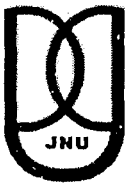
THE NEW PUBLIC MANAGEMENT (NPM): RELEVANCE TO HEALTHCARE SERVICES

Dissertation submitted to the Jawaharlal Nehru University
in partial fulfillment of the requirements
for the award of the Degree of

MASTER OF PHILOSOPHY

SIGAMANI P



CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067

2005

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
New Delhi - 110 067

DATE: 15/07/2005

CERTIFICATE

This dissertation entitled **THE NEW PUBLIC MANAGEMENT (NPM): RELEVANCE TO HEALTHCARE SERVICES** is submitted in partial fulfillment of six credits for the award of the Degree of **MASTER OF PHILOSOPHY (M. Phil.)** of this University. This dissertation has not been submitted for the award of any other degree of this university or any other university and is my original work.

(Sigamani P)

We recommend that this dissertation be placed before the examiners for evaluation.

Prof. K.R. Nayar

(Supervisor)

Prof. K.R. Nayar
Centre of Social Medicine &
Community Health SSS
Jawaharlal Nehru University
New Delhi 110 067

Dr. Rajib Dasgupta

(Supervisor)

DR. RAJIB DASGUPTA
Asstt. Professor
CSMCH / SSS
Jawaharlal Nehru University
New Delhi-110067

Dr. Ritu Priya

(Chairperson)

Chairperson
Centre of Social Medicine &
Community Health, SSS
Jawaharlal u University
New -110067

Tel: (011) 26704420, 26717676, 26717557 Gram: JAYENU Fax: 91(011) 26717586, 26704420

To

AMMA & APPA

ACKNOWLEDGEMENT

I am greatly indebted to my guides Prof. K R. Nayar and Dr. Rajib Dasgupta for their stimulating and valuable guidance, which helped me to shape my study very clear.

I thank each and everyone who has helped me in obtaining various sources of information however, I express my immense gratitude to Dr. Venkat Raman, Faculty of Management Studies (FMS), University of Delhi and Prof. James Bijörkman, Institute of Social Studies, The Hague, The Netherlands. I acknowledge all my teachers for their valuable suggestions and emotional supports which helped me to keep up my motivation and high determination.

My gratitude to Mrs. Rastogi, Mr. Dinesh Joshi, staff of JNU library, National Medical Library, and FMS (Delhi University) Library for their timely assistance. I thank all members of International Public Management Network (IPMN), who helped me to get clear idea about the new concepts and theories of New Public System Management.

My hearty thanks to my parents and friends for their continuous support and encouragement that enabled me to achieve so much in my life.

SIGAMANI P

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ABBREVIATIONS

ADB	Asian Development Bank
APVVP	Andhra Pradesh Vaidya Vidhana Parishad
CMP	Common Minimum Programme
DoH	Department of Health
EU	European Union
GATS	General Agreement on Trade in Services
GDP	Gross Domestic Product
GOI	Government of India
HCA	Health Care Administration
HSM	Health System Management
HSR	Health Sector Reforms
IBRD	International Bank for Reconstruction & Development
ICHA	Indian Confederation for Healthcare Accreditation
IMF	International Monetary Fund
IPMN	International Public Management Network
KNH	Kenyatta Natal Hospital
LDCs	Less Developed Countries
LPG	Liberalization, Privatization and Globalization
MDG	Millennium Development Goals
MNCs	Multi National Companies
MOH	Ministry of Health
NEP	New Economic Policy
NER	New Economic Reforms
NGO	Non Governmental Organization
NHS	National Health Services
NPE	New Political Economy
NPM	New Public Management

NPSM	New Public Sector Management
OECD	Organization for Economic Co-operation and Development
PHC	Primary Health Centre
PPPM	Public Personal Performance Management
PPPs/P3	Public Private Partnerships
PRB	Performance Related Budgeting
PSM	Public Systems Management
PVM	Public Value Management
RAP	Responsibility, Accountability, & Performance
RBI	Reserve Bank of India
SAP	Structural Adjustment Programme
SPM	Strategic Public Management
TNACS	Tamil Nadu AIDS Control Society
TNBCS	Tamil Nadu Blindness Control Society
TNHSP	Tamil Nadu Health System Project
TNMC	Tamil Nadu Medical Council
TNMSC	Tamil Nadu Medical Supply Corporation
TPM	Traditional Public Management
TQM	Total Quality Management
UNDP	United Nations Development Programme
UPA	United Progressive Alliance
WDR	World Development Report
WHO	World Health Organization
WHR	World Health Report
WTO	World Trade Organization

INTRODUCTION

"Paradigm Shift
From Welfare Oriented Approach to
Development Oriented Approach with Equity
to Provide Not Only the Piece Meal, but
Integrated Approach,
Not to Conform, But to Transform;
Not to Relieve, But to Release"

Over the past decade many countries have undergone public service reforms of some kind or the other. Usage of strategic management and logistic management in the public system brings certain changes in the existing system. There is a positive role for well performing and responsive public institutions. But, is this tool the appropriate one to reform the governance?

In the early 1990's the reforms turned their attention to social policy- policies on health, education, employment, housing and social welfare benefits, all underwent significant transformation. In most of the countries, New Public Management (NPM) was implemented in all sectors through RAP. This study reviews modernizing government agenda, and healthcare administrative changes, and examines the key issues that have arisen during the reform process. The review investigates recent NPM reform- the concepts of market friendly state intervention and good governance. The review also focuses on the recent ongoing international debates regarding the role of government and the performance of health sector.

NPM is based upon the introduction of private market perspectives and assumption into the public sector and using privatization, consumer choice and competition between service providers. It assures that private market condition increases efficiency, through the introduction of market mechanisms into the public sector. In the 1980's and 1990's analysis of public sector reform in the

United Kingdom(UK), had focused on the NPM, which is associated with the neo-liberal policies of the Conservative government. This led to a world- wide revolution in thinking about public sector management termed as the 'New Public Management' (NPM).

Research Goal

The primary purpose of the study is to review the approach of New Public Management (NPM) and its implications to healthcare services. We will compile some case studies and analyze different classifications of new public management strategies used in healthcare. Finally we will analyze the major issues and then relevance to health services. It begins with the review of literature and highlights some selected cases in some developed and developing countries.

The sources of the study are; publications of different government reports, reports by bilateral agencies, working papers of academic institutions, and presentations done by the experts on Public Sector Management and Public Policy.

Broadly, this study would examine the central concerns of New Public Management, and then implications to healthcare services. It also explores the perception and experiences of New Public Management at the global level and their relevance to healthcare services. This study specifically reviews the definitions, content, process, and sustainability of New Public Management process across the globe. And it also seeks to understand both the internal and external forces that are shaping the New Public management process.

Chapterization

Chapter One deals with the general and conceptual understanding of the specified concept, theory and practice of NPM, and its core elements. This is to understand the historical tradition behind the paradigm shift, and the reason behind the paradigm shift.

Chapter Two deals with New Public Management practice in the health sector with global experiences. It focuses on three different regions, namely developed nations, developing nations, and underdeveloped nations regarding the practice of NPM strategies in healthcare. It draws some lessons from the countries regarding its practice.

Chapter Three provides a brief review of the available evidence regarding NPM strategies in healthcare provision in India, especially from Tamil Nadu. This chapter gives insights into the changing role of state in healthcare services. It examines some recent attempts of the Tamil Nadu government, in health sector reforms such as contracting out of healthcare provision to the private sector, increased regulation of the private healthcare sector, the establishment of publicly funded 'autonomous' organizations by government, and the introduction of user fees for public healthcare services.

Chapter four analyses the limitations, challenging role of the state and some suggestions to strengthen the system.

CHAPTER-I

THEORY AND PRACTICE OF NEW PUBLIC MANGEMENT (NPM)

Modern management techniques are used in the public management in order to improve the existing public system and to provide meaningful service to the larger population. Thus, it includes the application of private management principles to the Planning, Implementing, Monitoring and Evaluation of public policy accountable to the people to strengthen people's participation.

This chapter explores the theoretical understanding of the growing concept of New Public Management and its various components. It throws light on the different stakeholders' participation, and its relevance to the public policy with special reference to the health policy. Importance is given to the government role in provisioning of services with the close consideration of Accountability, Equity, Equality, Economy, Efficiency, and Effectiveness. This chapter will provide some insights into the New Public Management and its core elements as paradigm for administrative reform. In the early 1980's, a new managerial approach developed in the public sector, about achieving higher levels of performance by government.

The worldwide emphasis on governmental and managerial performance through NPM-style of administrative reforms creates a rare opportunity for public administration structure (Lynn: 1997). It emphasizes the movement of performance against objectives, with defined responsibilities for achieving these objectives (Blackman: 2001). According to Jalal (2003) for Neo-liberals the solution was to reduce the role of the state and also to open it to quasi-market forces of competition. For some others such as international donor agencies, the typical reform includes:

- Increased efficiency- improving input-output ratio within the public sector, the rationale being to address the large size of public sector expenditure;

- Decentralization- transferring of decision making to lower- more localized levels of the public sector, the costs of centralized decision making and to create more flexible and responsive decision making;
- Increased accountability- making staff more responsive to the beneficiary;
- Improved resource management- increasing the effective use of human, financial, and other resources;
- Marketization- increasing the use of market in the public sector, (Heeks: 1998);
- Increased transparency- making public information easily available to the service users; and
- Enhanced partnerships- encouraging collaboration between various sectors to serve common causes.

While most of the reforms, largely run by the government in the 1970's and 1980's were directed towards the public sector, there has been a shift in the focus of the reform packages over involving other stakeholders in improving governance. Governance reform in the public sector can be observed in three main categories:

- Firstly within the government departments- as part of their routine procedures or as a result of pre-empire measures;
- Secondly, the larger sphere of governance- it involves efforts initiated by civil society, such as NGO's, and national and multinational donor agencies; and
- Thirdly, as collaborative ventures- across globe and with different stakeholders

It is a new approach to management challenges in the public sector that goes beyond both traditional public administration (TPA) and the NPM. Recently this is

known as a new paradigm, which emerged in the social sector. According to Gerry Stoker, the core features of the new management paradigm are the following:

Table-1 Different Paradigms of Management

	Traditional Public Administration (TPA)	**New Public Management (NPM)**
Key objectives of the system	Politically provided inputs, services monitored through bureaucratic oversight	Managing inputs and outputs in a way that ensures economy and responsiveness to consumers
Definition of public interest	By politicians / experts, little in the way of public input	Aggregation of individual presences, in practice captured by senior politicians or managers supported by evidence about customer choice
Preferred system of service delivery	Hierarchical department or self regulating profession	Private sector or tightly defined arms length public agency
Approach to public service ethos	Public sector has monopoly on service ethos, and all public bodies have it.	Skeptical of public sector ethos (lead to inefficiency and empire building) - favors customer service
Dominant model of accountability	Overhead democracy: voting in elections, mandated party politicians, tasks achieved through control over the bureaucracy	Separation of politics and management, politics to give direction but not hands on control, managers to manage, additional loop of consumer assessment built into the system
Role of managers	To ensure that rules and appropriate procedures are followed	To help define and meet agreed performance targets

Developed from Kelly and Muers (2002) cited by Stoker Gerry.

Traditional public management provides a particular set of solution to the challenges of governance; it relies heavily on a Weberian perception of the world. In Weber's political thought, three institutions are seen as essential to cope with the complexity of modernity and for delivering order to the governance process known as traditional public administration or Old Public Management. But the New Public Management critiquing the existing forms of service provision is based on a prescription for improvement based on introducing market. It includes the efficient and responsive answer to consumer needs, introduction of a puncher – provider divide within organization and the development of performance targets and incentives, and creation of autonomous organizations, (Stoker Gerry).

What is the New Public Management?

It is necessary to define the concept of the New Public Management and to understand the different components, and different stakeholder's involvement. We shall also look at the analytical theories behind the practice of NPM, and the relationship between the modernizing state and its implications to health services.

> *A simple definition by Pollit and Bouckawrt (2000), of Public Management reform is "Deliberate changes to the structures and process of public sector organizations with the objectives of getting them (in some sense) to run better".*

The original meaning of the NPM starts with the public sector reforms. NPM was used to describe a management culture that emphasizes the centrality of a citizen as a customer, and accountability for results. It also suggests structured choices to promote decentralized control through a wide variety of alternative service delivery mechanisms, including quasi-markets. Creation of semi-autonomous organization agency for service delivery is one of the principles of NPM in order

to improve three E's i.e. Economy, Efficiency, and Effectiveness in the public sector.

Over two decades, there have been some fundamental changes in the working of government resulting into major and visible management innovations in the organizational structure and system of government aimed at delivering greater efficiency, more response and flexible public services. The innovations have led to New Public Administration (Kaul: 1997). According to Ghuman, the conventional model of public administration is theoretically rooted in Wilsonian dichotomy of politics and administration, while Weberian theories of bureaucracy and Taylorian norms of work have been passing through turbulent period. The Tilburg Model gives an example of New Public Management:

Box: 1 The Tilburg Model* (Example of New Public Management)

The Tilburg Model (Example of New Public Management)
An interesting example of how this NPM menu can be put into practice in a city of Tilburg. The Tilburg model is composed of the following elements: ❖ The organization is consisting of an interdependent network of separate units. Each unit is a complete unit with its own finance and personnel functions. ❖ The units link with the other units in the organization and also with units / organizations. ❖ There is a clear distinction between the political part of the organization and the public management. The political part decides on the general framework and the strategy to be followed. They have to decide on what will be achieved. The management is responsible for implementation i.e. for delivery of the products that are demanded. The management can decide on how this is done. ❖ Contract- management throughout the organization. ❖ Decentralization into inter-departmental project-teams. ❖ Networking.

To implement NPM similar strategies can be observed. Frequently used strategies are: contract management, decentralization into inter-departmental teams and networking. Similar kind of NPM strategies are used in the Indian model i.e. creation of autonomous organizations, introduction of user charges, encouraging private contracting through competitive tendering etc.

The World Bank, Asian Development Bank and Special UN agencies like WHO, are trying to impose the logic of planned markets, and market mechanisms taken

* Tilburg is a city in the southern Netherlands, in North-Brabant (North Brabant) Province. Netherlands is one of the leading countries, which introduced the principles of The New Public Management.

from Neo-Classical economic model into the existing public systems (Nayar: 2003). The system of market friendly state intervention was introduced in almost many of the European countries and Commonwealth Nations in the world. This 'Paradigm Shift' coined as the New Public Management, presently existing in almost all the countries across the globe are directly or indirectly part of this new system (NPM).

According to Barzley, NPM evolved from three streams: It is "a body of doctoral beliefs" (Barzley: 2001), promulgated by "Economists" and "Consultocrats" (Hood and Jackson's 1991) in response to the failure of progressive public administration, secondly, to provide answers to, "What is the role of the government?", and the third stream explained that NPM constitutes " An empirical style of organization of public services" through relying more on markets or quasi-markets" that would ensure coverage, if allowed, in various sectors of government service delivery.

Government began to apply a programme of market-oriented change to the welfare state (Grand: 1991). NPM is significantly concerned with policy interventions in the executive branch for functions of government. It is more a systematic analysis of management policy, and that the policy of government as a whole and its institutional roles and routines. According to Barzley, NPM is either a blue print approach to policy design or as an Anglo-American approach to public management policy" (Barzley, 2001). It is also sometimes considered as a trend or a wave of reform (Jones, 2001).

NPM speaks about the need to make governments more efficient, and depends on evidence based output, many scholars described that the prominent concentration of the NPM is more on outputs instead of inputs, and their basic argument starts with three E's Economy, Efficiency, and Effectiveness. These are the core

components of the NPM. Basically, the reforms are intended to improve State and its Accountability. A variety of administrative innovations have become an integral part of administrative system of most of the developed as well as newly industrialized countries. Hood (1991) has codified administrative reforms as "New Public Management." And the following are the major doctrines/principles of New Public Management:

- opening to professional management in public sector,
- significance to explicit standards and measures of performance,
- greater emphasis on output controls rather than on procedures,
- shift to de-segregation of units in public sector,
- shift to greater competition in public sector,
- stress on private sector styles of management practice, and
- stress on greater disciplinary and parsimony in resource use.

Hood argued that there are three sets of core values in public management. One set focuses on keeping it clean and purposeful. Here the basic concern is to match resources to tasks and objectives, mostly measured in terms of money and time. A second set of core values concentrates on honesty and fairness. Here transparency, no arbitrary procedures, no abuse of office etc are important. Success in this field can be measured by the degree of trust or confidence and the ability to exercise citizenship effectively. A third set of core values in public management concentrates on resilience or survival. Here the central concern is to avoid system failure in the face of threat or challenge.

NPM claims to relate itself to other incarnations of these administrative reforms, which include managerialism, market based public management etc, (Bennett and Ferlie; 1996) and the post-bureaucratic paradigm or entrepreneurial government. According to Bennnet and Muralidaran (2000), the NPM includes greater responsiveness to consumers, developing organizational structure, which encourages innovation and competition; strengthening incentives for performance, and creating more output-oriented system. Administrative change was precipitated by the need to adjust to policy innovations. Reforms in the organization of the government and delivery of services (Warrington: 1997) are known as new models of state management which results in the reduction of public social expenditure as part of structural adjustment programmes (Navarro: 2004).

Theories of New Public Management

The New Public Management is a field of professional and policy discussion-conducted internationally- about public management, including public management policy, executive leadership, design programmatic organization, and government operations, (Barzelay: 2001).

> *In the field of public administration, the talk throughout the world is of change, of the transformations of government: new forms of governance, new relationships between citizens and their governments between the public, private, and nongovernmental sectors, new process of policy making, (Lynn1996).*

The new paradigm itself has been variously denominated. In addition to the popular "post-bureaucratic" label, other terms include "Managerialism", the "New Public Management", "market based public administration", and "entrepreneurial government".

According to OECD, the key reform thrusts are:

- a greater focus on result and increased value for money,
- devolution of authority and enhancing flexibility,
- strengthening accountability and control to client and service-orientation,
- strengthening capacity for developing strategy and policy,
- introducing competition and other market elements, and
- changing relationships with other levels of government.

In their '*Reinventing Government*', David Osborne and Ted Gaebler says that the reforms regarding American government "represent a paradigm shift", (1992, p. 19). The OECD, along with many other students of government such as Peter Aucoin and Michael Barzelay, among others, concurs "If these students of administration are right, we are moving into a world of post-bureaucratic, post-modern, post-industrial government". The following table provides a short summary of the paradigm shift:

Table-2 Overview on Changing Public Sector narratives from 1920's till today

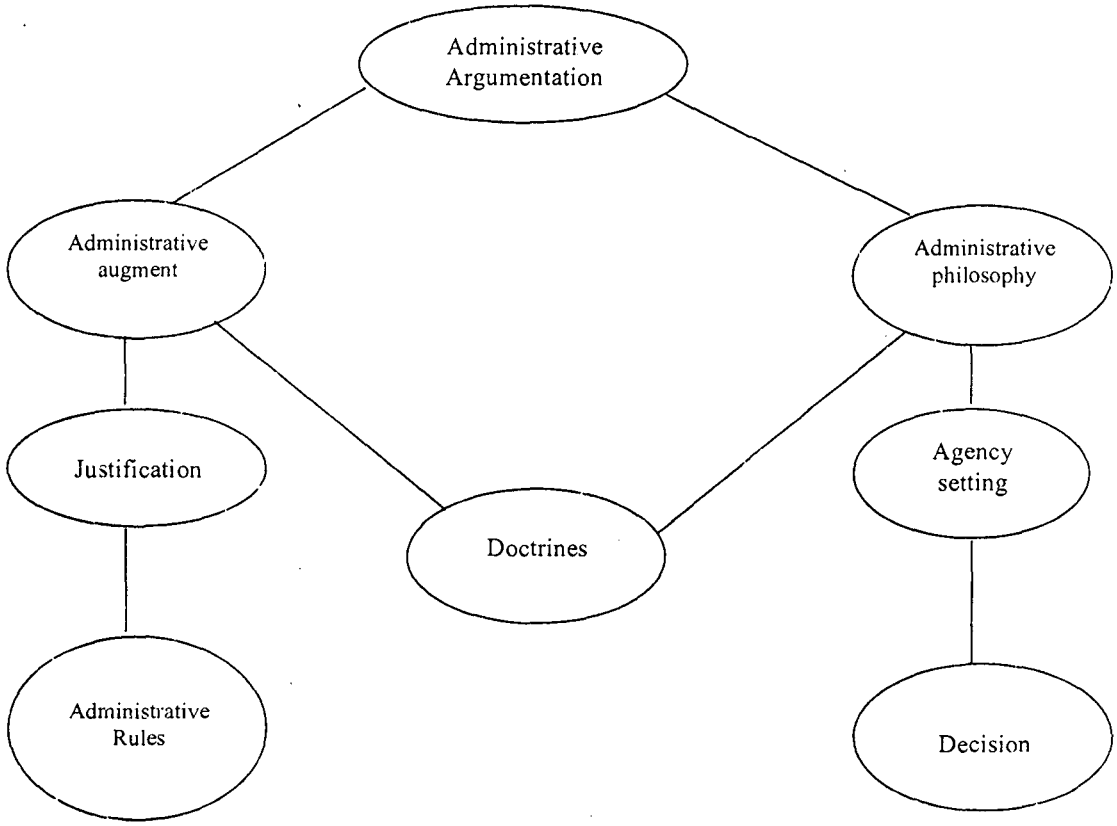
Aspect of Change	Time		
	1920s-1970s	**1980s- 1990s**	**Mid 1990s- today**
Key Challenge(s)	Public order and accountability (Legality and legitimacy)	State/ Administrative failure due to slack (Inefficiency)	State/ administrative failure due to complexity (ineffectiveness)
Overall approach	" Bureaucratism"	"Managerialism"	Governance
Administrative policy paradigm	Classical Bureaucracy (Traditional Public Administration)	New Public Management	New Governance
State paradigm	Active State (Welfare State)	Lean State (Minimalist State)	Enabling State(hollowed out State)

Source: Steurer R (Undated)

Why New Public Management?

It is a natural and a relevant question at this juncture. During mid 70's and 80's, there was a common tendency to ask why we need modernization within the existing system. As a term coined by political scientists working in the field of Public Administration in UK and Australia, the basic paradigm of NPM changes in the organization and management of executive government. Hood and Jacksons considered NPM both as an administrative augment and as an accepted administrative philosophy.

Figure: 1 Hood and Jacksons' Conceptual Framework.



Innovations in the Public Systems Management

During mid-seventies and early eighties, there was a greater change in the Public system across the globe, which reflected in the form of cutback in the social sector, especially Health and education. These are known as Management innovations in the organizational structure and system of government aiming at delivering greater efficiency, more responsible and flexible public service. The system of market friendly and Administrative innovations have become an integral part of the administrative system in most of the developed as well as newly industrialized countries. They are also known as the 'Evolutionary Innovations' within the Public Systems, (Hood: 1991).

Reinventing government is new way of doing business in the public sector or it is otherwise known as introducing market mechanisms within the public sector. This model represents a basic "paradigm shift" from the new deal paradigm of 1930's to 1960's toward the "entrepreneurial government"

Most entrepreneurial governments promote competition between service providers. They empower citizens by pushing control out of the bureaucracy, into a community. They measure the performance of their agencies, focusing not on the inputs bur on outcomes. They are driven by their goals- their mission runs not by their rules and regulations. They redefine their clients as customers and offer them choices. They prevent problems before they emerge, rather than simply offering services afterward. They put their energies into earning money, not simply spending it. They decentralize authority, embracing participatory management. They prefer market mechanisms to bureaucratic mechanisms. And they focus not simply on providing public services, but on catalyzing all sectors- public, private, and voluntary- into action to solve their community problems, (Osborne and Gaebler (1993).

The Paradigm Shift from Old Public Management to the New Public Management

The pressure on health system due to rising health needs led to the health system of many countries collapsing, health system reforms have attempted to respond to the serious challenge posed by these developments. Peter Berman defines, "Health sector reforms as the current wave of interest in changing the policies, practices and management systems within the health sector". It is sustained to improve efficiency, equity and effectiveness's in the health sector. Basically a health sector reform involves implementing user charges, community insurance schemes, stimulating private sector growth, and increased resources for the health sector.

The changes in health system organizations and managements are decentralization/autonomy of health facilities/departments, contracting out the health services through public-private partnerships.

At the same time, reforms are taking place in public sector in the name of downsizing it, productivity improvement, introduction of competition, improving geographical coverage, and improving the role of local government. In India, non-clinical services like dietary services, laundry etc have been contracted out to private parties in Rajasthan, Maharashtra, Tamil Nadu etc. Autonomous bodies like Medicare relief societies (Rajasthan), Rogi Kalyan Samities (Maharashtra), Andhra Pradesh Vaidya Vidhana Parishad, APVVP (Andhra Pradesh), have been formed giving public hospitals greater control to improve their efficiency, and power to create their own resources (User fees, donations etc). Tamil Nadu has setup autonomous bodies like Tamil Nadu Medical Supply Corporation (TNMSC), Tamil Nadu AIDS Control Society (TNACS), and Tamil Nadu Blindness Control Society (TNBCS) to work closely with the private sector/NGOs and be free of bureaucratic rigidities. Industries and NGOs have been requested to adopt PHC's and other health institutions (Gujarat, Andhra Pradesh, and Tamil Nadu).

The Characteristics of the NPM

There are two chief characteristics of New Public Management, free market economy values, and scientific methodological values. It is largely constituted with classical liberalism addressing administrative issues, (Guy: 2000). The following table describes the characteristics of the NPM:

Table: 3 Characteristics of the NPM

Budget Cuts	Vouchers	Accountability for performance	Performance auditing
Privatization	Customer concepts	Decentralization	Strategic planning / management
Separation of provision and production	Competition	Performance measurement	Changed management style
Contracting out	Freedom to manage (Flexibility)	Improved accounting	Personnel management (incentives)
User charges	Separation of politics and administration	Improved financial Management	More use of information technology
Legal budget/spending constrains	Rationalization of jurisdictions	Policy analysis and evaluation	
Improved regulation	Rationalization or streamlining of administrative structure	Democratization and citizens participation	

The NPM can be traced back to influence of public choice theory, management theory, classical public management, neoclassical public administration, policy analysis, principal agent theory, property right theory, the neo-Austrian school, transaction cost economics and "reinventing government' themes of public effectiveness. So, it is known as a paradigm change, (Edwalt: 2001). According to Roste (2004), New Public Management is one of the various types of innovations in the public sector leading to paradigm shifts. These shifts included a focus on result or achievements and personal responsibility of the concerned officer in the public sector.

The Millennium Development Goals (MDG) describes that health is not only an outcome of development but also one of its core determinants. One of the chief objectives of the MDG is to encourage transparency and accountability in government and to foster democratic participation in terms of improving healthcare system, strengthening essential public healthcare functions, and further development in human resources in the health sector.

CHAPTER-II

GLOBAL EXPERIENCES

Health service delivery is being restructured in many different ways in both industrialized and developing countries in the name of modernizing state (NPM). The previous chapter highlighted the elements and theoretical background and the paradigm shift of NPM. The present chapter provides a review of NPM practice in developed and developing countries. In general, it provides some insights into the NPM and its global experiences, and some observations from its practice.

The new form of entrepreneurial state intervention involved in many countries namely, economically advanced members of the Organization for Economic Co-operation and Development (OECD), developing countries, newly industrialized countries, and small and island states favoring a planned economic transition to development as a liberal welfare approach, (Qadeer: 2001). Most of them were forced to restructure the finance of public provision in the name of economic reform. In the 1980's, the OECD countries also witnessed ideological shift from welfare to markets, (Sen: 2003). Many of the industrialized nations have been implementing NPM principles into the public systems at different levels of development. (McPake: 2000, Sen: 1998). As a result characteristic of welfare approach slowly getting down, it reflects the issues of equity and equality in the public health.

The first region to be affected by the new economic policies was Latin America in the late 1970's. It was followed by the African countries during the late 1980's; and early 1990's, much of Asia also witnessed reforms of structural adjustment aimed at reforming the health and social sectors. Similarly, during the 1980's, the OECD countries also reassessed their commitment to public sector provision as part of an ideological shift from welfare to markets which was reflected in their stringent fiscal policies. After the reforms, it's brought down more power of healthcare financing links, from the governing private sector in healthcare to increasing economic inequality and to increasing economic inequality to the

poor's increased vulnerability. On the one hand, taxpayers are not satisfied with the public service; on the other hand, the private providers aim to maximize profit in the form of 'built bed for filled bed approach' as a result of variations and inequality.

The new changes affect the employment, standards of living, and poverty level. Structural reforms, which were implemented compensated in the public sector during the 1960's and 1970's in industrialized countries. It arrived in developing nations during 1980's in the name of improving the performance of government services through organizational reforms. It is called as NPM (or) 'Marketizing' reform or Management Innovations (Blunt...). It was also directly reflected in the public health practice. Health sector reforms initiated during this period aimed at efficiency, equity, and quality improvements. It also aimed at more systemic reforms in financing and health delivery system- a strategy used in the NPM practice. Some authors consider this approach as holistic (Preker: 2003, Borins: 2001) for strengthening the public system and governance system; and for improving the system meeting the needs of the taxpayers, (Wescott: 2000). Within the last ten years, NPM has emerged as a major reform strategy and is briefly applied in varying degrees to public sector agencies in a growing number of developed and less developed countries, (Taroni: 2003). It has become one of the dominant paradigms for public management across the world (Yamamoto: 2003).

As NPM reforms forge ahead in countries like the United Kingdom, New Zealand, United States of America etc, governments 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 in order to improve access to the quality of provision. It introduced fee paying market mechanisms in its health system, (Nitayarumphong and S.

Pannarunothai: 2003). It is also happening in countries like Columbia, Mexico, and Zambia (McPake: 2000), which are introducing different varieties of a purchaser-provider split to enhance public sector performance through the separation of policy and service delivery roles.

The NPM movement began to develop in the 1970s and early 1980's in order to improve effectiveness, responsiveness and performance of the state to the larger population. The first mover was United Kingdom that was reformed by Prime Minister Thatcher. The USA, which suffered heavily from recessive developments and tax, revolts of their citizens, also became the part of the drive. Later the national governments of other commonwealth countries, mainly New Zealand and Australia joined and after reforms got on the agenda of almost all OECD countries, a lot of other countries in the world too followed the suit (OECD: 1995). Until the early 1980s, the public sector in most countries was monopolistic, centralized, hierarchical, inflexible, unrealistic, and unresponsive to users and insulated from the private sector and other agencies outside government. In the words of Das Gasper:

.... The New Public Management... emerged in the 1980's especially in New Zealand, Australia and Britain and in sister forms in the USA.... they spared widely, especially in the 1990's around many OECD countries and from them to lower-income countries, not least in Africa, partly through promotion by international agencies like the World Bank, Commonwealth secretariat and management consultancy groups. At one stage NPM's proponents claimed to have intellectually defeated the older Public Management and to be in the process of replacing it ... NPM has done a lot to shake-up sleepy and self-serving public organizations, often by using ideas from the private sector. It provides many options for trying to achieve cost-effective delivery of public goods, like separate organizations for policy and implementation, performance contracts, internal

markets, sub-contracting, and much more. It has a strong inter- organizational focus, as is needed in Public Management. But it has been spread somewhat like a religion: it was assumed to be modern, relevant and superior, so there was need felt to prove that it suits the case concerned: to query this was held to show that you were outdated and reactionary... By now, NPM has lost much of its gloss, as experience mounts. In New Zealand, in many respects NPM's furthest frontier, the costs of a too narrow approach, to Public Management have been major and there is considerable backlash.

According to Mills there are some evidences from the Low and Middle-income countries regarding modernizing the existing public health system. Based on the recommendation of multilateral and bilateral aid organizations, competitive contracting with private sector was supported which was likely to improve the efficiency of services provision. Before introducing this system, it was found that there were deep-rooted inefficiencies and inequities within many publicly funded health systems. These countries have been attracted by the NPM ideas, which promised greater efficiencies through encouraging competition and increased clarity in relationships between funders and providers, (Walsh: 1995). New ideas of the role of the state in the health system placed emphasis on the competition as a means to improve efficiency, and the importance of making more use of private healthcare providers, and encouraging their expansion.

Paradigm Shift

Why is there a need to improve the existing public system? And what is the importance of paradigm shift in the public system? Will this innovative public system provide more responsive service to the larger population? Even if it would provide the service, how long it will sustain in the present system? The following sections will attempt to some responses to the above questions. The following

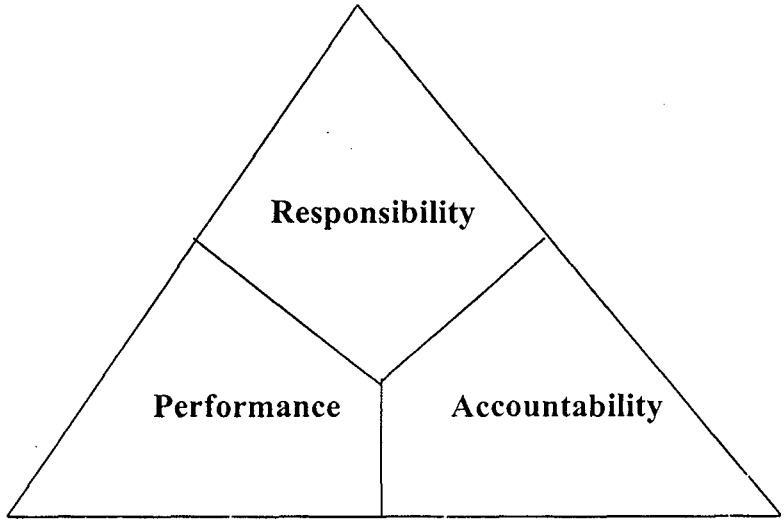
subsections are the experiences of some developed, developing and industrialized countries. The power of NPM has grown up in all areas of healthcare including, hospital services, catering, cleaning, laboratory work and health insurance.

Why Reform in Public Sector Management?

> *Over the past three decades, criticisms about government performance have surfaced across the world from all points of the political spectrum. Critics have alleged that governments are inefficient, ineffective, too large, too costly, over-bureaucratic, overburdened by unnecessary rule, unresponsive to public wants and needs, secretive, undemocratic, invasive into the private rights of citizens, self-serving, and failing in the provision of either the quantity or quality of services deserved by the taxpaying public.* (Jones: 2003).

Citing the above reasons, many governments have started voicing the need for less costly and less expansive government, for greater efficiency, and for increased responsiveness. Cost cutting, downsizing and disinvestment of government assets are the major components of NPM in order to improve the accountability to the clients and improve the performance. The following figure describes the different blocks and functions of the NPM.

Figure-2 The Building Blocks of NPM



The crux of the reform in each state is to improve the system in the form of focusing on Responsibility, Accountability, and Performance (RAP), which are the major building blocks of NPM. In brief ***Responsibility*** asks, "What managers and organization are responsible for", and it is concerned with 'uncoupling' government functions into policy and regulation on the one hand. ***Accountability*** asks, "To whom organization should be held accountable for delivery and quality". And **Performance** asks, "How managers of departments can be mobilized to improve the delivery of agreed outcomes. And at the same time, ministry of health has to develop the sufficient time to the concerns of parliament, formulate appropriate policy, and assure quality through state regulatory functions.

It has to demonstrate efficient allocation of scarce resources for health goods and services, and also monitor and evaluate health outcomes to assure that the public is receiving value for money. In the context of the 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 also. Margaret Thatcher had the political clout to impose her vision of government reform i.e. downsizing and causing competition between public and private sectors in record

time. She introduced the government wide 'Big Bang approach'. Graham Scott is the architect of the New Zealand reforms. His approach is "Fast is better than Slow". New Zealand also adopted all the three core building blocks of NPM. Robert Stone was the chief energizer of the US national performance review. For Katele Kalumba, past minister of health in Zambia; the approach was sector wide approach to health reform, and the autonomy of hospital management (McPake: 2000), separation and classification of policy roles etc. It also continued the RAP. Many other countries followed the "Learning by doing", such as, the autonomous agency programme in Singapore, which extends across all sectors; purchaser-provider split strategies in Mexico and Columbia; and managed competition and contracting and hospital autonomy initiatives in Kenya and Tanzania.

These are some examples and some features of the NPM and its organizational practice in the healthcare. In the last two decades, welfarism has suffered a worldwide setback with investment in the social sectors, especially health, being viewed as 'unproductive'. As a result, both developing and developed country governments cut into social welfare expenditure as a means of dealing with the fiscal crisis, (Baru: 1999) - the mobilization of the alternative resources to balance the financial crisis.

NPM Practice in Developed / Industrialized Nations in Healthcare

Industrialized countries are also the part of innovative structure for health systems (Mcpake: 1995, 2000) and also they are the initiators of the new model of reform, in terms of 'healthcare reforms': it tends to create a notion of bringing in positive change. It has been described as the process of improving the performance of existing system and of assuring efficient and equitable responses to further changes (Koivusalo: 2001). For example, this was reflected in the form of contracting out public services to the private partners. The World Development

Report (2003) emphasized the importance of public finance of essential clinical services but suggested the greater role of private and non-governmental organizations.

According to Vining, 'internal market' healthcare contracting is common in a number of developed nations. Especially, in United States the reforms are popularly called as " Managerialist' or' Reinventing Government", (Frant: 1996), with the notions taken up in United Kingdom, Finland, The Netherlands, New Zealand, Sweden and Canada. For example, in 1993 the largest hospital in Canada (the Toronto Hospital) began contracting out a broad range of services including, nutrition services, house keeping, plant operations, maintenance, transformation (both Patients and Goods), materials management and logistics and laboratory services, (Vining: 1999). In United States Hospitals, Food preparation, laundry, house keeping, clinical as well as emergency care, equipment Maintence were contracted out. In general, the following departments were contracted out in the European nations- Food Services, Emergency care, House Keeping, Laundry, Clinical diagnosis/and Equipment maintenance, Pharmacy, Plant operation, Rehabilitation/Physiotherapy, Financial Management, Psychiatry, Sub acute care, Security, Radiology, Gift shops, Managed care, Substance abuse, Materials management, Surgery and Anesthesia. (Source: developed from Moore. 1996:61, cited by Vining and Globerman: 1999)

The intention to modernizing the existing system is to improve productivity, efficiency, (Mills: 1997) quality and the public satisfaction. Several Latin American countries like Argentina, Brazil, Chile, Colombia, Costa Rica, and Mexico etc are trying to reform the way in which they finance and organize the delivery of health services to the poor (Abrantes: 1999). It was observed that the accountability mechanisms have been weak and focused on inputs; it leads to the inefficiency and frequently offered poor service quality. Latin America and some

of the OECD nations are trying to reform their healthcare system. It is similarly introducing new policies based on the Business ideology such as; Defining products and calculating unit costs, Linking costs and outcomes, looking for value for money, Taking stock of client needs, demand and satisfaction on regular needs, Holding personnel accountable for performance explicit in terms of reference, Demonstrating accountability to stakeholders by rigorously monitoring, auditing and evaluating its function and using monitory and other incentives to reward performance.

Within the British public sector apparently since the early 1980's, there is a movement of deep restringing (Pollit: 1990, Hood: 1991, Polidano: 1999), often seen as the rise of the "The New Public Management". The cohere process has not been confirmed to narrow focus or remain at the superficial level of formal structure, but rather a set of changes in structure and process. In the UK, the efficiency drive model is in operation whose objective is to make the public sector more business like; which involves the downsizing and decentralization model, focusing on desegregation, and the same time introducing financial targets in the public sector, quasi-markets, creeping privatization, public private partnerships and the outsourcing (Shaoul: 2003). And at the same time some of the South Asian Scholars support co-operative organization in health sector (Nayar: 2003) as one of the alternative approach to strengthen the public system and use of some form of alternative practice to strengthen the existing system. For example, co-operative, and decentralization are the part of the alternative method to provide better services to the population

Organizational flexibility and downsizing the management change model aims at integrating bottom up and top down approaches with greater focus on service quality. The introduction of the NPM was reflected on the restructuring of the publicly provided healthcare (the NHS). The above-mentioned 'reform' is used as

a description of value driven attempt to restructure Public Systems and it is not assumed that the outcomes of such reform have necessarily benefited the users.

The UK provides a good model of jurisdiction in which the Traditional Public Management model was developed in the 1850's and not removed and distributed as a paradigm until the 1980's. It was found from the mid 1970's onwards that a wider change in the political economy was linked to macro level restructuring within the public sector. The first attempt was to reduce public expenditure, introduce monetary targets and sell state assets, which was evident, following the pressure from the IMF. The main strategies were to downsize the public sector in order to reduce the power of the union and increase that of the management ('Managers must manage). It emphasizes to increase pressure to secure efficiency and value for money. The introduced new political economy was only a drive for reform within the public sector. Basically, reforms were focused on efficiency, equity, quality, choice and responsiveness and the accountability. The basic objectives of the reform process are piloted on five objectives:

- improve accesses to services,
- improve quality of services,
- improve efficiency in the use of resources and avoiding waste,
- improve amount of contribution within the programmes, and
- improve amount of funding for the delivery of health services.

In the name of modernization, contracting is one of main strategies practiced in New Zealand as a part of NPM. The contracting has emerged as management tool, which has some relevance to all types of Public System. In general, everyone needs new changes in everything, that's true in public system also. People expected the modernization, innovation, (Borins: 2001) in the public sector to occur primarily in response to internal problems. At the same time we can ask a

question, "What is the motive behind introducing modern management principles within the public system?" 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 expressed dissatisfaction with the traditional modes of public sector management, based on the overall observation.

The following is the major classification of NPM strategies used in the Healthcare Administration across the globe:

- Increased accountability in Public Personal performance management,
- Introduction of Performance related budgeting, Creation of Autonomous organizations, Managed competition and contracting,
- Corporatization, and
- Introduction of User Charges.

In health system management, the above strategies focus on the value for money, and outcome of the programme. In a nutshell, NPM is concerned with injecting business-like practices into public agencies with the expectation that change will be easier, more effective, and more permanent as a result; it is to improve performance of health systems.

In 1979, when Margaret Thatcher and her Conservative party came to power in the UK, a wave of reforms started to reduce the size of governance and to improve the performance of civil servants. Because the government was viewed as being too big, inefficient and wasteful, it owed huge proportion of the economy, and the new system was focused on the continuous improvement in management of the

economy. It played a major role in the strengthening of the NHS in the UK; and it had basically removed management functions from the ministry to a separate management entity. The following are the main focused reforms of United Kingdom: UK reforms were to give the service delivery organs the control over most of their decisions, Creating consequences for the performance of the executive agencies, and Accountability for the service delivery in a client based strategy that emphasize choice and quality of service. Client may be a consumer who benefit directly from the provision of a service (e.g. health consultations). But, in the case of public sector reforms in New Zealand, the focus was strictly on output/outcomes. And regarding formal contractual agreements, New Zealand holds a special place in the recent history of public sector reform in the name of NPM. These reforms focused on the public accountability through the specification of outputs, contractual arrangements (Mulgan...). The reforms can be achieved through management improvements. Large portion of the public sector had been corporate. In short, in New Zealand the reform has meant thinking about the 'public sector in private sector terms' it was reflected on the modernizing public system (Lynn: 1996, 1997) and more emphasis was laid on performance oriented government.

The process of Corporatization began in 1983, when the government was in the throes of a huge debate about the desirability of disinvesting publicly owned agencies that performed a conflicting mix of business, regulation and social roles. The Clinton Administration in the US adopted NPM, (Yamamoto: 2003) which despite the buoyant state of its economy had experienced problem in the civil service, under the slogan of "Reinventing Government" (Osborne and Gaebler: 1999). The main aims of empowering local officials have been to allow them to become more responsive and accountable to individual community and citizens (Borins: 2001). NPM reforms in Switzerland aims at, Improving customer

satisfaction, Quality of service provision, through contracting and Stakeholders' participation (Rieder: 2002).

Another example of NPM is Japan's practice during the post-war period where Japan had under taken those major public sector reforms in the central government (Yamamoto: 2003). Haiti incorporated preference based payments and bonus to successfully motivated staff to surplus money for preference targets. Managed competition makes use of contracting to reduce costs (through tendering) and increase effectiveness (through improved specialization of outputs designed and competitive forces). In Brazil, the Cooperatives were then given complete responsibility for administering and delivery of the services.

Modernization of Public Policy in the Developing Nations

Other developing nations have taken up elements of the NPM agenda i.e. Malaysia's experiments with Total Quality Management (TQM), result oriented management initiative in Uganda and NPM agenda such as privatization and downsizing in many African countries (Polidano: 1999). Governments of low and middle income countries often spend more than they collect from the Tax revenues, resulting in accumulating deficits and international debt (resulting from crises borrowing). Voter's attitudes to at least some of the overspending and inefficiencies in public sector, accountability and performance are some of the initiatives.

Public sector inefficiency in developing countries leads to managed market reforms in developing nations (Broomberg: 1994). In the case of Asian experiences, the importance of Responsibility, Accountability and Performance (RAP) was recognized. The new economic reforms brought problems such as the "Liberalization Privatization Globalization (LPG)"/advocates a 'rolling back' of

the state from the sphere of production and productive investment and a significant curtailment in the level of social expenditure, all of which go into the constitution of the package called 'Structural Adjustment Programme, SAP', (Patnaik: 1999). In the Cambodian experience, the contracting in the public system was introduced in order to ensure a greater focus on the achievement of measurable results (McPake: 1995) in the public system. At the same time, governments focused less on service delivery and more on other roles, which they are uniquely placed to carry out, such as planning, standard setting, financing and regulation. The main lessons learnt from the modernizing public health system in Cambodia is regarding its flexibility. Stakeholders like private sector, NGO's, and the state focus on outputs and outcomes.

In Bangladesh, the government used competitive bidding to identify providers of PHC services that would be less costly than government which was contracted out (Loevinsohn: 2002). There are two projects, one sponsored by the World Bank called "Integrated Nutrition Project" and another project sponsored by the ADB known as "Urban Primary Health Center". In both these projects, the services were contracted out to the NGO's and the contractors were responsible for delivering services including immunization, prenatal and obstetrics care, behavioral change communication and curative care, and contracting including management of tuberculosis and childhood illness. The available literature shows that the main lessons learnt from Bangladesh experience, are that the service providers have the autonomy to manage implementation as they see it best. This should foster innovation and rapid adoption to field condition, which should ultimately lead to greater effectiveness and efficiency in the public system. Contractors ensured accountability, and linking the contractors to tangible results, force both purchaser and provider to focus on important output and outcomes, rather than specifying process.

India has a legacy of private providers and high levels of out-of-pocket expenditure for health (Narayana: 2003). In India, the objective of the health sector reform is to bring about changes in the health system that will help meet national health objectives while making the system more accountable to the people (Nandraj: 2000). In Bombay, Hospitals Catering Services offered by privately contracted companies appeared to offer better value for money (Mills: 1997, 1998). According to Chawla, to improve performance of public hospitals increased autonomy and improvement in the allocative efficiency of government health spending are some of the highlighted areas of modernizing public health system in India. In Malaysia, the medical equipments, food supplement, etc are contracted out (Knoon: 2003).

An Assessment of the contracting of cleaning services in Thailand suggested that the service was provided from the private sector at a considerably lower price than it would cost to provide in house. In Bangkok, the provisions of major items of medical equipments are contracted out (Mills: 1998). Reorganization and modernization of the public sector has been under way in Vietnam, since the Doi Moi process was initiated in 1986. Major aid activities in this area have been sponsored by multinational and bilateral aid agencies. (Ives: 2000).

Organization of Managed Competition and the Contract State

Managed Competition involves public purchase and public private providers of health services, with the purchaser seeking to get the best value for money by contracting with the providers, who compete for contract.

Table- 4 Contracting Arrangements in the Health Sector of Developing countries

Type of Contract	Service Covered	Country/Region Involved	Reason for the Modernization
Non-Clinical	Laundry Cleaning Security Maintence Billing Catering	India, Malaysia, Srilanka, Zimbabwe, Thailand, Jamaica Lesotho, South Africa Venezuela, Zimbabwe, South Africa, Zimbabwe. Mumbai, Lesotho, Malaysia, South Africa.	To reduce over bureaucratization. Reduce load on Management, It was expected that service would be cheaper. To reduce wastages in the public system To provide better and quality of services to the people To obtained the latest equipment To encourage stakeholders participation in provision of public services through private /NGO's. (Mills: 1998)
Clinical	Acute Care Ambulatory Long term Diagnostic Laboratory Public Health	Peru, South Africa, Zimbabwe, Many countries in Sub-Saharan Africa through implicit contracts with mission facilities El Salvador, Peru, Namibia, S. Afr Cambodia, Bangladesh South Africa (TB and Psychiatric care) India, Thailand (CT, MRI) Malaysia (CT, X-ray) Nigeria, South Africa Mumbai (Vector control)	
Whole Hospital Management	High Tech Diagnostic	China, Bolivia	
Leasing		Thailand	
Joint Ventures		Not known	

Developed from Sara Bennet, Steven Russel, Anne Mills, John Fiedler, Benjamin Loevinsohn, and others

As an organizational strategy to inject NPM 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 purchase with the cost cutting and efficiency character of competitive providers.

NPM Movements and Practice in the Underdeveloped Region

African countries are not new to reforms. Before and after independence, they implemented a wide range of reforms, aimed at overhauling the public service for greater effectiveness, responsiveness and performance (Olowu: 2002). NPM is still in infancy in most of the countries. Quality improvement activities in healthcare system focus on patient care in hospitals, disease prevention, health promotion, and care deployment at population level (Eldar: 2003). The NPM highlights the importance of accountability, quality of service more patient (needy) people oriented service and to improve the quality through structure, process, and outcome approaches. Some African Countries notably Ghana, Kenya, Uganda, Zambia, South Africa, Malawi, and Zimbabwe are in the process of corporatizing their health systems (Mills: 1997).

John Halligan summarized the achievements of 'NPM' in these countries by noting that, 'Public Sector Reform' in the OECD during the last 20 years have been notable for the magnitude, breadth and significance of the changes. Most of the countries reduced their social expenditure on their budgetary allocations known as "downsizing State role in the social sector". Most Countries have reduced their general government outlay as percentage of their gross domestic product (GDP). It also shows that only a few (three) countries among the list of 12 countries are regarded as 'aggressive downsizers' - Ireland (- 7.9%), Netherlands (-9.8), and New Zealand (-8.4). Most others had only Marginal cuts including some seven countries (Japan, Switzerland, Finland, France, Norway, Portugal, and

Spain). Most countries in the bid to improve performance have used Managerialization, Contracting and Outsourcing. Contracting is increasingly recommended to developing countries as a way of improving the efficiency of the health sector (McPake: 1995). In Zimbabwe, despite 1990's process of modernization in terms of introduction of user charges, it brought down certain changes in the health system as the form of contracting.

The following five countries Ghana, Uganda, Tanzania, Kenya and Zambia, from Western, Eastern and Southern parts of the continent, received substantial donor support to implement NPM type reforms, their experiences. It gave emphasis more on tax reforms, civil service reforms, modernization of Public system, regulation of the private sector and economic management, and the creation of autonomous agencies in the form of strengthening public policies. It also emphasized the public sector responsibilities and accountabilities. In Costa Rica, according to Abramson (2001), in modernizing the public health system, contracting was used as a first step to improve coverage, quality and efficiency. The role of the public sector was considered in terms of setting up performance objectives and monitoring. Two large-scale projects in Senegal and Madagascar were based on community nutrition and given alternatives to the contracting services in rural areas as well as urban areas. Both the projects were contracted on service delivery and combining private administration with the public finance. There are also examples of contracting non-clinical and clinical services in hospitals, including preventive services such as pre-natal care and well baby clinics provided by missionary health centers and hospitals (Marek: 1999) in the name of modernizing the existing public health system. These focused on the development of information system and efficient use of human resources (Mills: 1997, 1998).

A standard of clinical service provided by a mining hospital in Zimbabwe, under contract from the ministry of Public Health indicated that the prices charged to the

government by the mining hospitals were comparable to the costs of government run public hospitals, but the quality of care at the Mine hospital was considerably higher. In the early 1990's, government workers were on the payroll even though they had not been present in the office for long duration of time. Further enquiry revealed that more than several hundreds of these civil service ghost workers had died. Yet, someone was still receiving and cashing on their payroll cheque. In southern Asian countries, it was found that many officials were not in the office. In Latin American nations, it was huge overlap and possible duplicates of functions. The proposed NPM addresses the above mentioned issues in the form of civil service reform. Public Personnel Performance Management (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.

The following table describes the Stone's Universal Truths regarding public performance management:

Box 2 Stone's Universal Truths.

Robert's Stone, Chief Energizer for NPSM reforms in the US government claims the following:

- Workers Know 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.

The most important NPM strategy is strengthening of public personnel management in the public system in order to strengthen the existing system and providing efficient system for the good result. And also it's an important organizational strategy for injecting NPM principle into Public System and focusing on the important principles of Responsibility, Accountability and Performance (RAP) of employees in the Public System.

Another form of reflection is the Performance Related Budgeting. In the early 1990's, the Inter American Development Bank singled out Colombia as one of the best examples of public sector management in Latin America. The reforms seem to have had three overriding objectives: To increase the solidarity of the health system by merging public and social security sub sectors; to introduce competition; and to introduce a contracting environment within a public health framework (McPake: 2000). It was decided that the prime aim and major financial allocation must be given to the priority areas assuring that public resources get best value for money in terms of technical efficiency, and at the same time the special concentration given to the performance budget, the government of Guinea, (Mills: 1998). Tanzania, and Uganda, has their performance budget in the field of Public Health education, in order to reduce wastages in the public system.

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

It always focuses on the inputs in order to bring down good result. It always focuses on performance related behavior of management related responsibility. And last but not least is the creation of Autonomous Agencies. The following

observation is the major part of the creation of autonomous organization in the public system: pilot autonomous agencies in Singapore health system, autonomous hospitals in Kenya, autonomous hospitals in Indonesia and case study from India.

Pilot Autonomous Agencies in Singapore Health System

Recent changes in the public health system is that the change of guards, like the growing of autonomous organization in the field of health practice, autonomous agencies took over full management of its own budget and called for its own tender bids. Autonomy is used in order to bring in private sector management skills through a board consisting of many members, creating greater response to consumers through consumer representatives on the group, creating more flexible organization to operate on more self-sustaining financial basis. These are the major components of the autonomous body, which are the major steps used in the Singapore pilot autonomous agencies model.

Autonomous Hospitals in Kenya

In Kenya, autonomy was given to Kenyatta Natal Hospital (KNH) in the late 1980's as a pilot project; and to hospitals in Indonesia in late 1980. These were responses of the government of Indonesia when it could no longer financially sustain its public health clinics and public hospitals, delivery of quality care, and meet the demands of its growing population. Objectives were to reduce government subsides to hospitals, through introduction of user fees, and the public funds to be utilized for promotive and preventive care; to retain hospital revenues and utilize them for hospital operations, including staff incentives; to increase hospital efficiency through better management of optimal resource utilization; and improve quality of hospital medical services.

It had some positive results in this project, in the way of efficient performance, a cost recovery rate that had reached a level of 50 precent. An assessment of Swadana hospitals in Java by Gani in 1995 revealed the following: overall management and financing of the hospitals had improved; the hospitals had become more cost conscious; all hospitals had seen good improvement; preparation of the separate budget plans incorporated principles of good budgeting; hospitals marked a positive image; and communicated their compliance with regulated bodies to meet good result and demand of the client.

Corporatization

Corporatization can contribute to continuous improvements in public performance by forcing public enterprises to become clean and mean in an open, competitive environment. In developing countries, Corporatization appears to be going on in terms of State-owned enterprises being sold to private (Polidano: 1999). Focused areas are Stakeholder's involvement, to satisfy customers and at the same time, they must strive to be publicly accountable and demonstrate standards of fairness. How these principles are applied to health? It was found that in public sector there was wastages and inefficiency, (Jakab et al: 2002). Therefore, they began to prepare policies in the NPM framework that would bring incentives for efficiency in the activities of these remaining government entities and departments. It was also directed to generating reasonable and well-directed solutions.

In short, all the nations across the globe had opened their services to market competition by the early 1980's. This led to the targeting of the service sector to the private. Most of the low and middle-income countries were forced to restructure the finance of public provision in the name of modernization by the conditionality prescribed by the World Bank, WHO, IMF etc. The new model

emerged because of dissatisfaction of customers, insufficient funds, and monopolistic form of government. Recently, most of the countries are directly or indirectly reassessing their roles in health service delivery and in particular in the provision of the health service in the name of NPM practice such as, contractual relationships influenced by 'NPM' ideas or introduction of it with efficiency gains as their prime motivation, irrespective of different political and economic structures. In USA, the creed of market competition (Woolhandler: 2003) and managed care in the health sector is most advanced and despite soaring costs, there is reduced public provision. In Western Europe, social health insurance reforms aimed at market competition and freedom of choice are taking place at the expense of deteriorating quality, equity and universality of provision. In developing nations, a varying mix of pressure arising out of SAP, among other factors, is dramatically reducing the role of the state.

It is evident that before introducing any new method; the policy makers should consider the felt needs of the population and real needs. There is a need to rethink about the business approach to the public health practice and at the same time there is a need for the regulated private market in healthcare practice, setting up Total Quality Management in the public system as well as in the private system and need for RAP in the existing public system. Public sector role in the social sector is very essential in order to provide service to the needy and the poor.

The recent ongoing debate is, why public sector service is withdrawing from the social sector in the form of cutback in social sector, especially, health and education and when taxpayers are dissatisfied with the quality of public service. On the other hand private sector concentrates more on curative care, raising issues about equity, accountability and responsibility given to the

contended issues. There is no doubt that there is a greater need for state effort in healthcare. It is very necessary in low and middle-income countries, for there is a greater need for state effort in healthcare especially, in low and middle income countries. And there is a greater need for state role as a regulator and policy maker to comply with RAP.

CHAPTER-III

NPM PRACTICE IN HEALTHCARE WITH REFERENCE TO TAMIL NADU

Health status is an important dimension of poverty which is the main determinant of economic status especially among poor families. Government has played a very limited role in financing, provision and regulation of social sector especially in healthcare. Apparently, there is a changing perception of the role of the government especially in the light of healthcare reform, undertaken as a part of SAP implemented in India from the early 1990's. This chapter attempts to review the changing role of the state in healthcare and examines some recent attempts of the Tamil Nadu government, such as:

- Contracting out of healthcare provision to the private sector
- Increased regulation of the private healthcare sector
- The establishment of publicly funded 'Autonomous' Organizations by government, and
- The introduction of user fees for public healthcare services.

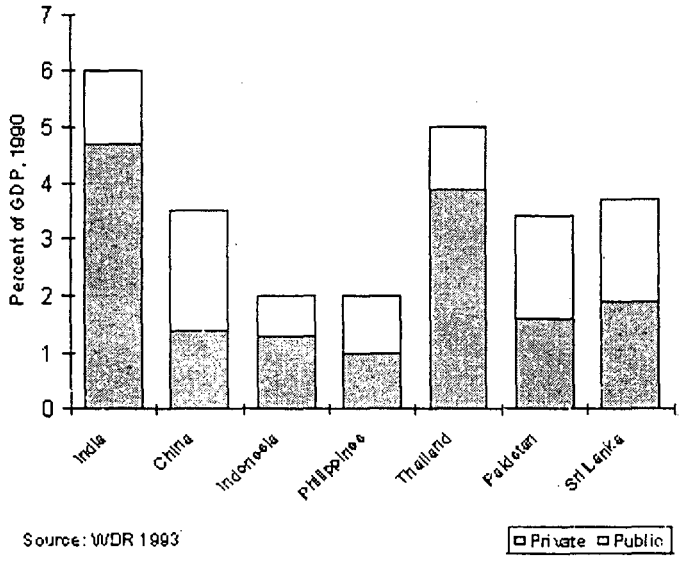
Most developing countries have pursued formal healthcare system strategies, which give primacy to government roles in financing and delivering health services. Despite decades of plans and investments based on this norm, the actual healthcare systems in many countries are quite different from what was intended or desired. Yet, policies and plans continue to emphasize a static approach. The current and potential role of non-government healthcare providers in achieving high levels of access to basic services is highlighted, using data from an extensive analysis of healthcare financing and delivery in India. Major problems related to quality of care and the financial burden of unregulated fee-for-service medicines is also documented.

India and many other countries need to rethink about their healthcare systems, development strategies to acknowledge and build upon the opportunities offered by the already extensive non-government healthcare sector, rather than to view

non-government services simply as a constraint to successful public programs. This chapter provides specific observations from Tamil Nadu healthcare system which has basically four objectives to realize:

- Equity
- Access
- Quality, and
- Efficiency.

Figure 3: Health Expenditure as a Percent of GDP: Asian Countries (1990)



The above figure shows the clear differences regarding government health expenditure in some of the developing countries. It automatically leads to the alternative approaches to restructure the existing system with the support of international organizations. For example, promotion to public-private partnerships

in provision of healthcare services is very much reflected on the cutbacks in the social sector.

Under the constitution of India, health is a state subject and each state has its own healthcare delivery system, developed on the basis of the overall framework by the Bhore committee (1946). The central government's responsibility consists of policy making, planning, guiding, evaluating and coordinating the work of various health authorities in addition to supporting various schemes through several funding mechanisms. In India as in many other countries, both developed and developing nations are rethinking the role of the state in the social sector. In line with the reforms in industrialized countries, the latest thinking in public management, and the policy recommendations put forward by several international organizations, and questions are being posed regarding the role of state in provision of public services.

A major concern to make governments more effective in achieving their overall policy goals has led to quite a broad reform of government organizational structures, system and even philosophy. This reform movement is sometimes referred as the NPM. Its elements as discussed in earlier chapters include creating greater responsiveness to consumers, developing organizational structures encouraging innovation and competition, strengthening incentives for performance, and creating more out-put oriented systems. All of these components are underpinned by a re-thinking on the role of government.

Working specifically on the health sector Musgrove (1996) identified the following five roles for government:

- Providing information
- Regulating

- Mandating
- Financing
- Providing or delivering of services.

Tamil Nadu state in India has a well-knit public healthcare system. However, its performance is constrained by inadequate funding adversely affecting the poor for whom facilities are intended. The following table indicates some important health indicators in Tamil Nadu in comparison with India.

Table-5 Health Indicators

	Population (000)		Life Expectancy	Infant Mortality (Per 000)		Fertility (Per000)	
	1985	1997	1995	1985	1997	1986	1997
Tamil Nadu	51370	58968	63.35	80	53	23.8	19
All India	765950	962380	60.3	95	71	32.9	26.4

Source: developed from Malaney: 2000

There have been recent attempts by the government of Tamil Nadu to further develop health infrastructure through investment in the construction of PHCs or extending hours of certain PHCs. It seems quality of service provided requires the ability of the health system to serve the needs of the population. In public health system, there is a greater need for an assessment of utilization pattern of public and private healthcare provision in the state. A recent study shows that the poor are increasingly turning to private providers due to dissatisfaction with the public

system. And private health system also is not adequately fulfilling the health needs of the poor, rather increasing their out-of-pocket-expenditure and indebtedness.

The Concept of inefficiency

Tamil Nadu is one of the two Indian states (the other being Kerala) where healthcare infrastructure is considered to be good. This can be constituted as a signal to indicate inefficiency which becomes the core of mutual factors influencing the utilization that stems out of supply side efficiency, (Wensins et al: 1998). The persistent failure of the public healthcare service has already led the people to believe that the public sector and efficiency are multiply exclusive. An efficient public healthcare delivery system is essential to serve the poor better, especially, when a third of the population earns income well below the subsistence level.

There are some sources for inefficiency. Basically, there are three major reasons for the sub-optimal functioning of public healthcare system in Tamil Nadu. First, the system itself is imperfect and doesn't fit into the desired normative framework (GOI: 1997). For instance, the actual number of community health centers falls short of the required number by 81.1% and the extent of deviation is such that each CHC in the state serves a much higher proportion (5.5 times) of population than its own capacity would allow (a CHC is meant to serve a population of 100,000).

Second, the existing public healthcare units lack certain essential facilities. Nearly 40% of the sub-centers do not have proper building and about 5000 (out of 8681) of them are left without male health workers. Similarly, 58.6% of the PHCs do not have laboratory technicians. The supply of materials is based on the availability of resources than on any demand assessment; the level of inadequacy in the state is

estimated to be in the range of 0.8-48.8 (World Bank: 1995). This state of the health sector in Tamil Nadu has significantly drawn the attention of the state government resulting into the launching of Tamil Nadu Health Systems Project aiming to improve the infrastructural facilities, especially, supporting with diagnostic tools with the aid of the World Bank.

Third, there is no optimum balance in the use of resources and the use of manpower. The share of manpower in total healthcare expenditure in the state has increased from 51.6% in 1875-78 to 63.0% in 1985-88. As against this, certain facilities remain idle either due to lack of complementary inputs or due to lack of maintenance. An imperfect system induces selective over-utilization of some centers and or facilities, ultimately resulting into crowd, poor quality, corruption and nepotism at the centers. Resource shortage, on the other hand, creates idle capacity in the form of unused buildings and underused manpower and machinery. Unbalanced use of resources excludes a specific sub-group of population from using the services. As a result, patients either have to make repeated visits to the healthcare centers or are forced to seek care from the private sector. Some scholars consider all the above problems as mere symptoms of the deep-rooted resource shortage. The large amount of resources required for scaling up public investment in health sector needs to look at several options to generate funds, (Bajpai and Sangeeta Goyal: 2005).

The Concept of Efficiency

The state policy concerning healthcare in India is to provide healthcare to the entire population through integrated health service. It is in this context that we need to examine the issue of efficiency. Efficiency in general economic terminology means absence of waste, or using the resources as effectively as possible to satisfy people's needs and desires (Samuelson and Nordhaus: 1992).

Defining efficiency with respect to public healthcare sector is trickier because it is people-oriented rather than profit-oriented. Clients/consumers in this case often try to influence supply behavior and the staff too behaves differently as they assume a much broader role than in their private counterparts.

Table-6 Government Spending on Health (Pattern of Public Investment in Health as a proportion (%) of the total plan investment)

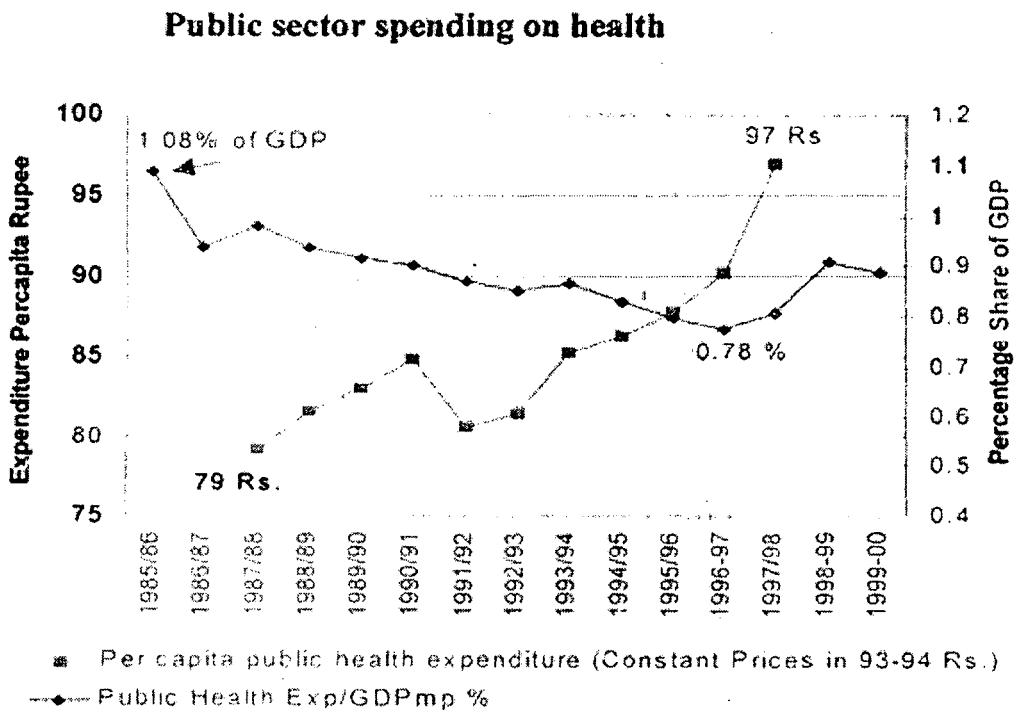
Plan	Period	Health	Family Welfare
First Plan	1951-1956	3.3	-
Second Plan	1956-1961	3.0	0.1
Third Plan	1961-1966	2.6	0.3
Annual Plan	1966-1969	2.1	1.1
Fourth Plan	1969-1974	2.1	1.8
Fifth Plan	1974-1979	1.9	1.2
Annual plan	1979-1980	1.8	1.0
Sixth Plan	1980-1985	1.8	1.3
Seventh Plan	1985-1990	1.7	1.4
Annual Plan	1990-1992	1.6	1.3
Eighth plan	1992-1997	1.7	1.5
Ninth Plan	1997-2002	1.3	---
Tenth Plan	2002- 2007	0.9	----

Developed from (Nayar: 1998)

The significance of the above table is that the government spending on health is declining. NPM or NEP in social sector is promoted as alternative solutions against this background. The major problem historically and more so presently under SAP is the under-funding of health services, "The investment by the government in healthcare has been inadequate to meet the demands of the people",

(Sunil: 1997). While this is the case, NPM advocates a reduction in the budgetary deficit. Thus spending by the government on social sector had to be curtailed. This is apparently contradictory; the following figure briefs the major budgetary changes in the public health spending on health:

Figure: 4. Public Sector Spending on Health



Source; Central Statistical Office: Ministry of Finance: RBI

Developed from the World Bank: (2001)

Some of the empirical Findings;

- Overall health spending in India is estimated at 4.5% of GDP, below the average of 5.6% for low and middle-income countries.

- Public spending on health in India rank is 0.9% of GDP, among the lowest in the world.
- Out-of-pocket private spending dominates, with 82% of all health spending from private sources.
- Hospitalization frequently results in financial catastrophe, especially without risk pooling; only about 10% of India's have some form of health insurance, mostly formal sector and government employees.
- The gap in public financing for health is widening between rich and poor states, retaining the gaps in outcomes.

The issue is: how will India expand public spending on basic health services to improve quality of service and the health of the poor? How can regional inequalities in health sector spending be decreased given decentralized financing and differences in implementation capacities? How will India be able to migrate from predominantly private out-of-pocket health financing to using risk-pooling mechanisms, particularly when incomes are low and when most people belong to rural informal sector? How can India develop the regulatory environment and information system to oversee new health financing mechanisms? And are there any other alternatives to strengthen the public health system, even if it's so and then how long it will sustain?

Alternative Policy Framework

Tamil Nadu is one of the font-runner states implementing the New Economic Policy of 1991 concentrating its efforts on industrial sector neglecting the social sector with the overall aim of enhancing the economic growth. The state is trying hard to inject certain reform elements into the health sector; for instance, drug distribution to government healthcare centers is now done through a separate

autonomous body within the government. It is functioning well as the health centers can now place the order directly with this body bypassing several other intermediates resulting in uninterrupted drug supply. In 2001, the government also introduced user fee on certain services such as parking, visiting patients during certain time etc. The whole approach is to enhance productivity with equity in the public system. The ability of the state to provide effective regulatory institutions can be expected to be a determinant of how well markets and the economy perform since regulating the large private sector is an important part of good governance (Kirkputrick: 2003). The following Box provides brief overview of functions, examples and challenges of the state in the social sector especially health.

Box- 3 Example of Health System Functions and Challenges Raised in India

Functions	Examples	Challenges
Overview Functions		
Policy Setting	❑ National Health Policy (1983) ❑ National Population Policy (2000) ❑ State Health Policy	❑ How to prioritize health needs and intervention? ❑ How to translate policy interventions into decisions on allocation of resources? ❑ How to address the needs of vulnerable population? ❑ How to provide meaningful framework for private sector participation in health?

Regulation and setting Standards	❑ Regulation of drugs quality, private nursing homes. ❑ Promoting quality assurance system (e.g. accreditation of hospitals, licensing of providers) ❑ Health Insurance regulation.	❑ How can regulation be done positively to influence behavior of public and private providers? ❑ How can sanctions be enforced effectively? ❑ How can market failures of private health insurance be ameliorated?
Providing Incentives	❑ Subsidizing health providers to work areas ❑ Duty exemptions, free lands for hospitals ❑ Providing materials, drugs and training to providers to follow good clinical practices	❑ How to monitor subsidies? ❑ How to direct subsidies toward public objects?
Developing partnerships	❑ Developing networks for providers who offer good quality, who contribute to national programmes ❑ Training NGOs and for –profit providers in national guidelines. ❑ Sharing information on disease surveillance.	❑ How to identify those providers who contribute to national objectives, and those who don't? ❑ What are the mechanisms to develop meaningful partnerships?

Information discloser and advocacy	❑ Disclosing good and poor quality health providers and products. ❑ Communicating standards for care and pricing to the public and to industry.	❑ How can information to consumers, providers, financiers, and government be used to improve accountability, quality, use, and cost of health services? ❑ Should government buy or directly produce its information services?
Monitoring and evaluation	❑ Measuring use of health services by identified groups (e.g. poor, women, SC/ST) ❑ Measuring health outcomes. ❑ Monitoring efficiency of health service and programmes.	❑ How can the capacity to develop and monitor health system functions and outcomes be strengthened? ❑ Who should conduct the monitoring and evaluation activities? ❑ How can monitor results is fed into planning and budgeting?
Raising Revenues	❑ Uses fees (out of pocket) ❑ Tax revenues and user charges ❑ Insurance premiums	❑ What is an adequate level of public funding? ❑ How can private spending on health be better collected and used?
Pooling Resources	❑ Health insurance (private for profit, non profit community financing, social insurance)	❑ How much should be level of payments? ❑ What should be in the package of benefits, and who will provide the service? ❑ How will the risks be pooled? ❑ How will the poor be subsidized?

Purchasing Services	❑ Contracting for clinical and non-clinical services. ❑ Salaries and grants for public providers and institutions ❑ Fee-for-service payments.	❑ When and how should government contract for clinical and non-clinical services? ❑ What is the best way to pay for publicly provided services? ❑ Are there ways to move away from user fees (which raise health costs) and towards global budget and capitation?
Inpatient care	❑ Private nursing homes ❑ Trust hospitals ❑ Public hospitals	❑ Should public hospitals be organized to be more efficient? ❑ How can catastrophic costs of hospitalization be ameliorating?

Developed from the World Bank: (2001)

The Case of Tamil Nadu

Sara Bennet and Muraleedharan conducted a study during 1997, in order to explore the development of NPM techniques used in the health sector in Tamil Nadu and to describe the extent to which new organizational arrangement for the provision of health services have been adopted; assess the performance of these new service arrangement, to identify factors affecting the capacity of government. This study is more about country specific and sector specific, which focused on NPM strategy, used in practice of health services. It was found that there was need to assign new roles to the state.

Healthcare reform in Tamil Nadu strengthening the government's role

India is often represented as an over-regulated economy. Yet government has played a very limited role in the social services and in healthcare in particular.

Research by a consortium of five UK institutions coordinated by the International Development Department in the School of Public Policy, University of Birmingham, explored the changing role of government in the health sector in Tamil Nadu. The study report concludes that despite the lack of an overarching policy framework, the pace of change in the Tamil Nadu healthcare sector was rapid. Further, reform should strengthen, not limit, the future role of government.

Partly because of its sheer size, India's healthcare system is very complex. Whilst government policy assigns a significant role to the public sector, government has actually played a very limited part in financing, service provision and regulation of health services. The private sector hosts some 73 percent of qualified physicians and 57 percent of hospitals. In addition, payment is often required for entry to 'free' government healthcare facilities. Services appear to be provided more efficiently if contracted out but the absence of reliable regulatory checks means that standards and quality of care remain patchy in private facilities (Varatharajan:1999).

Reform of India's healthcare system will have to work its way through several layers of government. State governments control the bulk of resources going to health and are also allowed much discretion as to whether or not to adopt central policies. In Tamil Nadu, the administration has forged ahead with reform in three areas:

1. Contracting-out of health services previously provided by the state to private organizations is now fairly common, though the total value of activities contracted-out is small.
2. New laws have strengthened regulation of the private sector, but their implementation has faced substantial obstacles and the system is still not effective, and

3. 'Autonomous organizations' have been found receiving substantial government support and performing tasks previously undertaken by government, but functioning in fact as private entities.

The Tamil Nadu Medical Supply Corporation is a case in point. They show signs of performing well but are still dominated by civil servants and do not appear to be accountable to their customers. (Bennet and Muraleedharan: 2000). The research report concludes that further reforms should be designed proactively to strengthen the role of government in healthcare and to enhance its credibility. Other conclusions of note to policymakers were that, the credibility of Tamil Nadu government among the public is low, mainly due to the poor quality of official health services and widespread corruption. And also there was lack of accountability among officials. Lack of flexibility in, and control over the terms and conditions of the health workforce limit the government's capacity to perform new roles. Officials at state level lack strategic vision and tend to tackle reforms in a piecemeal fashion. And some reforms aim to bypass government rather than achieve reform of government systems. These short-terms are due to the short lifespan of most state governments in an unstable political environment.

There is conspicuous lack of accountability at all levels. For example local level health workers tend not to feel responsible to the communities they serve, but rather to remote authorities at the state level. Drawing material from each of these case studies, the subsequent section considers the factors affecting government capacity to take role implied by NPM. A concern to make government more effective in achieving their overall policy goals has led to quite a broad based reform of government organization structures system. Purpose of the rethinking role of the state in order to provide a meaningful responsiveness to consumers, and developing organizational structures is to create more output based system.

The services can be divided into two types, namely direct provision of services and indirect services. Direct provision asks which government undertakes the service in an efficient and equitable manner. Contracting with private providers is used for direct provision of services, and also regulation of private sector is emphasized. The description of existing service-developed arrangement draws upon literature reviews, secondary data sources (such as government budget and plan documents) and in-depth interviews with government officials, representatives of the private sector providers, officials working for contracting, professional organizations and researchers studying these issues.

STRATEGY ONE - CONTRACTING OUT HEALHCARE SERVICES

Contracting for services has been a means to improve efficiency by promoting competition and to create greater transparency in the use of public funds. In order to enhance private sector participation, delivery of services through contracting is made appealing. A case study examining the cost–effectiveness of contracting arrangements for catering service in Mumbai (Bhatia and Mills: 1998) identified the following basic details of contracting in clinical and non clinical services such as: laundry, equipments, and maintenance. These are the major areas that were contracted out to the private clinically oriented services. The provision of high-technology diagnostic services was contracted out, and a variety of contractual approaches found.

Several of the contracts in Tamil Nadu were awarded on a non-competitive basis through direct negotiations between the department of health and the firm concerned. Revenues from the service provided came entirely from user fees. CT/ MRI scan facilities were contacted out to the private sector. Contract for laundry at the women's hospital in Chennai was given without any fixed price. The contractors were free to ask whatever price they wished. As new equipment had

been recently installed by the department of health, start-up costs should be low. The author of the study did not make any attempt to examine the quantity and quality of food provided by the contractors.

Regarding the high-tech services contracted out in Tamil Nadu, the main apparent difference from similar government services was the longer opening hours of the facility. While there has been some success with this approach, there have been a limited number of bidders, in part because of the government's reputation for delay in payments, and some difficulties faced by the bidders. In short, contracting identifies private sector tools and mechanisms to improve delivery of public sector services. Contracting has been defined as a normal market exchange process, which is formalized in advance on the basis of a contract. In the health sector in India, contracting takes different forms for different health services. For instance, in Tamil Nadu, bids for laundry services, are advertised in newspaper while for high-tech equipment and maintenance they are negotiated directly with the providers. And contracting has been attempted in various national programmes like blindness control and AIDS control programmes. In AIDS programme, the management of high-risk groups has been handed over to NGOs because of their better ability to interact with communities.

STRATEGY TWO - REGULATION OF THE PRIVATE PROVISION

The reforming state includes the regulatory framework for health. Few regulatory mechanisms have been well enforced in health because 80% of expenditure and 70% of healthcare contracts occur in the private sector. The very low level of public health expenditure remains a root of the poor performance of the health system in India. During this period three states namely, Maharashtra, Karnataka, and Delhi had legislation enforcing the registration of private hospitals, nursing homes, or diagnostic centers. In other states, private healthcare facilities have been

totally unregistered, unmonitored and free to locate as they wish (Bennet and Muraleedharan: 1997)

A conference of the Central Council of Health and Family Welfare in January 1997 concluded that a large number of private and voluntary hospitals were being operated without adequate staff, equipment, and infrastructure facilities. It urged governments to enact laws to provide for registration of such private hospitals. The legislative assembly of Tamil Nadu approved such bill. Two chief features of the Tamil Nadu private clinical establishment are health facilities that will require registering every five years. A 'Competent authority' will have the power to inspect and fine, or suspend or cancel the license of those which do not meet specified standards.

STRATEGY THREE - CREATION OF AUTONOMOUS ORGANISATIONS

The government has achieved more success with the development of autonomous bodies. Autonomy refers to the quality state of being self-governed; it implies that, the organization in question has a degree of power over its own actions. Autonomous organizations are also generally given greater decision-making power (ability to hire and fire staff, raise private sector capital, etc). In particular, there are three such bodies in Tamil Nadu; The Tamil Nadu Medical Supply Corporation (TNMSC), the State AIDS Control Society (TNACS), which were incorporated under the society registration act and the State Blindness Control Society (TNBCS). Bennet and Muraleedharan point out that the greater financial and managerial flexibility given to autonomous organization like TNMSC could be the basis for their success.

Tamil Nadu Medical Supply Corporation (TNMSC)

Organization

The Tamil Nadu Medical Supply Corporation was incorporated under the Companies Act, 1956; on 01.07.1994, and has obtained ISO 9001-2000 certification. Its Board of Directors administers the Corporation. With effect from 19.06.2004, a Chairman has been appointed to this Corporation who is also one of the Directors of the Board. The Managing Director looks after the day today administration of the Corporation.

Activities of TNMSC

Procurement, Storage and Distribution of drugs: The Tamil Nadu Medical Supply Corporation Limited ensures the ready availability of quality drugs, medicines, surgical and suture materials to the government medical institutions throughout the State.

The drugs and medicines are distributed to the government medical institutions through 24 drug warehouses in Tamil Nadu by a passbook system based on the financial allotment made by the respective Heads of Departments. The Corporation is maintaining 35 CT Scan Centers in Government Hospitals and 2 MRI Scan Centers one each at Government General Hospital, Chennai and Government Rajaji Hospital, Madurai to provide scanning facility to the public on nominal charges. Among the other activities, the corporation is serving medicines to dispensaries attached to the Tamil Nadu Electricity Board, Municipalities, Corporation, Panchayat union, Prison Department and Police Medical Hospitals, Juvenile Homes, Rehabilitation Homes, dispensaries attached to Co-operative Sugar Factories, Veterinary Institutions, Transport Corporation etc.

Tamil Nadu Medical Supply Corporation has also taken up the construction of 7 regional diagnostic centers in the state (building and equipment) at Thiruvannamalai, Villupuram, Pudukottai, Virudhunagar, Ramanathapuram, Namakkal and Tiruppur at a total cost of Rs.21.00 crores funded by government of India. A sales counter is being established at Kilpauk Medical College, to sell the life saving drugs to the general public as per the direction of government. And the work of maintenance of equipments in government hospitals has been entrusted to this corporation.

Recent Changes in Tamil Nadu Health System

> *"We are aiming to reduce the birth rate from 19.3 per 1000 to 15 per 1000, Infant Mortality Rate (IMR) from 52 per 1000 to 28 per 1000, Maternal Mortality Rate from 140 deaths per one lakh births to less than 100 per one lakh births and the death rate from 8 per 1000 to 6 per 1000 by the end of the Tenth Plan Period. These objectives would be achieved by appropriate policy interventions aimed at providing affordable and quality healthcare to the people of Tamil Nadu",* (Budgetary Speech by the Hon'ble state Minister of Health 2002-2003)

The Government Hospital for Thoracic Medicine at Tambaram, which has been playing an important role in providing treatment and counseling to patients suffering from HIV and AIDS, will be strengthened at a cost of Rs.4.7 crores during the next financial year. The Government of India is being requested to convert this institute into a Regional Institute for AIDS Prevention and Counseling. The Institute of Child Health at Egmore in Chennai will be modernized and upgraded at a cost of Rs.21 crores with financial assistance from Japan. The Government proposes to set up a world-class Hospital based on the Indian Systems of Medicine with public-private partnership in Chennai.

The Government will provide the land for construction of the hospital and the land value would be the equity contribution in the project. A Steering Committee is being constituted to finalize the modalities. This project will be the first of its kind in India.

Tamil Nadu is the first State selected to implement the "second generation" State Health Systems Development Project in India. The Project will extend support to civil works to hospital buildings including equipment, IEC, training, Health Management Information system, NGO supported activities, tribal health, healthcare waste management and Public Private Partnership related to District, Taluk and Non Taluk hospitals in the State. The project period will be of 5 years and approximate budget proposed for the project will be around Rs.560.00 Crores.

The World Bank team has made several visits to Tamil Nadu and finalized the activities to be undertaken under the project. The main activities to be taken up under the project are:

- Improvement of hospital buildings,
- Repair of buildings and provision of new buildings,
- Provision of equipment and hospital supplies,
- Provision of ambulances,
- Provision of training to the doctors and paramedical staff and Improvement of management of the hospitals.

The hospitals to be included in the project are 26 district headquarters hospitals, and 244 taluk and non-taluk hospitals. The total project cost stands at Rs.560 Crores. The appraisal mission had visited Tamil Nadu during July 2004 and the Project is likely to commence from October 2004. With this project, the

Government hospitals in the secondary sector are expected to provide better services to the poor public visiting these hospitals.

Project Description

The Project has been designed to address the existing constraints to access, utilization and quality of health services in Tamil Nadu, and thereby contributes to improving their health outcomes in the state. The Project Development Objective is to significantly improve the effectiveness of the health system, both public and private, in Tamil Nadu through:

(i) increased access to and utilization of health services, particularly by poor, disadvantaged and tribal groups;

(ii) development of effective interventions and pilot test to address key health challenges including non-communicable diseases;

(iii) improved oversight and management of the healthcare system (both public and private); and

(iv) increased effectiveness of public sector hospital services, primarily at district and sub-district levels.

The call for healthcare reforms from international donor agencies increased pressure for a critical evaluation of public healthcare and greater involvement of the private sector. And at the same time, the role of funding agencies played a vital role in the reform process (Baru: 2003).

Regarding the government's role in the health sector, we need to distinguish between the financing and provision of health care. In the past, financing completely came from the general tax revenues. To enhance government's role in

the health sector, accountability, better management, and innovative approach are needed in the public sector.

In Tamil Nadu as a part of the NPM reform, a number of changes were brought out regarding the role of government, including contracting out the establishment of autonomous organization and strengthening of regulatory mechanisms. Poor are still forced to turn to the private sector to fulfill their healthcare need; some of the sticking issues are,

- **Lack of vision**

  There seems to be lack of an overall strategic vision, particularly at the state level.

- **Reform versus bypassing of government**

  While there is centrally a need for greater investment in developing health infrastructure, reforms were being purchased often as means to circumstance public sector regulations. There is a need for huge investment in health to improve the infrastructure and medical services but lack of financial resources by the state leads to insufficient supply and provision of services. This results into people's dissatisfaction with the public services.

- **Accountability**

  Availability and accountability of staff in each level is very important in the public health system. Lack of monitoring means, staff often do not devote sufficient time or attention to individual patients. Lack of accountability is one of the core failures of the 'old' ways of the government. Local level health workers tend to feel accountable not to the community they serve but to remote state level authority who can possibly monitor their actions. Accountability: the new forms of government tend to make accountability

issues much more complex; who is a contractor accountable to? By what mechanisms organization is held accountable? The above mentioned study finds a high demand for private outpatient services, and anyway that healthcare utilization patterns are being determined primarily based on issues of quality rather than on access. Access and quality of the healthcare is relevant here (Priya et al: 2004).

We need a greater role of the stakeholder's participation in the providing of the public health services provision in both urban and rural areas in order to avoid such issues in public health practice. There is a need for evolving a workable definition of reform initiative undertaken, and also, we need well-documented reports to continue/terminate the reform. Need for better utilization of existing funds, creating balance amongst existing health personal and involving personnel from other disciplines such as economics, statistics, etc are certainly needed. But, all problems have to relate to the ongoing debates over how to optimize the quantity, efficiency, and equity of healthcare services. Given the very sharp health inequality that exists in India, the provision of health care, especially primary healthcare has to be a social concern and primarily the responsibility of the state, in order to provide basic healthcare coverage to all.

CHAPTER-IV

SUMMARY AND CONCLUSION

SUMMARY

'Millions elsewhere, have simply stopped seeking medical help for their ailments. The just cannot afford it. Some farmers have mortgaged to pay health bills' (The Hindu: 2005).

It is sometimes argued that the New Public Management (NPM) is an international phenomenon introduced with information package as per the importance and the context across the globe. NPM is the strategy of the state which draws techniques from professional management, but the philosophy is drawn mainly from the market approach. NPM reforms shift the emphasis from traditional public administration (TPA) to public management.

Key elements include various forms of decentralizing management within the public services (e.g., the creation of autonomous agencies and devolution of budgets and financial control), increasing use of market and competition in the provision of public services (e.g., contracting out and other market-type mechanisms), and also increasing emphasis on performance, outputs and customer orientation.

The following are the different components of NPM strategies used in healthcare; to encourage Public Private Partnerships for the provision of health services through contracting out clinical and non clinical services, creation of autonomous organizations in order to reduce government burden, providing more power to the decentralized society, provision of separate private paid wards in every public health centers, introduction of the resource mobilization in the society and introduction of user charges in the utilization of the public service. The NPM strategy in the public system has directly affected the plan period allocations by a reduction in social sector spending.

Downsizing public budgetary allocations to the social sector and introduction of user fees, especially in Africa, have been closely associated with Structural Adjustment Programmes (SAP). Autonomous agencies within the public sector are being created in some countries. Examples include autonomous hospitals in Ghana, Zimbabwe and Sri Lanka. Performance contracting and contracting out have been common policy option in most of the nations i.e. Ghana, Bolivia, Senegal and India. Contracting out is increasingly being adopted in the delivery of public services including urban services and ancillary health services such as cleaning, laundry and catering (e.g. Zimbabwe).

The present review focused on the following areas in the paradigm of public management in health:

- Changing role of the state in public policy focused on healthcare sector.
- Elements of NPM strategy used in healthcare services with the help of global practices.
- A few countries' experiences having introduced NPM.
- Explanation of the reasons for NPM. For example due to over-centralization, Tamil Nadu Medical Supply Corporation (TNMSC) came up in Tamil Nadu.
- Reforms aimed at improving healthcare targeting both the financing and production of services.
- Reasons for the reform such as internal and external factors including financial/economic ones and also related to macro economic changes at the global level, people's dissatisfaction, over centralization of the public services; and conditionality of the bilateral agencies.

Reform of the health sector has focused on some options i.e. the establishment of autonomous organizations, the introduction of user fees, the contracting out of

services and the enablement and regulation of the private sector. It is suggested there is need for accreditation and regulation of the private sector.

Limitation of the New Public Management

Until the early 1980s, the public sector in most countries was monopolistic, centralized, hierarchical, inflexible, and unresponsive to users. These negative features were used to practice the NPM strategies. There is a question why we need NPM? Is it due to lack of funds, or lack of accountability among public employees, or poor performance etc? The following are the recent arguments of many scholars in development sector. There are evidences from countries across the globe that user fee from the poor is not an option for generation of resources, because it will affect the essential public health functions. Promoting competition among agencies' response for public health functions does not improve efficiency.

However there is a greater need for sufficient government capacity/mechanisms to monitor the programmes effectively. There is a need for performance improvement in the public sector. Public sector norms and rules that impede effective administration should be changed wherever it is possible.

CONCLUSION AND CRITICAL ASPECTS OF NPM

NPM ideas have been reflected in the international health sector reform agenda. According to Osborne and Gaebler, the government should steer, not row (or as Mario Cuomo puts it, "it is not government's obligation to provide service, but to see that communities are provided"), and are empowered to solve their own problems; rather than simply deliver services; encourage competition rather than being monopolistic; be driven by missions rather than rules; meet the needs of the customers not the bureaucracy; concentrate on earning money rather than spending

it; invest in preventing problems rather then curing crises; decentralize authority and solve problems by influencing market forces rather that creating public programmes.

NPM encourages the introduction of private sector values into the public sector. It has served the interest of elites, particularly corporate elites, and has degraded the ability of governments to address the public interest, and has served as a vehicle for elevating the apolitical governance of free trade. But unfortunately it has not served the interest of the poor, since it brings the system more friendlily to those, who can afford. Based on the limited empirical evidences, the following are some of the critical aspects of NPM practice in healthcare,

- Public sector entities behave more like private ones, which raise question of what is the priority of state in provision of health services to the poor?
- Most of the case studies brought about reasons for NPM and different components of NPM but not its implications.
- Under the mentioned reform, does the service reach clients or does it improve existing provision?
- Polidaro (1999), his paper examines the argument that the NPM is inappropriate to developing countries on account of problems such as corruption and low administrative capacity?
- Many developing countries have taken up some elements of the NPM agenda,
    - Can the NPM work in the developing countries especially in health?
    - Is the NPM on appropriate reform model for developing countries?

- In India, those below the poverty line (BPL) continue to rely heavily on the public sector (93% of immunization, 74% of antenatal care, 66% of inpatient bed days and 63% of delivery related inpatient bed days, Mahal: 2001), and access to healthcare is increasingly becoming difficult especially for the poor, due the concept of value for money, in the public system?
- One can also raise the question of equity and sustainability? The principle of equity and social responsibility within the health sector is replaced by a policy that regards health as a market commodity, (Nayar:2004)
- It is very difficult to measure output and results in the social sector especially in healthcare.
- The private sector can complement public health provision and provide some type of services better; it cannot lead the health sector in a direction likely to maximize its services to the health of the population.
- According to Koivusalo (2001) the main intention of the reforms had always been to provide greater opportunities for the private sector rather than improve the services?
- High cost of management has tended to increase the overall unit costs, which are being transferred to the patients? And
- In Bombay the quality of services become poor after they have been contracted out despite introduction of user charges (WHO:2001)

There are some positive elements of NPM in healthcare, contracting will provide greater returns in improving public sector provision. The evidence from Bangkok and Bombay suggested that contracts were capable of delivering adequate non-clinical services at lower costs. In Bangkok, service quality of contracted services was better, because of better maintenance and downsizing. In South Africa, the costs of contract hospitals were lower than those of publicly run hospitals. However, these are large evidences from the point of view of the provision, there is very little evidence regarding how these have affected the use of the provision,

especially, by the poor sections. However this has negative implications for the employees with regards to the social security, medical benefits this examined some of the studies.

In Tamil Nadu, case report regarding the NPM experiences in healthcare covers the following: **contracting out** clinical and non-clinical services to the private sector, the establishment of publicly funded **'autonomous organizations'**, like creation of Tamil Nadu Medical Supply Corporation (TNMSC), were mainly followed because of the greater financial flexibility and managerial autonomy. Sara Bennett and V.R Muraleedharan study gives the main finding that each of the autonomous organization in Tamil Nadu appeared to be performing well. In particular, TNMSC appears to have considerably improved the quality and availability of drugs throughout the state, increased regulation **of the private** healthcare sector, such as laws on establishment of private healthcare facilities, and the introduction of **user charges** for the public healthcare services.

Autonomous hospital have been advocated as a means of improving efficiency (mainly through strengthening management), improving responsiveness to users by increasing downward accountability and increased use of market based incentives. User fees have been advocated as a means of raising additional revenue, improving the quality of care (by making providers more responsible to users), and increasing efficiency (by using fees structures to encourage the appropriate consumption of healthcare and improving the equity for those who can afford to pay).

Suggestions

The following are some suggestions drawn on the basis of the different countries experience:

- The clarity of roles, responsibilities and accountability is very important in implementing management reforms within the public system especially in the healthcare.
- The system should be made more responsible and accountable to the community.
- The structural innovation is necessary to focus much on Total Quality Management (TQM) in the public hospital.
- There should be proper tools to measure the availability of infrastructural facilities, staffs including medical and Para medical professionals, and the drugs.
- More focus should be laid on the performance measurement of the employees of each and every corner.
- There is a need to strengthen regular monitoring and evaluation mechanisms within the public health system.
- And there is also a need to focus much more on the alternative system to providing meaningful service to the needy people.
- Any reform needs to consider the issue of equity and affordability of the poor,
- Government can be part of the NPM if it has to retain control over quality, quantity, and price of services provided. And
- We need much more empirical evidence on the implications of NPM in healthcare.

The major limits of the NPM is that it can be possible only in profitable or even less profitable sectors but not in services or welfare oriented sectors. In countries like India, poor cannot afford to purchase healthcare privately, due to poverty and illness. And also the recent debate is that how long the innovative changes can be sustained in the public health system. We need to constitute proper monitoring system and regular performance appraisal system to determine TQM in the public health system.

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APPENDIX-1

GLOSSARY

GLOSSARY

New Public Management Glossary

This glossary contains terms about NPM-HSR, and majors terms used in the review work.

General Index

A
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Approach

B
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Burden of Disease

C
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Collaboration
Contracting Out
Cost-benefit
Cost-effectiveness
Cost-effectiveness efficiency
Cost-efficiency
Cost Sharing

D
Decentralization

E
Economics of scale
Effective
Effectiveness
Efficiency
Efficient
Empowering
Equity
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Externality

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Fee-for-service
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Financing
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G
Governance

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Health
Health care
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Health indicator
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L
Less Developed Nations
Living conditions

M
Management
Managed Care
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Managerial process for national health development

N
National health policy
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O
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Out-of Pocket Costs
Out-of-Pocket Expense

P
Payment
Policy
Policy-makers
Price
Public health
Project
Programme
Privatization
Public Good
Public Policy
Public Policy Development
Public Policy Dialogue

Q
Quality of life

R
Re-orienting health services
Resource management
Resources
Result

S
Self-help
Self-reliance
Self-sufficiency
Social capital
Stakeholder
Strategy

T
Target
Target audience
Total Quality Management (TQM)
Technical efficiency
Trends

U
Uncertainty

V
Validity

W
Willingness –to pay

A

Ability-to-pay

The economic capacity of an individual or organization to offer payment, usually in money, to obtain a good or service (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Actor

An institution, group, or individual that plays a major role within a particular sector, in the health sector, important actors are citizen groups working for a clean environment, medical associations, etc. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva,

Allocative efficiency

Allocative efficiency required that an economy provide its members with the amounts and types of goods and services that they most prefer. In standard economic theory it occurs when resources are allocated in such a way that any change to the amounts or types of outputs currently being produced (which might make someone better off) would make someone worse off. This is sometimes also called "Pareto efficiency". (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Approach

A means or method of attaining an objective or target (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

B

Beneficiaries

The individuals covered within a health care plan. In a publicly funded system, the beneficiaries are residents of a jurisdiction or members of a social insurance system, in a private plan; they are enrollees of the insurance plan. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Burden of Disease

An indicator that quantifies the loss of life from disease; measured in disability-adjusted life years, an indicator that quantifies the loss of healthy life from disease; measured in disability-adjusted life years

C

Capacity Building

The process by which individuals, organizations, institutions and societies develop abilities (individually and collectively) to perform functions, solve problems and set and achieve objectives. (Schacter, Mark. Capacity Building: A New Way of Doing Business for Development Assistance Organizations. Policy Brief No. 6. Institute on Governance. 2000. http://www.iog.ca/)

Collaboration

A process through which parties who see different aspects of a problem can explore constructively their differences and search for (and implement) solutions that go beyond their own limited vision of what is possible. Collaboration is a mechanism for leveraging resources; dealing with scarcities; eliminating duplication; capitalizing on individual strengths; building internal capacities; and increasing participation and ownership strengthened by the potential for synergy and greater impact. (University of Victoria. *Voluntary Sector Knowledge Network.* http://vskn.ca)

Contracting Out

The practice of the public sector or private firms of employing and financing an outside agent to perform some specific task rather that managing it themselves

Cost-benefit

The relationship between the cost of an activity and the benefits that accrue from it. (Health for All: WHO Terminology Information System, www.who.int/terminology/ter/wtd00012.html)

Cost-effectiveness

The relationship between cost and effectiveness (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Cost-effectiveness efficiency

Cost-effectiveness efficiency occurs when inputs are combined so as to minimize the cost of any given output. The requirement may also be stated such that output is maximized for a given cost. (Health Sector Reform and Sustainable Financing: a

learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Cost-efficiency

The extent to which financial resources are being used as well as possible.(Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Cost Sharing

The portion of a project or project cost supported by the grant recipient agency.

D

Decentralization

A process of transferring responsibility, authority, control, and accountability for specific or broad management functions to lower levels within a organization, system, or programme.

E

Effective

Showing results in accordance with the objectives and targets for reducing the dimensions of a problem or improving an unsatisfactory situation. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Effectiveness

The effects of the activity and the end-results, outcomes or benefits for the population achieved in relation to the stated objectives. The ratio between the achievement of the programme activity and the desired level which, during the planning process, the planners had proposed would result from the programme activity. The degree to which a plan, a programme or a project has achieved its purpose within the limits set for reaching its objective. The extent to which actions achieve predetermined objectives. An expression of the degree to which a programme has produced the effects as planned or desired. An expression of the desired effect of a programme, service or institution in reducing a health problem or improving an unsatisfactory health situation. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

The essential difference between efficiency and effectiveness is that the latter is related to the results achieved (or planned to be achieved), and the former to the cost, in terms of resources, of achieving those results. The latter approaches the meaning of the technical term cost-effectiveness. Costs are not involved in this measurement as they are in that of efficiency. Thus, effectiveness measures the degree of attainment of the predetermined objectives and targets of the programme, service or institution. The assessment of effectiveness is aimed at improving programme formulation or the functions and structure of health services and institutions through analysis of the extent of attainment of their objectives. Where feasible, the extent of attainment should be quantified. Where this is not feasible, a qualitative analysis of the relevance and usefulness of the achievement has to be performed however subjective and impressionistic such an analysis may be, until a more precise way of measuring is developed. The evaluation of effectiveness should also include an assessment of the satisfaction or otherwise expressed by the community concerned with effects of the programme, service or institution. (Hogarth J. Glossary of Health Care Terminology. Copenhagen, World Health Organization Regional Office for Europe, 1978)

Efficiency

The effects or end-results achieved in relation to the efforts expended in terms of money, resources and time. The ratio between the result that might be achieved through the expenditure of a specific amount of resources and the result that might be achieved through a minimum of expenditure. The skill with which resources have been used to achieve a given end. The extent to which resources are used as well as possible. See also effectiveness. See technical efficiency, cost-effectiveness efficiency and allocative efficiency. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Efficient

Productive of effects, effective, adequately operative. Productive of results, with the efforts expended on a programme, activity, task, etc. being as good as possible in relation to the resources devoted to it. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/) empowering

The process of giving people the hope and motivation that they need in order to improve their lives, now and in future. Often the primary objective of guided imagery and visioning workshops. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

Empowerment for health

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health. Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concern, devise strategies

for involvement indecision-making, and achieve political, social and cultural action to meet those needs. Through such a process people see a closer correspondence between their goals in life and a sense of how to achieve them, and a relationship between their efforts and life outcomes. Health promotion not only encompasses action directed at strengthening the basic life skills and capacities of individuals, but also at influencing underlying social and economic conditions and physical environments which impact upon health. In this sense health promotion is directed at creating the conditions which offer a better chance to ther being a relationship between the efforts of individuals and groups, and subsequent health outcomes in the way described above. A distinction is made between individual and community empowerment. Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Equity

Fairness in the allocation of resources or treatments among different individuals or groups. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Evaluation

A systematic and critical analysis of the relevance, adequacy, progress, efficiency and effectiveness, impact and acceptance of a programme or activity. (Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html) Judging something (a scenario, a policy, a strategy etc.) in terms of selected criteria (feasibility, desirability, equity, cost effectiveness, etc.) or comparing two or more items in terms of such criteria.

(Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

F

Fee-for-service

Fee-for-service refers to a payment mechanism whereby a provider or health care organization receives a payment each time a reimbursable service is provided (e.g., office visit, surgical procedure, diagnostic test) (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Final output of goods and services

Goods and services which are produced for consumption rather than as intermediate products used in the process of production. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Financing

Raising revenue to pay for a good or service. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Funding

Providing health care organizations with the financial resources required to carry out a general range of health-related activities. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

G

Governance

Governance is a network of system that rules all human activities-from-men-women relations to international relations. This is a system as well as a practice (Kishore J: 2002)

H

Health

Health is defined in the WHO constitution of 1948 as: A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. (Ottawa Charter for Health Promotion. WHO, Geneva,1986)

In the context of health promotion, the ability of an individual to achieve his potential and to respond positively to the challenges of the environment. This definition differs, for the purpose of health promotion, from that given in the WHO Constitution the all-embracing and idealistic description of which has often been viewed as unattainable and largely irrelevant to the lives of most individuals. In its present formulation, health is seen as a resource for everyday life, not as the object of living; it is a positive concept emphasizing social and personal resources as well as physical capacities. The basic resources for health are income, shelter and food. Improvement on health requires a secure foundation in these basics, but also information and life skills; a supportive environment, providing opportunities for making health choices among goods, services and facilities; and conditions in the economic, social and physical environments, the total environment, that enhance health. (World Health Organisation HED/HEP. Health Education and Health Promotion in Developing Countries 930506).

Health Administration

It is a branch of public administration which deals with matters relating to the promotion of health, preventive services, medical care, rehabilitation, the delivery of health services, the development of health manpower and the medical education and training. (Kishore J: 2002)

Health Care Reform

Reforms of the health care system or of any part of such system, including individual programs or temporary annual budget limitations.

Health Indicator

A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time). Health indicators can be used to define public health problems at a particular point in time, to indicate change over time in the level of the health of a population or individual, to define differences in the health of populations, and to assess the extent to which the objectives of a programme are being reached. Health indicators may include measurements of illness or disease which are more commonly used to measure health outcomes, or positive aspects of health (such as quality of life, life skills, or health expectancy), and of behaviours and actions by individuals which are related to health. They may also include indicators which measure the social and economic conditions and the physical environment as it relates to health, measures of health literacy and healthy public policy. The latter group of indicators may be used to measure intermediate health outcomes, and health promotion outcomes. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Health Outcomes

A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Such a definition emphasizes the outcome of planned interventions (as opposed, for example, to incidental exposure toe risk), and that outcomes may be for individuals, groups or whole populations. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programmes. It may also include the intended or unintended health outcomes of government policies in sectors other than health. Health outcomes will normally be assessed using health indicators. See also intermediate health outcomes, and health promotion outcomes. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Health Policy

A formal statement or procedure within institutions (including government) that gives priority to health or that recognizes health goals. It involves health services and those sectors outside health services that affect health. Sectors involves may include agriculture, energy, transport, industry, trade, aid, social welfare, environment, education and science. Health policy is often enacted through legislation or other forms of rule-making which define regulations and incentives which enable the provision of health services and programmes, and access to those services and programmes. Health policy is currently distinguished from health public policy by its primary concern with health services and programmes. Future progress in health policies may be observed through the extent to which they may also be defined as healthy public policies. As with most policies, health policies arise from a systematic process of building support for public health action that draws upon available evidence, integrated with community preferences, political realities and resource

availability. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Health Programme

An organized aggregate of activities directed towards the attainment of defined objectives and targets, which are progressively more specific that the goals to which they contribute. Each health programme should have its specific objectives and targets, whenever possible quantified, that are consistent with those of the national health strategy. The programme should set out clearly the requirements in health workers, physical facilities, technology, equipment and supplies, information and intercommunication, the methods of monitoring and evaluation, the timetable of activities, and the ways of ensuring correlation between its various elements and related programmes. (Health for All: WHO Terminology Information System, www.who.int/terminology/ter/wtd00012.html)

Health Promoting Evaluation

Health promotion evaluation is an assessment of the extent to which health promotion actions achieve a "valued" outcome. The extent to which health promotion actions enable individuals or communities to exert control over their health represents a central element of health promotion evaluation. In many cases it is difficult to trace the pathway which links particular health promotion activities to health outcomes. This may be for a number of reasons, for example, because of the technical difficulties of isolating cause and effect on complex real-life situations. Therefore, most recent outcome models in health promotion distinguish between different types of outcomes and suggest a hierarchy among them. Health promotion outcomes represent the first point of assessment and reflect modifications to those personal, social and environmental factors which are a means to improve people's control over their health. Changes in the determinants of health are defined as intermediate health outcomes. Changes in health status represent health outcomes. In most cases, there is

also 'value' placed on the process by which different outcomes are achieved. In terms of valued processes, evaluations of health promotion activities may be participatory, involving all those with a vested interest in the initiative; interdisciplinary, by involving a variety of disciplinary perspectives, integrated into all stages of the development and implementation of a health promotion initiative; and help build the capacity of individuals, communities, organizations and governments to address important health problems. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Health Resources

All means available for the operation of the health system, including human resources, buildings, equipment, supplies, funds, knowledge and technology. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Health Sector

The sector that includes government ministries and departments, social security and health insurance schemes, voluntary organisations and private individuals and groups, providing health services. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Health System

The complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places, and communities, as well as in the physical and psychosocial environment and the health and related sectors. A health system is usually organized at various levels, starting at the most peripheral level, also known as the community level or the primary level of health care, and proceeding through the intermediate (district, regional or provincial) to the central level. (Health for All:

WHO Terminology Information System,
www.who.int/terminology/ter/wtd00012.htmi)

I

Impact

The overall effect on health status and socio-economic development. (Health for All: WHO Terminology Information System 1997,
www.who.int/terminology/ter/wtd00012.html)

The total, direct and indirect, effects of a programme, service or institution on a health status and overall health and socio-economic development. (Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html)

Implementation

The carrying out of a project or programme. Involves not only the work itself, but all the practical supporting activities such as preparing terms of reference, fund-raising, setting up an organizational structure, communicating, and carrying out a project evaluation. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

Indicator

Any variable which helps to measure changes. Quantitative expression of a health state (or other element state), of an indirect or surrogate character, sometimes standardized by national or international authorities, usually of a summary nature. Variable susceptible of direct measurement that is assumed to be associated with a state that cannot be measured directly. Indicators are sometimes standardised by national or international authorities. Measure of the extent to which targets are being reached. Variable that helps to measure changes in a health situation directly or

indirectly and to assess the extent to which the objectives and targets of a programme are being attained. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Investment for health

Investment for health refers to resources which are explicitly dedicated to the production of health and health gain. They may be invested by public and private agencies as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to healthy public policies. Investment for health is not restricted to resources which are devoted to the provision and use of health services and may include, for example, investments made by people (individually or collectively) in education, housing, empowerment of women or child development. Greater investment for health also implies reorientation of existing resource distribution within the health sector toward health promotion and disease prevention. A significant proportion of investments for health are undertaken by people in the context of their everyday life as part of personal and family health maintenance strategies. See also healthy public policy. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

L

Less Developed Countries (LDCs)

These are the nonindustrialized nations of the Third World. Often they are former colonies of western nations that rely on the export of raw materials to maintain a precarious prosperity.

Living conditions

The standard of housing and material resources within the physical environment in which an individual lives. (World Health Organisation HED/HEP. Health Education and Health Promotion in Developing Countries 930506).

M

Management

The sum of the measures taken to plan, organizes, operate, and evaluate all the many interrelated elements of a system. Such measures are required to translate policies into strategies and strategies into plans of action for determining the action required to define and operate health programmes and ensure that the health system infrastructure is built up to deliver them efficiently and effectively.

Managed Care

Any health care delivery system that attempts to control or coordinate use of health services by its enrolled members in order to contain spending, improve quality, or both. Arrangements often involve patient education and disease prevention; formal programs for quality assurance and utilization review; a network of providers with some form of contract with the health plan to furnish a comprehensive set of services to enrollees; and financial incentives for providers and patients to use cost-effective treatments. HMOs and indemnity insurance plans with utilization review are both examples of managed care systems.

Managerial Process for National Health Development

A continuous process of systematic planning and programming carried out in collaboration with other sectors concerned with health. The managerial process for national health development involves:

Formulating policies and defining priorities;

- broad programming to translate these policies into a strategy with clearly stated objectives and targets;
- programme budgeting to ensure the preferential allocation of resources for the implementation of the strategy;
- preparing plans of action in the light of broad programming and programme budgeting, indicating the main lines of action to be taken in the health and other sectors to implement the strategy;
- working out detailed programmes for each of the programmes in the plan of action;
- implementing the programmes through their delivery by the health infrastructure and applying sound day-to-day managerial procedures;
- monitoring and evaluating programmes with a view to ensuring that they are proceeding as planned and that the services and institutions concerned are delivering them efficiently and effectively;
- preparing revised programmes as necessary with a view to introducing any modification or improvements recommended as a result of monitoring and evaluation;
- Ensuring the information support required for all the above. Whenever feasible, it is desirable that the managerial process for national health development be decentralized through delegation of authority and resources to intermediate and local administrative levels. A national plan of action is established for the whole county, but also, for example, provincial plans for the provinces and local plans for the local communities. The advantage of such decentralization is that intermediate levels are near enough to the community to respond to its needs and to the central level to put government policies into practice, and communities have greater opportunities for direct involvement. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Monitoring

The continuous follow-up of activities to ensure that they are proceeding according to plan. It keeps track of achievements, staff movements and utilization, supplies and equipment, and the money spent in relation to the resources available, so that if anything goes wrong immediate corrective measures can be taken. The information gained from monitoring is utilized for evaluation. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

National Health Policy

An expression of national goals for improving the health situation, the priorities among those goals, and the main directions for attaining them. A set of decisions to pursue courses of action aimed at achieving defined goals for improving a health situation. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

National policies, strategies and plans of action form a continuum, and there are no sharp dividing lines between them. In might therefore be unwise to specific in attempting to define them, but it is useful to indicate what each might entail. (Formulating strategies for health for all by the year 2000: guiding principles and essential issues. Geneva, World Health Organization, Geneva, 1979)

National Strategy

Based on national health policy, it includes the broad lines of action required in all sectors involved to give effect to that policy. A set of decisions which lays down the broad lines of action required in all the sectors concerned to give effect to the national health policy and indicates the problems and ways of dealing with them. (Health for

NPM IN HEALTHCARE- GLOSSARY

All: WHO Terminology Information System 1997,
www.who.int/terminology/ter/wtd00012.html)

New Public Management (NPM)

Focuses on the modernization of public institutions and on new forms of management and leadership of public administration. New Public Management" (NPM) focuses on the modernization of public institutions and on new forms of management and leadership of public administration. Not only one single NPM-model exists, but many country-specific ones. The German variant of the NPM is the so-called "Neues Steuerungsmodell" (NMS) which especially has been developed for the communal level. In Switzerland and in Austria the corresponding models are called

"Wirkungsorientierte Verwaltungsführung" VoV

New Public Management is an approach that aims to align policy and public administration increasingly with the rules of the management of the private sector. Thereby, the aim is not privatisation, but the fortification of the state. The exceptional aspect of NPM is that its arguments do not emanate from one single reform approach. NPM is rather a symbiosis and a broadening of the previous approaches. Ernst Buschor names ten characteristics that are relevant in NPM:

- Orientation on customers and citizens (Total Quality Management)
- Pressure on cost reduction and efficiency (Lean Production)
- Governance on the basis of effect and not on the basis of input (Budget, Employments)
- Distinction between the strategic (political authority) and the operational (departments) competences

- Distinction between the role of the funding agency (consumer and addressee) and the one of the cost unit of the service.
- Creation of structures that are similar to the ones of combines
- Binding mandates concerning the services for common economical tasks of the supplier
- Competition concerning the internal market, privatisation and the external award of contracts
- An all-embracing audit of the effect and of the norms and standards
- Stimulation of incentives of a nonmonetary nature and stimulation of efficiency pay
- There is no direct bonding from NPM to eGovernment. The initiation of NPM in a certain department does not automatically ask for the implementation of eGovernment and vice versa. Nevertheless, both of these terms mean the modernization and future orientation of the public administration. Thereby it is absolutely possible that they influence each other in a positive sense.

O

Objective

A specific goal of a project, such as generating input for a national health plan, providing a long-term perspective for consideration in the formulation of an essential drugs policy, etc. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

A measurable state that is expected to exist at a predetermined place and time as a result of the application of procedures and resources. Realistically attainable end. Those ends towards which an individual's or an agency's motives are directed; the desired or expected outcomes. The end result a programme seeks to achieve. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

'Objective', 'goal' and 'target' are all defined as a desired end-state sought by a programme or sub-programme. Since there are widespread differences in the ways in which various administrative systems relate these terms to each other - as to which are more general and more specific - this rather gross generalization seems unavoidable, (Schaefer M. Concepts and issues of programme evaluation in environmental health. Geneva, World Health Organization, 1972 - unpublished document DIS/WP/72.2, pp.48)

Opportunity Cost

The opportunity cost of a commodity is the value of the best alternative use to which those resources could have been put, the value of the productive opportunities foregone by the decision to use them in producing that commodity. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Out-of Pocket Costs

Total costs paid directly by consumers for insurance co-payment and deductibles, prescription or over-the-counter drugs, and other services.(Vital Signs, 1999)

Out-of-Pocket Expense

Payments made by an individual for medical services. These may include direct payments to providers as well as payments for deductibles and coinsurance for covered services, for services not covered by the plan, for provider charges in excess of the plan's limits, and for enrollee premium payments. (OTA, 1993)

P

Payment

The allocation of resources (usually money) to health sector organizations and individuals in return for some activity (e.g.: delivering services, managing organizations, etc.) Payment encompasses both funding and remuneration. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Privatization

In Reaganomics, traditional governmental functions were transferred to private owners or contractors on the ground of greater productivity.

Plan of Action

An updatable scheme defining activities for generating a product under a specific programme or a programme component by identifying 'who' does 'what', 'when', 'how' and for 'how much'.(Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html)

Policy

A set of statements and decisions defining priorities and main directions for attaining a goal. (Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html)

Policy-Makers

Individuals, especially those in official bodies, who have the authority to make decisions about what problems will be addressed within a particular sector and how these problems will be handled. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

Population-Based Funding Schemes

A funding scheme whereby money is nominally attached to beneficiaries, so that in a sense, the funds flow only to wherever the beneficiaries are. Capitation is an example of a population-based funding scheme. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Price

What must be given in exchange for something. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Price Index

A measure of the level of prices found by comparing the cost of a certain basket of goods in one year with the cost in a base year. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Programme

An organized aggregate of acitivities directed towards the attainment of defined objectives and targets, which are progressively more specific than the goals to which they contribute.(Health for All: WHO Terminology Information System, www.who.int/terminology/ter/wtd00012.html)

Project

A set of activities structured to generate products of particular significance to one or several programmes over a specific period of time, using various resources. (Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html)

Public goods

Goods and services are supplied by the government because it is not sufficiently profitable for the private sector to do so. This term is also applied to resources that are said not to be diminished by their consumption by any single person.

Public Policy

A set of interrelated decisions taken by public authorities concerning the selection of goals and the means of achieving them.

Public Policy Development

The complex and comprehensive process by which policy issues are identified; the public policy agenda is shaped; issues are researched, analyzed and assessed; policies are drafted and approved; and, once implemented, their impact is assessed. (*Code of Good Practice on Policy Dialogue.* p. 3.)

Public Policy Dialogue

Interaction between governments and non-governmental organizations at the various stages of the policy development process to encourage the exchange of knowledge and experience in order to have the best possible public policies. (*Building Blocks for Tobacco Control: A Handbook.* WHO: France. 2004, pp 68-69. Adapted)

Public Health

Public health is a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. A distinction has been made in the health promotion literature between public health and a new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the determinants of health, and the methods of solving public health problems. This new public health is distinguished by its basis in a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and a recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Quality of Life

The perception by individuals or groups that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfillment. (World Health Organisation HED/HEP. Health Education and Health Promotion in Developing Countries 930506).

R

Re-orienting Health Services

Health services re-orientation is characterized by a more explicit concern for the achievement of population health outcomes in the ways in which the health system is organized and funded. This must lead to a change of attitude and organization of health services, which focuses on the needs of the individual as a whole person, balanced against the needs of population groups. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Reprogramming

Revision of a programme if, on the basis of evaluation, it is found that the programme is not acceptable to the people for whom it is intended, is not proceeding according to plan, or is inefficient. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Resource Management

The most rational use of manpower, knowledge, facilities, and funds to achieve the intended purposes with the greatest effect with the least outlay. The rate at which and the extent to which a health system based on primary health care can be instituted in a country depends on the availability of resources and their employment to the best advantage. In resource management, a distinction has to be made between capital and recurrent cost. (Health for All: WHO Terminology Information System,www.who.int/terminology/ter/wtd00012.html)

Resources

The basic inputs to production - the time and abilities of individuals, raw materials such as land and natural resources (air, water, minerals, etc.) transformations and accumulations of these into capital (facilities, equipment, etc.), and knowledge of

production processes (technologies) (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Result

The direct effect, consequence or outcome of the application of a product. (Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html)

S

Sectoral

Refering to a specific division of some entity, especially within the activities of a government, such as the health sector, the educational sector, the economic sector, the environmental sector, and so on. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

Self-help

In the context of health promotion, actions taken by lay persons (i.e. non health professionals) to mobilize the necessary resources to promote, maintain or restore the health of individuals or communities. Although self help is usually understood to mean action taken by individuals or communities which directly benefit those taking the action, it may also in compass mutual aid between individuals and groups. Self help may also include self care - such as self medication and first aid in the normal social context of people's everyday lives. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Self-reliance

The capacity of an individual, a community, or national authorities to take initiative in assuming responsibility for their own health development, adopting measures that are understood by them and acceptable to them, knowing their own strengths and resources and how to use them, and depending solely on those strengths and resources. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Self-sufficiency

The capacity of an individual, a community, or national authorities to take initiative in assuming responsibility for their own health development, adopting measures that are understood by them and acceptable to them, knowing their own strengths and resources and how to use them, and depending solely on those strengths and resources. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Social Capital

Social capital represents the degree of social cohesion which exists in communities. It refers to the process between people which establish networks, norms, and social trust, and facilitate co-ordination and co-operation for mutual benefit. Social capital is created from the myriad of everyday interactions between people, and is embodied in such structures as civic and religious groups, family membership, informal community networks, and in norms of voluntarism, altruism and trust. The stronger these networks and bonds, the more likely it is that members of a community will co-operate for mutual benefit. In this way social capital creates health, and may enhance the benefits of investment for health. (Health Promotion Glossary. WHO, Geneva, 1998: 5-21. WHO/HPR/HEP/98.1)

Stakeholder

An institution, organization, or group that has some interest in a particular sector or system. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

Strategy

The broad lines of action adopted to give effect to a policy.(Programme Development and Management: WHO Terminology Information System, www.who.int/terminology/ter/pdmfinal.html)

T

Target

An intermediate result towards an objective that a programme seeks to achieve. A target is more specific than an objective and the period within which it is to be attained is usually specified. It also lends itself more readily to being expressed in quantitative terms. (Health for All: WHO Terminology Information System 1997, www.who.int/terminology/ter/wtd00012.html)

Target Audience

The group for which a product is intended (e.g. the target audience of this handbook or the target audience for the results of a project). (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)

Technical Efficiency

Technical efficiency requires that for any given amount of output the amount of input used to produce it is minimized. (Health Sector Reform and Sustainable Financing: a

learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

Trends

Patterns in variables over time, and particularly developments that are likely to have serious implications for a sector. (Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999:

U

Uncertainty

A situation in which an individual has incomplete information as to what is going to happen in the future. Economists sometimes distinguish between risk and uncertainty. Risk refers to a situation in which an individual knows the possible outcomes that will occur and the probability of each outcome occurring. Uncertainty refers to a situation in which the individual is ignorant of all the possible outcomes, the probability associated with known outcomes, or both. Insurance is possible in the presence of risk; it may not be possible under more general uncertainty., The reader should be aware that, in many contexts the two terms are often used interchangeably. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)

V

Validity

One of the characteristics for which surveys, reports, scenarios etc. should be tested during their construction. A valid scenario is one that is logical and internally consistent.(Garrett MJ. Health Futures. A handbook for health professionals. Geneva, World Health Organization, 1999: 289-305. ISBN 92 4 154521 6)289-305. ISBN 92 4 154521 6)

W

Willingness-to-pay

The maximum amount of money that an individual is prepared to give up to ensure that a proposed health care measure is undertaken. (Health Sector Reform and Sustainable Financing: a learning module of the Health Reform Online programme of the World Bank, www.worldbank.org/healthreform/flagship/class/module1/)