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## Chapter 6

# Management and Institutional Reforms

## 1. Background

The New Public Management (NPA) of the 1980s and 1990s sought to redefine the role of the government, from direct service provision alone to include stewardship, oversight and regulation. While NPA's successes and weaknesses are now better understood in the light of experience, it played a useful role in highlighting the importance of effective management of both public and private systems. Managing well is now seen as crucial to successful coordination of multiple resources, diverse people, and complex processes, as well as negotiating with stakeholders to achieve desired policy and program objectives and outcomes.

Assessments of health systems in both high- and lower-income contexts regularly cite poor coordination of resources and dysfunctional management structures and processes as serious constraints. In turn, better management capacity is seen to contribute significantly to effective implementation and achievement of desired goals and results.<sup>1</sup> In India, improved management and better regulation overall would go a considerable way towards meeting the need for synergy and convergence of efforts from both the public and private sectors to ensure Universal Health Coverage (UHC).

While the public health sector needs to be strengthened to assume multiple roles of promoter, provider, contractor, regulator and steward, the role of the private sector also needs to be clearly defined and regulated. At the peripheral level, systemic reforms must ensure effective functioning in the villages and urban local areas. Good referral systems, better transportation, improved management of human resources, supply chains and data, along with

upgraded facilities are essential at the higher levels, especially for secondary care.

## 2. Limitations in Management of Healthcare Delivery

### a) Inadequate Focus on Public Health - Both Preventive and Promotive

Health provision includes a mix of different kinds of economic goods that entail differing incentive structures and behaviour on the part of both providers and clients.<sup>2</sup> These are:

- i. public goods that are non-rivalrous and non-exclusionary, that is, preventive services
- ii. merit goods that have both private and public benefits, like immunization
- iii. private goods including curative services

Public health - preventive and promotive services - falls largely within the ambit of public and merit goods. But, as compared to curative services, public health has not been accorded sufficient importance by policies and programs in India. In part, this could be because private and merit goods are easier to measure and therefore easier to manage. While this is also true for some public goods such as immunization, TB control and vector control, broader public health functions such as policy-making, health surveillance and health awareness are more complex and difficult to measure.<sup>2</sup>

Public funding for health services in India has largely gone to medical services, with policies and strategies giving priority to curative services.<sup>3</sup> Public health services have been neglected, or limited to narrowly defined, single-focus programs. Fiscal

incentives for states to implement such single-focus, centrally sponsored programs may actually have led to the erosion of public health systems more broadly.

The amalgamation of medical and public health services has in many instances decreased career incentives for public health work.<sup>4</sup> There has been no real focus on developing public health leadership and encouraging sub-national levels to train and promote human resources in the area of public health. “Weaknesses lie, inter alia, in workforce planning: projecting future workforce needs and developing strategies for meeting these needs.”<sup>5</sup> In addition, separation of public health engineering from health services and amalgamation of all male grassroots staff have resulted in the elimination of environmental health services.<sup>4</sup>

In the private sector, which is the main player in service provision, incentives are tilted towards curative services and medical education.<sup>3</sup> This sector has few incentives to provide public goods and its interests result in under provision of merit goods.<sup>2</sup>

This focus on provision of curative care, with less or at times negligible emphasis on preventive and promotive care, not only results in poor health outcomes but can also dampen prospects for economic development.<sup>4</sup> The mix of health functions-including preventive, promotive, curative, and rehabilitative services - warrants much more attention and rigorous management processes to avoid over-emphasis of curative care at the expense of preventive and promotive services.

## **b) Lack of Public Health Regulation (including Standard Guidelines) and their Enforcement**

Regulatory and legal frameworks are essential building blocks for strengthening the health system and gearing it towards universal healthcare delivery. Such frameworks deliver by putting in place mechanisms that “reduce exposure to disease through enforcement of sanitary codes, ensure the timely follow up of health hazards, and monitor the quality of medical services

and products (including drugs).”<sup>3,5</sup> The government needs to put in place a set of “laws, administrative rules, and guidelines issued by delegated professional institutes” that are binding on the organisations and individuals that are part of the health system.<sup>3</sup>

The experience of Ministry of Health and Family Welfare (MoHFW) in implementing and monitoring legislation and enforcing regulations has raised some concerns.<sup>5</sup> The Ministry lacks a focal point for public health services, and the lack of a Public Health Act has led to the neglect and erosion of such services.<sup>4</sup>

The Clinical Establishment Act, the National Accreditation Board for Hospitals and Healthcare Providers (NABH) and the Indian Public Health Standards (IPHS)—under National Rural Health Mission—are attempts to define standards for healthcare facilities. However, these compartmentalized initiatives may have led to further fragmentation of an already segmented industry. The problem lies in not having a single, unified system to establish standards (for structures, processes about quality, rationality and costs of care, treatment protocols and ethical behaviour) applicable to both the public and the private sector; and to monitor the functioning of health facilities and compliance with established standards. Such a system is essential for ensuring accountability of these institutions and organisations.

In addition to the inadequacy of the overall regulatory and legal framework, it has been argued that, with regard to the “private health providers and insurers, the Indian government has adopted a laissez-faire policy. The rapid growth of the private sectors-which has occurred in the absence of any kind of public regulation, mandatory registration, regular service evaluations, quality control, or even self-regulation-has raised many concerns, most of which focus on quality of care”.<sup>3,6,7</sup> Ad hoc and piecemeal engagement of private providers by the public sector through widely varying Public Private Partnerships (PPPs) has raised serious concerns about the quality of the services provided, and the ability of the public sector to design and manage PPPs effectively.

### **c) Poor Use of Data and Poor Monitoring and Evaluation (including Performance Monitoring)**

Monitoring and Evaluation (M & E) has been an area of weak performance by the government as accountability has essentially been understood as a matter of enforcing bureaucratic controls.<sup>2,8</sup> The government does collect health profiles of various states, but does not effectively use this information for decision-making. Information quality is not adequately evaluated and there are seldom any audits of information systems. There is poor adherence to data collection protocols which are then rarely reviewed. The inputs and suggestions of the public system's own evaluation unit are not heeded, indicating the superficial nature of this unit and its authorities.<sup>5</sup> In addition, the epidemiological surveillance system is not designed to incorporate the findings and views of external researchers or community level organisations and experts, who often have valuable information and may not have vested interests in the findings. There is a neglect of inputs from the private sector and NGOs even though private providers provide the bulk of ambulatory services in India.<sup>5</sup> Evaluation of health services is done with little emphasis on assessing equity in health provision. There is widespread indifference when it comes to using evaluation records for promoting equitable access or improving outreach activities.<sup>5</sup>

Data collection, compilation and analysis need to be structured in a manner that can enable real-time monitoring, process corrections, evaluation, surveillance and monitoring with clear-cut guidelines on what is to be collected, when and how it is to be collected and who collects, analyses and uses it.

### **d) Inadequate Attention to Quality of Healthcare Services**

In India, the quality of healthcare services provided by both public and private sectors remains largely an unaddressed issue, despite widespread critiques by health researchers and NGOs, and some pilot

work done by UNFPA in a few states, and a more recent attempt by the NHSRC to develop and promote systematic guidelines and manuals. Current policies and processes for healthcare are inadequate to ensure healthcare services of acceptable quality and to prevent negligence or malpractice. "India lacks national or regional structures charged with conducting routine quality assessments."<sup>3</sup>

Systematic health-care quality assessments and controls are desperately needed to overcome major hurdles such as the "under use of key public health services and supply- induced over-utilization of new technologies."<sup>3</sup> A national-level accreditation body needs to be established that can assess facilities based on standard guidelines and protocols for provision of quality care and management of their own resources (human, infrastructure and logistics).

### **e) Poor Personnel Management**

Human Resource Management (HRM) is another neglected area. The "effectiveness of recruitment and retention policies" is seldom evaluated by the MoHFW.<sup>5</sup> Also, there is a near absence of an effective performance management system in the government, with almost no real processes for identifying and harnessing leadership potential. Support for addressing HRM issues at the sub-national level is even weaker.<sup>5</sup> Better defined human resource policies for assessing workforce needs and support for their development are clearly needed. Systematic appraisal of existing human resources, based on the growing needs and demand of the population, is also critical for future planning.<sup>9</sup>

Lack of managerial autonomy is a significant human resource issue affecting performance but conflicting views exist. A study from India reported the opinion of district managers who said more autonomy will help them do their job better, while their superiors felt that they had given enough powers to their managers.<sup>10</sup> Managerial autonomy, especially in personnel matters, favours development of a positive organisational climate and improves performance.<sup>2,11</sup>

Equally important is the fact that performance management systems in India have traditionally focused on inputs rather than concentrating on results and outcomes. In an internal study of the performance management systems implemented by the Indian government, the Second Administrative Reforms Commission says the following on the conventional performance management system in government:

*“Traditionally governance structures in India are characterized by rule-based approaches. The focus of the civil services in India is on process-regulation. With such focus on processes, systems in government are oriented towards input usage - how much resources, staff and facilities are deployed in a scheme, program or project and whether such deployment is in accordance with rules and regulations. The main performance measure thus is the amount of money spent; and the success of the schemes, programs and projects is therefore generally evaluated in terms of the inputs consumed.”<sup>12, 13</sup>*

## **f) Weak Management of Logistics and Supply Chains**

Effective management of logistics and supply chains is an important ingredient of an effective health system. The existing policies and operational procedures for procurement, supply and utilization of drugs, as well as the various medical products and devices are far from streamlined. Details of the various issues are dealt with in the chapter on Access to Medicines, Vaccines, and Technology.

## **g) Overly Centralised Financial Management**

Although a process of growing modernization and computerization of financial management is under way, major challenges remain. Among these, an important one is in the handling of centrally sponsored schemes in which the central government designs the scheme and provides funds (conditional or unconditional) to the states. The central government usually covers a substantial part of the costs initially and the states put in their funds later. Even though these schemes are not

binding on the states, “the fiscal leverage of the large initial central contribution makes them attractive.”<sup>4</sup> Nevertheless, states often do not respond adequately, and the challenges this poses are not minor ones.

## **h) Poor Accountability to Patients and Communities**

Communities and users of health services can report on their experiences with various health services by voicing their opinions and providing public feedback. However, no amount of choice, control or input from the community is useful unless users have reliable and accurate information on the services they are supposed to be monitoring. For example, the Indian government publishes a service charter that promises a set of minimum standards from government service delivery agencies. But no information is provided on what needs to be done if the standards are not being met, thereby giving no real incentive to service providers to perform.<sup>2,14</sup> The existing information-asymmetry problem in health needs to be overcome by putting much more information about services and service providers out in the public domain. The key purpose of disseminating information is to bring about general awareness of expected standards of service delivery and provider performance.

Partnerships between government and NGOs and researchers are critical to the successful evaluation of services at clinical and community level. Often, there is lack of converging evaluation efforts between governmental and non-governmental entities in assessing access and barriers related issues in health services. The health sector is only now waking up to the concept of community co-management of public services, whereas the education sector has long been benefited from such arrangements.<sup>5</sup>

Raising public awareness and building social participation is critical for the success of a public health system. Amongst other things, it builds constituencies and public support for policies and programs, generates compliance with regulations, and helps alter personal health behaviour.<sup>5</sup>

### 3. Management Reforms in the Indian Health Sector - Experiences to Date

Since the start of the economic reforms in the 1990s, there have been various initiatives to reform and support the development of the health sector, both at the centre and in different states. Many of these health-sector reforms at the state level have been influenced by donor agencies.<sup>15</sup> They generally include diverse initiatives to improve the management of the public health system and to support the development of Public-Private Partnerships (PPPs). Efforts to improve management and regulation of the private sector-informal, private or corporate - have been generally much weaker and poorly funded, if at all. The challenges posed to Universal Health Coverage by a largely unregulated private sector, large and small, have been consistently raised by civil society. However, they have received less attention from funding agencies.

The advent of the National Rural Health Mission (NRHM) in 2006 led to a number of experiments in different states aimed at decentralising financial management and raising the autonomy of health providers at sub-state and sub-district levels. Increased availability of untied funds and attempts to engage local communities through various modes of social participation have ranged from the setting up of Rogi Kalyan Samitis in hospitals to attempts at strengthening village level health planning through Village Health and Sanitation Committees, as well as increasing the role of elected panchayats in supporting healthcare provision.

Hospital Development Committees (or societies) have been formed in some states with representation from the local community, and these have been given powers and responsibilities to monitor the functioning of health institutions. These committees have functional autonomy and have been entrusted with rights and responsibilities with the intent to improve the functioning of public hospitals through better management and service delivery to patients.

While these attempts have had mixed success, they have generated a data base of experience on the basis of which reforms can evolve further. It must be noted that many of these reforms have tended to be more effective for curative services and are a less appropriate platform for public health and preventive and promotive services.

One area where there is promise of significant systemic improvement is in the procurement of drugs and medical supplies. The well-documented success of the Tamil Nadu Medical Services Corporation Ltd (TNMSC), which pioneered a system of centralized procurement and supply, is now being emulated in a significant number of states.<sup>16</sup> TNMSC's information technology, enriched procurement and distribution system has been shown not only to improve the matching of demand and supply for drugs and medical supplies, but also to check leakages and corruption. The end result has been increased availability of drugs to patients in the public system. In addition, centralized procurement of generics significantly reduces the cost of drugs that have been a major contributor to cost escalation in healthcare, particularly in the last three decades.

Another area of attempted management reforms has been in relation to the health work-force. Workforce management policies that are intended to improve health service providers' morale and professional satisfaction have been tried in some states. The attempted measures have ranged from educational to regulatory ones.<sup>16</sup> Some relate to retention of the workforce or to high priority or underserved areas through the provision of both monetary and non-monetary incentives and more rational transfer policies.

However, policy measures to improve the working and living conditions of health workers and to rationalize the deployment of personnel have not been a strong part of reforms. Again, the positive Tamil Nadu experience of creating a separate public health cadre leading to improved public health functions, has not (unlike the case of drugs logistics) been followed by other states. Under NRHM, some attempts have been

made to hire consultants to fulfill basic administrative needs, such as accounting and Information Technology (IT), and to reduce the burden of these tasks on medical officers in the PHCs and CHCs. While the presence of these contract employees is generally appreciated by medical officers, they do not yet provide the significant and integrated approach to management that is needed by both public health and health services.

An ongoing, frequently voiced concern of senior health managers is the concern not to create new cadres of permanent health workers who may become difficult to discipline and may have low productivity.<sup>16</sup> Consequently, the NRHM has tended to make new appointments on contractual terms, usually of one to three years duration.

However, excessive reliance on 'hire and fire' threatens to ensure workforce performance belongs to an earlier generation of approaches to worker management. In more recent times, improved systems of performance management and review are starting to be implemented that involve workers in management and focus on quality improvement and incentivisation at both individual and group levels. A change in mindset towards more modern and creative approaches to worker management is clearly needed.

A fourth set of changes relates to drawing the private sector into health provision for the public system. A variety of PPPs have been tried in the last two decades in order to implement improved management methods into the public system by devolving public services to private contractors. While the contracting-out of ancillary services such as laundry, cleaning, food provision, and diagnostic testing have been going on for quite some time, the recent thrust has been to engage the not-for-profit sector as well as profit-making contractors to provide other specific services. Private providers have been drawn in to provide health services, as in the Chiranjeevi scheme in Gujarat and NGOs and charitable trusts have taken up the responsibility of managing and upgrading the infrastructure of some of the public health facilities in seven states (Arunachal Pradesh, Assam, Bihar, Meghalaya, Madhya Pradesh, Odisha and West Bengal).

The effectiveness of many of these partnerships has not been evaluated and their general replicability to address the issue of providing good quality services in hard to reach areas has not yet been proven.<sup>17</sup>

The lessons from many of these partnerships include the need for government health-sector managers to have the capacity to manage private contracts and the ability to effectively define and enforce the obligations of the private sector and NGO providers as well as the government functionary.<sup>18</sup>

A review of various reports by the MoHFW and other stakeholders working in the health arena provides a reasonable understanding of the implementation of the different reforms cited above. However, there is still a paucity of evaluative evidence to present a strong case on the effectiveness of many of these reforms. An in-depth understanding of the mechanism of implementation of these reforms can serve as the scaffolding on which to build the future framework of management reforms in health for India. In the meanwhile, we have drawn from the existing evidence as well as the experiential knowledge of health managers to make the following recommendations.

## **4. Recommendations for Management/Regulatory Reform**

### **Key Assumptions**

The management / regulatory reforms recommended here are premised on the overall assumption that Universal Health Coverage (UHC) will be implemented through a tax-based system, with both public and contracted-in private providers who will be integrated into the system. It will be cashless at the point of service. All patients will get the same services in the UHC system, with smart entitlement cards to facilitate both patient and service monitoring. In integrating both public and contracted-in private providers within a single system, it is necessary to move beyond ad hoc PPPs towards a better-regulated and managed

system through new institutions and systematic capacity building in both sectors to design and manage contracts.

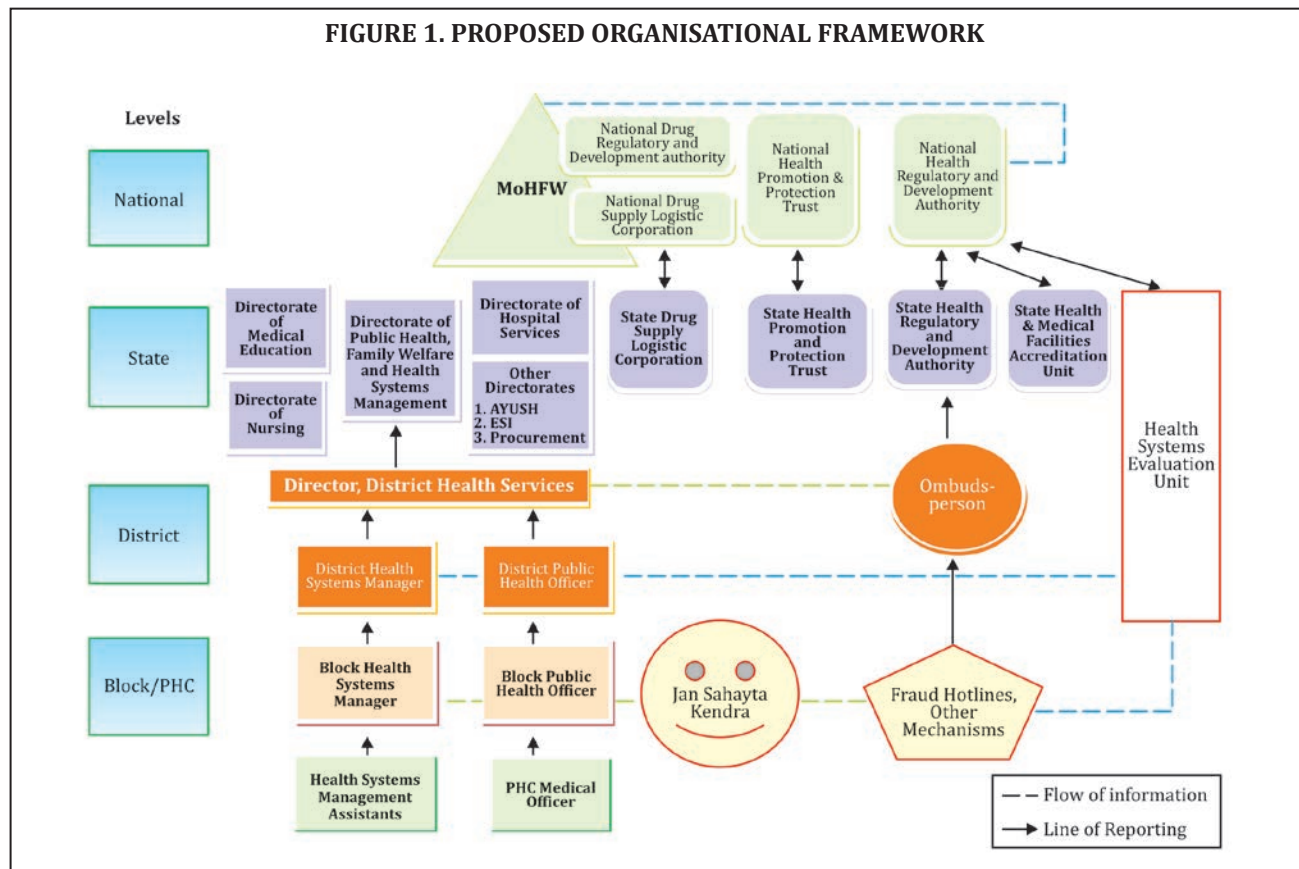
Management and regulatory improvements will therefore be required at the overall system level. In addition, reforms are also being recommended to improve the functioning of both public sector and private health institutions, as well as to smoothly integrate contracted-in private health institutions into the new UHC system. While all the recommendations

below apply to the public sector institutions, some do not apply to either the contracted-in private providers or to the non-UHC private providers. A summary of the scope of the recommendations is given in the following table.

The following diagram gives a snapshot view of the recommended organisational framework and the placement of the National Health Regulatory and Development Authority, HSEU along with other bodies described in later recommendations.

TABLE 1. SUMMARY OF THE SCOPE OF THE MANAGEMENT/REGULATION RECOMMENDATIONS				
		Public Sector	UHC Private Sector	Non-UHC Private Sector
1.	National Health Regulatory and Development Authority (NHRDA)	√	√	√
a)	System Support Unit (SSU)	√	√	√
b)	National Health and Medical Facilities Accreditation Unit (NHMFAU)	√	√	√
c)	Health System Evaluation Unit (HSEU)	√	√	√
2.	National Health Promotion and Protection Trust (NHPPT)	√	√	√
3.	Health System portal	√	√	√
4.	Drugs and Medical devices Regulatory and Development Authorities	√	√	√
5.	Accountability to patients / community	√	√	√
6.	Health Systems Management and Public Health cadres	√	No	No
7.	Performance Management	√	No	No
8.	Drugs Supply Logistics Corporations	√	Can opt in	No

**FIGURE 1. PROPOSED ORGANISATIONAL FRAMEWORK**



**Recommendation 1:** Establish a National Health Regulatory and Development Authority (NHRDA) statutorily empowered to regulate and monitor / audit both the public and the private sectors, and ensure enforcement and redressal.

The NHRDA will be linked to the Ministry of Health and Family Welfare (independent, similar to the Office of Governor, RBI vis a vis the Ministry of Finance) and will have strong statutory powers to regulate, monitor/ audit and ensure enforcement and redress for all providers. This authority will be supported at the state level by State Health Regulatory and Development Authorities (SHRDAs) with corresponding powers. The entry of states into the UHC system will be predicated on their setting up SHRDAs with powers determined uniformly across all states.

This regulatory and development body will be responsible, inter alia, for:

- i. overseeing and enforcing contracts for public and

- private providers in the UHC system accreditation of all health providers
- ii. formulation of Legal and Regulatory norms for facilities, staff, scope, access, quality and rationality of services, and costs of care with clear norms for payment
- iii. standard treatment guidelines and management protocols for the for the National Health Package so as to control entry, quality, quantity, and price
- iv. development and enforcement of patients' charter of rights including ethical standards and institutions of a grievance redressal mechanism
- v. evolving and ensuring adherence to standard protocols for treatment with involvement of professional organisations
- vi. establishing and ensuring a system of regular audit of prescriptions and in-patient records, death audit and other peer review processes



The following three Units are envisioned under the NHRDA:

- i. **The System Support Unit (SSU):** This Unit should be made responsible for developing standard treatment guidelines, management protocols, and quality assurance methods for the UHC system. It should also be responsible for developing the legal, financial and regulatory norms as well as the Management Information System (MIS) for the UHC system.
- ii. **The National Health and Medical Facilities Accreditation Unit (NHMFAU):** This Unit should be responsible for the mandatory accreditation of all allopathic and AYUSH healthcare providers in both public and private sectors as well as for all health and medical facilities. This accreditation facility housed within the NHRDA will define standards for healthcare facilities and help them adopt and use management technologies. A key function of this Unit will be to ensure meaningful use of allocated resources and special focus should be given to information technology resources. There should be corresponding state-level data consortium and accreditation agencies (State Facilities Accreditation Unit) under the National FAU to oversee the operations and administrative protocols of healthcare facilities.
- iii. **The Health System Evaluation Unit (HSEU):** This monitoring and evaluation unit should be responsible for independently evaluating the performance of both public and private health services at all levels – after establishing systems to get real time data for performance monitoring of inputs, outputs and outcomes.

The diagram below illustrates the division of functions and responsibilities of the three Units under the NHRDA.

The offices of ombudspersons at multiple levels, supported by an investigative staff and with statutory (including suo motu) powers, will constitute the

outreach arm of these regulatory bodies. Fraud hotlines and other mechanisms will be set up to enable the community to reach out to these offices. Community participation mechanisms, such as Jan Sahayata Kendras, that will link citizens/users with these structures, are contained in the recommendations of the Chapter on Community Participation and Citizen Engagement.

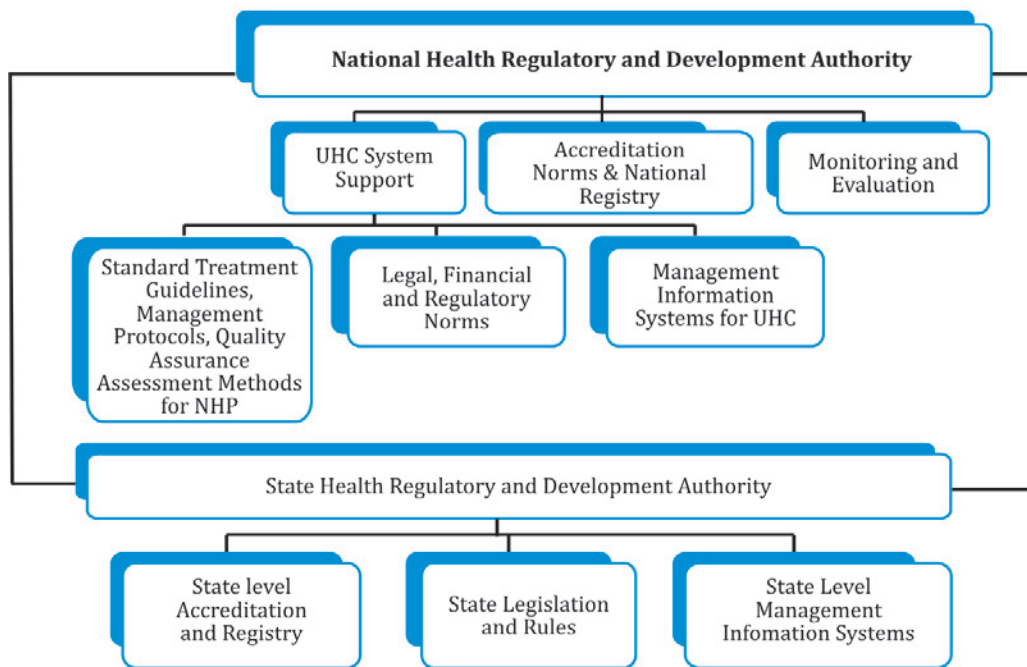
## Rationale

Regulation of the public and the private sector to ensure provision of assured quality control, scope and pricing of services is an essential management reform in the context of UHC. A structured regulatory framework that can monitor and enforce essential healthcare regulations to control entry, quality, quantity and price is necessary. Saltman and Busse (2002) posited health-sector regulation as fulfilling two different purposes, historically driven policy objectives versus managerial mechanisms.<sup>19</sup> While regulatory activity deriving from broad social and economic policy objectives tends to be normative and value-driven in nature, such value-driven decisions tend to change relatively rarely, usually as a consequence of major historical events, such as wars, the end of dictatorships, or political revolutions. The emergence of the National Health Service in the United Kingdom and similar systems in Spain and Portugal, or, of the Unified Health System (SUS) in Brazil after the fall of dictatorships, are some examples. Such changes make it possible to put in place a broad umbrella of values and goals for regulation overall.

The second type of regulatory activity is concerned with the specific regulatory mechanisms through which decision-makers seek to attain different types of policy objectives. These management mechanisms are technical and focus on micro-level activities at the level of the sub-sector, facility or institution.

Bennett et al (1994) provide a framework of healthcare regulation identifying various mechanisms, for example, entry to market, quality and safety, quantity and distribution, price, public information

**FIGURE 2. NATIONAL AND STATE HEALTH REGULATORY AND DEVELOPMENT AUTHORITIES**



and advertising, through which regulators attempt to fulfill health policy objectives.<sup>20</sup> Teerawattananon and colleagues later adapted this framework to describe health sector regulation in Thailand.<sup>21</sup>

What is clear from the different approaches to regulation cited above is that regulatory systems in health can be highly complex and that care must be taken to mesh policy goals and objectives to institutional mechanisms.

**Recommendation 2:** Mandate the accreditation of all healthcare providers (public and private, allopathic and AYUSH), and registration of all clinical establishments by the National Health and Medical Facilities Accreditation Unit (NHMFAU) of the NHRDA.

All public and private health providers must be accredited by a special unit, the National Health and Medical Facilities Accreditation Unit (NHMFAU), part of the National and State Health Regulatory and Development Authorities. All clinical establishments

must be registered under the Clinical Establishments Act. Accreditation—based on benchmarks and standards for quality of services, performance, facilities, infrastructure, manpower, machines and equipment and drugs—will be mandatory for all providers.

The NHMFAU will be mandated to do the following:

- Define standards for healthcare facilities to qualify for different levels of the healthcare pyramid. Healthcare facilities will be required to receive NHMFAU accreditation every three years and will receive a score on how well they meet the required standards. The score will provide each healthcare facility with an objective score of performance and comparison to peer facilities. There will also be a process to adjust the health entitlement packages as per the needs assessed by structured review of patient volumes and disease burden.
- Provide implementation support to healthcare providers to help them adopt, implement, and use certified Health Systems Management

**TABLE 2. HEALTH SECTOR MANAGEMENT MECHANISMS**

**Regulating quality and effectiveness:** assessing cost-effectiveness of clinical interventions; training health professionals; accrediting providers

**Regulating patient access:** gate-keeping; co-payments; general practitioner lists; rules for subscriber choice among third-party payers; tax policy; tax subsidies

**Regulating provider behaviour:** transforming hospitals into public firms; regulating capital borrowing by hospitals; rationalizing hospital and primary care/home care interactions

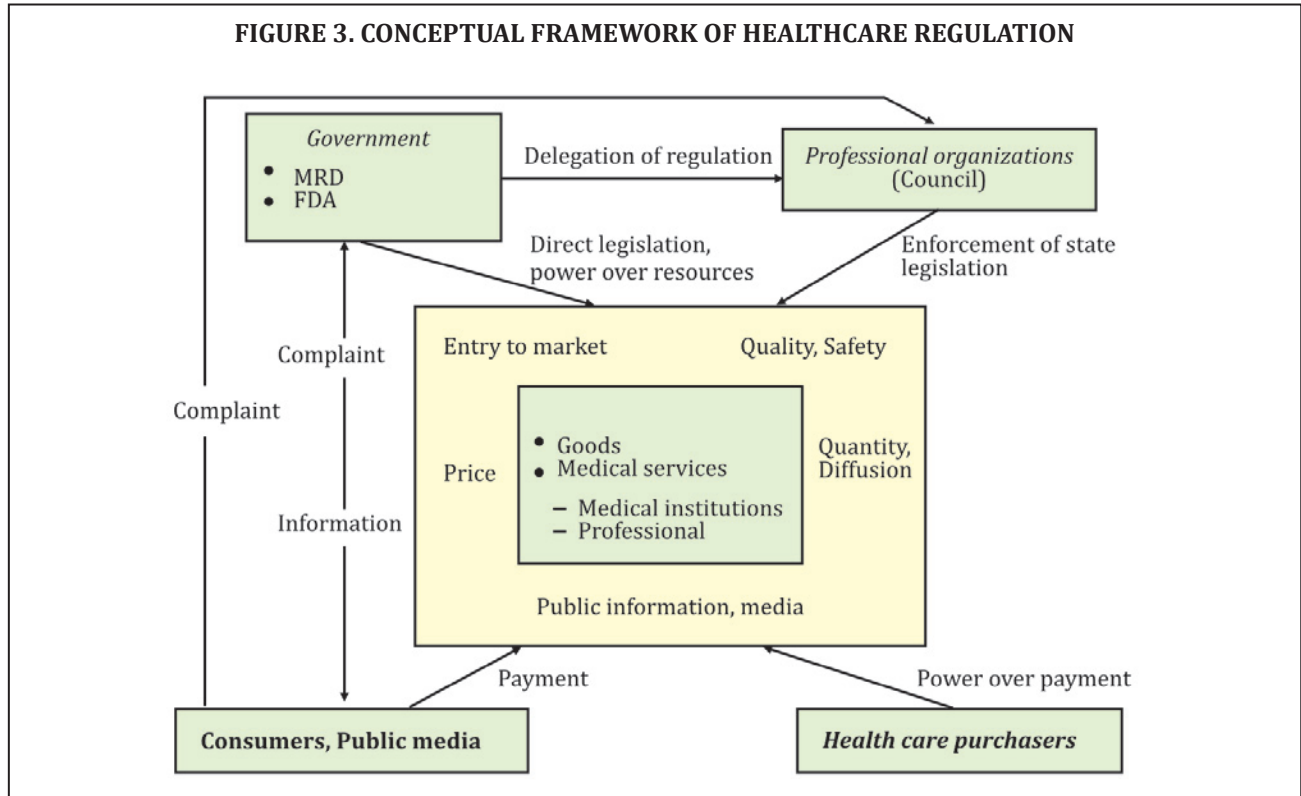
**Regulating payers:** setting rules for contracting; constructing planned markets for hospital services; developing prices for public-sector healthcare services; introducing case-based provider payment systems (e.g. diagnostic-related groups); regulating reserve requirements and capital investment patterns of private insurance companies; retrospective risk-based adjustment of sickness fund revenues

**Regulating pharmaceuticals:** generic substitution; reference prices; profit controls; basket-based pricing; positive and negative lists

**Regulating physicians:** setting salary and reimbursement levels; licensing requirements; setting malpractice insurance coverage

Source: Saltman and Busse (2002)<sup>19</sup>

**FIGURE 3. CONCEPTUAL FRAMEWORK OF HEALTHCARE REGULATION**



Source: Bennett et al (1994)<sup>20</sup>

(HSM) technology. NHMFAU will gather data and conduct research to identify best practices on implementations of certified health systems management technologies and provide templates for effective use to healthcare facilities.

- Establish criteria and a process to certify vendor HSM technology that can support meaningful use criteria. NHMFAU will work on defining a process for vendor certification, according to meaningful use criteria, and the vendor products for their applicability to diseases of national priorities.

## Rationale

A robust system of accreditation and certification will be essential to address the inherent problem of information asymmetry in the health sector, the growing complexity that comes with the development and implementation of technology and finally, the major health problems that India faces today, including the co-existence of infectious and non-communicable diseases and the mix of multiple public and private providers. Such a system will have to be IT-enabled so that technology can be harnessed to ensure quality and accountability.

**Recommendation 3:** Establish a system to independently evaluate the performance of both public and private health services.

The recommended Health System Evaluation Unit (HSEU) is envisaged as an autonomous body, set up under the National and State Health Regulatory and Development Authorities, whose specific objective is to evaluate and guide the delivery by the health system at all levels of both the public and the private sector. This performance monitoring will use several methods including systematic data collection of healthcare delivery components (including preventive and promotive services) through predetermined indicators. Establishment of feed-back loops would support use of this data for evidence-based planning.

Other methods include innovative IT solutions that will help monitor the quality of healthcare delivery

on a routine basis. The HSEU will use technology (IT platforms are detailed further in Recommendation 4 below) for data capture, processing, storage, reporting and analysis. The data will be collected on an ongoing basis and random checks will be performed as well. The aim is to evaluate the content and quality of the delivery of public and private healthcare systems. The main sources, required for an integrated evaluation system include inter alia the collection of information on the status - scope, quality, access, effectiveness and responsiveness - of healthcare delivery (both public and private healthcare providers), proper functioning of diagnostic services, specific surveys related to Quality of Care (QoC) and financial monitoring. Relevant analysis from project and policy evaluation will highlight the outcomes of previous interventions, and the strengths and weaknesses of their implementation. This may be used to improve both the design and functioning of the existing system.

The HSEU will have operational units at the peripheral (block), district and the state levels with connections to the central observatory, the National Health Regulatory Development Authority (NHRDA). The HSEU units will be staffed by public health specialists and data management experts and will draw on external expertise as well as youth or older volunteers who can support the gathering of data and evidence. Each unit at the block and district levels would work in close partnership with civil society partners and community support mechanisms as well as the local ombudsmen of the State Health Regulatory and Development Authority (SHRDA). Such participatory engagements with the community will help foster local ownership.

The HSEU will be set up as an integrated, functionally responsive system at different levels rather than as a single hierarchical unit. Decentralization of the decision-making process will ensure timely and effective response to evidence needs and opportunities. In the context of decentralization and health sector reform, demands for monitoring the performance of the health sector necessitate clarity on planned targets and measurement of results. These

processes require explicit standards for measuring performance, clear specifications of the relationship between inputs and outputs, and use of valid indicators to compare actual achievements with planned targets and outcomes.

One of the main challenges for the HSEU system will be institutionalizing the process so that it reaches all levels, the center, state and periphery. The other challenge will be to ensure participatory engagement by multiple stakeholders and convergence with other relevant sectors such as nutrition, water and sanitation.

## Rationale

A system for continuous evaluation needs to be set in place to inform managers, decision-makers and policy makers on the links between inputs, outputs and outcomes of health services and programs. Currently, program evaluations in the public health sector are stand-alone, not independent of program or service implementers, and rarely based on outcomes. The proposed HSEU is envisaged to fill this gap. HSEU will provide a basis for accountability in the use of development resources. Commitment, ownership as well as capacity building of the HSEU are important for a robust, efficient and effective health system.

**Recommendation 4:** Establish a National Health Promotion and Protection Trust (NHPPT) to play a catalytic role in facilitating the promotion of better health culture amongst the people, the health providers and the policy-makers.

This will be an autonomous entity at the national level with chapters in the states and will draw upon the strengths and experiences of similar efforts nationally and internationally. The NHPPT would be responsible for:

- Facilitating the promotion of a culture of good health among citizens, providers of health services and care in the public and private sector, policymakers and opinion leaders, the media and stakeholders in health. This would be brought about by providing funding and technical support for new, continuing, and additional projects on the Social Determinants of Health (SDH) with key collaborators and stakeholders; and by developing policies and institutional frameworks that serve to act on SDH and promote good health through policies on tobacco usage, alcohol and processed food by drawing on local context and examples from international best practices.
- Dissemination of health information on a variety of issues and diseases from the policy arena, research projects, civil society initiatives and other sources. This would also include information on the health system and accountability mechanisms via linkages with the HSEU and the National and State Health Regulatory and Development Authorities. Dissemination would also occur through the Jan Sahayta Kendras and health assemblies (see chapter on Community Participation and Citizen Engagement), and health promotion events at the grassroots level, by a variety of means including interpersonal communications, group and community outreach and mass communications, as appropriate. The idea of a television channel dedicated to health (akin to the Lok Sabha channel) may also be considered at the national and/or state level. Dissemination would include information to the public about new health products, healthy behaviours, relevant health promoting entitlements policies, as well as warnings against harmful products and behaviours, and policies. Health information will be made available in natural and human-made disasters and other emergency situations.
- Examining the health implications of other sectors including health impact assessments, thereby creating enabling environments for health. The details are discussed under the recommendations on Social Determinants of Health (SDH).
- Collaboration with international partners on information-sharing related to SDH to ensure that the best practices, policies, and lessons from the global context are appropriately disseminated to Indian policymakers, practitioners and the public.

## Rationale

The focus of health services in both the public and private sector has been on curative care with less or at times negligible emphasis on preventive and promotive care. Apart from provisioning all aspects of care, it is the responsibility of the public health authorities “to anticipate, monitor and avert health threats of all kinds.” In other countries, specific agencies address issues as such occupational health and environmental health in the United States and most European countries have agencies to monitor water supply, solid waste and sewage disposal, housing, food supply and others that may impact health.<sup>4</sup>

We believe that a beginning needs to be made in this direction through the establishment of a Health Promotion Trust that can facilitate and catalyze public awareness about key Social Determinants of Health, provide technical and expert advice to the ministry of health. It will also conduct key assessments and disseminate knowledge about the impacts of non-health sectors and policies on the health of people.

**Recommendation 5:** Establish a Health System portal to strengthen the use of information technology for better performance by both public and private sectors.

Information technology will be used as a major enabler for performance management including financial management through real time data flow to the HSEU, and through entitlement cards that will capture patient history and treatment. This will ensure full tracking of patients, portability of information, and lead to the creation of a central database with state wings, which in turn will provide information relevant for management of the health system such as health facility utilization rates. The system must guarantee data protection and patient privacy and ensure that ethical considerations in data collection, analysis and use are built in and enforced.

It will also be the backbone for other management innovations such as the use of electronic banking for financial management, the functioning of the HSEU

and the NHRDAs and SHRDAs. IT-based monitoring systems for real time tracking of services like the use of entitlement cards by the patients and use of e-banking for transfer of funds will be applicable to both the public sector and the “contracted in” private sector as a measure of management control. In addition, the various regulatory bodies will also use IT-enabled systems to ensure that non-UHC private providers comply with regulatory requirements.

The institutional home for IT in the health system will be NHMFAU (mentioned previously in Recommendation 2), which will also do the following:

- Oversee adoption of health information systems and define standards of meaningful use of resources and health management systems infrastructure. NHMFAU will promote use of health systems management information systems and will define stages of meaningful use with stages organized over time. Stage I, meaningful use, will cover one to two years after introduction of health management information systems, Stage II will cover two to five years after introduction and Stage III will cover criteria after five years of introduction of health information management systems. Monitoring protocols and surveillance protocols will be developed and implemented. NHMFAU will oversee use of health systems management portal and its meaningful use.
- Oversee information documentation, use and exchange between healthcare centers. NHMFAU will develop a Standards and Interoperability framework (S&I framework) to harmonize existing standards and improve sharing of standards across different organisations and federal agencies, making it easier to broaden interoperability through shared standards for data and services.
- Ensure clinical interoperability of information to enable seamless transition of patient data between healthcare facilities. Best practices will be defined and disseminated to ensure optimal use of NHEC.
- Define and promote standards of patient privacy and ethical use of patient data. NHMFAU will

develop an accreditation process, standards and monitoring protocol to ensure patient privacy and ethical use.

- Ensure that allied agencies can send and receive information from healthcare facilities. NHMFAU will develop procedures to monitor exchange of information with public health agencies, research organisations, regulatory authorities and educational institutes.
- Work to enable information analysis, coordination of healthcare strategies and work towards real-time epidemiology. NHMFAU will serve as a regional information exchange hub to allow for epidemiological analysis and real-time surveillance services.
- Promote and document healthcare innovations in healthcare facilities. NHMFAU will be mandated to document innovations in the healthcare delivery seen in different healthcare facilities and develop a national database of healthcare innovations within the healthcare systems. NHMFAU will also conduct surveys of technology innovations in their area and exchange this information with other NHMFAU facilities.

## Rationale

The use of IT is essential for effective management of the evolving UHC system. Given that the system is intended to cater to the needs of a billion people, and will have to navigate the complexities of a federal governance structure, multiple health systems, and a combination of public and private providers, effective use of IT is an absolute requirement to ensuring that the system is able to meet people's current and growing and changing needs. While the system cannot be introduced in one go, it will have to grow and evolve as the UHC itself evolves. A commitment to using IT and building up the capacity of the health system to use it well has to be made at the highest level.

**Recommendation 6:** Strengthen the Drugs and Medical Devices Regulatory Authority and expand its scope to include the Development function so as to better regulate the pharmaceuticals and medical devices sector.

This national level body will be responsible for providing a regulatory framework for the development, production, import, export, and use of pharmaceuticals and medical devices. Details are discussed under the recommendations in the chapter on Access to Medicines, Vaccines and Technology.

**Recommendation 7:** Engage the private sector for provision of healthcare through a well-defined "contracting in" mechanism, so as to harness the power of the formal private sector but with adequate checks and balances.

A well-defined "contracting in" mechanism is a pathway through which private-sector contributions may be effectively engaged for progress on universal coverage. "Contracting is a purchasing mechanism used to acquire a specified service, of a defined quality and quantity, at an agreed on price, from a specific provider, for a specified period."<sup>22</sup>

A stronger partnership between the government as a purchaser and the private sector as a provider would be the guiding principle for these public-private partnerships. Private providers being contracted-in for UHC would have to ensure that at least 75 percent of outpatient care and 50 percent of in-patient services are offered to citizens. These providers will be reimbursed at standard rates as per levels of services offered, and the NHRDA/SHRDAs would provide the strong regulatory framework and oversight necessary to supervise the contracted-in private sector. Accreditation through NHMFAU would ensure quality of care, rational interventions and medications, safeguarding of patients' rights and ethical practices. The Health System Evaluation Unit, along with its strong linkages to community monitoring through the office of the ombudsperson, would assess how

various inputs are deployed by the provider and track both immediate as well as longer-term outcomes. More details and the rationale are discussed under the recommendations in the chapter on Health Financing and Financial Protection.

**Recommendation 8:** Ensure strong linkages and synergies between management / regulatory reforms and accountability to patients and communities through systematic and institutionalized efforts.

The interface between the recommendations in this chapter and in the chapter on Community Participation and Citizen Engagement must be institutionalized through the establishment of strong links between the Jan Sahayata Kendras (detailed in the chapter on Community Participation and Citizen Engagement), and the hotlines and offices of health ombudspersons in the NHRDAs and SHRDAs. These must be clearly worked out, adequately funded and well resourced. They must also be linked to the HSEU's ongoing monitoring and evaluation mandate in order to ensure that community experiences are effectively reflected in the HSEU's monitoring and evaluation work and thereby in design changes and improvements.

## Rationale

There is increasing awareness in the government of the need for community involvement not only to ensure voice and accountability to citizens but also to improve the performance of public systems and delivery of services. Under NRHM, there have been laudable attempts to strengthen community participation in planning and monitoring of health service provision.

Nonetheless, one of the unresolved challenges is that community involvement often is disconnected from the rest of the system, with the feedback loops remaining weak or non-existent.

We propose filling this gap by linking citizen voice and redressal mechanisms to the accountability mechanisms being built in through the national and state regulatory authorities.



**Recommendation 9:** Introduce a specialized state level Health Systems Management Cadre and All India and state level Public Health Service Cadres in order to strengthen the management of the UHC system and also give greater attention to public health.

The setting up of separate Health Systems Management (HSM) and Public Health cadres that are well integrated with other departments and functionaries is recommended to address both the management and public health related inadequacies in the present system and to incorporate principles of professional management into decision-making in health institutions. This will give a strong thrust to the public health function-the preventive and promotive aspects of health-while also strengthening management.



The qualifications and experience of these proposed cadres have to be thought through carefully to determine appropriate levels so that they will mesh smoothly with the existing medical professionals. At the lower levels, these cadres will have a background in health management and / or public health, while at higher levels, they will have experience and credentials in both. The proposed cadre structure is as follows:



PROPOSED HEALTH SYSTEMS MANAGEMENT CADRE						
Level	Designation	Career Pathway	Qualifying Criteria	Reporting to	Functions	Remarks
Primary Health Center	Health System Management Assistants	↓	Bachelor's Degree in Management	Block Health Systems Manager	<ul style="list-style-type: none"> <li>• HR</li> <li>• IT</li> <li>• Finance</li> </ul> Work in coordination with the Medical Officer (PHC)	Lateral entry possible for peripheral health workers/ paramedical staff fulfilling qualifying criteria
Block (Block Program Management Unit)	Block Health Systems Manager		Master's in Business Administration (MBA) with specialization in Health Management plus work experience (for defined time period)	District Health Systems Manager	<ul style="list-style-type: none"> <li>• HR</li> <li>• IT</li> <li>• Finance</li> <li>• Community participation,</li> <li>• Quality assurance</li> <li>• PPP functions</li> </ul> Work in coordination with Block Public Health Officer	Lateral entry possible for medical officers; AYUSH/ nursing / BRHC professionals fulfilling qualifying criteria
District (District Program Management Unit)	District Health Systems Manager		Master's in Public Health plus work experience (for defined time period)	Director, District Health Services	<ul style="list-style-type: none"> <li>• HR</li> <li>• IT</li> <li>• Finance</li> <li>• Community participation</li> <li>• Quality assurance</li> <li>• PPP functions</li> <li>• Planning</li> <li>• Procurement and logistics management</li> </ul> Work in coordination with District Public Health Officer	

PROPOSED HEALTH SYSTEMS MANAGEMENT CADRE						
	Director, District Health Services		Work experience (for defined time period) as District Public Health Officer/ District Health Systems Manager	Director, Public Health, Family Welfare and Health Systems Management	Supervision of all services <ul style="list-style-type: none"> <li>• Preventive</li> <li>• Promotive</li> <li>• National Health Programs</li> <li>• Curative (at District Hospital / Sub-district Hospital / CHC/ PHC level)</li> <li>• Trainings</li> </ul>	Overall in- charge for the district. Will supervise the curative, public health, management services and the District Health Knowledge Institute
State (Directorate of Public Health, Family Welfare and Health Systems Management)	Deputy Directors, Joint Directors, Directors		Work experience (for defined time period) as District Health Systems Manager / District Public Health Officer/ Director, District Health Services			

PROPOSED PUBLIC HEALTH CADRE						
Level	Designation	Career Pathway	Qualifying Criteria	Reporting to	Functions	Remarks
Primary Health Center (PHC)	Medical Officer	↓	MBBS, Induction training	Block Public Health Officer	<ul style="list-style-type: none"> <li>Preventive</li> <li>Curative</li> <li>Promotive</li> </ul> Work in coordination with the Health System Management Assistants	
Community Health Center (CHC)	Medical Officer		Block Public Health Officer	<ul style="list-style-type: none"> <li>Preventive</li> <li>Curative</li> <li>Promotive</li> </ul> Work in coordination with the Block Health Systems Manager	Medical Officers from CHC may follow the curative services pathway and move to sub-district/district hospitals	
Block	Block Public Health Officer		<ul style="list-style-type: none"> <li>Preventive</li> <li>Promotive</li> <li>Supervision of curative services (at CHC/PHC level)</li> </ul> Work in coordination with the Block Health Systems Manager	Lateral entry possible for qualified public health professionals with experience (AYUSH / nursing / BRHC / Epidemiologists etc.)		
District	District Public Health Officer		Supervision of all services <ul style="list-style-type: none"> <li>Preventive</li> <li>Promotive</li> <li>National Health Programs</li> <li>Curative (at CHC/PHC level)</li> </ul> Work in coordination with the District Health Systems Manager			

PROPOSED PUBLIC HEALTH CADRE						
	Director, District Health Services		Work experience (for defined time period) as District Public Health Officer/ District Health Systems Manager	Director, Public Health, Family Welfare and Health Systems Management	Supervision of all services <ul style="list-style-type: none"> <li>• Preventive</li> <li>• Promotive</li> <li>• National Health Programs</li> <li>• Curative (at District Hospital/ Sub-district Hospital/CHC/ PHC level)</li> <li>• Trainings</li> </ul>	Overall in-charge for the district. Will supervise the curative, public health, management services and the District Health Knowledge Institute
State (Directorate of Public Health, Family Welfare and Health Systems Management)	Deputy Directors, Joint Directors, Directors		Work experience (for defined time period) as District Health Systems Manager / District Public Health Officer/ Director, District Health Services			

The Health Systems Management Cadre will be responsible both for improving the management of institutions as well as working with the Public Health Cadre to strengthen the public health functions. Health Systems managers will be expected to provide significant management inputs for managing public sector service provision as well as the contracted-in private sector. (Oversight of these contracts would rest with the N/SHRDAs but their day to day management would be with the Health Systems managers).

A major function of the HSM cadre will be to improve the quality of the functioning of health institutions by applying modern management methods in all areas. This will be especially important in the areas of facilities and service quality improvement. They will be responsible for implementing quality assessment, improvement and quality assurance for public sector health institutions, assisting them at district and sub-district levels to achieve quality certification and accreditation and to sustain these once achieved. These functions would thus improve accountability in the system and move towards more timely and effective responses to the needs of the beneficiaries of public health services. In addition, the cadre would take over much of the managerial functions that are currently over-burdening medical personnel in areas such as IT, finance, HR, planning and communication. The appointment of appropriately trained hospital managers at sub-district, district hospitals and medical college hospitals would improve the managerial efficiency and also enable medical officers and specialists to concentrate on clinical activities.

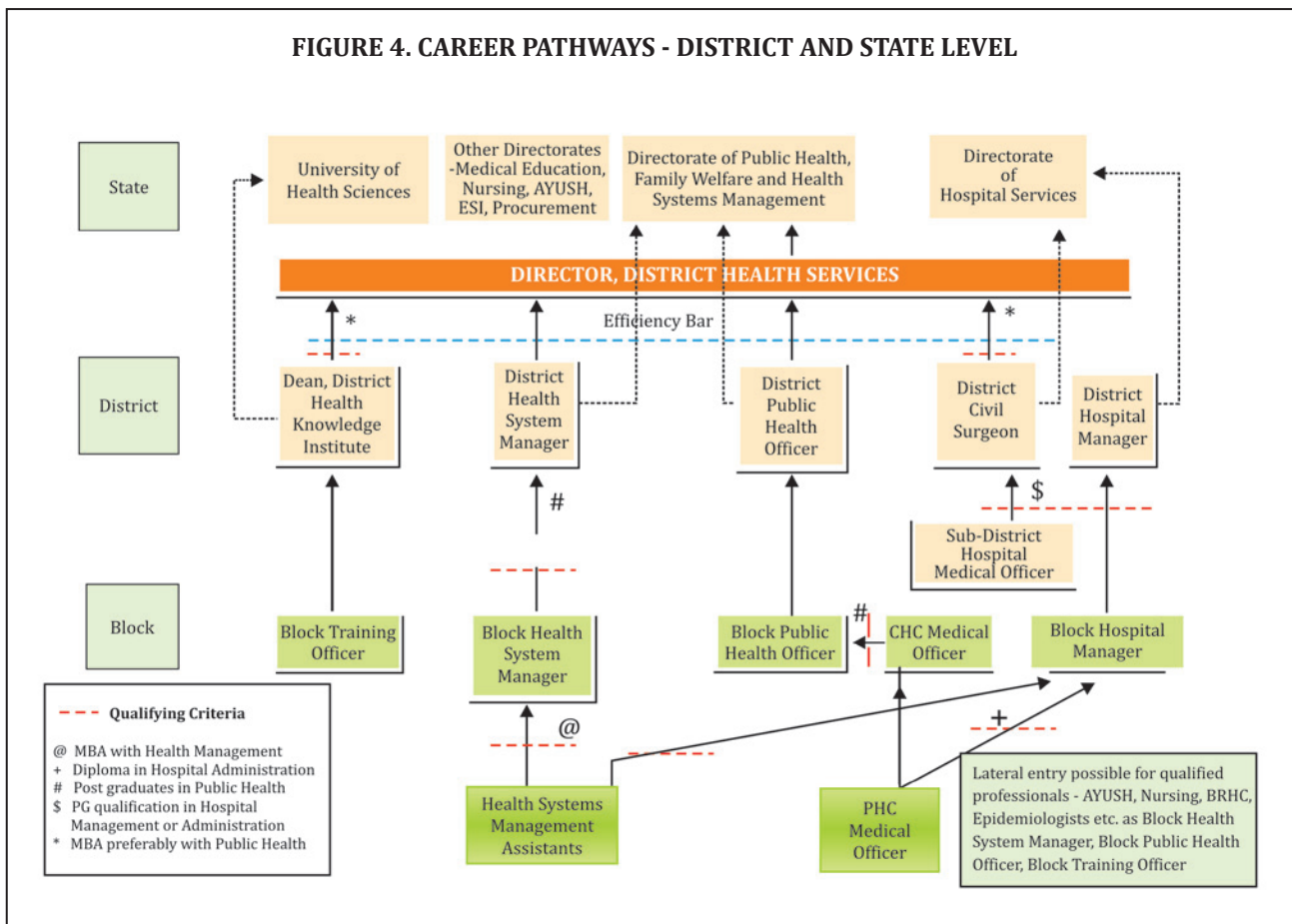
The responsibility for implementing public health functions would rest primarily with the All India

Public Health Service Cadre starting at the block and going up to the state and national level. The Block Public Health Officer would be in-charge at the block level and will supervise the preventive, promotive and curative services at the PHC and CHC levels. The medical officers at these facilities would report to him. Public health function at the lower level would be conducted jointly by the health service providers at the sub-centers and PHCs, together with the Health System Management Assistants. The latter would also obtain some public health experience in this way. This cadre will be an All India cadre. The medical officers will be recruited at the State level and following a fixed duration of service within the state, will be eligible for all India transfers.

The Director, District Health Services will be the overall in-charge for the district. His role will be critical to effectively supervising the curative, public health, management functions and the District Health Knowledge Institute in the district. At the state level, there will be a separate Directorate of Public Health, Family Welfare and Health Systems Management (DPH/FW/HSM) in addition to the Directorate of Hospital Services, Medical Education and others. The role of this Directorate (DPH/FW/HSM) would be to recruit, support and oversee the management of the health system, implement performance improvement measures and strengthen public health services. It would be staffed by professionally trained health system managers and public health professionals who are promoted to the Directorate after a number of years of experience of planning, management and oversight of public health services at lower levels in both rural and urban areas.

Figure 4 presents an illustrative management structure showing the different strands of health professionals that could evolve at different levels of the healthcare delivery system. The organogram also

shows the career paths for different cadres of health professionals with options both for promotion as well as shifting streams for advancement of careers.



### Rationale

Since the early years following the establishment of the three-tier health service provision system within the public sector, concerns have been raised about its quality, scope and reach. The UHC is to be built upon a unified system including both public and private providers, but in order for the public-sector institutions to be able to hold up their end, there will have to be a serious, concerted attempt to improve their performance in a variety of ways.

Two major gaps currently exist in this regard - inadequate attention to the preventive and promotive aspects of health (the public health function), and weak management brought on by loading managerial functions onto medical officers from the PHC level upwards, who have almost never received management training or credentialing. While the spine of the health services in the states will always be the medical professionals within it, it is essential to fill both these gaps in creative and innovative ways drawing on the growing availability of people with management credentials and experience as well as with public health degrees (although in smaller numbers). Tamil Nadu

state has made significant advances in this regard by passing a Public Health Act, and providing incentives and career pathways as well as providing higher level leadership in public health. There is considerable evidence to suggest that, as a strategy, this has had significant payoffs in terms of improved public health.<sup>23</sup> However, although Tamil Nadu has been able to go a considerable distance in improving public health, its performance could probably improve significantly by systematic incorporation of modern management methods for handling human resources and logistics, strengthening quality assurance, further integration of IT, and strategic and medium term planning. The creation of a separate program management unit at the block, district and state level under the NRHM has also helped to increase management skills especially at the lower levels. However, currently these units function largely as a support cadre to the rest of the Health Department, and as contract staff in support functions, there are no attractive pathways for this important function.

It is important to note that, given the shortage of trained doctors at every level, it would be a misallocation of scarce resources to divert them to non-medical functions such as management including the management of public health, as is currently being done. Furthermore, as one moves to the higher levels of the health system at the district, state and national levels, clinical credentials are needed less and less as tasks and roles become more and more linked to management, oversight and planning.

The absence of dedicated staff has led to considerable 'ad hoc'ism' in the management of health institutions and an inability to diagnose and correct management failures of which there are many. Nowhere is this more visible than in the area of quality assurance. Although there is wide acknowledgement that the quality of public-sector health facilities (from sub-centres to multi-specialty hospitals) and services leaves a great deal to be desired, the challenge of quality is even now only being addressed in a very limited way.

Both NHSRC and UNFPA are making important attempts to introduce quality assurance into the system. Again, the absence of a cadre whose training and job descriptions include quality assurance means that these attempts are likely to remain limited in their ability to actually transform the public-sector health institutions and system in a sustained way towards improved quality. If the UHC is to move forward with a balanced combination of well-functioning public and private institutions, this will not be enough.

There is, therefore, an urgent need to revamp HR planning for the public-sector health system by focusing on the best ways to focus on neglected aspects of public health, strengthen management inputs from the lowest levels up to the top, and combine clinical, public health and management functions in more organic ways that generate attractive career pathways for all three.

**Recommendation 10:** Require the use of performance management methods to improve functioning of staff and personnel in public sector institutions.

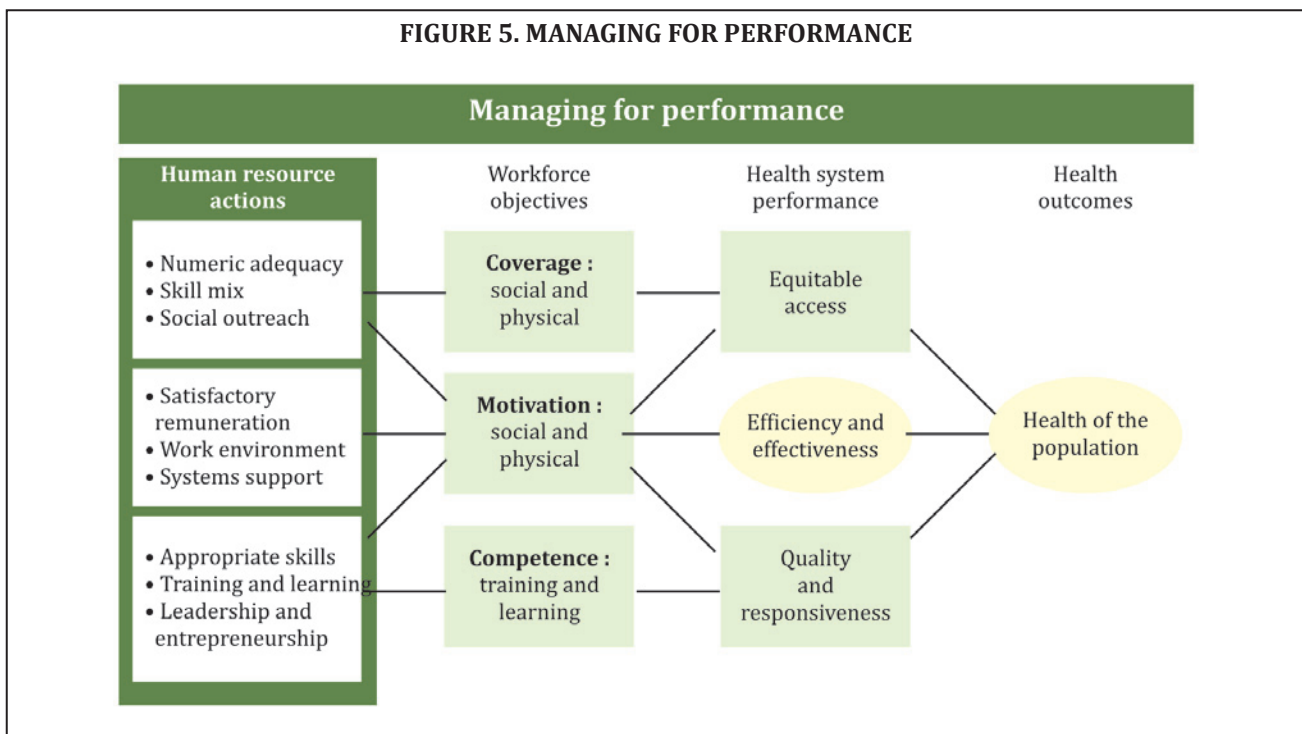
An important function of the Health System Management cadre will be performance management of the human resources in the public health sector. The HSM cadre's responsibilities would include recruiting, inducting, training, and setting up apprenticeships for newly hired personnel; defining clear-cut career pathways; instilling dedicated and committed attitude through pro-active, coordinated mentoring and motivation programs; team building and providing autonomy and flexibility for executing responsibilities. The cadre would also be in charge of ongoing input-output assessments; adequate and timely monitoring; supportive supervision; performance appraisals and responsive feedback on assessments; and incentives, including those based on the vulnerability index (e.g., higher payments for hard-to-reach locations). Staff performance would also be supported by better working conditions and clearer systems for supervision and accountability (detailed by the sub-group working on Human Resources for Health).

## Rationale

A growing emphasis on managing for results and obtaining value for money invested has heavily influenced health-sector performance assessment in a big way over the last two decades. Although ‘results-based management’ has limitations—especially in diverting attention away from qualitative improvements and becoming a mechanical strait-jacket when clumsily applied, the need to get the most

return for the investment of public funds is growing. When well used, performance management methods can help to focus attention on the relation between inputs, processes, outputs and outcomes in the health sector.

“Performance management is best defined as the development of individuals with competence and commitment, working towards the achievement of



Source: Joint Learning Initiative (2004)<sup>26</sup>

shared meaningful objectives within an organisation that supports and shares their achievement.”<sup>24</sup> In an ideal environment, these individuals are considered members of a team.<sup>25</sup>

Performance management can be an invaluable tool for assessing the performance of individuals and groups or teams, and rewarding or sanctioning behaviour. The field of human resource management has evolved by leaps and bounds in the private sector. While examples of the use of outdated and exploitative methods are still plentiful, there are also new

approaches to performance assessment that are built on more enlightened approaches and are mutually beneficial.

Health-sector managers in India (like their counterparts in other sectors) are very wary of creating regular staff positions on a large scale for fear of ending up with yet another category of workers who will have job security but without requirements for delivery. This wariness has led to reliance on contract and piece-rate workers, such as the ASHAs, on the assumption that job insecurity is the only method to ensure worker performance.



Modern human resource management methods suggest, however, that fear is only one possible goad to ensure work, and not necessarily the best one. Workers who function out of fear are typically poorly motivated to deliver more than the bare minimum, will not take risks or innovate, and cannot be trusted to work in teams. This insight was the basis of the labour system pioneered on a large scale in Japanese industry, where workers are viewed as critical contributors to quality and performance management in the system as a whole.

Modern performance management tools use a combination of methods that include both monetary and non-monetary incentives and individual and group rewards. As noted by Seagall (2000) <sup>27</sup> “In a situation where health workers get a respectable wage, acceptability of non-material rewards is much higher as employees value them more in the long term; these include peer recognition, a sense of making a contribution to the overall impact of the service, and solidarity with fellow workers.”

The use of such tools does not mean that workers who slack off or shirk responsibility go scot-free, but effective HR management is not primarily based on fear. Instead it harnesses many other motivations

that lie behind worker behaviour and starts from the presumption that most workers would like to do a decent job and be recognised for it. Those who attempt to beat the system can then be dealt with as they deserve without basing the entire HR system on the lowest common denominator.

**Recommendation 11:** Set up National and State Drugs Supply Logistics Corporations in order to strengthen the management of logistics and supply chains.

National and state-level utilities will be set up to ensure a transparent structure for bulk procurement and supply of adequate, rational, low cost, generic essential drugs down to the lowest levels which will be managed through an IT enabled system similar to the Tamil Nadu Medical Services Corporation Ltd., (TNMSC). All providers under the UHC (public and contracted-in private providers) will access generic drugs through this system, thereby ensuring significant cost savings and removing leakages from the drugs procurement and distribution system. This is discussed in detail in the chapter on Access to Medicines, Vaccines and Technology.

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