such services, as well as decisions to reconsider the UK’s internal market strategy.

Leverage also occurs when clients are empowered to take their business elsewhere. In the private sector, this happens spontaneously when dissatisfied *paying* consumers switch from one provider to another who is perceived to be better. In the public sector, consumer or demand-side power can be exercised in at least three important ways. First, NGO’s and consumer watch-dog groups can monitor and publish performance and quality information, thus arming consumers with information to make more informed choices. For example, beginning in 1994 in the US, the National Committee for Quality Assessment (NCQA) formed a consortium of health plans, employers, consumer representatives, labor, and health policy experts to develop a report card to evaluate and compare health plans (providers) in the areas of quality of care; member access and satisfaction; membership enrollment and utilization; and finance. Shortly thereafter, when readers consulted ratings in widely circulated consumer publications, they learned the following about Kaiser Permanent (KP), a leading HMO:²³

- KP won some of the highest ratings in a 1995 survey of 64,000 health plan members of 115 health plans located in 20 of the largest US metropolitan areas;
- 89% of members said they were satisfied or highly satisfied, compared with 88% in 1994;
- 83% of child members were fully immunized, compared with 83% in 1994;
- 69% of adults had cholesterol screening, compared with 70% in 1994;
- 73% of women were screened for breast cancer versus 71% in 1994.

As another example, the World Health Organization began undertaking surveys in thirty countries in the year 2000 to assess client satisfaction with quality of services. Results will feed into

²³ Kaiser Permanente, 1996, “Quality Initiatives and Outcomes Projects”, Oakland, CA: Kaiser Permanente, mimeographed.

WHO's multi-faceted attempt to measure performance of national health systems.²⁴ In Columbia, consumer assessments of managed care in 2000 show relatively high degrees of satisfaction for providers in different geographical regions. Measured on a 5 point scale (with "5" being highest), clients rated "quality of interpersonal care" between 4.181 to 4.528 across several geographical regions: quality of "amenities" between 4.169 to 4.566; and "degree of choice" from 3.947 to 4.181. In contrast, variation was wide on the proportion of clients having to wait more than one hour for service, ranging from a high of 75 percent in the poorest performing region to 46 percent in the best.²⁵

Second, government can help empower those without the financial means to switch, for example through vouchers, thus transferring purchasing power to customers. A voucher program, for example, typically transfers purchasing power to the client by giving him/her the means to pay for a particular service from the provider of his/her choice. Rather than supplying tax dollars directly to public schools in a traditional District, for example, some governments are channeling the tax dollars more directly to households in the form of a voucher, roughly equivalent to the cost of a child-year of education. The aim is to empower the household to pick the public or private school within the district that best suits parental preferences and the child's needs (i.e., closer proximity, higher perceived quality). It therefore places the onus on the school to provide quality education, and to attract the household's voucher as a means of securing payment for the school's recurrent expenses. Experiments in many US cities have demonstrated that this strategy forces schools to be cognizant of customer perceptions, and satisfy customer needs (such as by providing special education classes, foreign language training etc.).

Third, purchasers of health services can be established on behalf of consumers and can make use of provider payment mechanisms (e.g., capitation payments) that can empower clients. To illustrate, a capitation scheme gives a predetermined amount of tax dollars *per capita* to each public health provider in a district to supply an agreed upon "package" of services for the duration of, say, one year. Assume that amount is \$50 per capita per year. The total amount of funds received by the health provider (e.g., a rural clinic) is then determined by multiplying the number of people that ***enroll for service for, say, a year's duration***, at the clinic, times the per capita amount. If 1,000 people are enrolled, for example, then the facility would receive $\$50 \times 1,000 = \$50,000$. People need not enroll at the same facility in the future: they can "vote with their feet" and enroll with a different provider if they are dissatisfied with the health services of their current provider (e.g., they do not get the package of services promised, or it is provided at low quality). If increasing numbers of dissatisfied or prospective patients switch to another health facility, the managers of the disfavored facility will quickly see the negative implications for their annual budget. They will have to shape up their services or look elsewhere for employment.

Reimbursement of public health facilities by capitation therefore forces providers to be cognizant of the needs and satisfaction levels of their clients. This often provides the impetus among providers to introduce client satisfaction surveys -- allowing clients to express their views and providers to hear them. It also results in 'quality competition' between providers, lest a higher

²⁴ Assessment of performance criteria was initiated in WHO's World Health Report, 2000, but came under heavy criticism because the empirical basis of various indices of performance used in the report were weak. The current round of client satisfaction surveys aims to fill one of the outstanding gaps.

²⁵ Diana Margarita Pinto Masis, 2002, "Managed Competition and Quality of Care from the Consumers Perspective: Evidence from Health Care Reform in Columbia", Boston: Unpublished Ph.D. Thesis, Harvard School of Public Health.

quality provider begins to attract away all the clients. Crudely speaking, capitation puts a “bounty” on the heads of all potential customers, motivating providers to take notice of them, as well as design innovative ways of attracting them. Imagine the effect this might have in rural clinics in many low-income countries, where health care personnel are often criticized as being rude and inattentive of poor, low-income patients. Capitation thus empowers the client and penalizes negligent providers.²⁶ This kind of scheme has been operating in Thailand’s Social Insurance Fund since 1999, and has been operating in a rural District in Tanzania, called Igunga Community Health Fund between 1997-2002.

This last building block of NPSM -- accountability to clients -- works best when elected officials are permitted to define the goals of public agencies in terms of customer satisfaction, and then hold service providers accountable for satisfaction levels. Many public agencies behave as though they occupy a near monopolistic position, with the implication they need not be too worried about the neglected client. Most public agencies are also part of larger systems that use bureaucratic rules to control service providers, with the implication that enforcement of quality standards tends to be left to central levels of government -- a largely top-down approach. Hence, increase the clout of the customer-oriented building block of NPSM, it is important to also use the performance enhancing building block. In short, to force public bureaucracies to transform themselves into more entrepreneurial organizations, customer strategies need to be wedded to consequences for performance, as well as the kind of decentralized management (or autonomy) that derives from uncoupling policy and service functions most.

CAPTURING SYNERGIES

As noted previously, rather than trying to control what people do (from the top-down), the three building blocks of NPSM work together to influence what employees want to accomplish. They also work simultaneously to get employees to care about achieving the organization’s goals. Whether one is working in a policy-making public agency, a public service delivery agency, or a public compliance agency, the issues are the same:

- get people to be *clearer* about their agency’s goals as well as their professional responsibility to see those goals realized;
- provide people with the *incentives* to make a difference and consequences for failing to accomplish goals;
- increase the sense of *relevance and immediacy* of achieving the organization’s goals by putting employees in closer contact with the customers they serve;
- increase transparency and accountability on all fronts.

In the final analysis, it is the incentive structures that are crucial for economic performance, and the three building blocks of NPSM work together to shift the values, belief system, and organizational culture towards this end. Managerial culture in public agencies changes to the

²⁶ It is also important to note that capitation can be abused by providers insofar as perverse incentives may be in place for them to underserve clients for the guaranteed per capita amount they receive. Clients are at risk of not perceiving they are underserved because of asymmetries of information, whereby highly specialized medical personnel usually know more about needed services, and could shirk on providing them. Since asymmetries of information are at the heart of this issue, government has an important role to play -- through regulation -- to assure that clients are indeed receiving the services they require.

extent that there is now greater emphasis on measuring performance in outputs rather than inputs; improving management information systems; introducing cost control mechanisms; ensuring that incentive systems and rewards are compatible with the objectives. Synergies are expected to take place when improved outcomes set new standards of performance, thus stimulating a process of continuous improvement over time.

No pretense is made that the three building blocks of NPSM, even when used in tandem, or even when backed with strong political commitment, will magically transform public bureaucracy and its organizational culture. What is expected, rather, is that the three building blocks will work directly on several dimensions known to shape organizational culture, and that these in turn will exert indirect, but important impacts on others. This is illustrated in Table 2. A relatively strong and direct impact is anticipated on an organization's (1) purpose, (2) incentive systems, (3) accountability, and (4) shifts in the locus of managerial control, power, and responsibility. Changes in these organizational dimensions might reasonably be expected over a 3-4 year period because they can be influenced by NPSM-related policy decisions, clearly specified agreements and contracts, and tools like customer surveys.

The changes brought about through the first column of Table 2 are then expected to force changes in the organization's (5) administrative systems, (6) organizational structure, (7) organizational tasks, and (8) work processes. For example, the administrative and organizational process of designing, tendering and reviewing contracts in the UK National Health System evolved over time from a highly rudimentary process to a more refined process as agencies gained experience and perfected their approaches. Such impacts tend to be indirect, however, take time to evolve, and must demonstrate their worth prior to being accepted. This second set of factors might reasonably be influenced by NPSM over the medium term (say, 4-8 years).

Table 2: Impact of the Three Building Blocks of NPSM

| <i>Strong & Direct Impact on Organization's</i> | <i>Indirect Impact on Organization's</i> | <i>Highly Lagged Impact on:</i> |
|---|--|---------------------------------|
| 1. Purpose | 5. Administrative Systems | 9. Leaders' Predispositions |
| 2. Incentive Systems | 6. Organizational Structure | 10. Employees' Dispositions |
| 3. Accountability Systems | 7. Organizational Tasks | 11. External Environment |
| 4. Locus of control/power/responsibility | 8. Work Processes | 12. History and Tradition |

Source: Adapted from Osborne and Plastrik, 1997

Greatest resistance to change tends to lie in historical and cultural predispositions that have long been held by leaders and employees. This set of factors, listed as items 10-14 in Table 2, can be expected to take considerable time to modify (perhaps stretching over two decades?). Such predispositions may even work to sabotage the introduction of NPSM reforms, before they are given a chance to prove themselves. This problem can be tackled by (i) drawing attention to respected champions of the NPSM, (ii) involving employees in study tours of NPSM experiments that are underway, (iii) initiating and closely monitoring NPSM pilot reforms, (iv) promoting open forums to vent concerns about NPSM, and (v) mobilizing evidence-based support.

Sometimes, those most resistant to change, who are attached to the old ways, must be replaced by those willing to experiment and adopt promising new methods.

ARE THERE LIMITS TO WHAT BUSINESS-LIKE PRACTICES CAN ACHIEVE?

The search for an appropriate set of NPSM practices does not come without complications.²⁷ Public sector managers not only face the challenge of implementing business-like practices to improve economic efficiency (as in the private sector), but must also cope with the responsibility of remaining *publicly accountable* to taxpayers and voters. In the context of health sector reform, therefore, the desired outcomes will extend beyond improved performance of public agencies in terms of effectiveness and efficiency, to include *fairness and equity* as well.

This dual burden is illustrated in Table 3 in the form of differences between a formerly public agency that has been privatized versus one that is undergoing NPSM reforms. Column 1 depicts the goal, motivation and challenges that confront the manager of a former public agency that is being divested to the private sector. When this happens, the new managers tend to face only one, relatively unambiguous set of challenges. They must capture market share, demonstrate profitability, or go out of business. They tend not to be held accountable for equity. An example is the privatization of a formerly public agency responsible for purchasing and supplying electricity to businesses and residences.

In contrast, when public agencies undergo NPSM reforms that do not include privatization, they face a dual set of goals, performance and challenges. One set closely parallels the challenges facing managers of a newly privatized agency, while the other is unique to the public sector: taxpayers demand that performance be guided not only by efficiency and quality but by equity concerns, fairness and justice. Because these two goals are sometimes in conflict, public sector managers can become ensnared in tradeoffs between efficiency and accountability, and cannot rely solely on cost, efficiency, and business-like criteria to guide their behavior. An example is the application of business practices -- including user fee policies -- at district and national hospitals, where hospital administrators are forced to contend with the inability to pay by poor patients through exemptions policies. Such conflicts are at the heart of debate concerning the effectiveness of NPSM, motivating some observers to argue that public accountability requirements limit the effects of NPSM.²⁸

²⁷ David Osborne and Ted Gaebler, 1992, *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector* (Reading, Mass: Addison-Wesley).

²⁸ Osborne and Gaebler, 1992, *ibid.*

Table 3: Public Sector Reform Strategies

| | Divest (1) | New Public Sector Management (2) | |
|-------------------|---|---|--|
| Goal | Downsize | Economic Efficiency | Public Accountability |
| Motivation | <ul style="list-style-type: none"> • Reduce public sector deficits & spending • Reduce size of public sector • Reduce excess burden of taxation and inefficient 'crowding out' | <ul style="list-style-type: none"> • Value for Money | <ul style="list-style-type: none"> • Due Process • Transparency of Rules • Fairness |
| Challenges | <ul style="list-style-type: none"> • become competitive • attract paying customers • satisfy shareholders • demonstrate profitability | <ul style="list-style-type: none"> • Increase 'X efficiency'²⁹ • Increase flexibility • Influence worker incentives • Shift emphasis from inputs to outcomes • Transform rule-driven organization | <ul style="list-style-type: none"> • Impartiality in resource allocation • Move from hierarchy to participation & teamwork • Empower clients rather than "provide for" • Promote individual and group justice in the form of "fairness" • Equal protection in the face of unequal income • Know/accommodate demand |

²⁹ X-efficiency (coined by economist Harvey Liebenstein) is the effectiveness of a firm's management in minimizing the cost of producing a given output or maximizing the output produced by a given set of inputs. In the former case, X refers to the output; in the latter case, X refers to the set of inputs.

PART III: ORGANIZATIONAL STRATEGIES FOR NPSM REFORMS

Imagine you are the Minister of Health, charged with the responsibility of making major improvements in the performance of civil servants in the country's national health system through the adoption of New Public Sector Management (NPSM) practices.³⁰ How would you go about it? What would you do first? And how fast would you move?

If you were Margaret Thatcher, commandeering a political bulldozer on a wave of political support, you would likely opt for a government-wide Big Bang approach. Thatcher had the political clout to impose her vision of government reform, downsizing, competition between public providers, and privatization in record time -- regardless of the public outcry heard from many constituencies. The Thatcher reforms adopted all three-core building blocks of NPSM -- as previously described in Figure 2 -- on a government-wide basis.

If you were Graham Scott, architect of the New Zealand reforms, you would likely propose that "Fast is better than slow", but you would also warn that lack of preparation and consultation in health will likely jeopardize progress. That awareness has further prompted Scott to caution the government of Mongolia about moving too fast in its zeal to introduce Big Bang public sector reforms in a country that is only beginning to emerge from a long tradition of communism and centralized control. The New Zealand reforms also adapted all three-core building blocks of NPSM on a government-wide basis.

If you were Robert Stone, Chief Energizer, of the US National Performance Review, you might surmise that had US business leaders had been responsible for applying government-wide NPSM reforms -- instead of the US Congress -- the country would probably have undergone a dramatic, Big Bang overhaul -- just as in the private sector! You would also lament that the US national congress has favored a 'go slow' approach. The US reforms concentrated largely on the second (performance) and third (accountability) building blocks of NPSM on a government-wide basis.

If you were Katele Kalumba, past Minister of Health in Zambia, you would strongly endorse the sector-wide approach to health reform that the government adopted between 1993-98, especially the separation and clarification of policy roles (at the center) versus the service provision roles and management of devolved budgets at district level. You would also point out, however, that injecting NPSM reforms in just one sector (health), without creating the appropriate enabling environment across all sectors will create a drag on what NPSM can achieve. Problems in Zambia manifest particularly in the management of civil service personnel and the authority to hire, fire, and reward performance by line managers. The Zambia reforms contained all three building blocks of NPSM but in only one sector -- health.

³⁰For a detailed discussion on organizational reforms options in the health sector, see Preker A.S. and A. Harding, Eds., 2003, *Innovations in Health Service Delivery: The Corporatization of Public Hospitals, Health, Nutrition, and Population Series*. Washington, World Bank; and Jakab M., A.S. Preker and A. Harding, 2002, *The Introduction of Market Forces in the Public Hospital Sector: From New Public Sector Management to Organizational Reform*, Washington, World Bank.

Finally, if you were representing many other countries and contexts, you might well advocate a more incremental, learning-by-doing approach, such as (i) the Autonomous Agency program in Singapore which extends across all sectors, (ii) purchaser/provider split strategies in Mexico and Columbia which feature managed competition and contracting, and (iii) hospital autonomy initiatives in Kenya and Tanzania. In each of these countries, pilot approaches and experimentation are in place, with next steps contingent on lessons learned.

Whatever the approach adopted, it is useful to identify different *organizational strategies* that might be employed to strengthen the three core building blocks of NPSM -- responsibility, accountability, and performance -- in public agencies. Part III of this paper identifies five such strategies including (i) personnel performance management, (ii) performance-related budgeting, (iii) autonomous agencies, (iv) managed competition and the contract state, and (v) corporatization.

No pretense is made that the five strategies noted above are inclusive of all NPSM tools and techniques. These five are featured here because they incorporate or mimic business-like practices towards increasing the effectiveness and efficiency of employees, line managers and senior managers.³¹

An additional caveat is that none of the organizational strategies reviewed here can be so conveniently carved up for implementation and analysis in the real world. Nor are they likely to work in complete isolation of each other. Indeed, they may overlap.

ORGANIZATIONAL STRATEGY 1: PERSONNEL PERFORMANCE MANAGEMENT (PPM)

In the early 1990's, a team of international experts conducted a public expenditure review in an East African country and discovered that thousands of so-called ghost workers were on the payroll, even though they had not been seen in the office for long durations of time. Further inquiry revealed that more than several hundred of these civil service ghost workers had died. Yet *someone* was still receiving and cashing their payroll checks!

In a Southern Asian country, a team of international experts conducted spontaneous visits to a number of government offices in the Ministry of Health, only to find that many officials were not on the job. On probing deeper, the international experts were advised to pre-announce their visits, with the expected result that the respective government officials would be motivated to come to work, and be on hand.

In a Latin American country, a visiting team of experts were asked to review the functions of several higher-level civil servants in a newly established service agency, towards discerning areas of responsibility, overlap and possible duplication of functions. However, when they asked to see "terms of reference" or "job descriptions" for the relevant positions they were told there were none, at least for distribution and review.

³¹ Another important vehicle for improving public sector performance and accountability is decentralization. It is not included among our five organizational strategies, however, because it is inherently a public sector strategy and it makes use of one or more of our five organizational strategies to achieve its intended effects.

Rectifying the kinds of problems above is perhaps the most visible, overt challenge facing the New Public Sector Management. More difficult is to motivate employees to take ownership of an agency's goals, accountability for outcomes, and to feel pride when they are realized. And perhaps the most difficult challenge of all concerns the preparation of a professional cadre of managers in contexts where management skills have always tended to be weak, and management per se poorly understood.

A New Public Sector Management organizational strategy that addresses the kinds of problems noted above is called Personnel Performance Management (PPM).

- ***PPM is a process that engages both employees and managers in an interactive process to identify performance goals, criteria of accountability, and developmental actions to improve skills and performance in the future. PPM mimics business-like practices because it rewards performance, responsibility and accountability of employees and line managers with consequences and incentives.***

Operating principles of PPM are that:

- Managers have primary responsibility for coaching staff to achieve improved performance and results,
- Staff have primary responsibility and accountability for their own performance and development
- The key interface is an ongoing dialogue between performer and manager
- PPM is a shared responsibility.³²

PPM takes on immense importance as an organizational strategy for injecting NPSM principles into public agencies because (i) human resources represent a large share of government (and MOH) recurrent expenditures -- 60-75%, (ii) employees and line managers make almost all decisions regarding inputs and use of resources, and (iii) clarification of individual performance expectations helps align individual efforts with institutional goals.

PPM takes on even greater urgency in contexts where new managerial, administrative, and technical roles are rapidly being created -- for example, to manage hospital "hotels", negotiate reimbursement agreements with health care providers, and formulate and evaluate service delivery contracts. In the UK, for example, the reformed National Health Service has resulted in a five-fold increase in general and senior managers from 4,600 in 1989 to nearly 23,000 by 1994. Skill shortages and managerial capacity has emerged as a major issue.³³

³² Adapted from presentation by Ken Avis, International Financial Corporation, to World Bank Institute Flagship Program on Health Sector Reform and Sustainable Financing, Washington, DC, November, 1998.

³³ A similar expansion in managerial functions can be anticipated as part of decentralized health administrations and devolved budgets in many countries (Module 9), again adding to the importance of PPM in contexts where bureaucratic control is shifting further away from the center.

PPM is based on the premise that workers -- employees and line managers -- are a public agency's greatest resource (see Box 1). It seeks to enhance public sector performance by:

- involving public sector employees more directly in establishing their professional goals over an agreed planning period -- for example, fiscal year 1999,
- linking personnel performance to the satisfaction of other team members as well as clients,
- giving employees more of a direct stake in their organization's results, and
- providing appropriate consequences for top performers (e.g., pay increases or other bonuses) and poor performances (e.g., no pay increase, termination of employment).

It is when all four of these dimensions come together than PPM can feed strongly and effectively into the aims of NPSM.

Box 1: Stone's Universal Truths³⁴

Robert Stone, Chief Energizer for NPSM reforms in the United States government claims the following:

- Workers know work better than managers and politicians;
- Consumers know what they want better than managers do;
- People are capable of things you and they never dreamed of.

Establishing annual performance agreements: A first step in the PPM process is to establish annual performance agreements, based on consultations between the employee and his/her supervisor. The purpose of annual performance agreements is to activate employees to start thinking about the tasks and results ***they aim to achieve*** over the work year, as well as the kinds of attributes they will exhibit in carrying out their duties. Annual performance agreements are particularly effective in motivating staff when they emphasize ***results*** or ***outcomes*** to be generated by the employee's actions, rather than the action itself. For example, the line-manager of a hospital outpatient department might agree with his/her hospital CEO to reduce the prevalence of STDs in the population served by the hospital. This qualifies as a result or outcome, whereas simply introducing an STD screening program for women and men is more akin to an action -- without responsibility for a result or outcome being specified.

Performance agreements hold employees accountable for results because expected work outcomes or targets are discussed between employee and supervisor, agreed upon, and recorded at the beginning of the year. This agreement is then used as a basis for performance assessment at the end of the year. For example, the Annual Performance Agreement provided in Box 2 serves as the basis for performance 'contracts' between employee and supervisor in a multilateral development agency that has a large portfolio of assistance for 'health'. The first part of the form focuses on a "Results Agreement" and specifies what is to be accomplished in a particular year. Usually, employees enter three to five specific results agreements specific to the tasks they expect to perform over the duration of one year.

The second part of the form in Box 2 contains a "Behavioral Assessment" with generic categories that are of importance to the employee's agency or department. In the case of the multilateral

³⁴ Presented by Robert Stone at a World Bank seminar on "Government Reorientation" (Washington DC: World Bank, June 11-12, 1998).

development agency, four behavioral assessment criteria are to apply to all of its employees, with the implication that all employees will be rated on these same four criteria each year. These criteria are (i) client orientation, (ii) drive for results, (iii) teamwork, and (iv) personnel management. This part of the form targets behavioral changes in employee attitudes, interpersonal relations, and client orientation over time. Evaluation of employees on these criteria will therefore take place annually over a period of several years.

The third part of the form in Box 2 contains a “Development Actions Assessment”. This section identifies actions -- such as applied technical training, enrollment in a University course, or study tours -- that would help improve the staff member’s future performance. In the multilateral development agency, it is mandatory that employees spell out Development Actions and that the employee and his/her manager agree on freeing up time and resources to assure the needed training takes place. This is a particularly appealing dimension of PPM because (i) it provides the staff member with the opportunity of identifying training that he/she feels would enhance his/her performance, (ii) it signifies that the employer places a high premium on investing in the human capital of his/her employees, and (iii) it can serve as a record of continuous improvements in the staff member’s skill profile.

The PPM, as described above, is not only designed to serve as a performance-enhancing device for employees in say, a production or service unit. The aforementioned international development agency requires all line managers to complete the form as well -- in consultation with their supervisions -- and to identify developmental actions that will enhance their managerial capacity.

For such performance agreements to have clout, however, they must be tied to a set of economic and other incentives. The aforementioned international development agency accomplishes this by (i) rating or quantifying the employees performance on each of the annual work program results, (ii) rating or quantifying the employees performance on the four behavioral dimensions, (iii) adding up the overall performance scores, and (iv) linking the results with a performance pay-raise and promotion schedule.

In cases where financial rewards are not permitted, other kinds of incentives can be entertained such as:

- Quasi-financial incentives such as paid time off, new equipment or amenities,
- Bonuses: one-time cash awards in addition to salaries, that go to individuals or teams that achieve specified performance targets,
- Gain sharing: gives employees a clear economic stake in increasing their productivity, in the form of a guaranteed portion of the financial savings their organization achieves -- as long as specified service levels and quality are reached,
- Performance pay: “merit pay” that ties pay schedules and pay raises to performance, by linking a substantial portion of employee pay to performance.

Box 2: Sample Overall Performance Evaluation

| | | | | | |
|--------|----------|-----------------|------|--------------|-------------------------------------|
| Name: | JOHN DOE | Level: | | Primary | <input checked="" type="checkbox"/> |
| Title: | | PMU/Unit: | | Supplemental | <input type="checkbox"/> |
| UPI#: | | Period covered: | From | To | |

| | | | | | | |
|--|---|------------------------|-------------------------------|------|--------------------------|------|
| RESULTS ASSESSMENT (Up to 5 Key Work Program Results/Team Contributions for which staff member was responsible): 1. (Example: Be on the job every working day -- no goofing around) 2. (Example: Eat smaller lunches and lose 30 pounds so I can work harder and faster) 3. (Example: Cut back my cigarette smoking and stop contaminating the breathing area of my work fellows) 4. (Example: Wear my seatbelt everyday and stop speeding) 5. Read more novels off the job than on-the-job | (1) | (2) | (3) | (4) | (5) | (6) |
| | 1--not attempted; 2--minimally effective; 3--partially effective; 4--largely effective; 5--fully effective; 6--exceptionally effective | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| BEHAVIORAL ASSESSMENT Client Orientation Understands client; Produces services and products for clients; Uses knowledge to equip clients; Meets clients' needs Drive for Results Makes things happen; Is proactive; Balances "analysis" with "doing"; Sets high standards for self; Commits to organizational goals Teamwork Collaborates with others; Shares knowledge; Acknowledges others' contributions; Works effectively in diversity (culture and gender); Seeks help as needed People Management (For Managers) Selecting, Coaching & Appraising Staff; Planning & Managing Staff to Achieve Quality Results; Encouraging Innovation and Open, Team Based Environment; Inspiring Trust; Influencing & Resolving Differences Across Boundaries | 1--not demonstrated; 2--weak; 3--improving; 4--competent; 5--strong; 6--outstanding | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| DEVELOPMENT ACTIONS ASSESSMENT (Development Actions staff member agreed to pursue): 1. (Example: Take computer upgrading so I can word process instead of writing in pencil) 2. (Example: Take a course in the new public sector management so I can become twice as effective and get bonuses) 3. | Not Accomplished | | Partially Accomplished | | Accomplished | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| OVERALL COMMENTS (optional) Supervisor: Staff Member: | | | | | | |
| SIGNATURES | | | | | | |
| I have discussed this evaluation with my supervisor: | | | | | | |
| Name & Title of Supervisor | | Supervisor's Signature | | Date | Staff Member's Signature | |
| | | | | | | |
| COMMENTS (optional) and ACTIONS RECOMMENDED OR DECIDED (if any) | | | | | | |
| Name & Title of Reviewing Manager | | | Reviewing Manager's Signature | | | date |
| | | | | | | |

Linking Performance to Client Satisfaction: Annual performance agreements can also provide employees with potent feedback on how useful their work and service has been to a range of clients. On the one hand, the agreement can help define who the employee's clients are or should

be -- in other terms, who he or she should be held accountable for delivering results. On the other hand, the agreement can serve as a formal device whereby clients have the opportunity to offer praise or criticism for the work done. Multiple clients are served when an employee carries out functions that are not only relevant to the results promised by his/her own division, but that yield support functions to other divisions as well. In the case of the aforementioned intentional development agency, feedback from each employee's clients is actively sought by managers, serving as an important input to PPM end-of-year evaluations.

Summing Up:

PPM is an important organizational strategy for injecting NPSM principles into public agencies because it impacts on two core building blocks of the NPSM paradigm -- performance and accountability. PPM rewards performance with incentives, such as pay raises and bonuses. Performance records in a particular year can then serve as a benchmark against which future PPM agreements can be formulated and acted upon. Moreover, gaps in performance can be addressed by the employees themselves by enrolling in specially tailored training programs. PPM rewards accountability insofar as (i) a range of clients can be pre-defined, and (ii) client input can be sought when managers undertake a PPM evaluation. Depending on one's position or role, a "client" could comprise a voter, a patient, a co-worker, or another department or unit.

An appealing feature of PPM is that practices making use of economic incentives can be introduced relatively quickly, even though government may be unwilling to restructure laws governing civil service employment. At the same time, the effectiveness of PPM will be undermined if managers are not empowered to hire, fire, or reward stellar performance with financial or other appealing bonuses. Moreover, the effectiveness of PPM will be undermined if insufficient time is devoted to preparing managers and employees for the task. Potential problems with PPM are noted in Box 3.

Box 3: Potential Problems with Personnel Performance Management

Increased Time Pressures on Managers: The PPM process tends to be time consuming, especially if a manager is responsible for a large number of staff. Time involved includes meeting with each staff individually to determine performance objectives at the beginning of the performance period (e.g., calendar year), and as well as at the end of the year. Often, managers must solicit input for many other persons more directly involved with each staff member, again demanding more time. If the PPM process is to be done well, managers must be given the time to do it and plan accordingly.

Lack of Clarity Over Purpose and Process: Most organizations experience considerable staff turnover with each new employee having to learn procedures. Confusion almost always centers around PPM -- how to do it, when, what constitutes a well-completed personnel consultation process. This confusion can be reduced considerably by preparing a briefing package, with examples, and making it available to all new staff.

Inconsistency or Variability Among Managers: Managers frequently have different skills in conducting a PPM with employees, and may use different "standards" when rating performance. For example, a very direct and demanding manager may seldom award a high performance rating to employees, whereas another less demanding manager may give his/her employees a far higher proportion of high performance ratings. Employees correctly perceive that such differences may hurt their careers in the future. This problem can be partially resolved by conducting briefing and training sessions for all managers, so as to promote agreement on agency-wide criteria. Even so, managers will have to be monitored for their behavior in this regard.

Failure to Match Performance with Promised Incentives: Performance incentives (e.g., pay raises) are typically associated with the PPM process. For example, many public agencies or private companies will link pay raises to levels of performance achieved, and will communicate the pay increases well in advance. Failure to deliver on these incentives -- for example, due to budget shortfalls, or policy changes made by senior management -- will seriously undermine the respect of staff for the PPM process.

ORGANIZATIONAL STRATEGY 2: PERFORMANCE-RELATED BUDGETING

In the early 1990's, the InterAmerican Development Bank singled out Colombia as one of the best examples of public sector management in Latin America. The government was particularly praised for achieving "fiscal discipline" because it had balanced public expenditures and public revenues. Yet at a recent seminar convened at the World Bank, Colombia's Vice Minister of Finance, Eduardo Fernandez, remarked that Colombia's achievement at the time was far overstated. He lamented that his government had largely concentrated its energies on only one highly visible dimension of its budget problems -- aggregate fiscal discipline -- while letting two other critical areas slip. These were (i) prioritizing the composition of expenditures across sector ministries, and (ii) assuring that public resources get best value for money (i.e., technical efficiency). According to Fernandez, these latter budgetary issues had been guided less by decisions based on prioritizing and costing, than by competing politics, stakeholder demands, financial crises associated with government deficits, inflexibility, lack of any measures of 'performance budgeting', and lack of transparency.³⁵

Minister Fernandez's concession applies equally well to a great many other developing countries. A few years ago, the government of Guinea designated public health, primary education, and road maintenance as spending priorities. Yet public funds that were supposed to be allocated to these priorities often ended up being allocated to other areas instead. And no system existed for costing policy proposals or subjecting them to rigorous scrutiny. When expert consultants arrived to cost out Guinea's policies to meet the government's stated priorities, the results showed that funds for the priority programs would have to triple over the succeeding four years! To do so would require drastic and unrealistic cuts by other sector expenditures.

The Guinea experience confirms a World Bank finding that an especially negative consequence of weak institutional capacity in Ministries of Health or Education is an inability to specify the budget and make budgetary forecasts, based on sound and realistic assumptions.³⁶ This not only undermines transparency and predictability in decision-making, but also weakens public confidence in government decision-making. In recent years, for example, unrealistic budgets have resulted in shortfalls of actual recurrent expenditures of more than 50% in Tanzania and 30% in Uganda. Such shortfalls tend to be commonplace because governments tend to promise too much, above and beyond what tax revenues can accommodate.

Transparency and coherence are further compromised when governments and line Ministries make use of extra-budgetary funds to cover budget shortfalls. When extra-budgetary funds are tapped on a frequent basis -- and injected into public expenditure streams by political fiat -- they tend to undermine the role that government budgets should be playing as roadmaps of expenditures and expected outputs. Extra-budgetary sources accounted for more than 50% of total federal expenditures in Nigeria during the mid-1990's.

Finally, the value of the entire budget making process is jeopardized by long lags in the production of financial accounts and audits. As a result, decision-makers often have little sense of the costs or outcomes of the policies they are responsible for. In Uganda, for example, an expenditure tracking exercise revealed that a significant portion of funds allocated for basic social

³⁵These observations were made by the Vice Minister at a seminar convened by the World Bank's Learning and Leadership Forum on "Government Reorientation", June 11-12, 1998.

³⁶World Bank, 1997, World Development Report, (Washington DC: World Bank).

services never reached the intended health clinics or schools, particularly in rural areas. This is partly explained by a budgeting process that focuses almost exclusively on the allocation of inputs rather than the results they are intended to achieve.³⁷

Experiences such as the above, have led Malcolm Holmes of the World Bank and others to summarize characteristics of budget systems that are most in need of reform as follows:³⁸

- An almost exclusive focus on inputs, with assessments of performance linked weakly or not at all to outcomes;
- A short-term input focus that fails to adequately take account of longer-term costs;
- Strong incentives to spend everything in the budget early in the year and as quickly as possible, for fear of cuts;
- Overall, few incentives to improve the performance of resources provided.
- Last minute budget cuts by Ministry of Finance that undermine predictability and flow of resources and planned expenditures at sector level.

Because poor money management is so closely linked to poor outcomes, the problems noted above tend to undermine all three-core building blocks of NPSM -- responsibility, performance, and accountability. How can such problems be “cleaned up” to the extent that the performance of policy makers, managers, and implementers can be improved?

Malcolm Holmes argues that a first step in the ‘clean up’ process is to realize that good budgeting requires attention to three levels:³⁹

- Level 1: fiscal discipline to assure public expenditures don’t exceed public revenues
- Level 2: prioritization of the allocations of public expenditures to assure value-for-money
- Level 3: technical efficiency to assure maximum return for each dollar spent.

The organizational strategy we propose here -- Performance Related Budgeting -- cannot pretend to resolve all issues pertaining to Levels 1-3, but it can make an important difference.

- ***Performance Related Budgeting (PRB) stresses the importance of identifying measurable outcomes to be achieved by public expenditures, thus introducing greater transparency into the budgeting process, as well as accountability for goals sought. PRB also sets the stage for estimating unit costs and assessing ‘value for money’.***

³⁷Emmanuel Ablo and Ritva Reinikka, 1998, “Do Budgets Really Matter? Evidence from Public Spending on Education and Health in Uganda”, (Washington DC: Macroeconomics 2, Africa Region, mimeographed.).

³⁸World Bank, 1998, *ibid.*

³⁹The three levels are borrowed from, and discussed in depth by Malcolm Holmes and others in, World Bank, 1998, *Public Expenditure Management Handbook*, Washington DC: World Bank.

Within Level 1 of Holms' taxonomy, decisions can be taken to replace "soft" budgets with "hard" budgets at national or sector level, thus specifying more clearly the budget envelope that implementers have to work. In this case, PRB contributes to performance expectations when implementers succeed in delivering promised outputs and outcomes within the hard budget constraint. Such performance expectations can be established government-wide, at Ministerial level, for example by the District-level purchasers of health services in countries like the UK, New Zealand, and Zambia. This mimics business-like practices insofar as private companies are forced to work within hard budgets, unless they are willing and able to borrow against tomorrow's revenues. Doing so, however, carries a penalty insofar as loans must be paid back with interest. This will eat into profits, returns to shareholders, and employee incentive payments.

Within Level 2, decisions can be taken to strategically prioritize public expenditures across different sectors, with commitments by the Ministry of Finance that those expenditures will indeed be available to implementers. PBR can help at this level because a common complaint of Ministers of Finance is sector budgets are weakly formulated and rationalized -- weak in the sense that expenditures are seldom based on unit costing and expected outcomes are seldom made clear. This results in weak negotiating power when sector budgets are negotiated with Ministries of Finance. As a result, assurances of stability and predictability of funding at sector level may not be forthcoming, thus jeopardizing chances that desired outcomes at sector level will be achieved.

Within Level 3, decisions can be taken to allow local managers to be more flexible in their budget allocations, with the authority to move funds to areas where returns promise to be greatest. This mimics business-like practices insofar as self-employed shop owners and line managers in the private sector tend to have complete or considerable autonomy over budgets, reallocating resources to places of best competitive advantage if and when necessary. PRB can serve this function by replacing *traditional line-item* budgeting by a costing and resource allocation process that links expenditures to deliverables.⁴⁰

Traditional line-item systems came into favor in the public sector during the late 19th and early 20th century as a way of introducing spending controls and reducing corruption. Their appeal lies in relative simplicity, lack of ambiguity, and potential for control of expenditures through easy comparison with prior years, and through detailed specification of inputs on which money is to be spent. The weaknesses of such systems, however, are that they provide no information about why money was spent, or on the efficiency and effectiveness of programs. In addition, line-item systems are almost all associated with a short time horizon, leading to failure to take longer-term costs into account. A focus on line-item controls further leads to micromanagement of budget implementation by central agencies, and the feeling that 'hands are tied' among lower level managers and implementers.

Compared to line-item budgeting, performance budgeting divides proposed expenditures into activities within each organization and a set of workload measures that relate the activity performed to costs. Emphasis is placed on linking what is to be produced (outcomes) with the resources required to produce it. Performance budgeting indicates a shift from budgeting based on

⁴⁰ In a line item system, expenditures for the coming year are listed according to objects of expenditure, or line items. These line items are often quite detailed, specifying how much money a particular Ministry or department is permitted to spend on personnel, fringe benefits, travel, equipment, etc. In many such systems, central budget offices and finance ministries play the role of "controller" and establish procedures designed to prevent overspending.

expenditure control, to budgeting based increasingly on management concerns. It aims to empower managers by engaging them in the process of preparing explicit information on expected costs, prices, service types and levels. This is precisely the kind of information that the private sector seeks to use in extracting greatest returns (profit) for expenditure and investment. In public sector agencies, managerial effectiveness can be expected to improve in the process because;⁴¹

- Managers are motivated to differentiate between essential and non-essential activities when the cost implications of all activities are compared with available funding;
- Managers are in a better position to (i) justify additional resources to fulfill their service provision goals, or (ii) explain why such goals are unachievable with current funding, when they are able to project gaps between projected expenses and resources;
- A transparent budgeting exercise helps managers to ensure that organizational resources are spent only on the agreed activities;
- Evidence-based budgets allow managers to evaluate the actual costs of activities (as well as unit costs), thus contributing to decisions about whether some activities (or contractors) are too costly;
- Transparent budgets contribute to ‘performance benchmarking’ (i.e., achievements per dollar spent), across teams, facilities, divisions or departments, by establishing where greatest value for money was attained, thus setting standards against which others might compete;
- Budgets contribute to performance assessments of managers by linking targeted outcomes to expended resources, with shortfalls in expectations linked to moneys wasted.

Budgetary Reform in Honduras:

The use of transparency and accountability in budgeting to enhance performance in the health sector can be illustrated in the case of Honduras. Prior to 1995, the budgetary situation of the Ministry of Health was not unlike that in many developing countries insofar as it undermined the performance of financial managers, accountants and planners in the following ways:⁴²

- The use of historical budgets provided no incentives for improved performance because historic budgets make it unnecessary to evaluate past performance when allocating future levels of funding. For example, in 1991-95, government funds for public hospitals grew by 40% in real terms, but hospital discharges grew by only 13% and outpatient visits (including emergencies) grew by 28% with no significant changes indicating a more complex case-mix.
- The system contributed to inflexibility and stasis in reallocations of funds because it did not permit managers to reallocate funds for personnel. Even when reallocation was formally within the discretion of the MOH, the fear that it may be illegal or the knowledge that it

⁴¹ Adapted from a background paper by Stephen Sacca, William Newbrander, and Gerald Rosenthal, 1997, “Managing Financial Resources” prepared for the World Bank Institute ‘Flagship Course on Health Sector Reform and Sustainable Financing’, Washington DC: mimeographed.

⁴² World Bank, 1998, Honduras: Toward Better Health Care for All, Washington DC: World Bank.

might be administratively complex bred immobility in the context of a bureaucratic culture which prefers to avoid risks.

- Although an enormous quantity of statistics was compiled within the MOH, the information was neither aggregated in a way that would facilitate decision-making during the planning of budget allocations, nor was it analyzed to provide feedback on performance.

After 1995, the situation began to change rapidly with the publication of the country's first National Health Accounts (NHA). For the first time in Honduras' history, it was clear that the MOH was only one important player in the country's health care, representing about 24% of total national expenditures on health. An implication was that the MOH should clarify its comparative advantage in health -- rather than trying to do everything. This manifest in a law in 1997, to reconfigure administrative responsibilities for public funding and provision of health services in the country. First, a new Vice-Ministry of Financing and Administration was created to manage budgetary transfers to the health sector, and provide support to the Ministry as a whole in computation and statistics. Second, the existing Vice-Ministry of Health Services was to remain in place, but focus its activities on the direct provision of services by MOH. Third, the Vice-Ministries of Population Risks and Sector Policy were to be joined into a single Vice-Ministry of Health Policy and Regulation. These changes in public administration aimed to force a wedge between financing, provision and regulation, thus setting the stage for greater focus and clarity of functions on budgetary matters.

To complement these changes, the government of Honduras has taken steps to inject greater flexibility in MOH budgetary processes, as well as greater accountability for funds used. MOH plans to relax highly centralized constraints that limit transfers of funds between budget line items, relax rules governing purchases of drugs and medical materials, and ease up on rules blocking the use of revolving fund. Performance of departmental and district-level budget officers will be monitored and evaluated by documenting new administrative procedures, with special attention to the areas of audits, stock maintenance, monitoring of payroll and hiring of personnel, and accrual accounting.

To achieve greater budgetary accountability, Honduras' MOH plans to pay public and private providers by results achieved. This parallels reforms in Chile. Under this new scheme, autonomous health regions and national hospitals are to sign management contracts with the MOH, and negotiate specific, monitorable objectives within an established system of rewards and penalties.

The Financial Management Initiative in the UK

More than a decade ago, the UK government started to devolve budgetary powers within central government departments under the general label of the Financial Management Initiative (FMI). FMI aimed to assist government departments to structure their budgets in a way that introduced greater clarity of objectives, improved accountability, and resulted in more emphasis on reconciling spending decisions and accountability for results. Without this information, it was argued, voters had no possibility of verifying whether their mandate was being fulfilled, or whether inputs were being allocated in a way that avoided resource wastage. The FMI initiative embodied three major dimensions:

Modification or replacement of line-item budgeting: Towards improving budget flexibility, line items can now be rolled into more aggregated categories of running costs, thereby empowering

budget officers to reallocate funds as needed on a more timely basis. This transfers authority to department or agency managers to use the funds as they see fit to accomplish their organization's objectives.

Linking planned expenditures to planned outcomes: Traditionally, when public expenditures were allocated to broadly conceived programs -- with specific line-items -- a satisfactory "budgetary outcome" occurred at the end of the fiscal year when funds allocated to the line-items were shown to have been expensed. In such an accounting system, it was entirely feasible that all funds could have been expensed satisfactorily, but with no impact on community or individual health. By linking planned expenditures to planned outcomes, the FMI initiative build accountability into the budget.

Accrual accounting: Traditionally, public expenditures were "accounted for" in terms of whether line item allocations to different departments, or within departments to different items such as the construction of a hospital (e.g., fixed costs) or payment of salaries (e.g., recurrent costs) had been used up. This process typically placed managers in a passive mode, as they await bills and then tallied up commitments and expenditures *at the end of the fiscal year*. Accrual budgeting, on the other hand, fosters a much tighter monitoring process as well as more proactive managerial control. Expenditures are recorded as they accrue, with budgetary balances being summarized each month or quarter. This puts the manager in a much better position to assess the pace of expenditures, their destination, how they measure up to planned outlays, and prospects of ensuing deficits or surplus.

Prior to the introduction of FMI, government departments had little, if any, relevant information about objectives, about how resources were allocated, or about costs. The system of line item budgeting had focused upon the costs of inputs and functions, not the costs of outputs or activities. Also, those who made decisions about budgetary control were frequently different from those who managed the service. Given these incentives, those who provided the service did not regard themselves as responsible for providing value for money. There was nothing to encourage the search for cost savings.

The new budgetary reforms have worked to make managers (i) more flexible in their decision-making and allocative efficiency, (ii) more accountable, in terms of value-added and output gained, for the moneys spent, and (iii) more aware of their expenditure patterns, levels, and timing. And when managers have information that enables them to understand the activities that give rise to spending (the "cost drivers"), they are in a better position to control costs.

Summing up:

Performance Related Budgeting contributes to managerial responsibility (to live within hard budgets), performance (linking inputs to outputs), and accountability (transparency in use of public funds). A performance related budget can apply to:

- Ministry of Health,
- a public purchaser of health services such as a District Health Authority,
- a provider payment contract negotiated by the public sector with private health care providers,
- a decentralized service unit such as a health district, or
- any service unit within a Ministry or a district that is charged with managing its own budget.

When performance-related budgets fall short of targets (expected outcomes), adjustments can be made to improve performance in the future. Moreover, the process of establishing unit costs, sets the stage for benchmarking and more realistic forecasting of budget needs in the future -- based upon costs and outcomes in the past.

None of these positive outcomes should be expected overnight, however. As noted in Holmes' diagnosis of three levels of budgetary planning, attention to Level 3 concerns will be seriously compromised if insufficient attention is given as well to Levels 1 (aggregate fiscal discipline) and Level 2 (prioritization of intersectoral resource allocations). Moreover, considerable preparation and political commitment is required to implement PBR, even at sector level, as noted in the checklist of potential problems in Box 4.

Box 4: Potential Problems with Performance Budgeting

Political commitment to Budgetary Reforms: The Ministry of Finance must agree to replace traditional line-item budgeting by performance budgeting. This will be problematic if the Ministry of Finance continues to hold line ministries accountable for the use of line items.

Accounting systems must be functional: The inability to track expenditures and relate them to outcomes will entirely undermine the process of measuring performance (or technical efficiency of funds spent). Systematic accounting of such information is also critical to establishing unit costs, and to using those unit costs as benchmarks for the next round of expenditures.

Auditing is critical to assuring accountability: Unless reliable auditing of public expenditures takes place, the public sector will fail to obtain needed assurances that funds are accounted for and that leakage from the system is not taking place due to corruption. Without reliable auditing, central levels of government are unlikely to yield the assurances over spending controls that line-item budgeting assures.

Staff capacities: The performance budgeting process transfers responsibility (as well as empowerment) for financial forecasting, expenditure control and cost containment from central levels of government to more decentralized levels. Often, staff at decentralized levels need additional training to manage financial planning, estimate unit costs, and relate those costs to more detailed outputs or outcomes.

Clarity of purpose and outcomes: Staff engaged in performance budgeting must be clear about the policy objectives of the ministry or department they serve, as well as the outcomes that are to be achieved. This requires clarity, as expressed in policy or strategy documents, with attention to measurable and monitorable outcomes. With this information in hand, performance budgets can be established. Without it, it may not be clear what agreed priorities the new budgets are serving.

Enforcing a hard budget: A hard budget forces providers to "live within" a pre-specified budget envelope of funding, whereas a soft budget is more forgiving, allowing government to top up funding gaps. Hard budgets are preferred because soft budgets tend to undermine incentives to adhere to forecasted expenditures and performance targets. However, should expected or promised services not be made available, political pressures and public accountability may force governments to relax hard budgets.

Stability of funding and policy environment: A change to performance budgeting entails changes in the way that business needs will be planned for and executed. This will involve increased power and control being delegated to managers of line ministries, departments, and districts, as well as large outlays of energy and resources to prepare for the new systems. In such contexts, unstable funding and shifts in the policy environment may do more damage to the morale of staff than would have taken place under traditional line item arrangements (where the new investments in time and energy have not taken place and instability is the norm).

Levels 1, 2 and 3 should work together: Getting all levels of the budgeting process working together should not be expected to take place overnight, but will evolve. Attention to each level is important because, as explained earlier, each level reinforces the others. Understanding how each level is performing is also important to understanding why performance budgeting may be falling short of expectations.

ORGANIZATIONAL STRATEGY 3: AUTONOMOUS AGENCIES (AAs)

In 1996, the government of Singapore embarked on a major experiment by commissioning eleven government departments and three Ministries headquarters as Autonomous Agencies (AAs).⁴³ The fourteen new AAs were part of a pilot to improve the performance of public agencies through new public sector management practices. Three of the new AAs were formerly under the operational management of departments within the Ministry of Health:

- the Tao Payoh Polyclinic (TPP) that serves mostly lower socio-economic class patients (see Box 5);
- the Tampines Polyclinic (TMP) that emphasizes health education and health promotion and serves mainly middle-class and elderly residents (see Box 5); and
- the Institute of Science & Forensic Medicine (ISFM), responsible for scientific and medical investigations involving food and drug analysis.

Each of the fourteen new AAs was obliged to meet a number of performance criteria that were established by government quality assurance committees. In total, 230 key output and performance targets were agreed upon, covering effectiveness, efficiency, and quality of services. At the same time, the AAs were given considerable autonomy and flexibility to manage their own affairs. For example;

- *procurement flexibility*: AAs were allowed to form their own tender boards for procurement of between \$2,000 and \$70,000 US dollars, versus past practices, which required that procurement of above \$2,000 thousand must be submitted to tender boards.
- *financial flexibility*: AAs were freed from line item budgeting that in the past had required Ministry of Finance approval to transfer funds between line items.
- *personnel flexibility*: AAs were allowed to appoint lower level officers and confirm their appointments upon a satisfactory period of probation, and were able to promote individuals into higher job categories (as long as the candidate's skills met technical specifications).

In addition, the AAs were presented with an entirely new set of incentives to motivate staff. If the AA achieved 85 percent of its performance targets, and achieved bona fide expenditure savings in the process, then 50 percent of the savings could be used for organizational improvements, with the remaining 50 percent going to managers of the AA for purposes of improving staff welfare (e.g., working conditions, amenities, social events).

These reforms, enacted as part of Singapore's AA policy, illustrate fundamentals of our third organizational strategy -- granting autonomy to public agencies. Though Singapore is moving cautiously in its AA program, it has mimicked business-like practices by combining increased flexibility to manage finances and cut costs, with staff incentives for improved performance. Over time, the AAs will increasingly operate independently of government management and control, subject to negotiated agreements and regulation (to assure quality).

⁴³ For a more detailed review of the Singapore experience see Phua K.H., 2003, "Attacking Hospital Performance on Two Fronts: Network Corporatization and Financing Reforms in Singapore, Chapter 12, in *Innovations in Health Service Delivery: The Corporatization of Public Hospitals*, Preker A.S. and A. Harding, Eds. Washington, World Bank, p. 451-484.

Box 5: Pilot Autonomous Agencies in Singapore's Health System

Tao Payoh Polyclinic (TPP):

In FY96, TPP had a budget of about \$280,000US Singapore dollars and a staff of 65. On becoming an Autonomous Agency, TPP took over full management of its own budget, and called for its own tender bids. Autonomy was granted to employ health attendants and clerical officers, thus enabling TPP to recruit staff more quickly. The doctor-in-charge of the clinic assumed responsibility for leave applications, assisted in the deployment of doctors to the various regional zones, and maintained the clinic manpower mix.

TPP immediately initiated new services and improved existing ones as a means of appealing to its clientele. As part of its continual assessment, TPP also monitored attendances on a monthly basis at its Well-Woman Clinic, Family Planning, Coronary Risk Screening, Smoking Cessation Clinic, and Basic Health Screening programs. Feedback was also obtained from patients towards improving services. Overall, TPP achieved about 55% of its targets for FY96. For example, TPP's clinical services aimed to see 95% of patients registered within 45 minutes upon arrival at the registration counter, and succeeded in seeing 98% within this time. It aimed for an average audit score for medical records of 95% and achieved 93%. Average audit scores for diabetes management and Well Women Management were 80% and 80%, respectively. Pressure is now on TPP to accomplish these higher scores, especially in numerous areas where TPP services performed relatively poorly. Overall, TPP aimed to achieve a patient satisfaction score of 80% and achieved 89%.

Tampines Polyclinic (TP):

In FY96, TP had running costs of about \$800,000US dollars, and a staff of 173. On becoming an Autonomous Agency (AA), TP staff was briefed on their additional responsibilities as an AA clinic and they responded positively to the new challenges. TP took more responsibility for managing its financial and fiscal matters, and demonstrated faster procurement as authority for purchases up to \$5,000 was delegated to the Head of TP. The clinic introduced more structured programs with increased efforts in health education. One significant improvement was to upgrade the professional competence of staff through regular weekly teach-in sessions over lunch.

TP performance was observed to improve in the form of shorter time to complete work and services, resulting in increased efficiency to meet rising expectations of TP's clients. Overall TP achieved somewhat less than 50% of all of its performance targets, doing very well on some, relatively poorly on others. For example, TP clinical services aimed to register 95% of patients within 45 minutes of arrival at the registration counter, with 95% of those to be seen by a doctor within 60 minutes of being registered. Achieved performance was 94% and 89%, respectively. The average targeted score for diabetes management was 80%, whereas performance was considerably less at 65%. Overall, TP aimed for an average patient satisfaction score of 80% and achieved 85%. By the end of the year, TP saw an increase in total attendance to 293,116 over FY1995 levels, an increase of 6%.

Again, each target that TP set for itself has become a benchmark against which performance can be judged and incremental improvements made. The targets themselves can be adjusted upwards with improved capacities, therefore initiating a process of continuous improvement.

Source: Ministry of Finance, Budget Division, Autonomous Agencies FY1996 Performance Review, Government of Singapore, 1997

At the end of the first year of Singapore's pilot, seven of the 14 AAs had achieved at least 85 percent of the agreed target levels, while most of the remaining AAs achieved more than 50 percent of the performance targets. Overall 106 of the original 230 targets pursued by the 14 pilot AAs were revised upwards for Fiscal Year 1997.

As part of the continuous improvement process, the AAs that had fallen short of the 85 percent level were given the opportunity to review why they had fallen short of performance expectations. This review exercise was particularly relevant and valuable for the three AAs in the health sector because their success was relatively poor, necessitating more focused assessment and corrective action (see Box 4). In some cases, this led to more realistic agreements on what could be achieved during the next Fiscal Year.

One year later, another 102 ministry headquarters, departments, and government-funded statutory boards were launched as AAs. With this move, practically the entire Civil Service and all government-funded statutory boards will operate as AAs, with the exception of a few organizations, which, for security reasons, cannot switch over fully to the new framework.

As the government broadens its AA initiative, it plans to introduce additional changes to address problems observed by managers and staff including complaints that:

- the rewarding criteria were too stringent,
- there was insufficient motivation for individuals, since the savings from good AA performance were allocated by AA managers on behalf of individuals, rather than given to staff *per se*,
- AA responsibility for personnel was still too inflexible; and
- the mindset of employees was slow to change.

Does Autonomy Always Look the Same?

'Autonomy' is a slippery word, and its usage varies in the hands of different writers and observers. The range of objectives we attribute to autonomization -- as an organizational strategy of NPSM -- are the following:

- distancing a public agency from government in order to prevent politicization of decision-making and to allow managerial decisions to be based upon examination of facts (rather than interest-group pressure);
- bringing in private sector management skills through a board comprised of a Chief Executive Officer and other officials, on fixed term contracts;
- creating greater responsiveness to consumers through consumer representation on the board;
- side-stepping cumbersome government regulations pertaining to civil service regulation, procurement regulation, etc., and hence creating a more flexible organization.

Autonomization policies are also used to force agencies to operate on a more self-sustaining financial basis. To this end, AAs are not only required to live within their budgets but are often

expected to supplement reduced government funding with revenues from user charges and cost-recovery. For example, when a large tertiary public hospital was granted autonomy in Western Africa, government announced that its contribution to the hospital's operating costs would be reduced by 20 per cent per year. This forced the hospital to implement stricter cost-recovery policies, to make its services more attractive to patients, and to become financially self-sustaining within five years.

In Indonesia, autonomization of hospitals is being pursued not only because government could no longer sustain them, but because it wanted to reallocate a larger share of its scarce public funds away from tertiary level care to primary and preventive health care. Again, user fees and cost recovery policies featured prominently in this policy. In such cases, business-like practices come strongly into play because CEOs of AA's must maintain a financial bottom line, or possibly be fired for not doing so.

When autonomization extends to government owned hospitals -- as it usually is in the health sector -- controversy tends to arise over the introduction of user fees (to accommodate financial sustainability) and equity of access. Hospitals may be able to stay afloat if they raise their prices enough, and still attract enough patients, but at what "cost" to the poor. The Indonesia case noted above, and reviewed later, takes up this issue directly.

Autonomous Hospitals in Kenya:

In Kenya, autonomy was granted to Kenyatta National Hospital (KNH) in the late 1980s, as a pilot experiment. Autonomization of individual facilities or agencies such as KNH, is typically achieved by appointing a Board of Directors, comprised of representatives from the private sector, NGOs, and the public sector. The CEO of the Board of Directors, as well as the day-to-day managers and employees tend to receive financial rewards or bonuses when they deliver goods and services efficiently and effectively, and satisfy their primary clients

Prior to 1987, KNH was under the direct control and management of MOH, and all revenue received by the hospital -- in excess of the expected and budgeted amount -- was turned over to the Treasury. A study conducted in 1985 concluded that the highly centralized decision-making regarding KHN had manifest in all sorts of problems including:⁴⁴

- The centralization of the management and accounting for KNH's large share of government funding at MOH headquarters made it very cumbersome to operate the hospital properly. The MOH staff who made most of the decisions affecting the hospital had a remote relationship with the hospital and did not take advice from hospital personnel.
- KNH's hospital director had no job description and limited authority to exercise functions crucial to improving the efficiency of KNH.

⁴⁴ Julius Meme, David H. Collins, and Grace Njeru, "Hospital Autonomy in Kenya Before and After Kenyatta National Hospital Experience", Nairobi: Paper presented at East Africa Regional Senior Policy Seminar on Sustainable Health Care Financing", Nairobi, February 24-28, 1997, sponsored by Economic Development Institute, World Bank, 1997.

- KNH played little part in the recruitment, deployment and discipline of its staff. Moreover, staffs were transferred in and out of the hospital without consultation, and at short intervals, making it difficult to apportion responsibility and expect accountability.
- The lack of a hospital tender board or central supplies department, and poor procurement and management of supplies and equipment were resulting in significant losses.
- KNH was comprised of many components, which did not have a clear relationship to the main hospital, making it difficult to ascertain their relevance and role in an overall KHN “business plan”.

In 1987, government decided to grant KNH increased autonomy, whereby the government retained ownership of the hospital but, in effect, a Board of Directors was established to become legal custodian. The main changes in the distribution of authority before and after KNH became an autonomous entity are summarized in Table 4.

Initially, managerial changes affecting KNH were slow to take place because managers and staff did not have the necessary skills and experience to take on more responsibility, and plans had not been well set out to strengthen critical areas to be taken over from the MOH, such as planning, personnel, finance, accounting and procurement. As the Board became more involved in management, however, the skills of its members with private sector expertise played a positive role, as did the participation of senior civil servants familiar with government funding and patronage.

By the late 1990s, the combination of a strong Director and Board have resulted in better senior managers being hired, and the impact is being felt in terms of improved systems. Positive observations regarding the functioning of KNH are:

- KNH has greater control over its budgetary affairs, and is more effective at shifting expenditures freely among line items, now that it receives a block grant from MOH.
- Financial management has been improved by adopting accrual accounting, and incorporating responsibility for fixed assets into KHN budgets. Financial statements have been produced in a more timely, detailed, and accurate fashion providing much greater financial transparency. Better financial control has contributed to improved revenue collection.
- Management has succeeded in improving salaries for KNH staff to the extent it is now able to attract higher quality doctors, nurses and administrators. This applies particularly to nurses.
- Clinical management has improved with a clearer definition of roles, more delegation to departmental level, and more involvement of teaching staff in management.
- Improvements in supplies have come from the freedom to procure directly through KNH’s own Tender Board and through the decentralization of budget management and quality control.
- There appears to have been some improvement in technical efficiency due to the increased availability of supplies and improvements in building and equipment maintenance, which have allowed staff to be more productive.

- Expenditure on staff as a share of recurrent expenditures fell from 60% in 1986/87 to about 50% by 1995, compared with 70% of the overall MOH budget that goes to salaries and allowances.

Table 4: Distribution of Authority Before and After KNH Became Autonomous

| Area of Authority | Before Autonomous Status | After Autonomous Status |
|--|---|--|
| Ownership | Government | Government |
| Management | MOH | Board |
| Hospital Policy | MOH | Board |
| Allocation of Resources to Hospital | Treasury/MOH (line item budget) | Treasury/MOH (block grant) |
| Donor Funding | Treasury/MOH | Board within ceiling set by Treasury & MOH approval |
| Allocation of Resources within Hospital | MOH | Board |
| Use of Cost Sharing Revenue | Treasury (excess over budgeted amount) | Board |
| Setting User Fees | MOH | Board with MOH approval |
| Allocation of Financial Surplus | MOH | MOH |
| Community Input | None | None |
| Accounting Procedures | Government | Board |
| External Audit | Auditor General | Auditor General |
| Hiring & Firing Staff | MOH | Board |
| Salary & Benefit Levels | Government | Government |
| Prosecution of Fraud | Government | Board |
| Pension Arrangements | Government | Board |
| Procurement | MOH | Board |
| Maintenance | Ministry of Works | Board |

Source: Julius Meme, David H. Collins, Grace Njeru (1997)

- Though data are not available, it is generally believed that quality of care has improved due to greater availability of drugs and medical supplies, better maintenance of buildings and equipment, and more productive and motivated staff.

Autonomous Hospitals in Indonesia and India:

By the late 1980's the government of Indonesia recognized it could no longer financially sustain its public health clinics and public hospitals, delivery quality care, and meet the demands of it's growing population.⁴⁵ At the time, government expenditures on health were only US\$3 per capita, in a country, which spent about US\$12 per capita spent on health annually.

⁴⁵ For a more detailed discussion of the organizational reforms in Indonesia, see Lieberman S.S. and A. Alkatiri, "Autonomization in Indonesia: The Wrong Path to Reduce Hospital Expenditures: Chapter 14," *Innovations in Health Service Delivery: The Corporatization of Public Hospitals*, Preker A.S. and A. Harding, 2003, Washington, World Bank, 511-532.

In 1991, therefore, the government introduced a policy (Presidential Decree No. 38) to convert publicly financed hospitals into 'self-sustaining', autonomous hospitals (translated into 'Unit Swadana' hospitals). Objectives of the Unit Swadana policy include:

- reduce government subsidies to hospitals, through introduction of users fees, with the saved public funds to be utilized for promotive and preventive care,
- retain hospital revenues and utilize them for hospital operations, including staff incentives,
- increase hospital efficiency through better management of optimal resource utilization,
- improve quality of hospital medical services.

In addition, the Unit Swadana policy was seen as a way of compensating for deficiencies in the management and organization of government hospitals. As pointed out in a review by Ascobat Gani, hospital management did not have the autonomy and flexibility to improve hospital efficiency and quality. This applied particularly to hospital budgets, since funds came from different sources and managers lacked the authority to consolidate them. Moreover, there were no functioning committees on quality assurance in most public hospitals.⁴⁶

An appealing feature of the Unit Swadana policy is that it was implemented carefully -- on a pilot basis -- with considerable attention devoted to certain minimal conditions that should be in place before a hospital aspires to Unit Swadana status (i.e., self-sufficiency). Prior to being converted to Unit Swadana status a hospital had to demonstrate:

- efficient performance for 3 consecutive years,
- a cost recovery rate that had reached a level of 50 percent,
- evidence of commitment from the hospital administration, especially the director,
- evidence of commitment/support from local government and the Ministry of Internal Affairs,
- evidence the community served by the hospital had the ability to pay for its own medical services, as indicated by socio-economic data in the region.⁴⁷

Conversions to Unit Swadana status began first with five hospitals in Java, one provincially owned and run and the rest under central MOH management. Another 11 hospitals, owned and managed by provincial and district governments were given autonomous status in 1993. By 1997, conversions to Swadana included 13 general hospitals and 2 specialized hospitals owned by MOH, as well as 46 hospitals owned and run by provincial or local governments.⁴⁸

An assessment of Swadana hospitals in Java by Gani in 1995 revealed the following:⁴⁹

- overall management and financing of the hospitals has improved,

⁴⁶ Ascobat Gani, 1996, "Improving Quality in Public Sector Hospitals in Indonesia", *International Journal of Health Planning and Management*, Vol. 11, p. 275-96.

⁴⁷ Gani, 1996, *ibid.*

⁴⁸ Ali Alkatiri, Ministry of Planning, Indonesia, presentation to World Bank Institute Flagship Program on Health Sector Reform and Sustainable Financing, Washington DC, November, 1998.

⁴⁹ Gani, 1996, *Op.cit.*

- the hospitals have become more cost-conscious, with hospitals using unit cost information for bargaining and more rationally payments from insurance companies,
- all hospitals were forced to establish good inventory systems,
- preparation of separate hospital budget plans incorporate principles of good budgeting,
- hospitals have marketed a positive image and communicated their compliance with regulatory bodies,
- increased revenues resulted in increased allotments for operations with 30% going to staff incentives,
- utilization by clients has not diminished with changes in price,
- client surveys since 1993 reveal improvements in patient's perceptions of and satisfaction with cleanliness, medical and inpatient services, and administrative services. These improvements are apparently attributable to increased availability of services and the positive attitudes of hospital staff,
- equity in treatment does not seem to have suffered in the catchment populations, because the hospitals cross-subsidize expensive treatments in class I hospital beds with reduced charges for class III beds.

Other assessments have been undertaken by Alkatari in 1998 and by various USAID missions (as reviewed in Alkatari)⁵⁰ Alkatari's review of six Swadana units confirms several of the positive organizational findings by Gani, and reports a substantial rise in the ratio of cost-recovery to recurrent expenditures, growth of incentive payments to hospital staff, and high levels of patient satisfaction (in one hospital). He also reports data showing growth of the share of private hospitals in total hospitals between 1988 to 1997 from 26% to 34%, perhaps in response to wider introduction of cost-recovery and competition over quality. At the same time, however, Alkatari notes that public subsidies to the Swadana hospitals have grown as well, thus placing into question the overall effectiveness of Swadana units in reducing overall MOH expenditures on hospitals.

There still remains a degree of centralized control over the planning/budgeting process for the revenue from fee collection insofar as the hospital management must submit a yearly expenditure plan showing how fees will be spent alongside government subsidies from national, provincial and district sources. Managers of the newly autonomous hospitals indicate, however, that this budgetary supervision does not represent a major obstacle to their ability to decide how to use their funds. Though hospital Directors continue to be appointed by the central MOH, and not by any locally accountable authority, they are at liberty to modify the hospital's management structure as well as performance norms.

India: In 1986, the Andhra Pradesh Council for Hospital Management (APCHP) was created by an act of Parliament in the Indian state of Andhra Pradesh (population of 66 million) to serve as an autonomous, quasi-government agency. Starting with 140 district and community hospitals, the APCHP soon took over all area hospitals as well, and by 1993 had 163 referral and secondary-level hospitals, representing 9,646 beds.

APCHP functions as a parastatal organization, and effectively replaced the branch of the Department of Health that was entrusted with the administration of hospitals. Thus, APCHP itself was given organizational autonomy by the government, as distinct from giving autonomy to each and every hospital. APCHP is managed by a Governing Body comprised of appointed

⁵⁰ Ali Alkatiri, 1998, Op cit.

representatives from the government, elected representatives of the people, and representatives of financial institutions. The APCHP is headed by a Commissioner, supported by a number of Joint and Deputy Commissioners and administrative and legal staff. Several physicians are also on the payroll of APCHP, and are located at the various district hospitals.

A study by the 'Data for Decision-Making' group at Harvard University observed that ACHAP had scored positively on a number of performance criteria. For example, it was observed to have brought substantial improvement in the area of "resource mobilization", and some improvement in the areas of efficiency and quality of care and public satisfaction.⁵¹ Some of the factors responsible for ACHPA's positive performance include;

- The parastatal model has the advantage that the government has had to deal with only one organization with regard to purchasing, provision, and regulation, instead of 160 different autonomous hospitals.
- APCHP took many innovative steps to manage and control funds at its disposal, including a reclassification of expenses to follow a more functional categorization; a concurrent audit system and an internal auditing wing; and delegation of a number of financial powers to hospital superintendents and district coordinators, especially for minor and routine repairs.
- APCHP initiated several positive steps to improve inventory control, especially in the area of drug supply. A monthly central monitoring of stock was introduced for about 55 drugs, and new rules /procedures were introduced whereby the purchasing officers were required to take existing stocks into account before placing fresh orders. These improvements in financial and inventory management were slow to materialize, but once the changes were set in motion they proved to be very effective.
- APCHP has had commendable success in many managerial decision-making situations, for example, the introduction of simplified and result-oriented policies on repairs and maintenance has reduced "down-time" due to equipment repair and overhauls from over six months (in most cases) to less than two weeks.
- APCHP has significantly improved the preparedness of hospitals to meet emergency situations (e.g., availability of oxygen cylinders, refrigerators, suction apparatus); by improving the water supply in all 162 hospitals by installing bore wells, and augmenting municipal sources; and by upgrading electrical capacity and addressing power shortages.
- APCHP introduced several innovative ways of raising resources to augment funds it receives from government, including user charges, donations, lotteries, the Annandana schemes, and external assistance.
- The improved performance of APCHP contributed to the approval of a World Bank loan in 1993 for US\$133 that is helping the APCHP and the government of Andhra Pradesh to finance activities that will strengthen institutions for policy development and implementation

⁵¹ See Ramesh Govindaraj and Mukesh Chawla, 1998, Recent Experiences with Hospital Autonomy in Developing Countries – What Can We Learn? Boston: Harvard School of Public Health, Paper 32.2; Peter Berman, 1998, "Hospital Autonomy: 5 Case Studies" Nairobi: Paper presented to Regional Seminar on Health Finance in Africa, World Bank Institute, mimeographed).

capacity, and improve the quality, access, and effectiveness of health services at district area and community hospitals.

On a less positive note, the Data for Decision-Making Study pointed out that autonomy has meant little to the staff employed in APCHP because changes in performance have not been accompanied by incentives and rewards for APCHP staff. As a parastatal, APCHP has also been somewhat vulnerable to government influence, such that effective autonomy has been diluted in several instances. Furthermore, hospitals continue to be non-autonomous, with the result that benefits of autonomy at facility level may have been diluted.

Summing Up:

Granting AA status to public agencies is an important NPSM organizational strategy because it mimics many business-like practices in the private sector that are believed to be important for increasing responsibility, accountability and performance. It works well, and AAs can successfully mobilize resources for the services they provide, then scarce public funds can be freed up and targeted more cost-effective to primary and preventive care (as in Indonesia).

When cost recovery and user charges are in place, managers of AAs have a tremendous incentive to increase productivity and reduce costs, especially when they are permitted to retain “savings” to reward employees. In such contexts, managers will also be strongly motivated to utilize Personnel Performance Management to improve performance of their employees, as well as appropriate Performance Related Budgeting practices to link AA expenditures to outcomes. Client accountability strategies will also contribute to continuous improvements of AAs, when they face market competition for clients, and must therefore market their services and satisfy customer demands for quality, etc.

However, autonomy should not be expected to automatically enhance performance. A host of potential problems have been observed to undermine progress in this important area, as flagged in Box 6.

Box 6: Potential Problems with Autonomization of Hospitals and Polyclinics

Autonomy Does Not Automatically Enhance Performance: Most governments that grant autonomy to public hospitals and polyclinics do so incrementally, with increasing responsibility for self-management and self-financing being granted over time. Usually this process encounters political and legislative bottlenecks, administrative uncertainties associated with new roles and responsibilities, and inadequate management skills to do the job. The outcome, over a short period of time, might well be negative (on balance) with improvements registered in only a few areas. Lessons of experience suggest that the process of autonomization is a learning process, with considerable learning-by-doing.

Autonomy is Often Compromised by Managerial Shackles: While managers of autonomous agencies tend to gain increased flexibility in planning and allocating resources, as well as pursuing technical efficiencies in the provision of services, a major shackle tends to prevail in the form of an inability to hire and fire staff who are civil servants. Without the authority to hire and fire, managers are unable to achieve cost-savings by reducing underemployed and unproductive staff. In addition, staff protected by traditional civil service provisions tend to be immune from important incentive structures -- such as the threat of being fired if they underperform.

New Cadres of Administrative and 'Hotel' Skills are Required: Autonomization requires more than a board of directors comprised of private and public sector figures. It requires managerial personal, responsible for the day-to-day operation of hospital hotels and service clinics that must begin to operate on a competitive footing by appealing to clients. Investments in new cadres of skills must be planned and budgeted for to assure that the management and administrative staff of new autonomous agencies become competent at performance budgeting, personnel performance management, contracting, and MIS systems.

Achieving Financial Sustainability may Conflict with Equity Goals: Most initiatives to autonomize public agencies are motivated by a desire to reduce pressures on the public purse, and transfer responsibility for raising revenues to the newly autonomized entity. This responsibility typically translates into more aggressive cost recovery policies and higher user fees at newly autonomized agencies. It may also prompt development of special, dedicated services targeted to higher paying customers -- such as special private wards in hospitals. To assure financial survival, managers of newly autonomized agencies may be forced to turn their backs on traditional non-paying customers -- the poor. Perception of such behavior by advocacy groups is likely to lead to a sharp attack on autonomization policies.

Pressure will Mount for Effective Government Regulation: It is not implausible that freedom from traditional, central control will allow autonomous hospitals and polyclinics to place their self-interest, or even the interests of local politicians, above those of consumers. This applies particularly to monitoring how budgets are used and ascertaining if outcomes (and client needs) are being met. In many respects the relationship between government (i.e., the Ministry of Health) and an autonomous hospital or polyclinic becomes similar to that between contractor and contractee -- with all the responsibilities and complications associated with that relationship (see Box on "Flagging Potential Problems with Contracting").

Enabling Environment Laws will have to be Disseminated and Implemented Widely: Autonomization cannot commence, nor can it proceed successfully without necessary changes to the country's legal framework. While this may appear relatively simple insofar as central government agencies will be involved, the actual implementation of the changed laws frequently encounters confusion at decentralized levels of government -- often involving conflicts with local government laws and mandates. This must be anticipated with changes and possible conflicts reviewed at the initial stages of autonomization

ORGANIZATIONAL STRATEGY 4: MANAGED COMPETITION & THE CONTRACT STATE

In 1993, the government of Nicaragua decided that the National Social Security Institute (NSSI) would no longer be a direct provider of health care for NSSI's two major health insurance programs -- one covering common illnesses and maternity services, the other covering worker health risks. Rather, the role of NSSI would be limited to being the financier and administrator of its payroll-financed health insurance programs, with the managers of each program contracting with accredited health care organizations to treat patients. This decision reflects the

government's desire to launch a form of managed competition, whereby performance quotas and quality standards are built into contracts, and public and private provider organizations compete for the right to "win" the contracts. As such, it adopted an organizational strategy that serves NSPM goals by clarifying NSSI's responsibility for financing (not provision), and shifting responsibility for quality provision and client satisfaction to provider organizations -- through contractual arrangements.

The first step in this 'managed competition' process was to identify provider agencies interested in participating in NSSI's program and require them to qualify as an accredited health care provider. To be accredited, they had to:⁵²

- meet NISS-established minimal human resource and physical infrastructure requirements,
- agree to provide a basic package of medical and surgical services;
- agree to receive a per capita allotment as full payment for all of the itemized basic services to be provided to insurance card holders;
- agree to pay the economic subsidy that NISS is required to pay sick and/or temporarily incapacitated insured workers (i.e., a small, set percentage of the worker's salary); and,
- sign a contract agreeing to these terms.

Through this process, NISS has increasingly made use of 'the market' and competitive forces to select willing providers over the last decade. As a purchaser of services, NISS was further able to identify the services to be provided to its clients, as well as how much it was willing to pay. NISS therefore assumes the role of a 'price maker' whereas providers willing to serve as accredited health care providers become 'price takers'. Furthermore, the arrangement between NISS and individual providers is formalized in binding contracts. Failure to comply involves consequences such as loss of accreditation and loss of contracts.

This kind of arrangement can be a good deal for agencies like NISS. By requiring that provider organizations not only assume responsibility for meeting accreditation standards, but supply a basic package *within* a predetermined payment schedule, the NISS can transfer considerable financial risk for the provision of services to the provider. 'Transferring financial risk' is an important concept in public-private collaboration, because it is through this transferring process that the public sector taps private sector capacities, and binds the private sector to deliver by negotiated contracts.

When orchestrated with government approval, involvement of both public and private providers, and conducted on a large scale, the arrangements described above qualify as managed competition within the contract state (MCCS).

- ***Managed competition involves public purchasers and public and private providers of health services, with the purchasers seeking to get the best value for money by contracting with the providers who compete for contracts. The centrality and prevalence of contractual arrangements in all transactions -- formulating, negotiating, and monitoring and evaluating contracts -- gives rise to the nomenclature of 'the contract state'.***

⁵² John Fieldler, 1996, "The Privatization of Health Care in Three Latin American Social Security Systems", Health Policy and Planning, Vol. 11, No.4, p. 406-17.

Purchaser-Provider Split

In countries where managed competition has been introduced on a broad scale, policy-makers often describe the resulting structural arrangements as a ‘purchaser-provider split’. A purchaser-provider framework is in place when:

- government initiates a split between public purchasing (who pays for the services) and public provider roles (who supplies the services):
- the purchasers act as the consumer’s/patient’s agents, with emphasis on contracting, and
- public and private providers of services are required to compete for contracts.

The Purchaser -- often a public agency -- generally has the following responsibilities;

- carrying out population/epidemiological needs assessments of the population it serves
- developing and publishing plans to improve health (strategies, priorities, targets)
- determining a purchasing strategy to assure quality health care is delivered
- determining service specifications (price, volume, quality)
- selecting providers that are qualified to provide services (internally or externally)
- contracting for services
- monitoring services

The Provider -- a public or private supplier -- has the following responsibilities;

- delivering quality services
- considering issues of access, location, and standards
- establishing realistic and competitive prices (if cost recovery is in place)
- understanding the cost structure of their own business
- ensuring that adequate information and monitoring system are in place to review contractual arrangements with the Purchaser -- e.g., achievement of agreed upon outcomes and targets.⁵³

The most widely publicized purchaser/provider split prevails in the UK’s National Health Service. In 1991, the government created District Health Authorities (DHA) to serve as purchasers of health services its citizens, financed by general tax revenues. The DHAs purchased services from autonomous hospitals as well as from alliances of GPs, called GP fundholders, through competitive and negotiated contracts. As the system evolved, GP fundholders began to purchase services from the autonomous hospitals as well, thus forcing the hospitals to compete on price for both DHA contracts as well as GP Fundholder contracts.⁵⁴

To facilitate the purchaser/provider split and the process of managed competition in the UK formerly public hospitals became National Health Service Trusts, with greater autonomy to manage their own affairs and compete for contracts. Not all hospitals turned into trusts, and trust status alone did not create competition. Rather, competition was driven more by the fact that provider organizations no longer received budgets but were contracted for care. Under this new

⁵³ Oceana Health Consulting, 1997, Purchaser Provider Separation and Public Health, Australia.

⁵⁴ GP fundholders were in place up to the late 1990s, then replaced – largely for political reasons – by community-based groupings of physicians.

arrangement, the District Health Authorities could now purchase services from *any* hospital Trust, not just those former public hospitals that had always relied on government sources of revenue.

Over the short run, managed competition was expected to (i) reduce prices that purchasers had to pay hospitals and GP Fundholders for care provided, (ii) reduce the actual costs that the hospitals and GP Fundholders incurred as they became ‘leaner and meaner’, and (iii) increase price adjusted quality of services. Over the longer term, managed competition was expected to impact on the market structure of providers by (i) downsizing larger, inefficient hospitals, (ii) leading to ‘exit’ or closure of inefficient competitors, and (iii) prompting ‘entry’ of new, more efficient hospitals and GP Fundholding configurations.

Empirical studies measuring the impact of managed competition in the UK are relatively few, and are limited to analysis of short-run effects. This is because political changes downplayed managed competition in the late 1990s, to the extent that analysts felt that managed competition did not have sufficient time to fully prove itself. Available evidence suggests:

- Managed competition appears to have been an appropriate response to wide variations in provider prices which showed more than a five-fold difference between highest and lowest prices for certain GP procedures prior to the purchaser/provider reforms, because such differences could not be accounted for by non-price factors alone.⁵⁵
- Competition had the effect of lowering some prices offered to GPs by purchasers. This effect was more evident, however, for low-cost interventions than for high cost interventions. In addition, District Health Authorities that purchased a relatively large share of a provider’s service capacity, appeared able to lower the provider’s prices through greater bargaining power.⁵⁶
- Competition appears to have had a significant, though delayed effect on costs incurred by providers. By 1994/5, 25 percent of the hospitals in the most competitive markets had decreased their costs by around 14 percent, compared with cost decreases of only 4 percent by the 25 percent of hospitals in the least competitive markets.⁵⁷ As with the GPs, costs appear to be consistently lower when the hospitals deal mainly with a single large DHA purchaser.
- Competition appears to have shifted the balance of power from hospital specialists to primary care and from providers of care to the purchasers of care. As a result, health authorities focused more on population needs rather than institutions, primary care and public health received more attention, and GP Fundholders made services more accessible to a broader client base.⁵⁸

⁵⁵ S. Ellwood, 1992, “Cost Methods for NHS Healthcare Contracts”, London: Chartered Institute of Management Accountants.

⁵⁶ C. Propper and N. Soderlund, 1998, “Competition in the NHS Internal Market: An Overview of its Effects on Hospital Prices and Costs”, *Health Economics*, Vol. 7, pp. 187-97.

⁵⁷ I. Csaba, “Quasi Markets and Hospital Behavior: Analysing the UK Health Reforms”, Liverpool: Paper Presented to the Health Economists Study Group Conference, January 1997.

⁵⁸ Chris Ham, 1998, “Innovations in Organization of Health Service Delivery Country Case Study: The United Kingdom”, mimeographed, and published in Preker and Harding, 2003, *Innovations in Health Care Delivery; Reform within the Public Sector*, World Bank, Washington DC.

- Managed competition did not result in a ‘quick fix’ because it’s success is so heavily dependent (and will falter) without (i) effective purchasers, (ii) strong incentives, (iii) appropriate regulation, (iv) management capacity at all levels, and (v) political commitment. Because all these conditions were not sufficiently in place in the UK, reforms featuring managed competition enjoyed a mixed success.⁵⁹

Who Competes for Contracts?

Managed competition and the purchaser-provider split mimics business-like practices in the private sector largely through tendering for contracts. Table 5 identifies some prevalent forms of contracting, services covered, and countries involved. Competition for publicly financed contracts can involve:

- public organizations -- in which only public organizations are allowed to compete,
- public and private companies -- public-versus-private competition,
- private companies only -- private-versus-private competition.

Table 5: Contracting Arrangements in the Health Sector of Developing Countries

| Type of Contract | Services Covered | Country/region Involved |
|---|--|---|
| <i>Non-clinical</i> | Laundry Cleaning Security Maintenance Billing Catering | Bombay, Malaysia, Sri Lanka, Zimbabwe, S. Afr. Thailand, Jamaica Lesotho, S. Afr. Venezuela, Zimbabwe, S. Afr. Zimbabwe Bombay, Lesotho, Malaysia, S. Afr. |
| <i>Clinical</i> | Acute care Ambulatory Long term Diagnostic Laboratory Public health | Peru, S. Afr., Zimbabwe, many countries in Sub-Saharan Africa through implicit contracts with mission facilities El Salvador, Peru, Namibia, S. Afr. (GPs), Cambodia, Bangladesh S. Afr. (TB and psychiatric care) Thailand (CT, MRI) Malaysia (CT, X-ray) Nigeria, S. Afr. Bombay (vector control) |
| <i>Whole hospital management</i> | High tech diagnostic | China, Bolivia |
| <i>Leasing</i> | | Thailand |
| <i>Joint ventures</i> | | Not known |

Adapted from Sara Bennett, Steven Russel, Anne Mills, John Fiedler, Benjamin Loevinsohn, and others.

⁵⁹ Chris Ham (Ibid); and text from presentation to World Bank’s Human Development Week, March, 1999.

When only public companies are involved, governments make use of internal markets and “competitive benchmarking”, whereby the performance of several public organizations is measured and compared via report cards, performance tables, and other types of scorecards. This creates psychological competition between organizations, and appeals to public official’s and employees’ pride and desire to excel. It can also be used as the basis for financial rewards.⁶⁰

When public and private providers compete for contracts, managed competition becomes operable -- for example, public versus private hospitals, clinics, or labs. Performance consequences are involved because providers who provide value for money win new contracts and enjoy performance bonuses within their own organization. Providers who lag in performance quickly see demand for their services (in the form of contracts) drying up. Market feedback provides a powerful incentive to public entities to improve performance. In order to remain competitive, lagging providers will feel pressure to organize their production more efficiently.

When only private providers compete for contracts, purchasers have the advantage of pitting private sector innovators against one another, without having to absorb negative consequences should some private providers go out of business. The same degree of detachment does not exist when public and private agencies compete, because government will likely be called upon to rescue underperforming public agencies. Contracting in health may be undertaken to (i) expand the role of the private sector -- in terms of hours, service mix or geographical coverage – in health care, (ii) help ensure that private providers serve public health goals, or (iii) by-pass broader government bureaucratic constraints.⁶¹

In more developed countries, the beneficial effects of contracting have been established for some time. For example, a UK National Audit Office in 1987 reported that cost savings associated with the new contracts for non-clinical hospital services were in the order of 20 to 30%.⁶² Changes in cost were due to changes in wage rates, changes in the number of hours worked, and the number of staff. Domberger, Meadowcroft and Thompson (1987) further report that it was the threat of competitive tendering in the UK, which caused hospitals to reduce costs.⁶³ Milne and McGee (1992) concluded that “when looked at in terms of the costs saved, particularly domestic services, but even for catering, [contracting] must be judged some success ... even when account is taken of the financial costs of setting up competitive tendering ...”.⁶⁴

Similar lessons about the benefits of tendering, contracting, and competition have been distilled in the US by Osborne and Plastrick (1997). An extensive review of examples in United States government agencies has led gurus of NPSM to conclude, “Where governments use competitive contracting willingly and enthusiastically -- they typically save 20-30 percent. No reporting process, auditing procedure, or budget procedure has ever gotten a public organization to put

⁶⁰ Osborne and Plastrick, 1997, *ibid*.

⁶¹ Adapted from a presentation by Sara Bennett at World Bank Human Development week, March, 1999.

⁶² UK, National Audit Office, 1987, *Competitive Tendering for Support Services in the National Health Service*, Session 1986-87, HC 318, London: HMSO.

⁶³ Domberger, S., Meadowcroft, S., and Thompson D, 1987, “The Impact of Competitive Tendering on the Costs of Hospital Domestic Services”, *Fiscal Studies*, Vol. 8, no. 4, pp. 39-54.

⁶⁴ Milne, R., and McGee, M., 1992, *Compulsory Competitive Tendering in the NHS: A New Look at Some Old Estimates*” Institute for Fiscal Studies, Vol. 13, no. 3, August, pp. 96-111.

anywhere near the energy into improvement that competition has, ... Enormous energy goes into getting prices down for competitive bids.”⁶⁵

Do Contracts Improve Performance in Developing Countries?

Tanzania: In Tanzania in the early 1990’s, the government negotiated a loan from the World Bank to rehabilitate various health facilities in several poor rural districts, and to construct others where services were entirely lacking. The first phase of the construction work was to concentrate on primary health centers -- first points of contacts for people seeking medical help -- with rehabilitation and construction of ten first referral, district hospitals to follow.

To oversee the work, the government hired a dynamic public servant who was working in the President’s office, Mr. Felix N’Daba, who had established a very good record of completing quality projects on time when he was Commissioner of local government services. N’Daba faced a hard choice in administering the World Bank funds for reconstruction. Should he give the funds to the government’s public works department, or “contract out” these non-clinical services to a private firm. His personal preference was to engage the services of a private firm because he knew the government’s public works department was often criticized for shabby work. But he was also politically savvy, knowing if he gave all the money to private firms, he’d be branded as a traitor by powerful government departments.

So N’Daba pursued a mixed strategy. He paid public works to rehabilitate a few of the primary clinics, and contracted a private company to rehabilitate and construct a few others. A year later, a tour was arranged involving government and World Bank officials (including the author) to inspect the work. The differences were startling. Physically, the buildings rehabilitated or constructed by the private sector looked like new buildings -- well-constructed structures, quality finishing, all details tended to. Those constructed by public works, on the other hand, were often uneven, structurally flawed, with many details incomplete. Moreover, public works took far longer than the private sector to complete the work -- at the same cost.

The contracting arrangements initiated by N’Daba were novel to many Tanzanians because the country had just emerged from forty years of socialism. N’Daba’s strategy of engaging both public and private contractors fostered a “competitive environment” because the products of public works versus private companies were on display for all to see. In an important sense, the resulting products -- the rehabilitated or constructed clinics -- served the country as benchmarks against which further work and progress would be judged.

In the next round of tendering for contracts. Tanzania’s public works departments would be forced to produce higher quality work in less time, or lose out to the private sector. In short, competition between providers, and the use of competitive tendering, rewards performance and yields unpleasant consequences for those unable or unwilling to be competitive.

Brazil: In 1995, in Sao Paulo, the Municipal Government passed a law that created 14 Medical Cooperatives to serve patients across the entire metropolitan area.⁶⁶ Each cooperative constituted

⁶⁵ Osborne and Plastrik, 1997, p. 141.

⁶⁶ This material on Sao Paulo derives from a presentation at the World Bank’s 1998 Human Development Week on the Municipality of Sao Paulo’s Health Care Assistance Plan.

a provider network that combined different providers at different levels within the health care system. The Municipal Government then allocated its existing public funds for health to the Cooperatives through capitation, at the rate of R\$11 for each potential resident in Sao Paulo, per month. The residents were then allowed to enroll with the Medical Cooperative of their choice to receive treatment, with the Cooperative receiving the capitated amounts (times) its total number of enrollees.

The Cooperatives were then given complete responsibility for administering and delivering the services. They hired their own President, initiated competitive tenders for medical supplies, drugs and most equipment, and gave physicians an incentive to join the Cooperative in the form of ownership (one man/woman, one vote). The Cooperatives were also free to select an external management contractor for overhead activities such as accounting and payroll, hospital management, catering, grounds maintenance, cleaning and equipment repair. This left their staff free to concentrate their energies on clinical issues and patient care. The Municipal Government, on the other hand, retained ownership of the physical assets of the public health system -- which were now under the administrative management of the Medical Cooperatives. It also required that doctors would have to work and demonstrate productivity, to be rewarded by salary bonuses of up to 33% in productivity pay.

The Medical Cooperative (MC) scheme demonstrated impressive results. The number of patient encounters after MC was initiated was 15.5 million in 1997 and 11.8 million in 1996, versus 7 million in 1995 before MC was initiated. Patient encounters in 1997, as a percentage of those in 1995, has increased to 172% for childbirths, 200% for ICU internments, 137% for surgeries, and 100% for ambulatory patients. This has been accomplished while reducing the number of physicians by 25%, reducing the patient cost by 50%, holding budgets almost constant (viz. 1995 levels), and achieving a 95% satisfaction rate. Unfortunately, this novel approach was truncated in 2000 for political reasons because the initiatives in Sao Paulo were viewed as being too different and out of sync with the prevailing federal system of health care delivery.

Other Contexts: Though formal evaluations of contractual arrangements are few and far between in most developing countries, there is evidence to suggest that contracting of non-clinical, as well as clinical services, can work to improve efficiency in many different contexts. For example,

- In Bangladesh, government used competitive bidding between 2000-2001 to identify providers of primary health care services that would be less costly than government provision. The average cost per beneficiary for the winning bidders was 35% lower than what had been estimated during the design of the project. For the winning bidders, the cost per beneficiary per year was on average \$0.64 and ranged from \$0.42 to \$0.98. Currently, the Government spends about \$2.00 per capita per year on all health services, hence the contracted price appears to be affordable to the Government and may represent a saving on their current expenditure.⁶⁷

⁶⁷ Benjamin Loevinsohn, 2002, "Practical Issues in Contracting for Primary Health Care Delivery: Lessons from Two Large Projects in Bangladesh", Flagship Online Journal, (<http://www.worldbank.org/wbi/healthflagship>)

- In Bombay, hospital catering services offered by privately contracted companies appeared to offer better value for money than those provided in-house.⁶⁸
- An assessment of the contracting out of cleaning services in Thailand suggested that the service was purchased from the private sector at a considerably lower price than it would cost to provide in-house.⁶⁹
- A study of clinical services provided by a mining hospital in Zimbabwe, under contract to the Ministry of Public Health, indicated that the prices charged to the government by the mining hospital were comparable to the costs to government of running a nearby public hospital, but quality of care at the mine hospital was considerably higher.⁷⁰
- Contracting with NGOs in Haiti between 1999 and 2001, incorporated performance-based payments and bonuses to successfully motivate staff to surpass many performance targets. Compared with a starting benchmark of 40% immunization coverage, and a target of 44%, one of three participating NGOs achieved 79% coverage. A second surpassed the 49% benchmark and 54% target by achieving 69% coverage. And the third NOG surpassed the 35% benchmark and 38% target by achieving 73% coverage.⁷¹

Caveats Regarding Managed Markets and Contracting

A linchpin of managed competition and ‘the contract state’ is that public and private providers are ready, willing and capable of responding to the challenge of competition and the opportunities afforded by contractual arrangements. Yet, even in a highly developed country like the UK, the capacity of providers within managed markets to respond to competition has been questioned, particularly in less populated, rural areas. On the one hand, widespread complaints that the drafting, negotiating and safeguarding of many short-duration contracts has raised transaction costs to intolerable levels have led to reforms favoring longer-term contractual arrangements. On the other hand, asymmetries of information between purchasers and providers – a ‘principal agent’ problem -- have led to reforms favoring greater trust and sharing of information between purchasers and providers.⁷²

⁶⁸ M. Bhatia, 1995, “Contracting for Non-Clinical Services in Bombay”, Bombay: Tata Institute for Social Sciences, paper Presented to the Second Meeting of the Collaborative Research Network on the Public - Private Mix, Sept. 4-8, Worthing, Mimeographed.

⁶⁹ V. Tangcharoensathien, S. Nittayaramphong, and S. Khungsawatt, 1995, “Contracting for Health Care in Thailand”, Bangkok, Ministry of Public Health, Paper Presented to the Second Meeting of the Collaborative Research Network on the Public Private Mix, Sept. 4-8, Mimeographed.

⁷⁰ Barbara McPake and C. Hongoro, 1993, “Contracting out in Zimbabwe: A Case Study of a Contract between Wankie Colliery Hospital and the Ministry of Health”, London: London School of Hygiene and Tropical Medicine, Health Economics and Financing Program, Mimeographed.

⁷¹ Rena Eichler, Paul Auxila, John Pollock, 2001, “Performance-Based Payment to Improve the Impact of Health Services: Evidence from Haiti”, Flagship Online Journal, (<http://www.worldbank.org/wbi/healthflagship/>)

⁷² Maria Goddard and Russell Mannion, 1998, “From Competition to Co-operation: New Economic Relationships in the National Health Service”, Health Economics, Vol. 7, pp.105-19.

Reservations concerning the capacity of managed markets to respond are more pronounced in less developed countries, especially in very low income countries with large rural populations, where the private sector is relatively disorganized and few private providers are operating. Though some of the problems involved can be put down to high transaction costs, as well as provider inefficiencies, it is instructive to revisit the Nicaraguan example provided at the beginning of this section. On the one hand, the purchaser/provider split in the government's social security scheme (INNS), was well thought out from a purchaser perspective. On the other hand, however, it appears somewhat flawed from the perspective of private providers, and its acceptance and growth has been relatively slow.

Three reasons have been advanced to explain the slow uptake by private providers in Nicaragua.⁷³ First, health care organizations wishing to participate incur expenses to satisfy the human resource and physical infrastructure requirements to qualify as accredited providers, yet are guaranteed nothing by becoming accredited. Second, responsibility for providing all of the services that patients demand (under the contractual arrangements) has put the providers at considerable financial risk. Two private sector multi-practice clinics in Managua apparently went bankrupt owing principally to their having lost significant sums of money hospitalizing their clientele. Third, the INSS has saddled providers with the onerous financial responsibility of paying sick workers an economic subsidy -- meaning sick leave benefits. Fiedler (1996) suggests these problems could have been largely avoided had the INSS (i) performed an adequate stakeholder analysis to determine their size and capacity, and (ii) initially focused on a relatively small-scale problem or pilot that has high visibility and/or that had a high probability of being successfully reformed.

Although managed competition makes use of contracting to reduce costs (through tendering) and increase effectiveness (through improved specification of outputs desired and competitive forces), it is also true that the process of contracting itself involves costs. The 'ex ante' costs of contracting include (i) preparation of contracts, (ii) tendering of contracts, (iii) choice of potential partners, and (iv) negotiation with them. 'Ex post' costs of contracting on the other hand include the time, human resources, and money involved in monitoring performance, and absorbing failed contracts.

A literature review by Mills (1995) concludes that transaction costs are in the order of 7% of the total value of the contract value (bids) in the UK, rising to as much as 20% in the United States. In the UK, the cost of monitoring contracts could rise to as much as 30% higher than the cost of monitoring the direct supply of services.⁷⁴ A risk is therefore apparent in contracting insofar as the transaction costs will absorb part, and in some cases, even all the efficiency gains achieved through the contract.⁷⁵

⁷³ John Fiedler, 1996, *ibid.*

⁷⁴ Anne Mills, 1995, "Contractual Relationships between Government and the Commercial Private Sector in Developing Countries: Are they a Good Idea in Health", London: Paper presented to the Second Meeting of the Collaborative Research Network on the Public/Private Mix, London School of Health and Tropical Medicine, Sept. 4-8, Mimeographed; and Anne Mills and Jonathan Bloomberg, 1998, *Experience of Contracting: An Overview of the Literature*, Geneva: World Health Organization, Macro-Economic Health Development Series 33.

⁷⁵ Jean Perrot, Guy Carrin, and Fabrice Sergent, 1997, "The Contractual Approach: New Partnerships for Health in Developing Countries," Geneva: World Health Organization, WHO/ICO/MESD.24, Mimeographed.

One way of holding down transaction costs is to shift cost of preparing, monitoring and evaluating contracts to the contractor. To illustrate, when putting contracts out to tender (for example, to provide X goods and services, and meet Y targets), public sector agents can require that potential contractees submit proposals that describe how they will provide X to meet Y -- over what time horizon, and at what cost. Public sector agents can also require that proposals submitted by contractees contain procedures and estimated costs of monitoring and evaluation. Again, competitive processes and the ingenuity of the private sector are tapped in this regard to provide most cost-effective solutions.

On the other hand, when public sector agents do not trust the market or competition to yield the best contract proposals, they can pursue negotiated contracts. This process makes use of collaborative planning, involving partners that are judged to have a good reputation. Again, responsibility for preparing the contract specifications can be shifted to the contractor, with the added plus that the contractor can be privy to the skills and resources actually available to the contractee. Such privileged knowledge is not available in the tendering process, because the contract states intentions rather than a summary of resources at hand. Finally, negotiated contracts result from a transparent process, with considerable scope for involvement by other concerned stockholders, such as community representatives.

Summing Up: As an organizational strategy to inject NPSM into the public sector, managed care and the contract state can contribute to continuous improvements in responsibility, performance and accountability by combining the clout held by public purchasers with the cost-cutting and efficiency characteristics of competing providers. Purchasers have clout because they have considerable buying power and can negotiate deals to squeeze greater value for money. Providers pursue efficiency and cost-cutting because they must provide more services for less money than their competitors to win contracts. The 'institutional memory' of the purchasers facilitates benchmarking on the basis of recorded unit costs and outcomes, and thus prospects for 'ratcheting up' performance demands on providers in subsequent contracts. Finally, management of both purchasers and the providers will be motivated to adopt personnel performance management techniques (PPM), as well as performance-related budgets, thus contributing to improvements all around.

Caution is required on the other hand, regarding a large number of potential problems that can undermine the cost-savings and positive performance effects of contracting. Both contractor and contractee must be well prepared and well informed, as conveyed by the potential problems flagged in Box 7.

Box 7: Potential Problems with Contracting

Expected Savings: Contracting of non-clinical and clinical services is expected to generate savings for public purchasers by utilizing more efficient private firms, and transferring financial risks to them to perform according to contractual obligations. But experience shows that significant “transaction costs” are incurred by public sector agencies that are involved in designing, administering, and monitoring and evaluating contracts. By some accounts, these transaction costs range from 7 to 20 percent of the value of the contract.

Capacity of the Contractor: A contract is only as good as it’s contents, with the implication that the contractor must be skilled at specifying expectations and outcomes, understanding how different contractual forms and payment mechanisms may affect performance, and assuring satisfactory performance. Most studies suggest that steps need to be taken to improve public sector management skills in this area -- that is, training in how to prepare contracts.

Selection and Capacity of the Contractee: Ideally, many private or NGO organizations will bid for a contract, and will provide sufficient information to allow the contractor to make the best choice. But in limited markets, or in countries where the private sector in health tends to be small or weak, the number and capacity of bidders may be limited. Assessments need to be undertaken and assurances given that the contractee can indeed deliver -- has the human resources and financial sustainability to do so.

Level of Detail and Kinds of Tasks: The level of detail in contracts, and the kinds of tasks selected, will vary depending on the nature of the service and the ease of specification. Non-clinical services, such as catering, laundry, and maintenance of vehicles, is *relatively* straight forward in terms of quantity of items or activities anticipated, and quality standards to be achieved. The same does not apply, however, to clinical services, especially when attempts are required to link their provision to outcomes.

Requirements of the Regulatory Environment: As public agencies increasingly transfer responsibility for delivering services to private organizations (via contractual arrangements), commensurate attention has to be given to the role and capacity of the regulatory environment. On the one hand, public contractors will have to assure that contractees are aware of and abide by existing regulations that pertain to private markets -- such as minimum wage laws. On the other hand, the public sector will have to devise and enforce new regulations that assure that “market failure” does not undermine health service provision. Confidence needs to be strong that government regulatory agencies can assume increasing responsibility in expanding private markets in health provision.

Complexities of Price-Setting: By legally agreeing to provide a range of services for an agreed contractual amount, the contractee runs the risk of incurring a financial loss if more money is required to delivery the services than had been anticipated. While this is part of the appeal of contracting -- to shift the financial risk from the purchaser to the provider -- contractees are aware of the potential costs of this risk and will demand some form of built-in compensation. Usually this takes the form of a larger contractual amount than would be justified by the cost of providing the agreed services alone. It is important to understand such complexities of price setting, and how they will tend to vary according to how the contractee is to be paid -- by a block amount, on a cost and volume basis, on a capitation basis.

Monitoring and Evaluation: Funds and human resources must be dedicated in contractual arrangements to assure that performance is sufficiently monitored and evaluated. Such information is critical to appraising whether outcomes are achieved, enforcing contracts, and undertaking mid-course corrections if performance is failing. Virtually all studies of the contracting process conclude that this important dimension is given inadequate attention or is poorly implemented.

Adversaries of Contracting: While it is indeed valuable to debate the virtues of contracting and to seek evidence on their performance, it is important to recognize that there are many dimensions on which contracting may (or may not have) appeal. For example, negative findings regarding high transaction costs might be balanced by positive findings regarding greater clarity and specificity of outcomes, as well as stimulus of private markets. Weak, initial management capacity by public sector contractors might be offset by improved management capacity over time, resulting in a stronger ethic of performance based agreements. Slippage on quality standards might be offset by greater impetus to improve a traditionally poor regulatory environment, leading to progressive quality improvements over time.

ORGANIZATIONAL STRATEGY 5: CORPORATIZATION:

In the mid-1980's, New Zealand not only had a heavily protected economy, but the scale of government intervention and ownership was among the greatest of the industrialized countries. By 1990, much of that protection had been removed, there was widespread abandonment of internal intervention, and large portions of the public sector had been corporatized. Indeed, New Zealand's corporatization program is unprecedented in its scale, speed and rate of evolution.

The process of 'corporatization' began in 1983 when the government was in the throes of a huge debate about the desirability of divesting publicly owned agencies that performed a conflicting mix of business, regulatory, and social roles. The outcome of this debate took the form of recommendations to transform entire government agencies that produced goods and services with commercial value into public corporations -- called 'State Owned Enterprises' (SOEs). Ministry of Finance guidelines published in 1985, as well as supplementary explanations, suggests there were seven key objectives of the corporatization process:⁷⁶

1. SOEs would be set up on an individual basis, depending on their commercial purposes, under the guidance of Boards modeled on the private sector. Boards of SOEs are to have the authority to make the decisions necessary to meet the objectives in (1) above. They are to have responsibility for major investments, recruitment, and other strategic decisions. (Ministers retain overall responsibility for the SOEs performance but should not be more closely involved.)
2. Managers of SOEs are to have a single, clear objective -- to maximize commercial performance and to run SOEs as successful business enterprises. This is intended to provide a direct and unambiguous focus, facilitate monitoring, improve accountability, and prevent inconsistent political objectives from affecting operations.
3. Managers of SOEs are responsible for using inputs, for pricing, and for marketing their products within performance objectives set by ministers.
4. Management performance should be closely monitored -- by Ministers, the Treasury, and some private sector monitoring.
5. Managerial rewards and sanctions should be strongly in place to reinforce incentives for performance, with salaries and employment being linked to performance.
6. Most SOEs will no longer have statutory monopoly protection or preferential access to government business, with the implication that in markets where potential competition exists, the SOEs will be exposed to it.
7. SOEs will be encouraged to raise funds in capital markets, rather than at subsidized rates from the state, without explicit government guarantees on debt. They must earn a rate of return on equity capital in line with the market, and pay dividends and taxes to government. They can purchase material and other inputs from any source rather than be required to use government services and, in most cases, can employ labor on a similar basis to the private sector.

⁷⁶ Thomas Clarke and Christos Pitelis (eds.), 1993, *The Political Economy of Privatization*, London: Routledge. See, in particular, the chapter by Alan Bollard and David Mayes.

The last characteristic noted above distinguishes ‘corporatization’ from autonomization of public agencies.

- ***Management boards of corporatized agencies are required to raise funds in capital markets and earn a rate of return on equity capital. This parallels management boards of private hospitals who must do the same thing. Corporatization of formerly public agencies falls short of outright privatization, however, because government constitutes the corporatized agency’s main shareholder and assumes implicit liability for its assets. Crown corporations are largely immune from bankruptcy, given an implicit government guarantee. In a private company, on the other hand, individuals and investment funds serve as shareholders, there is no explicit or implicit government guarantee protecting their investments, and bankruptcies are commonplace.***

By 1986, a State-Owned Enterprises Act provided for the appointment of a board of directors for each corporatized SOE in New Zealand, accountable to the Minister of Finance. A further responsible Minister was designated to hold the shares of the SOE (ownership of its capital), who, in turn, would be responsible to Parliament for the performance of the enterprise. Each corporatized SOE was to issue a statement of corporate intent including corporate objectives, the scope of activities, accounting policies, performance targets, estimated returns, commercial valuations, and other information. The Act also specified that the SOE would deliver annual, half-yearly and other information to the shareholding minister. The operational and organizational differences between the newly corporatized SOEs and traditional government departments are summarized in Table 6.

In 1987, nine SOEs came into existence: coal, electricity, property management, land, forestry, the Post Office, the Postal Bank, telecommunications, and air traffic control. The change affected some 60,000 government employees. Box 8 summarizes several important procedural issues that were raised prior to or during the transformation process that were not always satisfactorily resolved.

For the first time in New Zealand’s history, these new public enterprises would lose their statutory monopolies and would face market pressures. Although government still owned their assets, SOEs would now have to pay taxes to the government and could no longer draw free capital from government revenue sources. They would have to report to independent boards of directors instead of elected officials. The boards of directors would negotiate the corporate direction with ministers. They would select and contract with chief executives, who would be unshackled from government employment, budgeting, and procurement systems.

Over a five-year period, the SOEs registered impressive gains. Telecommunications increased its productivity by 85% and cut prices by 20%. The coal SOE maintained previous production levels with half the workforce, while cutting prices by 20%. The rail SOE cut freight prices in half, while turning a \$77 million loss into a \$41 million profit. As a whole the SOEs increased their revenues by 15% and quadrupled their profits within five years. By 1992, they were paying roughly \$1 billion in dividends and taxes.

Table 6: Operational and Organizational Dimensions of SOEs in New Zealand

| | Government Department | Corporatized Agency or SOE |
|---|------------------------------|-----------------------------------|
| <i>Ownership/Legal Responsibility</i> | | |
| -- Shareholders | Parliament | Minister |
| -- Dividends | n/a | Crown/bondholders |
| -- Liability | None | To Crown |
| | Unlimited | Unlimited but private insurance |
| <i>Government Guarantee/Protection</i> | Explicit | Implicit |
| <i>Discretionary Behavior</i> | | |
| -- Board Autonomy | n/a | Moderate |
| -- Ultimate Threat | Reorganization | Privatization |
| <i>Managerial Autonomy</i> | Little | Considerable |
| <i>Setting Dividends</i> | None | Treasury/Minister |
| <i>Constraints on Operation</i> | | |
| -- Statutory Monopoly | Probable | Mainly removed |
| -- Source of Finance | Consolidated funds | Private capital markets |
| -- Operational Scope | Limited | Wider |
| -- Organizational Flexibility | None | Some |
| <i>Objectives</i> | | |
| -- Commercial | Mixed | Single |
| -- Other Objectives | Regulatory/policy/social | Only when contracted |
| <i>Incentives/Sanctions</i> | | |
| -- Management | State Services Commission | Board |
| -- Employees | State Services Act | Employment Contracts Act |
| <i>Internal Monitoring</i> | | |
| -- Board | n/a | Minister/SOE Unit |
| -- Top Management | SSC/Minister | Board |
| - Middle Management | Secretary | CEO |
| <i>External Monitoring</i> | | |
| -- Spending Plans | Parliament | Minister/capital markets |
| -- Financial Accounts | Audit Office | Audit Office |
| -- Overall Performance | Treasury/SSC/Committees | SOE Board/Treasury |

Source: Adapted from Bollard and Mayes in Clarke and Pitelis, 1993, *ibid.*

Box 8: Issues and Steps in the Corporatization Process in New Zealand

The record of corporatization in New Zealand is best viewed as a variety of processes that usually led to a well-functioning SOE over time, rather than in a single, redefined step.

First, to commence the process, it was generally agreed to set up an establishment board or steering committee to oversee the transitional arrangements in an orderly way, and to prepare the ground for SOE status. In some cases, however, the transition pace was slow and indirect, mainly because of changes of mind by politicians and bureaucrats concerning the appropriate organizational forms, and difficulties over the valuation of assets held by the public agency. In other cases, there was a gap between formal SOE status and the transfer of assets, during which the new organizations had to operate with unclear balance sheets.

Second, it was generally agreed to establish the valuation of the assets and liabilities of each public agency that were to be transferred to the new corporation. However, this became a hotly contested exercise that forced a complete rethinking of the value of certain activities and assets. In some cases, the government “wrote off” these debts during the transition. In other cases, however, SOEs inherited unstructured debt, and complained that this put a constraint on their reinvestment abilities.

Third, there was little agreement on whether public agencies should be internally restructured prior to becoming an SOE, or following corporatization. Where Boards were established prior to corporatization, they tended to carry out early restructuring of employment, finance, and operations. In such cases, the Government assumed the cost of redundancy and debt, leaving the new SOE’s management to start with a clear balance sheet. However, in most cases SOEs had to deal with this restructuring after corporatization, and sometimes the costs of doing this held up the restructuring.

Fourth, it was generally agreed that ultimate regulatory frameworks, and deregulation, should be worked out prior to public agencies becoming SOEs. However, such frameworks were not always in place in time and past public agencies that had operated with mixed objectives -- including provision of policy advice, regulation, and social objectives -- found themselves facing competition almost immediately on becoming an SOE.

See Bollard and Mayes (1993) in Clarke and Pitelis (1993)

An OECD review of available evidence suggests that corporatization and deregulation have had positive effects on the efficiency of government businesses in performing commercial services, though empirical findings pertaining to their achievement of social goals are generally unavailable (i.e., public accountability).⁷⁷ Of particular significance has been the increasing reliance on contracting out the delivery of services to the private and voluntary sector providers. The new contractualism has been prevalent in health and welfare sectors. Managerial and accounting reforms in the core public services have also generally received widespread, if qualified, support from politicians and senior executives.⁷⁸

Moreover, “there is near universal agreement that New Zealand government is much better managed now than before”.⁷⁹ These impressions are largely confirmed by an independent study conducted by Allen Schick in 1996 for the New Zealand State Services Commission and the Treasury.⁸⁰ A large number of managers interviewed by Schick “... are convinced that services

⁷⁷ OECD, 1996, OECD Economic Surveys 1995-1996: New Zealand (Paris: Organization for Economic Cooperation and Development).

⁷⁸ OECD, *ibid.*, 1996, p. 109.

⁷⁹ Allen Schick, 1996, *The Spirit of Reform: Managing the New Zealand State Sector in a Time of change*, Wellington: Report prepared of the State Services Commission and the Treasury.

⁸⁰ Allen Schick, 1996, *ibid*

have been upgraded and that staff are more sensitive to the concerns of clients and to the quality of services provided them". Some managers "... estimated that the reforms had produced annual efficiency gains of 10 percent or more."

The gains to New Zealand's corporatization policy were far beyond anyone's expectations, says Graham Scott, an architect of the policy. And with those gains emerged a greater boldness regarding the virtues of privatization, and the prospect of selling off SOEs and other public businesses to the private sector. Thus, between 1991-95, the government sold more than 20 state organizations, including the Bank of New Zealand, the Rural Bank, the Post Office Bank, the Shipping Corporation, Government Life, the Forest Corporation, the Tourist Hotel Corporation, the Telecom Corporation, and others.

Application to health: As they sold off the SOEs, government ministers contemplated ways of applying the lessons of their startling success to what they called the core public sector -- comprising services with positive externalities and public goods content.⁸¹ They assumed that waste and inefficiency were also rampant in health, education, defense, policing, criminal justice, environment, and welfare agencies. Yet, there was the widespread belief they could not create market discipline to correct these problems through extreme models of corporatization and privatization. Thus, they began to prepare a New Public Sector Management framework that would bring analogous incentives for efficiency into the activities of these remaining government entities and departments,⁸²

- Ministers would negotiate performance agreements with all departments and ministries, which would agree to produce a specific quantity and quality of outputs at a specified price.
- The senior civil servant running each department or ministry would work on a fixed-term performance contract, rather than having permanent tenure.
- The new chief executives would have the freedom to manage their organization's resources, with the result that the Treasury Department's control over day-to-day budgets shifted to the chief executives, CEOs had power over purchasing decisions and could buy what they wanted when they wanted it, public servants lost their guaranteed tenure, and unions lost the ability to bargain uniformly for government employees in different departments.
- Departments and ministries faced incentives to manage their finances effectively including accrual accounting, and interest charges (payable to the Treasury) on the value of the public assets they were managing.

⁸¹ For a more detailed discussion on the application of corporatization to the hospital sector in New Zealand, see Scott G., L. McKenzie and J. Webster, 2003, "Maladjustments in the Corporatization Model: Hospital Reform in New Zealand: Chapter 8, " *Innovations in Health Service Delivery: The Corporatization of Public Hospitals*, Preker A.S. and A. Harding, Eds., 2003, Washington, World Bank, pp305-344.

⁸² A major report was commissioned on the effects of the NPSM -- the Logan report. It concluded that vestiges of the NPSM (described above) had already had a significant and beneficial impact on the effectiveness and efficiency with which the core public service operates.

One of the most startling innovations in New Zealand's Health sector was the separation of political and managerial roles through the association of outcomes with the Minister of Health and outputs with the chief executive of the NHA. The minister -- representing citizens -- was to identify desired outcomes, and then negotiate and purchase desired outputs from the Chief Executive of the NHA. The Chief Executive was then to take responsibility for selecting the necessary inputs (services and providers) to achieve the agreed outputs.

However, when the government made sweeping changes to transform -- or corporatize -- government owned hospitals into Crown Health Enterprises (CHE), major problems emerged. As in the UK, clinicians balked at the new arrangements. Costs began to increase, rather decline, by about 5 percent per year, and the CHEs were plagued by persistent deficits.⁸³

On comparing differences between successful State Owned Enterprises in New Zealand during the late 1990s and the relatively poor performance of Crown Health Enterprises thus far, Graham Scott emphasizes that;

- the CHEs encountered a rigid and resistant labor market (in the form of powerful clinicians), whereas the SOEs did not;
- the CHEs had no clear output measures, whereas the SOEs were able to formulate and agree to them;
- the CHEs were in a monopoly position (few of them) and thus were not oriented to enter into competition, whereas SOEs occupied a partial monopoly and could be directed to compete;
- the CHEs were held publicly accountable by a government "third party payer" (i.e., national health insurance), whereas SOEs could be made answerable to individual consumers (through their purchases).⁸⁴

Scott's message is not to suggest that New Zealand's health sector is an inappropriate candidate for the application of quasi-corporatization that aims to inject NPSM into the health sector. Rather, he points out that there is no standard template, such as an SOE template that can be

⁸³ Notes provided by Graham Scott to World Bank Institute Flagship Course Presentation, 1998.

⁸⁴ On the negative side, several critics maintain that corporatized SOEs still remain vulnerable to operational weaknesses. The following perceptions are advanced in support of this view;

-- The absence of a (share) market for ownership in an SOE, reduces the incentives for owners of the SOE (ministers) to monitor management performance; the same applies to the performance of Board Directors who will not hold shares in the company.

-- There is little threat of a take-over or bankruptcy for an SOE, an ultimate motivation for improved performance by managers and directors.

-- Because government guarantees on SOE debt will tend to be viewed as implicit -- notwithstanding official disclaimers -- there will be less pressure on management resulting from the "cost" of funds/debt or the threat of financial failure.

-- Despite the "hands off" approach in the SOE structure, the possibility of political intervention in managerial or directorial responsibilities still exists.

applied to CHEs.⁸⁵ He refers to corporatization as a process of discovery. He proposes that the application of NPSM should be thought of as an experiment, requiring careful prior analysis of the health system and its major stockholders. He urges that policy makers form a clear hypothesis about how they expect the new design to function, what it is expected to accomplish, and then stringently measure its success over time. And he underscores that performance failures can often be traced to insufficient clarity and communication about roles and responsibilities -- to the principals, agents, and general populace.

Surprisingly, a more positive response to reforms in New Zealand's health sector came from the private sector and General Practitioners. GPs acknowledged some of the virtues of adopting business-like practices in health -- such as contracting and improved financial management -- but they did not want to become involved in such practices on a daily basis. They wanted to devote their energies to practicing medicine. Thus, they created Independent Practice Associations (IPAs) to would manage the business aspects for the GPs, and to create a buffer against the many new and seemingly complex changes imposed by government.

By 1995, there were over 40 independent and locally situated IPAs around the country, representing over 50 percent of New Zealand's GPs.⁸⁶ This 'spontaneous' formation of IPAs was viewed positively by New Zealand's Health Reform Directorate because, previously, it had no clear idea how contracting arrangements between regional government purchasing authorities and primary health providers would work. With the formation of IPAs, however, the regional health authorities could contract with a few IPAs, compared to hundreds of individual GPs, thus saving on contracting costs. Moreover, the professional expertise brought to bear by IPA staff would significantly simplify the process of negotiating contracts.

A case study analysis of an IPA called 'Pegasus' in Christchurch, representing 90 percent of the local GPs reveals that the contractual accountability requirement between NZ regional health authority and Christchurch GPs seems to have been resolved through the IPA structure. GPs only have to be accountable to other GPs and their patients, whereas governmental caps on the regional health budget as well as contractual accountability for GP services is taken care of by the IPA as a whole. Moreover, Pegasus has worked on behalf of the GPs to identify areas where costs can be cut and savings generated, with commensurate agreements with the Regional Health Authority that the IPA can keep part of the savings for other uses. In the first 9 months of Pegasus' operation, this has worked favorably in the area of laboratory tests and pharmaceuticals. For example, upon producing cost information and steering GPs towards more cost-effective procedures, Pegasus was able to achieve a 30 percent decrease in laboratory usage, producing a savings of over \$1 million NZ.⁸⁷

Summing Up: Corporatization can contribute to continuous improvements in public performance by forcing public enterprises to become 'lean and mean' in an open, competitive environment. Formerly public agencies that are corporatized must satisfy shareholders, live within a financial bottom line, generate revenue, and satisfy customers. At the same time, they must strive to be

⁸⁵ Scott's reflections are contained in overheads provided to the author, entitled "Outline of Corporatization Issues with Reference to New Zealand's Experiences".

⁸⁶ Kerry Jacobs, 1997, "A Reforming Accountability: GPs and Health Reform in New Zealand", *International Journal of Health Planning and Management*, Vol. 12, pp. 169-85.

⁸⁷ Kerry Jacobs, 1997, *ibid.*

publicly accountable, and demonstrate standards of fairness. All the prior NPSM modalities come into play, with survival of the corporation's management at stake.

On the other hand, the move to corporatize 'core public agencies' -- where public accountability is strong and public goods and positive externalities are involved -- is an extremely complex undertaking. It must be well thought out and guided by an effective transition team, and is likely to produce a hybrid or quasi- form of corporatization as illustrated in New Zealand's health sector. Potential problems are flagged in Box 9.

Box 9: Potential Problems with Corporatization

Need for a Transition Phase: Experience reveals that corporatization of formerly public agencies is a deeply political process insofar as (i) the status, valuation and transfer of public assets must be determined, (ii) public accountability for performance is involved, (iii) civil service reform is inevitably involved, and (iv) appropriate organizational forms must be determined. Moreover, when governments pursue corporatization on a broad scale, changes of mind by politicians and bureaucrats can result in shifting agendas and priorities. In anticipation of this process, there may be value in setting up an "establishment board"; to oversee the transitional arrangements in an orderly way, and to prepare the ground for corporate status. This approach was usefully adopted in New Zealand.

Valuation of Assets: The valuation of assets and liabilities of each public agency that are to be transferred to a new corporation is likely to be a hotly contested exercise regarding (i) what should be included in the assets and liabilities, and (ii) how they should be valued. In some cases, governments may be willing to 'write off' a public agency's liabilities (debts) during the transition to corporate status. When this happens, the newly formed corporation is given a "clean slate", free from prior obligations. When this does not take place and the new corporatized agency inherits unstructured debt, this may put a constraint on its reinvestment abilities, thus undermining future viability of the new corporation.

Timing of Internal Restructuring: When agency-specific management or transition boards are established prior to corporatization, they may be empowered to carry out early restructuring of employment, finance, and operations. In such cases, government tends to assume the cost of redundancy and debt, leaving management of the newly corporatized agency to start with a clear balance sheet. In contrast, when these tasks are left entirely to the management of the newly corporatized agency, restructuring might be a time-consuming and costly process that interferes with performance.

Regulatory Framework and Deregulation: Prior to corporatization, most public agencies serve mixed objectives -- including provision of policy advice, social objectives, and regulation. Once corporatized, they may find themselves facing competition almost immediately from profit-oriented companies that face no such social or regulatory operating constraints. It is important, therefore, to establish the ultimate regulatory framework -- including deregulation of appropriate activities -- that will determine the market environment within which the new corporations must compete.

Rigid and Resistant Labor Markets: Corporatization of public agencies that are staffed by highly organized, powerful labor groups are likely to face resistance, especially if corporatization is seen as a strategy to reduce expenditures, the workforce, and the wage bill. This concern is particularly evident in the health sector, where clinicians have fiercely resisted efforts to transform public hospitals into autonomous entities groups, let alone sector-wide policies to make medical personnel responsive to market forces and managed competition.

Disincentive Effects of Continued Government Guarantees: Corporatization of formerly public agencies involves a variety of operational and organizational changes that aim to make the new management more business-like and responsive to market forces. In many instances, however, some degree of government protection or guarantees against bankruptcy will remain. This suggests that managers of corporatized agencies may not face the same disincentive effects associated with poor performance (i.e., bankruptcy, hostile take-over, loss of job). Critics of corporatization are quick to point out that such differences may undermine competitive zeal.

Demands on Management Capacity: Successful corporatization demands full attention to skills needed to manage a large business entity in a competitive market. Skill requirements will be particularly heavy in the area of budgeting and financial analysis, market analysis, and personnel management. In many less developed country contexts, such skills are hard to come by, especially in weak sectors where salary levels tend to be relatively low (e.g., health).

Sources: Bollard and Mayes (1993) in Clark and Pitelis (1993)

CONCLUSION

Principles and practices associated with the ‘New Public Sector Management’ are all quite recent. Making sense of the new terms involved, how they interrelate, and the kinds of impacts they are expected to have represents a major challenge to those seeking to understand and apply the new NPSM paradigm. An even greater challenge is to document evidence demonstrating that the five organizational strategies reviewed here have indeed resulted in appreciable improvements in public sector performance. Studies are few and far between -- especially in the health sector -- with the implication that enthusiasm over NPSM should be appropriately cautious until more evidence is forthcoming.

Nevertheless, there are good reasons to welcome the principles of NPSM because they offer a potentially inspiring alternative to traditionally sluggish performance in the public sector. Identifying business-like practices that can be usefully mimicked and imported into public agencies appears to be informed by the right kinds of problems, and appears to be generating reasonable, and well-directed solutions.

There is also value in knowing that OECD countries have been grappling with NPSM reforms as part of their endeavors to purge inefficiencies in public agencies, and get more value for money. Policy makers in developing countries have often been urged to consider the same kinds of reforms, sometimes by international experts and by policy papers associated with international Banks and bi-lateral aid agencies. Appreciating where the ideas came from, how they evolved, the lessons learned and best practices (if any) is an important means of empowering developing country officials to make more informed choices.

Perhaps the greatest challenge facing those wishing to implement NPSM reforms lies in the political domain. Political commitment to such reforms is critical because NPSM entails fundamental shifts in power, new kinds of transaction costs, and interconnectedness of NPSM agendas across Ministries and at high levels of government.

Perhaps the most important obstacle to implementing of NPSM reforms in developing countries concerns capacity issues -- the capacity of government agencies or intermediaries to contract, or to introduce new, more complex accounting and financial systems. Though designed to improve management performance, NPSM must rely on a critical mass of adequately trained managers. Recall the fivefold increase in general and service managerial positions in Britain’s National Health Service. In contrast to developing countries, prospects tend to be relatively good to tap managerial expertise from the private sector. In many developing countries, however, the pool of high-level skills is far more limited, professionally trained managers are a rarity, and relatively low compensation in Ministries of Health tends not to attract recruits from the private sector.

Finally, successful implementation of NPSM reforms requires far more knowledge about requisites in the “enabling environment” than is currently available. This applies particularly to organizational strategies favoring autonomization and corporatization of public agencies. Enabling environment conditions that need further assessment and documentation -- through applied cases -- include;

- appropriate legal structure (public or private law) and regulations
- governance issues (decision making rights before/after reforms)

- management autonomy
 - definition of scope of operation (mandate/mission)
 - hiring/firing, salaries, personnel - including legal status
 - procuring inputs
 - mix/volume of inputs
 - retention of funds
- ownership (who gets return on capital/assets)
- payment systems and contracting/purchasing arrangements
- incentive structures
 - sticks (lower pay, firing, bankruptcy)
 - carrots (bonuses, promotions, profits)
- competitive framework
 - patients voting with their feet
 - private purchasing power
 - competitive public purchasing
- management capacity
- resource requirements
 - information (financial, services, and outcomes)
 - human capital



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