Public Management and the Essential Public Health Functions

PEYVAND KHALEGHIAN and MONICA DAS GUPTA *

The World Bank, Washington, DC, USA

Summary. — This paper provides an overview of how different approaches to improving public sector management relate to the so-called core or essential public health functions such as disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, and health policy development. Using the principles of agency theory, the paper summarizes key themes in the public management literature and draws lessons for their application to these core functions, especially in low- and middle-income countries.

Key words — public health functions, public service delivery, public management, health policy, provider incentives, developing countries

1. INTRODUCTION

This paper provides an overview of how various approaches to improving public sector management relate to the so-called core or essential public health functions (EPHFs) such as disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, and health policy development. The purpose of the paper is to summarize key themes in the public management literature and draw lessons for the EPHFs. To this end, we use agency theory (or the principal–agent problem), which examines how a principal (e.g., the central government) can ensure that the agents' (e.g., local implementation agents) incentives are consistent with assuring the principal's objectives. Using this approach, we highlight implications for the EPHFs of management reforms which seek to assure effective service delivery by creating incentive structures through mechanisms such as purchaser–provider splits, contracting, provider payment reforms, and decentralization. Section 2 summarizes “new public management” and related approaches. Section 3 reviews traditional approaches to public administration and their relevance to the EPHFs. Section 4 summarizes lessons.

Two points are essential to understanding the discussion that follows. The first relates to the nature of the EPHFs. In economic terms, most EPHFs are public goods. This means that they are nonrival (i.e., consumption by one person does not restrict consumption by another) and nonexclusionary (i.e., their benefits accrue to the entire population and cannot be restricted to a discrete group). For example, once erected, a health education billboard benefits everyone who views it, no matter how many people do so (i.e., nonrival); and anyone who wants to view it can, given its public location (i.e., nonexclusionary). This is distinct from private goods—e.g., cancer treatment—which, like most commodities, are both rival and exclusionary. Some disease control

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services fall into a middle category of “merit goods” because they have both private and public characteristics. Immunization is one example. While immunization has private benefits for the vaccinated individual, it also has public benefits because of its contribution to herd immunity and the protection of others. These distinctions are not purely academic. The market would have few incentives to provide public goods, and would be expected to underprovide merit goods. They have major implications on how services should be financed and delivered and are fundamental to our discussion.

The second point relates to the difference between public health services and public health functions. Some traditional public health services—immunization, STD clinics, TB control, etc.—are merit goods, while others (such as vector control) are public goods. However, the public health functions—policy-making, disease surveillance, population health assessment, health education, etc.—are almost all pure public goods. The service-function distinction is not always made clear in the literature but is of considerable practical relevance when it comes to questions of management and financing. Public health services are often relatively easy to measure, for example, with indicators such as the number of children immunized or the number of TB cases treated. This makes them easier to manage and provides a wider scope for innovations in service delivery compared to public health functions and those services whose public good nature and complexity of measurement pose special challenges. The public health functions are more akin to other “core government functions” such as revenue collection and maintaining law and order, and draw on similar principles for their management.

2. THE NEW PUBLIC MANAGEMENT

Until the early 1980s, the public sector in most countries was monopolistic, centralized, and hierarchical, with an inherent tendency to be inflexible, unresponsive to users and insulated from the private sector and other agencies outside government. With budget crises and the realization of significant inefficiencies in the public sector in the early 1980s, and with the coincident rise in theories such as public choice theory, principal–agent theory, and transaction cost economics, it was recognized that traditional approaches to public administration were in need of reform. A range of reforms—collectively referred to as the new public management or NPM—rapidly formed a new model of state management. At the heart of these reforms was a shift from government by control to government by contract. This typically involved changes in organizational structure (e.g., moves toward managerial autonomy or corporatization of public entities) and introduction of market processes (e.g., through formal privatization or market-simulating reforms within the public sector, such as purchaser–provider splits and decentralization), and it came to imply a redefinition in the government’s role from that of direct service provider to one of stewardship, oversight, and regulation (Batley, 1999a). The poster-country for these reforms was New Zealand, where sweeping reforms were carried out in the late 1980s—sparring no sector—and which remains the most comprehensive example of an NPM-motivated public sector reform process to date (Bale & Dale, 1998).

The concepts of NPM resonated with health policy specialists and had a major influence on health reforms in the 1980s and 1990s. In most cases, reform efforts made no distinction between curative and preventive services and applied similar prescriptions to both. Some concepts—such as purchaser–provider splits, hospital autonomy, and decentralization in order to increase local managerial autonomy and accountability—were effective and took hold for curative services. The greatest success was reported in industrialized countries with high levels of administrative capacity and political stability, such as Singapore and New Zealand, though developing countries such as Ghana, Zimbabwe, Sri Lanka, and Thailand also attempted them to various degrees (Russell, Bennett, & Mills, 1999). For public health and preventive services, however, impact evaluations—which were not conducted until the late 1990s—revealed a less positive picture. In this section, we examine new public management strategies for public health under three headings: (1) true market reforms, that is, those involving user charges and provider competition; (2) pseudomarket reforms, for example, purchaser–provider splits, contracting and other market-simulating reforms; and (3) decentralization, “the public sector equivalent of privatization” (Bird, Ebel, & Wallich, 1995).
Market reforms involving user charges have been abundantly documented to have a negative impact on preventive services. User fees have been shown to cause immunization coverage rates to fall (WHO, 1999). The same has happened with other disease control activities. In Nicaragua, for example, reductions in the government budget for malaria control led some areas to adopt user charges for diagnosis and treatment, a practice that had been proscribed since 1947; these in turn led to a fall in the numbers being tested and a consequent rise in malaria incidence (Garfield, 1999).

For the EPHFs, user charges are not an option. These are typically funded from public resources, since consumers will not voluntarily pay for disease surveillance or health education campaigns, given their public good nature. But in some countries, severe reductions in the health budget have forced public health agencies to generate their own revenues by any means possible (Bloom, 1998; Bloom & Gu, 1997). Some have responded by seeking donor funds to support public health; others have used within-facility cross-subsidies from curative care to public health, though this has only been effective when the two services were jointly managed and a high level of commitment to public health was present. For example, in China, no such compensations were provided. In the early 1980s, China embarked on a radical program of economic reforms. The reform program included introduction of service charges in health facilities to make up for reductions in budgetary support from the government, and a laissez-faire attitude toward competition between providers, including providers at different levels in the service hierarchy. The idea was to improve efficiency by exposing health facilities to competitive market pressures. Reforms were applied to all health agencies, curative and public health alike. By the mid-1990s, government budgetary support covered only salaries at health facilities and provided nothing for operating costs, which were supposed to be covered by revenues from the facility itself. The impact of this incentive environment on curative care has been well documented.

A recent study evaluated the impact of these reforms on public health and preventive services and found mixed but generally negative results (Liu & Mills, 2002). Interlevel competition led to a decline in information sharing and technical assistance between public health agencies at township, district, and province levels, with negative consequences for disease surveillance and training opportunities for lower-level staff. The need to generate revenues led to an underprovision of public goods (surveillance, health education, preventive services) and a bias toward high-revenue services such as fee-based health inspections; reduced efficiency by causing duplicate inspections from public health agencies at different levels—each of them motivated by the need to generate revenues—and a general overprovision of inspections; and had negative equity effects because of agencies’ tendency to focus on profitable enterprises rather than carrying out inspections across the board. The most significant finding was a fall in the provision of public preventive services that could not be charged for, including outbreak investigation and response activities, preventive programs such as immunization and vector control, monitoring of disease incidence and health status, and health education programs. Since the government budget provided only for salaries, public health agencies had to cross-subsidize these activities from revenues generated through profitable activities such as health inspections. Not surprisingly, most agencies did not do so consistently. An MOH report in 1993 found that for nonrevenue generating services, more than 80% of public health agencies were performing below expected standards; a third were provided at less than half the required level (Liu & Mills, 2002).

A second category of NPM-inspired reforms involves the use of market principles within the public sector and the promotion of contractual relationships between the public and private sectors. The usual process involves creating a split between purchasing and provision; using output-based contracts for which private and public firms compete (rather than input-based financing of public agencies alone); giving managers greater autonomy; and experimenting with incentive payments and other ways of improving worker productivity. The motivation is to improve efficiency by introducing market competition and reducing the monopoly power of government agencies. We discuss each approach separately.
(i) Splitting and contracting

“Splitting” refers to the creation of separate agencies to purchase and provide services, the former contracting with the latter on the basis of expected outputs rather than controlling them in a hierarchical way. “Contracting” includes not only public–public contracts, as in the case of purchaser–provider splits wholly within the public sector, but also the use of private firms or providers to deliver government services—sometimes in competition with public providers—through contracts with a purchasing entity. In both cases, the idea is to move away from public management via hierarchical control and toward management by contract.

Splitting purchasing from provision has several effects. By separating the two functions, it allows purchaser and provider agencies to each concentrate on their area of comparative advantage; forces purchasers to be explicit about what they want from service providers; and helps purchasers hold providers to account. It also allows private companies to compete for public contracts, in principle improving efficiency. Some countries have taken the concept to great lengths. In New Zealand, even the military is divided into a purchaser, the Ministry of Defense, and a provider, the Defense Forces. In this case, the motivation was not to introduce competitive pressures, since there is still only one provider, but rather to improve accountability relationships and make explicit the government’s expectations of the military (Bale & Dale, 1998).

These reforms have also been implemented in several developing countries, though not as extensively as originally thought. As several studies have pointed out, implementing a government by contract approach requires strong management capacity and good information systems and can impose significant administrative costs, particularly for services where measurement is difficult. Contracting is only effective when outputs can be clearly specified and performance clearly measured (Bennett & Mills, 1998); and even then, different organizational and contractual models can lead to widely different outcomes for the same service (Mills et al., 2004). Contract specification must be clear, information must be available for monitoring purposes, and an arm’s-length relationship must exist between government and provider (Batley, 1999). While this may be the case for some preventive health services—immunization, cold chain management, campaign-based activities, or nutrition interventions—it is not the case for most EPHFs. Why? First, because measuring performance in the EPHFs is complex, costly, and requires strong information systems; second, because contract management of this sort requires technical and administrative capacities that are weakly developed in many countries, for example, in monitoring, negotiation, and prompt payment (McPake & Mills, 2000).

Functions such as surveillance are so complex and spread out that monitoring a private contractor would be a costly exercise—however good the indicators chosen—and might lead to principal–agent related efficiency losses such as those observed when hard-to-monitor services are decentralized (Hurley et al., 1995). Effective monitoring also requires a high level of technical capacity within government, without which contractors will take advantage of their informational advantages vis-à-vis the government and fail to be held accountable. Even for more straightforward services like curative care, the monitoring function often proves difficult to design and sustain in the long term. A common argument for contracting out to the private sector because capacity is low in government in developing countries is therefore flawed: for contracting to work well, capacity needs to be high. Governments with a low capacity are likely to have a low ability to write, monitor, and enforce contracts for complex services. Contracting should therefore be approached with care and not as a substitute for strengthening the capacity of government itself. Given the high transaction and monitoring costs involved, efficiency gains are unlikely (Batley, 1999).

(ii) Managerial autonomy

Essential to effective “management by contract” is giving line managers the autonomy to fulfill their contracts however they see fit. Thus, as part of NPM reforms, governments not only drew up contracts for public agencies that specified outputs rather than inputs; they also gave their managers the autonomy to manage inputs and human resources and develop implementation strategies without interference. In some countries, this has involved legislative changes to place public agencies under corporate law and remove them from civil service rules; in others, it has involved efforts to relax these rules directly.

Given the complexity of contract-based approaches for the EPHFs, is managerial autonomy relevant to these activities? The answer is
a qualified yes, because of the stifling effect of centralized, command-and-control management on service delivery in general. Governance arrangements in many developing countries provide little if any autonomy to line managers. This has at least two harmful effects: it deprives managers of the freedom to adapt services to local conditions and to manage staff and resources flexibly, and it hinders the development of general management skills in the public sector. Standard rationales for limiting managerial autonomy are to ensure consistent policy implementation and prevent corruption, but in many developing countries these limitations frequently exceed what is necessary to achieve these objectives. This may not be recognized by central-level managers and policymakers. In India, for example, 80% of district health managers said that having more autonomy would help them do their job better, while their superiors at the state level consistently thought they had enough autonomy already (Das Gupta, Khaleghian, & Sarwal, 2003). Grindle (1997) points out that a certain degree of autonomy—especially in personnel matters—can help managers develop a positive organizational climate and improve performance. Giving managers the scope to experiment with resource allocation and financing might help ease the problems associated with fiscal centralization, such as the irregularity of budgetary transfers and associated disruptions in paying staff or suppliers (Das Gupta et al., 2003). But too much autonomy can also be a dangerous thing, leading not only to policy fragmentation and self-serving behavior by managers but also imposing high transaction costs (Batley, 1999).

That said, each type of service will have its own balance. For some, such as law enforcement and provider licensing, where conformity and consistency are essential, managerial autonomy may need to be circumscribed. But for others—investigating health hazards, building community health profiles, providing health education and mobilizing community partnerships, among others—moderately widening the scope of managers’ authority can promote innovation and improve the adaptation of services to local circumstances without compromising the essential integrity of the function or impeding the need for consistency in core areas (e.g., notifiable diseases, basic reporting systems, etc.) (Grindle, 1997; Sung, Hsu, Shih, Shih, & Twu, 2003).

Experience with managerial autonomy is an essential precondition for the introduction of more complex administrative reforms. Batley (1999) points out that many countries, some of them encouraged by technical enthusiasts in the donor community, have jumped directly into complex second-generation administrative reforms such as purchaser–provider splits, contracting out, etc. without strengthening administrative skills and general management first. Not surprisingly, these reforms have failed. As Schick (1998) points out, wide-ranging autonomy should not be introduced into public sectors characterized by informality and weak rule enforcement, since autonomy in these contexts can lead to abuse. [For example, the deficiency of formal systems is often offset by informal behavior, for example, low pay is compensated by weak monitoring of absenteeism or the taking of informal payments.] As the basic elements of public management and strengthening internal controls are established in the public sector, autonomy can be gradually expanded (Schick, 1998).

(iii) Improving productivity via performance incentives

A third strategy involves the use of performance-linked pay, bonuses, and other financial and nonfinancial incentives to influence provider behavior. A large literature exists on provider payment methods in the curative sector, but these methods do not transfer easily to most public health activities for several reasons. Since it is easier to measure curative services than public health ones, incentive systems can be linked to outputs more easily. This is not true of all public health services—immunization, family planning, and mass Vitamin A supplementation do have measurable outputs, for example—but for public health functions, the complexity of their measurement makes it difficult to incentivize performance. But even for measurable public health services such as immunization, linking rewards to achieving targets is not without problems, because this often intensifies false reporting (UNICEF, 1996). This can push up monitoring costs which in turn can outweigh the expected productivity gains associated with the incentive scheme in the first place: or in the absence of effective monitoring, it can lead staff to redirect their attention away from service delivery and toward data manipulation, thus reducing effectiveness (Van Herten & Gunning-Schepers, 2000). An alternative strategy to measure performance—the use of health outcomes—is also
suggest that performance incentives in public health should be team or network based rather than individualized, given the importance of collaboration. Third, they highlight the role that nonfinancial incentives—recognition, training opportunities, etc.—can play in encouraging a good performance in a sustainable way.

(c) Decentralization

Decentralization was a common theme in health and public sector reforms in the 1990s and remains so today. Its assumed benefits centered on the fact that it brings decision-making processes closer to the community and thereby improves the quality of information available to local decision makers, ensuring that local decisions are relevant and adapted to local needs and improving the ability of the public to hold decision makers and their agents (i.e., public officials) accountable. However, there are few empirical studies illustrating the operation of these assumed benefits and whether and for what activities they materialize.

What limited evidence does exist shows that realization of these benefits has not been universal, and that decentralization needs to be carefully designed in order to avoid pitfalls (Khaleghian, 2004). In some countries, decentralization has led to corruption and elite capture because of inadequate checks and balances at the local level. In others, local decision makers—unconstrained because of the lack of accountability mechanisms at the local level—have continued much as they did before, showing greater allegiance to central superiors than to local representatives. In many others, local officials have found themselves without the basic administrative capacity to take on their new roles, leading to failures in service delivery and the basic functions of government. In yet others, decentralization policies have weakened central government agencies to the extent that their corrective hands are tied, leading to policy fragmentation, an inability to take residual responsibility when jurisdictional inequalities fail, and an inability to adjust for interjurisdictional inequalities. 14

In addition to capacity and institutional prerequisites, a further set of conditions is necessary for decentralization to be successful. These relate to the nature of the activity being decentralized. Put simply, activities and services that are “visible” to the public, that have direct, measurable benefits to individuals and for which the public is prepared and able to express wants and preferences tend to fare better under
decentralization than others. School management is one example. Since parents have a vested interest in the effectiveness of their schools, and since they are able—even if without perfect accuracy—to judge the quality of the school’s activities, devolving the responsibility for schools to a local government can be an effective strategy, as can introducing community co-management in the form of school boards. But public health functions, and many public health services, do not have these characteristics. They are either invisible, hard to measure, or have benefits that are difficult to quantify for individual communities and are therefore neglected by self-interested local authorities. Akin et al. (2001) summarize the theoretical argument as follows:

This raises a dilemma for the EPHFs. On the one hand, many EPHFs need local adaptation and tailoring to be effective and cannot be implemented in a rigid, centrally determined way. This is especially true in large and diverse countries with interjurisdictional differences in language, culture, or epidemiological profile. On the other hand, decentralization—in the sense of formally transferring the responsibility for these functions to local government—seems not to work well either. Different approaches have been used to resolve this dilemma. Some countries have retained central management of the EPHFs but established field offices to adapt and tailor them to local needs. This was the prevailing pattern before the 1980s, when the dominant model of decentralization in developing countries was deconcentration to field staff rather than devolution to independent local governments (Manor, 1999). The advantage of this approach is that it preserves interjurisdictional consistency and prevents local neglect of invisible services (or those that do not bring in more votes); but without some managerial autonomy, local adaptation may fail to materialize. The other method—which has become more common in recent years as countries have adopted wide-ranging devolutionary policies, sometimes as part of structural adjustment efforts—has been to compensate for local control of the EPHFs by retaining a measure of central influence through financial controls such as grants-in-aid or earmarked funds. This is typically a “second best” solution implemented after the EPHFs have been devolved, since reversal of decentralization policies seldom occurs (Dillinger, 1994; Manor, 1999); and it faces a number of implementation problems in developing countries, not least of them being the difficulty faced by central health authorities—themselves reduced in strength and number by decentralization policies that typically reduce the size of central government—in monitoring the activity of local governments. So while formal devolution makes adaptation more likely, it makes central oversight more difficult and in turn can have a negative impact on the effectiveness of surveillance, health promotion, and other efforts.

As implied above, the decision on which path to take is politically driven and does not necessarily follow the logic of technical or economic criteria (Smith, 1997). The implications for the EPHFs therefore differ according to local political factors, including political factors within the health sector (Collins, 1989). Several
generic issues do emerge, however, from the above discussion. First, the EPHFs are inherently poor candidates for devolution to local government control, particularly when local governments are weak. Even if this devolution occurs, it should not be accompanied by full fiscal responsibility for these functions, since the incentive environment facing local governments—even in industrialized countries such as the USA—typically leads to underfinancing or underprovisioning. Second, and irrespective of the path chosen, decentralization policies should not be allowed to reduce the strength or capacity of central government agencies concerned with the EPHFs. Without strong central oversight and support, whether of deconcentrated field offices or of health officials in local government, the delivery of key public health functions will suffer. Central public health staff serve a number of important functions. In addition to oversight and technical support of health staff at subnational levels, they receive and interpret information for the benefit of policy makers, and have the interjurisdictional perspective necessary for effective disease control. Third, effective management of EPHFs—whether in a deconcentrated or devolved setup—requires better measurement instruments and attention to management.

3. A RETURN TO THE “OLD PUBLIC ADMINISTRATION”? 

Given the extent of market failures in the health sector, particularly for public health functions, and the limited administrative capacity of governments in most developing countries, the role of NPM-inspired reforms is limited and a return to “old public administration” might appear necessary. This does not imply that public health should be managed in a centralized, bureaucratic, and unresponsive way. It just means that other approaches to strengthening management need to be found, ones that take into account the characteristics of the public health functions and focus on improving their delivery by the government itself. This section summarizes three such approaches: management capacity building; reforms to improve organizational climate; and efforts to improve performance by improving accountability, both hierarchically within government and externally to the public and civil society.

(a) Management capacity building

Russell et al. (1999) highlight the limited capacity of service managers in developing countries and give examples of how even basic administrative tasks—such as record-keeping and paying suppliers, etc.—are carried out poorly and inconsistently. Strengthening these capacities is a necessary precondition for improving management: hence, perhaps, the affection of donors for training activities and management-strengthening exercises. But this kind of direct, training-oriented capacity-building is not sufficient: changes in the broader administrative context are also necessary. In some countries, for example, unit managers are forced to make repeated visits to superiors in the capital to gain approval for basic administrative functions such as releasing pay and signing leave forms (Nchinda, 2003). This is not evidence of weak administrative capacity but rather of weaknesses in administrative systems and rules—the weakest areas being finance, accounting, and human resource management (Russell et al., 1999)—that are equally important targets for corrective intervention. Similarly, the lack of general management skills is not always a matter of poor training; it just as often reflects centralized decision-making structures and rigid civil service rules that deprive managers of the opportunity to use these skills, often in spite of numerous donor-sponsored training activities. As a result, managers may either leave the public sector, lose their skills, or use them for personal rather than organizational gain (e.g., by covering the tracks of corrupt activity more effectively).

One area of specific relevance to the EPHFs is the ability of managers to collaborate across agency lines (Das Gupta et al., 2003). Many public health functions rely on coherent, coordinated action by a number of agencies—disease surveillance agencies, local governments, water boards, private medical providers, etc.—and break down when this collaboration is weak. The ability to collaborate is not an inherent quality of managers; indeed public choice theorists believe that managers actually have the reverse incentive, that is, to compete with other agencies and expand their own turf. The negative impact of this kind of behavior on public health functions is obvious. Reversing it requires a combination of direct interventions, for example, sensitizing managers to the importance of collaboration, and institutional changes that facili-
tate and require it, such as joint strategies, formal collaborative relationships, staff exchanges, and incentive structures that encourage rather than inhibit teamwork. 20

This implies several things for the EPHFs. First, it suggests that training programs for managers will by themselves be insufficient to sustainably improve performance. Second, it shows how complex administrative reforms can only be implemented on a foundation of good general management. Third, it illustrates the substantial effect which institutional context can have on managers’ ability to gain and use their skills. Put simply, efforts to strengthen management of the EPHFs would need to go beyond training to also consider changes in the institutional environment, or if change is not possible, to find ways of insulating programs from its harmful elements. We next discuss two approaches relevant to the latter point: changes in organizational culture and methods to improve accountability.

(b) Organizational culture and institutional context

Just as training efforts are necessary but not sufficient for improving public management, public sector reforms focused on pay, staffing levels, and government reorganization alone do not succeed in fostering the changes in work attitudes, ethics, and organizational culture necessary for significant performance improvements to be realized (Lindauer & Nunberg, 1994). Some of these changes are actually antithetical to the work attitudes necessary for effective action, such as when competition is introduced to services such as disease surveillance for which interprovider cooperation is essential. 21 Grindle (1997) hypothesizes that the “missing link” in public sector reforms is a focus on organizational culture. She defines this as “a shared set of norms and behavioral expectations characterizing a corporate identity” and uses case studies from five high-performing public institutions in developing countries to illustrate its dimensions. As Stiglitz (1999) points out, government programs often fail because of inadequate incentives, but this does not mean that they cannot work.

(i) Factors associated with good performance in public organizations

Grindle (1997) identifies four such factors: a sense of organizational mission, defined as a widely held sense of purpose within the organization; management styles that encourage participation, flexibility, teamwork, problem-solving, and equity; clear performance expectations for staff; and managerial autonomy, particularly in personnel matters.

—Organizational mission and mystique

Organizational “mystique” arises when workers feel that they acquire prestige and a good reputation by working for their organization, and when their organization has a reputation for competence, respect, and social contribution. Health staff in Bolivia reported a high degree of pride in their organization and a personal commitment to maintaining its good reputation by contributing to the quality of services delivered (Grindle, 1997). Key elements of this “mission and mystique” factor included a strong sense of service among staff; identification with norms and values that were thought to have universal validity, such as honesty and political noninvolvement; a sense that the organization and its employees were somehow unique, whether in their practice or the nature of their mission; a sense that staff selection was based on competence or skill (and thus, a sense of pride in being part of the organization); and absorption of the organization’s mission by staff, making it a personal mission as well as an organizational one. These factors were found to be independent of salary scales or other remuneration. Promoting the emergence of these factors requires committed leadership and explicit action. In an example from Brazil, Tendler and Freedheim (1994) summarize the use of public information campaigns by a provincial government to improve the public perception and status of first-level health workers. The campaigns had a two-fold purpose: they helped health workers feel good about their jobs by conveying a positive impression to the community, and they helped overcome resistance and political capture by lower-level governments—in this case local mayors—by publicizing the higher-level government’s support of their mission (Das Gupta, Grandvoinnet, & Romani, 2004).

—Good management

Grindle (1997) identifies four managerial characteristics that are correlates of good performance. These include open and nonhierarchical interactions between managers and staff; managers who insulate their staff from perverse elements of the institutional environment (e.g.,
rigid civil service rules, political interference, or demands for patronage); managers who use incentives and rewards in a consistent, fair way (even those as simple as "employee of the month" recognitions); and managers who encourage teamwork among staff. Fairness in the application of rules and distribution of rewards is the critical factor here.

—Performance expectations. Organizations get the best out of staff when staff realize that their performance affects their career enhancement. In many developing countries, this message is hard to get across: when civil service rules or political patronage lead to promotions based on seniority or political connections rather than merit or performance, workers have little incentive to perform well. As Mookherjee (2001) points out, in some settings, political superiors reward or punish compliance with their own personal agendas, rather than merit based performance. But some managers and organizations find ways around this, whether by enforcing strict selection criteria (such as examinations or multiple interviews) to impress on candidates the importance of quality and performance; by using induction periods, probationary periods, and time-limited contracts to communicate organizational norms and performance expectations; by having clear job descriptions even when these actions are not part of general civil service norms. The key message to workers should be that performance matters, and that good performance will be rewarded—even if only through recognition or other nonpecuniary means—and poor performance punished.

—Managerial autonomy, particularly in personnel matters. For an organization to rise above public sector norms, managers need at least some autonomy in personnel matters. Managers need the autonomy to advertise and fill vacant positions, reward people on the basis of merit, and sanction those who do not meet performance expectations. This basic autonomy is lacking in many developing countries (Das Gupta et al., 2003). Granting managers discretion over these decisions does not always lead to better performance—it may actually have the reverse effect if managers use their newly gained authority for private benefit—but it does appear to be an important precondition for performance improvement.

(ii) The problem of context

Focusing on organizational culture alone will not address the problems of a hostile work context. Just as workers are not motivated by pay changes alone, they may also fail to respond to changes in the organizational microclimate if the external environment of civil service rules and procedures—what Grindle calls the “action environment” and others call the institutional context—provides significant barriers to action. Surveying the effectiveness of health management reforms in five developing countries, Russell et al. (1997, p. 773) draw similar conclusions about the impeding effect of hostile organizational climate on managerial change. They point out the difficulty of changing this climate given the entrenched nature of existing institutions and the influence of vested interests within the public bureaucracy. Grindle (1997, p. 491) argues that a focus on organizational culture should not substitute for efforts to improve the broader institutional environment, and that promoting organizational characteristics that create positive cultures may be the “missing ingredient” in the disappointing results of many civil service reforms.

In response to these problems, some countries have experimented by delegating functions to parastatal agencies. In India, some disease control programs have been delegated to semiautonomous agencies that operate with public money but outside the formal public sector. The purpose of these reforms was to unburden program managers from civil service rules, expand their autonomy in hiring staff, allocating resources and tailoring programs to local needs, and introduce community oversight by appointing external members to agency boards. Experience with these “disease control societies” has been mixed. In some settings, autonomy has been exercised responsibly and programs have become flexible, effective, and locally adapted. In others, it has led to increased rent seeking in procurement and a change in the distribution but not the extent of patronage. Establishing autonomous agencies can also undermine the coherence of government action more broadly (Das Gupta et al., 2003). These agencies can create policy and budgetary instability in several ways, including by creating a constituency for earmarked funds that undermines the government’s ability to reallocate resources as priorities change; and creating liabilities for the government if agencies borrow against state assets. Above all,
they seek to bypass organizational problems, rather than resolve them.

(c) Accountability

In the final analysis, the effectiveness of service delivery depends on the extent to which those who deliver it are held accountable for their performance. In this section, we consider two kinds of accountabilities: hierarchical accountability, which is based on bureaucratic controls within government; and social accountability, which involves communities in management and monitoring of programs.

(i) Hierarchical accountability

This involves monitoring the performance of public servants, rewarding them for good performance and punishing them when performance is bad. This is easier for some services than for others. For services where the output is easy to measure—the number of bricks laid or amount of taxes collected—this type of accountability is relatively straightforward. Tax collection reforms in Brazil, Mexico and Ghana bear out this point. In all three countries, tax collectors were given a pecuniary incentive linked to their productivity in collecting taxes, as a result of which collection rates improved dramatically. In other countries, pay reforms were used rather than monitoring, the intention here being to reduce corruption by “raising the stakes” due to the higher wages which corrupt officials would forfeit if caught. The Becker–Stigler theory postulates that these two approaches are interactive, with higher pay and higher monitoring intensity both contributing to better performance and reduced corruption (Becker & Stigler, 1974). Studies of corruption and government performance in several contexts confirm the validity of this hypothesis (Mookherjee, 2001).

When measurement is difficult, however, it becomes much harder for supervisors to monitor and incentivize staff performance—and correspondingly easier for staff to manipulate the system in their favor—leading in turn to principal–agent problems and accountability failures. This applies to several of the EPHFs. Surveillance, for example, becomes less visible the more effectively it is carried out. Without strong internal controls and process measures, the first sign of a failing surveillance system can be a major outbreak. The same is true of health promotion. As a result, these staff operate in an accountability vacuum and have little incentive to “get it right”. Monitoring can also be difficult for other reasons as well. In the case of health inspection, problems can arise when inspectors are expected to survey a large area and there are few supervisors above them. Unless alternative measures are in place for monitoring by local stakeholders, inspectors have little incentive to perform efficiently or honestly, since the likelihood of being caught or punished is low.

These points have important implications for the use of bonus payments and other ways of rewarding good performance. If measurement is weak or imprecise, whether because the service in question is hard to monitor or because monitoring is done poorly, it becomes difficult for managers to identify good performance and reward it accordingly... Mookherjee (2001) writes:

How does one measure the output of a teacher, or a policeman?... Measuring and rewarding the more measurable dimensions may be dysfunctional, since they may cause the official to divert effort towards those dimensions that are measured, at the expense of those that are not. For instance, if teachers are evaluated on the basis of their students’ grades, they might then be motivated to redirect their teaching to emphasize examination technique at the expense of real learning; in extreme cases even to leak exam questions to their students.

This underscores the complexity and danger of using personalized incentives as a way to improve agency performance. It also highlights the fact that choices about monitoring are the product of two countervailing forces: the desire for simplicity, which makes measurement easier and cheaper but runs the risk of creating perverse incentives, and the desire for comprehensiveness, which creates more accurate incentives but can be costly to implement. Here, too, the institutional context matters. In settings where political corruption is widespread, monitoring rules are set by politicians who have a vested interest in keeping them weak (Mookherjee, 2001). Using data from 12 countries, Shirley and Xu (1998) show how this leads performance-based incentive schemes to fail. The impact of such incentives on cooperative behavior is also relevant, as discussed earlier.

What do these points imply for the EPHFs? First, they suggest that monitoring should not focus only on outcomes, given their distal and distant nature, but should instead use carefully chosen proximate measures that can be used to monitor performance while still being relevant to the production of outcomes. Second, they highlight the potential role of information...
systems—both HIS and MIS—in providing data inputs for service monitoring. And third, they imply that for public health functions and services, broadly based performance measures linked to groupwide incentives are probably more effective than highly specific measures linked to individual ones.

(ii) Social accountability

Another approach is to make service providers accountable to their clients, either by having community members participate in managing the service or by providing them with information, choice, or opportunities to voice their concerns if the service fails to meet their expectations. Examples can be divided into interventions dominated by community co-management, choice, information, or “voice” mechanisms.

Community co-management has been a favorite of primary health care enthusiasts since the Alma-Ata conference in 1978. Examples abound, among them the role of communities in managing service during the civil conflict in Panama, irrigation in South Korea, the emerging role of Panchayati Raj Institutions in overseeing health services in India, the important role of communities in Bamako Initiative countries, and the use of community boards to oversee public hospitals in some industrialized countries. Extensive examples can also be found in the education literature, where community co-management of schools has received much attention (Mookherjee, 2001). The basic idea is that community input will improve the quality and local tailoring of services and make sure providers do their job properly. A teacher will find it harder to shirk if community members are, in effect, his bosses; likewise a health worker may take a less heavy handed approach to her clients if they are involved in decisions regarding pay or promotion. The second approach is to expand the range of providers and give consumers a choice regarding whom they use: in other words, to create a market for the service. Primary curative care is one area where this strategy is commonly used; another is the use of vouchers for primary education, both of which are intended to put competitive pressure on providers (doctors, schools) and thus improve their quality and responsiveness to client demands. As discussed above, choice mechanisms—and related marketizing reforms—are a poor fit for services that have public goods characteristics or significant externalities. They are therefore of little benefit to the EPHF's and can actually be quite harmful, as the earlier discussion and the China example of Liu and Mills (2002) so clearly shows.

The third approach involves disseminating information about providers' performance or expected standards of service delivery. These range from notices on a clinic door to information on test scores or procurement prices for basic drugs. In a well-known example in Uganda, a Public Expenditure Tracking Survey revealed that 87% of school funds were “leaking”—that is, disappearing—between central government and schools, either into other programs or into private pockets. In response, the government started to publicize the amount of monthly transfers to each district in the newspaper and over the radio, and required primary schools to post notices on all inflows of funds. A year after starting the program, leakage had fallen to 10% as district officials and school administrators found themselves under greater scrutiny by the public and the media (Reinikka & Svensson, 2001). A similar campaign was waged by the government of Buenos Aires, Argentina, in response to pharmaceutical price escalations that were thought to be a result of corruption in procurement. In this case, the fact that the government was collecting information was by itself sufficient to cause prices to fall—presumably because corrupt officials assumed the data collection would be followed by some sort of crackdown (Di Tella & Svedoff, 2002). Information-based approaches do not have to be government driven. A free press and civil society can also serve similar functions, as Samuel Paul’s report cards on public services in Bangalore show (Paul, 1998). Here, an NGO collected and disseminated information on the performance of public utilities and health providers in urban Bangalore. Some improvements in service delivery were reported to follow, though these were more prominent in services such as water and power where private demand was high.

The fourth approach is to provide channels for users to voice their concerns and preferences regarding the service. Client surveys are one such approach. In these, client feedback to the provider is used to influence service delivery. Another approach is the use of patient advocates or other independent bodies to which service users have access and which have formal influence with providers.

These four approaches are interactive and mutually reinforcing. Information cannot improve service delivery unless accompanied by some recourse method, whether it be control,
choice, or voice; and no amount of control, choice, or voice is useful unless service users have reliable, accurate, and easily interpreted information about the activity they are supposed to be monitoring. These linkages are frequently ignored. In India, for example, the government publishes a service charter that promises a set of minimum standards from government service delivery agencies. But until recently, the charter provided no information on what people could do if these standards were not being met, giving service providers no real incentive to perform (Government of India, 2002). The same is also true of simpler strategies: for example, a notice of opening hours on a clinic door means nothing unless other methods exist for service users to call the doctor to account should he fail to show up. Also relevant are linkages to other ways of improving service delivery, such as the use of choice, voice, or community co-management as a complement to contract-based approaches to delivering primary care (Mills et al., 2004).

Like political decentralization, these approaches are most effective for private, measurable services such as water supply, irrigation, education, and primary curative care. They are less effective for “invisible” services such as the EPHFs, in which communities tend to be less interested because of their public goods characteristics. The media also tends to neglect these “invisible” services—except when they break down and cause a crisis. As a result, while outbreaks receive plenty of attention, routine service delivery in public health may receive no attention at all. In India, democracy and a free press have helped to ensure outbreak control but not routine disease control, analogous to Sen’s (2000) analysis that they have been effective in preventing famines but remarkably ineffective in preventing chronic malnutrition (Das Gupta et al., 2003). Thus, relying on informational strategies or the media to hold providers accountable for “invisible” services is not, by itself, a complete solution.

Context is also relevant. If a community is invited to manage, say, water or irrigation services, it needs the authority to do so effectively. But this authority is not always provided, and community boards find themselves delegated with administrative functions but constrained by civil service rules, patronage structures, or other impediments to the real exercise of control. The same could be said of choice, voice, and information-based interventions, all of which can be compromised by institutional contexts that “stack the deck” in favor of poorly performing agencies and their staff.

What can be learned from these strategies for the EPHFs? On the surface it would seem the answer is nothing. All of them seem to work best for services where public demand and interest is high, which is not the case with most of the EPHFs. With adaptation, however, the basic principles of social accountability can indeed be applied (with the possible exception of choice, for reasons described earlier). While accountability to the public may not be effective, accountability to civil society organizations with an interest in public health can. This would require the presence of such groups in society, and efforts to create and support them. It would also require institutional changes to allow the exercise of these practices, such as freedom of information laws, forums for nongovernment inputs to be heard, and regulations mandating a timely government response. For social accountability to work for the EPHFs therefore, two steps are required: establishing a constituency for the functions within civil society; and establishing institutional structures to release and disseminate information, allow the exercise of voice, or formalize co-management relations in a way that allows accountability to emerge. This represents a fruitful area for policy experimentation and an important complement to the more direct methods of improving performance described earlier.

4. SUMMARY OF KEY LESSONS

Curative services, preventive services, and essential public health functions have important distinctions that make it impossible for policy prescriptions and organizational forms from one to be applied to the others without adaptation. We summarize the key lessons of the paper below.

Provider incentives are complex and difficult to design for the EPHFs and cannot be simply transferred from the experience with curative care. For example, user fees are not an option for the EPHFs because of their public goods characteristics. For incentives to be useful, measurement indicators need to be chosen carefully: complex instruments may be unworkable and costly, while instruments that are too simple may increase the likelihood of opportunistic behavior. Incentives, where used, should be team or network based rather than individualized and should not neglect the role of non-financial benefits.
Performance improvement can also be achieved in more traditional ways, for example, by having fairly implemented merit-based selection and promotion criteria, clear job descriptions, etc. These should typically be implemented before the adoption of complicated performance incentive schemes and may be sufficient by themselves.

Promoting competition among agencies responsible for public health functions does not improve efficiency—on the contrary, it impedes collaboration and technical assistance and can therefore compromise the effectiveness of activities such as surveillance and health promotion. Organizational reforms that rely on provider competition (such as purchaser–provider splits) are therefore not applicable to the EPHFs.

Contracting works for some preventive services but not for the EPHFs. For preventive services that are measurable and discrete, such as immunization or campaign-based programs, contracting can be an effective approach—provided there is sufficient government capacity to manage the contracts effectively. But for the EPHFs, where measurement is complex, expensive, and requires strong information systems, contracting imposes transaction and monitoring costs that make efficiency gains unlikely and reduce effectiveness.

Decentralizing the EPHFs needs to be approached carefully, since studies from a variety of political and administrative settings indicate that local governments tend to have little incentive to invest in public goods and systematically neglect them. The EPHFs should either remain under central control—with managerial autonomy or other strategies to permit local adaptation and responsiveness—or subjected to alternative forms of central oversight and control such as grants-in-aid, earmarked funds, etc. To ensure this, the central agencies responsible for the EPHFs need to retain their strength, rather than downsizing across the board as decentralization proceeds. This is needed, given the importance of central coordination, oversight, and technical assistance for EPHF functions.

The institutional environment—that is, the formal and informal rules and norms at work in government and society at large—are an influential determinant of government effectiveness, and especially for the EPHFs. As a result, efforts to build management capacity through training are helpful but not sufficient to improve managerial effectiveness for the EPHFs. Public sector norms and rules that impede effective administration should be changed where possible. If this is not possible, alternatives—such as insulating programs from these norms and rules or promoting organizational cultures and accountability arrangements that achieve this indirectly—should be pursued instead.

Managerial autonomy is important for the EPHFs as a way of promoting adaptation and innovation. It should be introduced cautiously to avoid abuse—though not so cautiously that it fails to materialize at all—but it should also be balanced with instruments to ensure an appropriate degree of policy and program consistency across units and jurisdictions.

Strengthening hierarchical accountability within the public health system is essential to strengthening the EPHFs. This requires changes in the capacity, autonomy, and behavior of service managers, but also requires monitoring systems and instruments that are weakly developed at present in many developing countries.

Monitoring is critical but instruments need to strike the right balance between simplicity and complexity and should be designed for operational rather than research use. Outcome measures are not useful for month-to-month program management which requires more proximate indicators. Information systems can provide data inputs for this kind of monitoring but are frequently too weak to do so.

Standard information and voice-based strategies do not work particularly well for the EPHFs but can be adapted to do so. This might involve constituency building for the EPHFs and the use of civil society and media groups to monitor and have input to decisions concerning them.

NOTES


2. For descriptions of agency theory in the health sector, see Hurley, Birch, and Eyles (1995), Bossert (1998), Gauri (2001), and Gauri, Cercone, and Briceno (2004). The theoretical and technical issues in this paper apply to both developed and developing countries, but the lessons are of greatest relevance to developing countries with fledgling service delivery systems.
3. Of course, what goods are actually provided through public funds is typically resolved through political processes, which may or may not be influenced heavily by technical considerations.


5. For example, in Vietnam (discussed below).


9. Such as those reported by Marek, Diallo, Ndiaye, and Rakotosalama (1999) in Senegal and Madagascar, for example.


13. Khaleghian, field observations.


16. Khaleghian (2004) also presents empirical evidence of this phenomenon with a multivariate analysis of the impact of decentralization on immunization coverage in low- and middle-income countries.


19. See also Marek et al. (1999).


24. See the citation from Schick (1998) above.


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