



Public Management and the Essential Public Health Functions

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

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1. INTRODUCTION

This paper provides an overview of how various approaches to improving public sector management relate to the so-called core or essential public health functions (EPHFs)¹ such as disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, and health policy development. The purpose of the paper is to summarize key themes in the public management literature and draw lessons for the EPHFs. To this end, we use agency theory (or the principal–agent problem), which examines how a *principal* (e.g., the central government) can ensure that the *agents*² (e.g., local implementation agents) incentives are consistent with assuring the principal's objectives.² Using this approach, we highlight implications for the EPHFs of management reforms which seek to assure effective service delivery by creating incentive structures through mechanisms such as purchaser–provider splits, contracting, provider payment reforms, and decentralization. Section 2 summarizes “new public management” and related approaches. Section 3 reviews traditional approaches to public administration and their relevance to the EPHFs. Section 4 summarizes lessons.

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

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services fall into a middle category of “merit goods” because they have both private *and* public characteristics. Immunization is one example. While immunization has private benefits for the vaccinated individual, it also has public benefits because of its contribution to herd immunity and the protection of others. These distinctions are not purely academic. The market would have few incentives to provide public goods, and would be expected to underprovide merit goods.³ They have major implications on how services should be financed and delivered and are fundamental to our discussion.

The second point relates to the difference between public health *services* and public health *functions*. Some traditional public health services—immunization, STD clinics, TB control, etc.—are merit goods, while others (such as vector control) are public goods. However, the public health functions—policy-making, disease surveillance, population health assessment, health education, etc.—are almost all pure public goods. The service-function distinction is not always made clear in the literature but is of considerable practical relevance when it comes to questions of management and financing. Public health services are often relatively easy to measure, for example, with indicators such as the number of children immunized or the number of TB cases treated. This makes them easier to manage and provides a wider scope for innovations in service delivery compared to public health functions and those services whose public good nature and complexity of measurement pose special challenges. The public health functions are more akin to other “core government functions” such as revenue collection and maintaining law and order, and draw on similar principles for their management.⁴

2. THE NEW PUBLIC MANAGEMENT

Until the early 1980s, the public sector in most countries was monopolistic, centralized, and hierarchical, with an inherent tendency to be inflexible, unresponsive to users and insulated from the private sector and other agencies outside government. With budget crises and the realization of significant inefficiencies in the public sector in the early 1980s, and with the coincident rise in theories such as public choice theory, principal-agent theory, and

transaction cost economics, it was recognized that traditional approaches to public administration were in need of reform. A range of reforms—collectively referred to as the new public management or NPM—rapidly formed a new model of state management. At the heart of these reforms was a shift from government by control to government by contract. This typically involved changes in organizational structure (e.g., moves toward managerial autonomy or corporatization of public entities) and introduction of market processes (e.g., through formal privatization or market-simulating reforms within the public sector, such as purchaser-provider splits and decentralization), and it came to imply a redefinition in the government’s role from that of direct service provider to one of stewardship, oversight, and regulation (Batley, 1999a). The poster-country for these reforms was New Zealand, where sweeping reforms were carried out in the late 1980s—sparing no sector—and which remains the most comprehensive example of an NPM-motivated public sector reform process to date (Bale & Dale, 1998).

The concepts of NPM resonated with health policy specialists and had a major influence on health reforms in the 1980s and 1990s. In most cases, reform efforts made no distinction between curative and preventive services and applied similar prescriptions to both. Some concepts—such as purchaser-provider splits, hospital autonomy, and decentralization in order to increase local managerial autonomy and accountability—were effective and took hold for curative services. The greatest success was reported in industrialized countries with high levels of administrative capacity and political stability, such as Singapore and New Zealand, though developing countries such as Ghana, Zimbabwe, Sri Lanka, and Thailand also attempted them to various degrees (Russell, Bennett, & Mills, 1999). For public health and preventive services, however, impact evaluations—which were not conducted until the late 1990s—revealed a less positive picture. In this section, we examine new public management strategies for public health under three headings: (1) true market reforms, that is, those involving user charges and provider competition; (2) pseudomarket reforms, for example, purchaser-provider splits, contracting and other market-simulating reforms; and (3) decentralization, “the public sector equivalent of privatization” (Bird, Ebel, & Wallich, 1995).

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