3rd International Conference

on Public Policy (ICPP3)

June 28-30, 2017 – Singapore

Panel T17aP11 Session 1

Public Hospital Reforms in India, China and South East Asia: Consequences for Accountability and Governance

Title of the paper

Private Sector Solutions to Public Sector Problems: Critical Appraisal of Public Hospital Reforms in India

Author(s)

Altaf Virani, M. Ramesh and Zeger van der Wal

(National University of Singapore)

Date of presentation

Thursday, June 29, 2017

Private Sector Solutions to Public Sector Problems: Critical Appraisal of Public Hospital Reforms in India[1]

Altaf Virani, M. Ramesh and Zeger van der Wal

(National University of Singapore)

This is a discussion draft. Please do not cite.

Abstract

This paper focuses on health system reform and recent changes in the governance of public hospitals in India. It critically reviews some of these reforms and proposes a conceptual model using which they can be analyzed. The paper questions the assumption that public and private healthcare providers respond to performance-oriented instruments in similar ways, despite their different objectives, motivations and constraints. It discusses the implications of these differences and examines the possibility that certain instruments that are effective in improving performance in private healthcare organizations might have ineffectual or adverse outcomes in the public sector context.

Keywords

Health System Reform, India, Public Hospitals, Performance, Autonomy, Accountability, Motivation

[1] The paper benefited from inputs provided by several experts, government officers and program managers in charge of executing these reforms in Gujarat, Maharashtra and Karnataka. We acknowledge the support provided by the relevant agencies of the governments in these three states.

1. Introduction

In recent decades, there has been by a progressive shift in how public organizations are being managed, from a traditional administrative approach to a more entrepreneurial 'public management' style of governance, aimed at modernizing the public sector and making it more efficient. Policy literature has identified two distinct strands of this movement (Larbi, 1999). The first, inspired by managerialism, is characterized by the infusion of scientific management and businesslike practices in government, such as flexible organizational structures, rationalization of unwieldy bureaucracies, greater decision space for public managers, professionalization of service providers, separation of funding, procurement and service provision, and output-orientation, reflected in the use of devices like Management by Objectives (MBO) and performance-related pay. The second is rooted in new institutional economics, which exalts the merits of incentives arising from free competition and a focus on citizens as customers, instead of just consumers of public services. This forms the basis of market-oriented reforms that many governments have introduced in their social sectors.[2] While the former provides the tools for effective and efficient administration, the latter creates the conditions that can potentially nudge public organizations to leverage their improved management capacities, for bringing about improvements in performance under market pressure. Both strategies involve the use of instruments that seek to alter the operational autonomy, accountability and incentives of public managers and frontline service providers. The objective of reform is to align these levers in a manner that can lead to desirable changes in the behavior of both providers and consumers of

[2] According to Loayza and Soto (2003), a market-oriented reform is "a policy measure that allows and induces the competitive participation of private agents in a sector, activity or market". Private participation and competition among private agents are the key elements in their definition. The objective of such reform is to achieve economic efficiency through policies that reduce distortions in the economy, through deregulation and reduction in the depth and scope of state control. For a more detailed exploration of the subject, see Rodrik (1996) and Williamson (1990).

public services, resulting in performance improvements at the organizational level, and ultimately the attainment of larger policy goals.

However, while there is a firm basis for such reforms in organizational economics and management literature, there is little scholarship on their relevance to (and effectiveness in) public organizations, given the different dynamics and unique structural constraints of the public sector. For instance, the decision space available to managers in public organizations is usually considerably restricted as compared to those in the private sector, which limits their maneuverability (Bossert, 2008). There is an added dimension of public accountability that public organizations have to contend with (Saltman et al., 2011). Public sector employees also have distinct value systems and motivations (Perry and Wise, 1990; Van der Wal et al., 2006 and 2008), which might result in distinctive patterns of response. Moreover, performance expectations are quite different in public and private organizations – the former are primarily concerned with ensuring equitable access to public services and better social outcomes for all citizens, the latter have a clear profit motive. Better service quality and operational efficiency are means to generate higher revenue and improve the bottom line in the private sector. It is therefore conceivable that instruments that are normally effective in improving performance in private organizations might have ineffectual or even adverse outcomes in the public sector context.

This paper examines these issues through a review of health system reform in India, using public hospitals as examples of restructured public organizations. The National Rural Health Mission (NRHM) in 2005 brought about several reforms, including greater autonomy to public hospitals,

employee incentives, performance targets, demand-side financing, community monitoring and public-private collaboration. In light of the discussion above, the paper proposes a conceptual model that can be used to understand performance in public organizations, and a lens through which reform programs in India's healthcare sector can be analyzed. It looks at the character of some of these reforms and the mechanisms through which they seek to affect hospital performance, and juxtaposes them against the proposed model to identify potential opportunities, impediments and implications.

In particular, we focus on two kinds of interventions geared towards improving performance of public hospitals in different ways. The National Health Insurance Program or *Rashtriya Swasthya Bima Yojana* (RSBY), and similar programs at the state level, create fund generation opportunities for public hospitals and leverage local autonomy for their use through Patient Welfare Committees called *Rogi Kalyan Samaitis* (RKSs), to get them to compete with private hospitals and improve services. On the other hand, quality assurance and improvement programs use a target-oriented management approach that drives improvement through benchmarking, team goal setting and recognition for success. Based on the model and evidence from existing research on the subject, the paper explores how these programs might affect the performance of healthcare providers, whether change dynamics might be different in both kinds of programs, and how factors or features inherent to the public sector might either facilitate or impede the effects of these programs.

On the basis of these arguments, the paper makes a determination of whether private sector mechanisms for performance improvement might work equally well in public organizations, and

whether 'public ethos' is likely to be compromised if performance is extrinsically driven and accountability is performance-oriented, than if it is intrinsically motivated and accountability is more democratic. It proceeds to highlight the structural reforms and interventions that might help optimize the functioning of public health facilities, and motivate healthcare providers to produce performance that is both effective and consistent with the ideals of the public sector.

2. Governance as an organizing framework for reform

All organizational reforms essentially involve changes in governance, that seek to alter the institutional arrangements and rules of engagement to regulate how actors behave "in ways associated with better performance and outcomes" (Savedoff, 2011). The governance perspective thus provides an organizing framework within which different reform initiatives or instruments can be located and understood vis-à-vis one another. While some of these instruments leverage the strengths of the government, others employ market-based mechanisms to overcome failures that are inherent to governments, and deliver public services more efficiently (Wu and Ramesh, 2014). Synergies between the different instruments in the policy mix and their alignment with the policy goals are critical for delivering effective performance (Gunningham and Sinclair; 1999; Rogge and Reichardt, 2016).

It follows therefrom that for the intended improvements in performance to be realized, organizations must offer the right incentives for actors to pursue objectives that are in the overall interest of the organization and its constituencies, and provide an enabling framework that helps both facilitate and monitor their behavior (OECD, 2004). Performance is affected through a complex chain of determinants (e.g. decision rights, incentives, administrative control,

stakeholder participation, values, ethos and motivation) that create the necessary conditions for congenial work practices (e.g. use of information, performance monitoring and appraisal, professional competence, workplace policies, resource management and infrastructure development), which in turn influence the behavior of organizational actors to ultimately affect how organizations perform (actual output or results achieved against targets for indicators such as efficiency, outreach, equity and service quality), and the eventual outcomes for clients or citizens (e.g. returns on investment and fulfillment of development objectives) (Savedoff, 2011) (See Fig. 1).

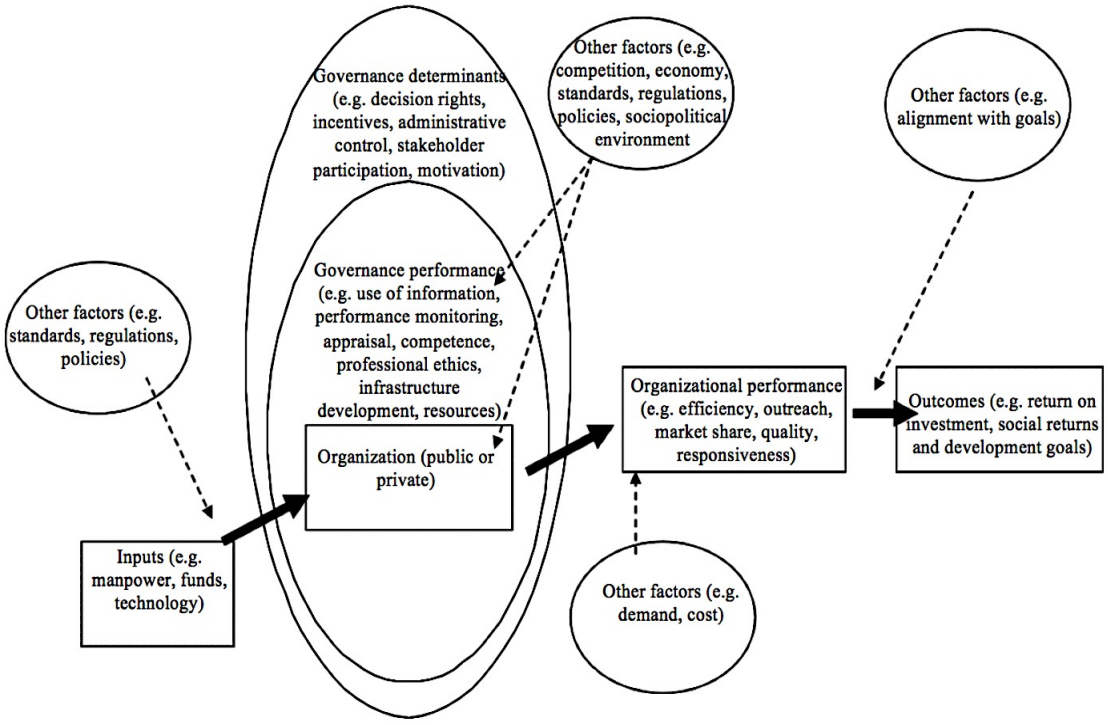

Figure 1: Savedoff's model of organizational reform

Source: Adapted from Savedoff (2011, p. 9) and WHO (2015, p. 10)

3. How public and private organizations are similar, and how they are different (and why it matters)

There is a view that public and private organizations face similar constraints and challenges, and therefore a generic approach to management is required (Murray, 1975). Rainey and Bozeman (2000) find that both public managers and business managers respond similarly to questions that assess goal clarity, despite the perception that goals in public organizations are multidimensional and ambiguous. They also share similar perceptions about organizational formalization, refuting the idea that public organizations have more rules and procedures. These assertions are supported by Boyne (2002) who found that only 3/13 of his original hypotheses about public-private differences empirically held up to scrutiny – that public organizations are less flexible and that public managers are less greedy and less committed to organizational goals. These indicate major public-private differences in structural features, value systems, motivations and performance orientation, which make it imperative for public organizations to be treated differently from private sector organizations when considering the use of specific reform instruments, as they might have different outcomes.

3.1. Structural issues

Autonomy constitutes the first of two structural elements that affect organizational performance. Autonomy refers to the "extent to which organizationally relevant decision-making is inside the organization" (Holdaway et al., 1975). Public managers face more constraints in matters of personnel and purchasing rules. They have less flexibility and autonomy in determining organizational objectives, limited ability to engage in long-term planning, and minimal control over subordinates (Allison, 1986; Rainey et al., 1976; Rainey and Bozeman, 2000). It is

acknowledged that allowing larger decision space for care providers in the health sector, encourages them to use their discretionary powers, to innovate and make choices different from those they would make under a more centrally-controlled system (Bossert, 1998). One can expect these choices to have positive effects on hospital performance. For example, researchers have identified institutional autonomy and competition as key factors in determining the success of hospital reforms in terms of improvements across a variety of indicators such as quality of care, patient responsiveness and clinical outcomes (Bloom et al., 2010).[3]

While autonomy provides the stimulus to facilitate behavioral change that can potentially improve operational efficiency and effectiveness, it can also give rise to agency problems, and negatively affect performance. Because doctors are now able to influence decisions that have a bearing on care provision, but also have financial consequences (for self and for the hospital), problems of moral hazard and inducement emerge (Chaix-Couturier et al., 2000). Organizational objectives can be compromised, if incentives are not properly aligned. For this reason, autonomy reforms succeed only when there is adequate accountability and institutional control to regulate the behavior of agents, prevent misuse of authority and drive performance in the intended direction. Accountability can thus be considered a modulating factor that regulates the effects of autonomy on organizational performance. It keeps people (and organizations) in check.

Accountability mechanisms typically seek to introduce some form of answerability through performance reviews, appraisals, administrative hearings and community monitoring practices,

[3] Bloom et al. (2010) use data from 1,200 hospitals in seven countries to show that improvements in hospital management practices are associated with better clinical outcomes, higher patient satisfaction rates and higher productivity. They also find that giving managers more autonomy and introducing mechanisms that instill competition among hospitals, stimulates the adoption of better management practices by hospitals and improves their performance.

or enforce sanctions through legal and regulatory requirements, media oversight and market accountability (Brinkerhoff, 2003). The nature of these mechanisms depends on their purpose, and plays a critical role in determining what goals an organization works towards. The goal of performance-oriented mechanisms for instance, is to evaluate performance and hold the organization (and its employees) to account against set targets in terms of outputs and outcomes. Political or democratic accountability mechanisms seek to ensure that governments fulfill their obligations and poll promises, respond to citizens' interests and to societal concerns. This latter form is operationalized through the electoral process, administrative oversight and various forms of citizen engagement. Market-based accountability in the private sector is often stronger and more effective, as compared to political and administrative accountability systems in the public sector. Das et al. (2015), for example, find that market mechanisms lead private healthcare providers to expend more effort and deliver correct treatment, as compared to their public counterparts (or compared to their own behavior in government practice). In recent years, increased focus on performance management in public organizations and the use of market-based instruments, have reshaped accountability relationships in a manner that has shifted responsibility from traditional political institutions, towards managerial and professional forms of accountability (Behn, 1998; Mattei et al., 2013). While they haven't necessarily replaced one another, and do coexist (Willems and Van Dooren, 2011), they can be in conflict if aligned poorly, leading to public organizations working at cross-purposes with their policy goals.

3.2. Value systems and motivations

Values are the ethical principles and moral standards that guide one's behavior. Work ethos is an individual's attitude in the workplace, and provides meaning and purpose to his or her actions.

Together, they shape the underlying motivations of employees, and help determine the choice of behavioral change devices that might succeed in bringing about the desired changes in behavior to improve performance. While public and private organizations share a common set of values that are critical to their operations, they have essentially distinct value systems and moral ethos, in keeping with their separate roles in society and different organizational objectives (Jacobs, 1992; Van der Wal et al., 2008).

Theories of Public Service Motivation (PSM) have sought to dispel the notion that motivations in public and private sectors are essentially similar, making it necessary for individuals in public organizations to be treated differently from those in private sector organizations. PSM refers to the predisposition of public employees to "respond to motives grounded primarily or uniquely in public institutions and organizations" (Perry and Wise, 1990). Persons with high levels of PSM prefer working in public organizations that display a high level of 'publicness', particularly in social sectors such as education and healthcare, as they offer intrinsic rewards and opportunities to work for others' welfare (Dur and Zoutenbier, 2014; Georgellis et al., 2011; Vandenabeele, 2008). The lower prevalence of fraudulent practices such as 'upcoding' among non-profit hospitals, in contrast with for-profit hospitals and those that convert to for-profit status, may be attributed to higher levels of PSM as well as lack of profit motives (Silverman and Skinner, 2004).[4] Philanthropic motivations of public employees, coupled with the distinctive features of public organizations such as multiple goals, multiple principals and lack of competition, render high-powered incentives, such as pay for performance (P4P), relatively ineffective (Besley and Ghatak, 2005; Dixit, 1997). Higher extrinsic incentives are in fact known to 'crowd out' intrinsic

[4] 'Upcoding' is a fraudulent medical practice in which the provider bills for higher Diagnosis-Related Group (DRG) codes that suggest higher than actual morbidity, and more extensive and expensive treatment than was necessary or was given.

motivation, and dissuade intrinsically motivated individuals from joining the public sector (Cerasoli et al., 2014; Frey and Jegen, 2001; Georgellis et al., 2011). Public employees are more motivated by interesting or challenging work opportunities, or higher level responsibilities that give them a sense of achievement or fulfillment (Canton, 2005). Workplace practices that foster managerial trustworthiness, goal directedness, group culture, employee participation, feedback, job satisfaction and career advancement, leverage intrinsic motivation and are therefore more likely to be effective (Moynihan, 2005; Moynihan and Pandey, 2007; Favero et al., 2014).

Ironically, public organizations are also more likely to attract lazier individuals, who are willing to forego the high-powered incentives that are prevalent in the private sector, in return for the relative comfort, assured compensation and less competitive work environment that the public sector provides (Dur and Zoutenbier, 2014). This might explain the widespread prevalence of low-powered incentives in public organizations, and why extrinsic instruments may not work very well.

Public organizations are known to have lower productivity than private firms. Public hospitals for example, are known to be less cost-efficient than non-profit hospitals, which are in turn less cost-efficient than for-profit hospitals (Mutter and Rosko, 2008). It is also well known that private sector organizations respond more aggressively to financial stress and business cycles. Eldenburg et al. (2004) found that the board and CEO turnover in US hospitals was affected by poor financial performance for all but public hospitals, implying that a general lack of ‘performance culture’ and the more societal outlook of public organizations permit greater tolerance of poor performers than in the private sector. The motivation to adopt and follow

governance practices often associated with higher performance, is weak in organizations that are not primarily profit-driven or performance-oriented (Eldenburg et al., 2004; Robbins and Taylor, 2014). The mere implementation of performance-oriented policies in public organizations is therefore no guarantee that there will be commensurate improvements in performance, because of the mismatch between values, work culture and motivations on the one hand, and adopted instruments on the other.

However, extrinsic and intrinsic motivations do not exist exclusively and are not incompatible, but act jointly to affect performance. While extrinsic incentives might have 'crowding out' effects on PSM, they may still produce performance improvements, through net increase in motivation (Cerasoli et al., 2014). Extrinsic and intrinsic motivations are essentially different kinds of drivers, so they might affect performance in different ways. Moynihan (2010) argues that New Public Management (NPM) type reforms that employ market models in the public sector might have adverse consequences such as moral hazard, due to the high-powered incentives in play. If so, this might possibly indicate greater convergence between the public and private value systems and expansion of their common core values (Van der Wal et al., 2006), at the cost of erosion of public values (Jørgensen and Bozeman, 2002). For accountability systems in the public sector to then be effective, democratic forms of accountability such as citizen participation that require higher levels of PSM, might have to be superseded by more market-based forms that link incentives to the required patterns of performance (Coursey et al., 2012).

Despite academic literature that suggests the relative ineffectiveness of extrinsic instruments in the public sector, there is a prevailing view among policymakers that poor performance in public

organizations is somewhat due to the absence of high-powered incentives that are found in private firms. This has led governments to privatize public services and use mechanisms such as demand-side financing to replicate such incentives in the public sector (Dixit, 1997). Whether these have been effective or have elicited different responses in comparison with intrinsic instruments, are important questions that merit investigation.

3.3. Performance orientation

While some measures of organizational effectiveness might be applicable to both the public and private sectors (increasingly so as public organizations are becoming more customer-oriented), public and private organizations have different goals and different notions of performance, and thus use very different parameters to assess performance (Parhizgari and Gilbert, 2004). Also, whereas performance measurement tools are widely used in private firms, they are poorly implemented in public organizations, due to technical and managerial challenges in adapting performance management practices from the private sector, given their different contextual conditions, and lack of knowledge and expertise (Adcroft and Willis, 2005).

Despite these problems, there are many examples where performance indicators have been successfully applied to assess work performance in the public sector. For instance, they have played a critical role in the movement towards greater managerial oversight in clinical practice in the UK (Exworthy et al., 2003). Results-based management in government organizations (driven by international agencies like the World Bank) has led to the production of voluminous data and information on performance, and their subsequent use to help governments evolve better policies and programs (Power, 1994).

Van Thiel and Leeuw (2002) have argued that this focus on outputs may cause unintended effects that can adversely influence public sector performance. Public organizations have certain unique traits that often make it counterproductive to develop and use performance indicators that are downright adopted from the private sector. Moreover, in the NPM era, public organizations are subject to both professional and democratic accountability. Technical and managerial indicators of performance often conflict with the larger institutional-level indicators, creating tensions that can potentially be averted or resolved through a more holistic approach to governance design (Lemieux-Charles et al., 2003). Reconciling the two is relatively more challenging in public organizations.

4. An integrated model of organizational reform

The conceptual model proposed in this paper is situated within this larger narrative that public and private organizations operate in fundamentally different contexts. The model incorporates multilevel elements drawn from organizational and policy literature that are known to affect performance. Performance is affected through interactions between the structural characteristics of the environments within which public and private service providers operate (such as their extent of operational autonomy and the nature and strength of accountability controls), and their orientation in terms of inherent values, ethos and motivations (See Fig. 2).

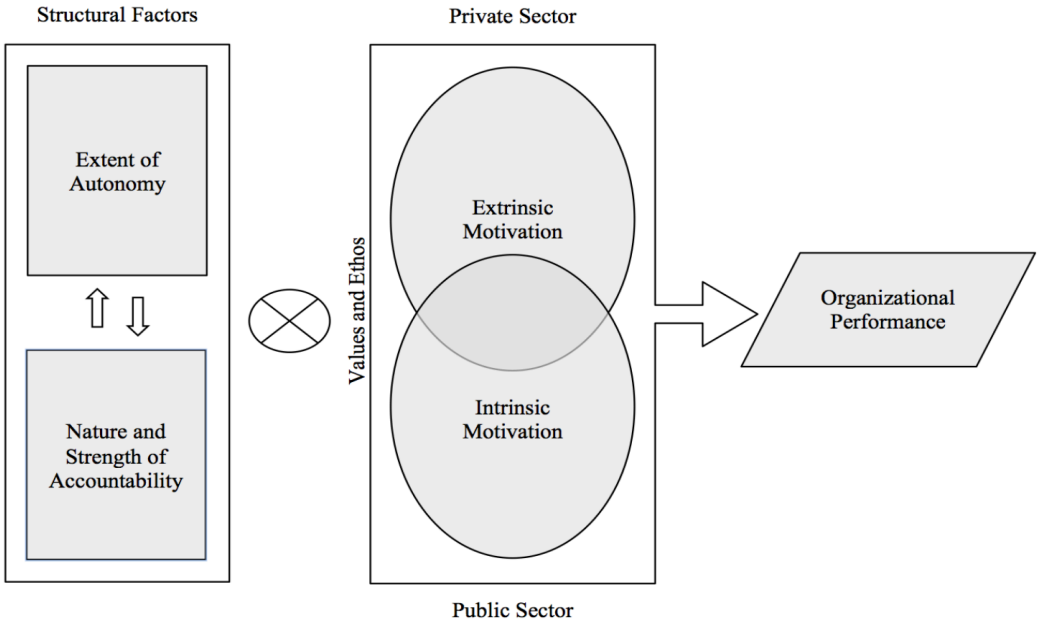

Figure 2: Integrated model of organizational reform

This framework is more nuanced than Savedoff's model, because it regards performance as resulting from the interplay of systemic and personal influences, as well as public-private differences across both sets of factors. Moving forward, we will use this model to examine the nature and potential effects of some of India's key reforms in the health sector.

5. India's public health system challenges

The public health system in India is underfunded, poorly managed and overwhelmed by its growing population and demographic transition. Despite the existence of a large public network of healthcare institutions in the country, there are major rural-urban differences in the availability of services and weaknesses in referral linkages between the primary, secondary and tertiary tiers of the health system (HLEG, 2011). India has a mammoth but grossly under-funded government health infrastructure and workforce that is overloaded and inadequate to meet the health needs of

the population. The total public spending on health, currently estimated at about 1.2% of the Gross Domestic Product (GDP), is one of the lowest in the world (HLEG, 2011). Bulk of this expenditure is incurred towards the provision of curative services. Moreover, states spend a major portion of their health budgets on obligatory expenditures like salaries, wages, pensions and interest payments, leaving little fiscal space for substantive investments in infrastructure, equipment, essential drugs, medical and civil supplies, maintenance, capacity building of personnel and upgradation of systems (Duggal, 1997; HLEG, 2011; Reddy and Selvaraju, 1994). Healthcare delivery in the public sector is therefore rife with resource constraints, infrastructural dilapidation, staff shortages, poor management and low service quality (HLEG, 2011). Also, given regional differences in public spending on health, state-specific priorities and political regimes, there are large inter-state variations in the distribution, capacity and quality of public health infrastructure, services and outcomes.

While the delivery of health services is largely the responsibility of state governments, the central government has tended to drive health policy formulation and, to some degree, its implementation through the institution of financial controls and technical and administrative support for health programs. Given its massive financial and organizational clout, the central government determines to a great extent what programs are implemented by the states and how they are executed. It also uses this leverage to persuade them to work towards common national priorities and objectives. These programs are uniformly implemented across the country by the states, which themselves have little influence or maneuverability except in determining the operational modalities. Of late, there have been concerted attempts to give state governments more freedom and flexibility in the implementation of centrally sponsored health programs.

States can also implement other initiatives that complement national programs. While there has been a progressive shift towards greater decentralization, the systems for implementing participatory governance processes within the states are still weak, underpinned by the lack of transparency, poor local capacity and insufficient devolution of critical administrative and financial powers to state and local governments.

Given the limited capacity and problems in the public sector, private healthcare provision and financing have moved in to fill the vacuum and now occupy the dominant position in India's health services sector (HLEG, 2011; The World Bank, 2001). The roles of government and private healthcare providers were completely reversed between the periods 1986-87 and 2004 with the rapid (but ad-hoc and uncontrolled) expansion of the private health sector following economic liberalization and deregulation (MoHFW, 2007). Private providers currently service a major chunk of the population (roughly 78% of outpatients and 60% of inpatients) in both rural and urban areas across the socio- economic spectrum. Nearly 80% of doctors, 26% of nurses and 49% of hospital beds across the country are in the private sector (Planning Commission, 2012).

Privately delivered healthcare is also largely privately funded, most of it paid for through Out-of-Pocket payments directly by the consumers (HLEG, 2011). Though health insurance in India is widely available through both public and private insurance companies, and in the form of community-based schemes offered by some Non-Governmental Organizations (NGOs), private health insurance covers only about 55 million people and is limited to relatively small sections of the well-to-do urban population and some rural pockets. In the last few years, several publicly-financed insurance schemes like the RSBY, have been funded and implemented by the center

and several state governments, targeting households below the poverty line (BPL) and some categories of informal-sector workers such as beneficiaries of the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS), street vendors, domestic workers, and construction laborers. These typically provide cashless hospitalization coverage to enrolled beneficiaries through contacted private insurers and the freedom to choose between empanelled public or private hospitals for obtaining a defined set of inpatient services. Approximately 243 million people are insured under such government-sponsored programs and other social insurance schemes such as the Employee's State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) for specific groups, which is still a small percentage of India's total population (Planning Commission, 2012). Financial access to good quality healthcare remains an issue.

Perhaps the biggest challenge for India's health system is poor regulation of healthcare providers and lack of a comprehensive policy framework for regulating health services in both the public and private sectors (Bali and Ramesh, 2015a, 2015b; Peters and Muraleedharan, 2008; Sheikh et al., 2013a). The current approach to healthcare regulation has been passive, mostly through entry-level registration and licensing requirements for healthcare providers and accreditation of medical and paramedical educational institutions, with poor systemic capacity and mechanisms for monitoring and appraisal of healthcare practice. There is multiplicity and superficiality in the prevailing standards of care and wide variability in their implementation. Regulatory provisions for registration and licensing, medico-legal guidelines for practitioners and laws for the protection of consumer interests have been poorly enforced and are more or less ineffective

(Bhate-Deosthali and Khatri, 2011; Muraleedharan and Nandraj, 2003; Peters and Muraleedharan, 2008; Sheikh et al., 2013b).

Due to the limited success of legal and bureaucratic approaches to healthcare regulation, the emphasis has gradually shifted to self-regulation. For example, there is a growing trend for healthcare providers (both private and public) to seek voluntary accreditation from external accrediting agencies such as the National Accreditation Board for Hospitals and Healthcare Providers (NABH), the National Accreditation Board for Testing and Calibration Laboratories (NABL), the Joint Commission International (JCI) and the International Organization for Standardization (ISO), in order to give assurance of care quality and inspire confidence among consumers (Peters and Muraleedharan, 2008; Sheikh et al., 2013b). Such accreditation or other kinds of quality audits are often required for empanelment of hospitals under health insurance programs (including for government-financed schemes). However, there remain serious concerns about cost, institutional capacity and willingness to self-regulate and the reliability of such assessments. Given this situation, market-driven mechanisms such as induced competition have become more popular due to their potential for positively influencing the performance of healthcare providers, through their ability to affect the health-seeking behavior of consumers.

The current challenge is to develop the infrastructure and capacity of public hospitals and galvanize public healthcare providers to provide good quality care, and to regulate the private healthcare sector for compliance with statutory requirements and ethical norms.

6. Recent reforms

The launch of the NRHM by the Ministry of Health and Family Welfare (MoHFW) in 2005, was a major step towards overhaul of this overly centralized and top-down health system, and gave more powers to the states to set up state-specific targets, create need-based plans and implement localized innovations, within the programmatic framework provided by the central government. The Mission adopted a multipronged approach, focusing on the other determinants of health, increasing overall public health spending, mainstreaming alternative systems of medicine to supplement existing services, reducing regional imbalances in health infrastructure especially for primary care, operationalizing Community Health Centers (CHCs) at the block level as first referral centers, integrating programs and pooling resources, optimizing the health workforce, decentralizing the management of health programs to the district level and deploying village level health workers for community outreach (MoHFW, 2011a).

It also undertook a slew of management reforms that are of interest to us from a behavioral perspective, such as greater autonomy to public hospitals at sub-state and sub-district levels, incentives to motivate employees, performance targets, demand-side financing programs, benchmarking quality in government health facilities, community monitoring and participation, and collaborations that aim to leverage private sector capacities towards public objectives. Each of these create conditions that can influence the behavior of public healthcare providers, by expanding or controlling their discretionary authority, designing inducements or deterrents, artificially creating a competitive marketplace, or setting goals to help direct one's efforts.

International experience with market-based reforms has been generally found to have poor outcomes from a social perspective. Existing evidence seems to suggest that such reforms may encourage public hospitals to change their behavior, in ways that economize their functioning, but compromise the core public service goals of public hospitals (Bogue et al., 2007; Chaix-Couturier et al., 2000; Hsiao, 1994). Government regulation is thus critical to ensure that market competition delivers not just economically efficient results, but also fair, equitable and politically accountable outcomes (Hsio, 1994; Ramesh, 2008). It is also imperative that the right instruments are used, to nudge the behavior of healthcare providers towards more acceptable outcomes. For instance, instruments that leverage the intrinsic motivations of public sector workers are more likely to produce the kind of performance that is socially desirable.

There is little evidence on the effects of such reforms in India, and little discussion of their positionality within the larger governance framework. In the following sections, we discuss three kinds of programmatic strategies that are part of the reform paradigm, and aimed (at least in part) at improving the performance of public hospitals in different ways. This is in no way intended to be a compendium of all the relevant programs or a full account of their details. We refer to only specific programs as representing a certain class of interventions that we discuss in relation to certain elements in the conceptual model of organizational reform that we presented earlier. The paper provides a superficial overview, so that readers can understand their role in the policy space and the main issues, without getting bogged down by the details.

6.1. Policy-induced competition through demand-side financing

In 2008, the Indian government launched the National Health Insurance Program or *Rashtriya Swasthya Bima Yojana* (RSBY), a demand side financing program that provides a cashless insurance cover for hospitalization, in over 10,000 empanelled public and private hospitals across the country. The cover includes hospitalization benefits (including maternity benefit and pre-existing diseases) for up to INR 30,000 per annum for a family of five on floater-basis, and a transportation fee of INR 100 per hospital visit. The beneficiary pays an annual fee of INR 30 towards administrative expenses. The central and state governments share the premium contribution in a 75:25 ratio (90:10 in special regions) (Planning Commission, 2012).

The program was initially targeted at households below the poverty line (BPL), but was later expanded to include workers in the unorganized sectors, as well as to households above the poverty line (APL) in some states, under a modified plan. RSBY is currently operational in 25 states. A total of 41 million families have been enrolled, and almost 12 million hospitalization events have occurred till date (MoHFW, 2016). Originally implemented by the Ministry of Labour and Employment (MoLE), the program is now overseen by the Ministry of Health and Family Welfare (MoHFW) and administered by state governments through a decentralized implementation system. Several states have implemented modified versions of this government-sponsored health insurance program or complementary programs that have different benefits, such as coverage for catastrophic health events or high-end surgical treatment. A new National Health Protection Scheme (NHPS) based on the RSBY blueprint will provide expanded coverage and eventually replace the RSBY.

The RSBY and other such programs have two main objectives. First, they seek to reduce out-of-pocket expenditure on health and increase access to health services, by lowering financial barriers. Second (though less acknowledged), they provide citizens the freedom to choose between empanelled public and private hospitals, spurring competition among hospitals for a larger slice of the expanded market. Because public hospitals are allowed to retain the fees reimbursed to them by the insurer, and to use these funds to develop facility-level infrastructure and provide incentives to hospital staff, it is expected that hospitals will improve their performance and offer better quality services, for financial rewards. Since bulk of the health budgets are typically spent on recurring expenditures like salaries, wages, pensions and interest payments (Duggal, 1997; HLEG, 2011; Reddy and Selvaraju, 1994), RSBY revenues can potentially provide the critical financial resources required to make the necessary facility-level improvements and expenses on care provision. Therefore, from a policy perspective (while not explicitly articulated), the RSBY program is aimed at improving the efficiency of the health system, by utilizing excess capacity in the private sector, optimizing efficiency, and providing the motivation and the means for public healthcare providers to perform better.

Evidence on the effects of the RSBY program is mixed and conflicting. Some studies suggest that the program has led to reductions in Out-of-Pocket expenditure and reduced barriers for accessing care (Gupt et al., 2016). Others find that for poorer households, catastrophic expenditure on hospitalization has significantly increased (perhaps due to inadequate coverage or moral hazard) (Selvaraj and Karan, 2012). Even if the RSBY may have led to reduction in household spending on healthcare, the implementation of the program does not provide adequate handholding and support to marginalized populations, making it more likely for them to be

discriminated against, or to have to pay for treatment that is normally covered under the program (Babajanian et al., 2014). Several studies have highlighted the low utilization of healthcare services under RSBY due to lack of awareness and information among target populations (Asfaw et al., 2014; Devasenapathy et al., 2015; Rajasekhar et al., 2011; Rathi et al., 2012), inaccessibility of empanelled health facilities (Rathi et al., 2012), operational restrictions causing service shortfalls and drug stock-outs in public hospitals (Gupt et al., 2016; MoHFW, 2011b), low administrative capacity within hospitals and delays in reimbursement to healthcare providers (Rajasekhar et al., 2011). There are also reports of private hospitals indulging in unethical practices in some states (Press Information Bureau, 2014), which are consistent with the experience of Community-Based Health Insurance (CBHI) schemes in parts of India (Desai et al., 2011).[5] This is significant because a majority of hospitalization claims under RSBY are from private hospitals.

Several state governments have been proactive in issuing directives to public health facilities and pushing them to improve their quality of services for RSBY beneficiaries, through initiatives such as the formation of District Quality Management Teams, grading of health facilities to meet quality standards and empanelment criteria, strengthening administrative capacity for claims management and liaison with insurers, medical and facility audits, sensitization efforts, autonomy for utilization of funds generated through the program and staff incentives. There are indications that there is now greater use of public hospitals by RSBY patients than before, but the evidence is largely anecdotal, and there is no clarity on whether this is due to perverse

[5] A total of 407 private hospitals were de-empanelled from RSBY, after investigations by a high level team from the MoLE in 2012, regarding unindicated hysterectomy operations performed on young women who did not require the procedure.

provider behavior or because public healthcare providers are improving quality and administrative capacity to service insurance clients (Asfaw et al., 2014; MoHFW, 2011b).

6.2. Decentralized facility-level governance

One of the key reforms under the NRHM was greater emphasis on decentralized health planning and management, and greater autonomy to public health facilities. Facility-level groups such as Patient Welfare Committees or *Rogi Kalyan Samaitis* (RKSs), and Hospital Development Societies have been set up in most states, with representation from the local communities and *Gram Panchayats* (local self-government organizations). These committees are technically autonomous in operational matters and have oversight responsibilities, revenue generation authority and some degree of autonomy for priority spending on infrastructure and facility upgradation. They have the powers and the responsibility to monitor the functioning of healthcare services in public hospitals and to redress grievances. They receive RKS grants, annual maintenance grants and untied funds (flexi-funds) to help maintain the facilities. They are also empowered to take decisions on procurement, user fees, renovation and provision of utilities such as water filters and electrical inverters (MoHFW, 2011a).

While there is little doubt that decentralized governance has to some extent promoted greater efficiency, accountability, responsiveness, mobilization of resources and community ownership, the systems for implementing the RKS, are weak and poorly functioning in most states. RKSs suffer from insufficient devolution of administrative and financial powers, lack of transparency, weak organizational capacity and cohesion, poor awareness of roles and responsibilities and non-prioritization of facility-level health agendas. Several assessments of RKSs have had similar

findings (Adsul and Kar, 2013; Sharma and Hotchkiss, 2001; Shrivastava and Bobhate, 2012; Singh et al., 2008). RKS members are often not selected in keeping with the guidelines. They meet irregularly, are unaware of their individual roles in the committee and do not execute their responsibilities earnestly. Meetings of their Governing Bodies, which have representation from NGOs and eminent civil society members, and those of their Executive Bodies, which have people's representatives, happen infrequently and often take place in their absence. There is little representation from different categories of hospital staff. Most members are not professionally oriented or knowledgeable about the functioning of hospitals in general, and are poorly acquainted with how funds are actually being spent. They depend on the expertise and directives of the signatories (usually bureaucrats or senior medical officers in administrative positions), who control all financial transactions and play a major role in determining how funds are spent.

With the introduction of the RSBY and similar insurance-based programs, health facilities receive large funds in the form of claim reimbursements (besides funds from other sources such as user fees and donations) that are deposited in the accounts operated by RKSs, which can be used for facility development as per guidelines. Despite the relatively greater autonomy and funds available to make improvements, the weaknesses in RKS governance suggest potential accountability concerns, which might negatively affect facility performance, and impair the ability of public healthcare providers to make targeted improvements in the quality of services they provide.

6.3. Quality improvement programs

Quality improvement has become a major focus area under the National Health Mission (NHM) in recent years, to the extent that major administrative thrust and financial resources are being invested in operationalizing quality-focused programs. The current portfolio of quality improvement consists of several fragmented initiatives that operate in isolation and there is no explicit unified macro framework or quality policy within which the different strategies exist. The implementation of these programs has been quite ad hoc and variable across states, and state governments have only very recently begun to consolidate the various preexisting quality initiatives into the new nationally formulated programs which have been propagated to the states for their adoption. Clear guidelines have brought some uniformity in implementation, though states are still in the process of making the transition and the lack of clarity on the larger policy framework and agenda that underlies the operational strategy persists.

The forerunner of current quality initiatives was the Quality Assurance (QA) program, which was piloted under the NRHM in 2007, first in select districts of Gujarat, and then scaled up to six other states including Maharashtra and Karnataka, through assistance from the United Nations Population Fund (UNFPA). The objectives of this program were to assess and improve the quality of services in public health facilities and inculcate a QA approach within the district health system. The program aimed at improving performance using a target-oriented approach implemented systematically via an organizational apparatus. Quality improvements were expected to occur from facilities being able to benchmark and gauge where they stood, know how to improve, monitor their own progress, and be recognized for successfully executed improvements. The pilots focused mainly on Reproductive and Child Health (RCH) services in

Community Health Centers (CHCs), Primary Health Centers (PHCs) and sub centers. They demonstrated the usefulness of using checklists to improve service quality, and the possibility that QA could be institutionalized, with some technical assistance and reinforcement (Khan et al., 2006). Anecdotal reports from the field suggest that the program created greater awareness and sensitization towards the quality agenda, and that the health staff became better equipped to appreciate the importance of QA processes. These observations are consistent with quality management literature, which identifies goal setting and quality training as potent drivers of quality improvement (Field, 2014).

Under the program, a team of district level health officials, called the District Quality Assurance Group (DQAG), carried out assessments of health facilities. The District Health Officer led this team comprising of district program officers, block level health officers, supervisory staff and NGO representatives under the overall supervision of the State Program Management Unit (SPMU). An extensive checklist of standards was used to assess the facilities. The checklist covered a broad range of areas including the availability of drugs, provider availability, conditions of the facility, care delivery parameters and review of records. Each facility was given an aggregated score on three parameters: input (readiness), process (service delivery) and outcome (performance). The team communicated the results of the assessment and the gaps identified to the Medical Officer (MO) in-charge of the facility and made recommendations for improvement. Repeat visits were conducted every four months to assess changes in performance against the previously identified gaps.

Limited evidence from rudimentary assessments of the pilots indicated that district officials and the MOs used the information from the assessments to bridge gaps in quality, and progressively nudge facilities to improve performance (Khan et al., 2008a, 2008b). Flexi-funds available with the RKS were used for this purpose. Considerable improvements were seen on the readiness parameter, whereas even while service quality improved, it never met the desired expectations, possibly suggesting that simply improving readiness may not be a sufficient condition for commensurate improvements in service quality. There may be systemic elements that need to be addressed (which is perhaps more difficult to do).

While the QA program has been seemingly phased out over the years, the concept of self- and peer-assessments, as a method to demonstrate compliance with established quality standards and continually monitor and improve performance, has become more prevalent. Initial attempts were limited to select health facilities undergoing ISO 9001 certification, and others applying for accreditation by the National Accreditation Board for Hospitals and Healthcare Providers (NABH). More recently, the National Quality Assurance Standards (NQAS) have been evolved for public hospitals from existing quality standards and guidelines, through a consultative process with experts. There is an institutionalized framework, guidelines and processes for implementation, training and capacity building of assessors and service providers, and handholding support to help health facilities undergo accreditation. Facilities that do well on the internal assessment are recommended for State Level Certification and National Accreditation, if they meet or exceed expectations and perform above set thresholds during subsequent external assessments. Besides getting facilitated and being recognized as achievers, there is also a substantial financial reward for health facilities that get nationally accredited, a majority (75%)

of which goes to RKS operated accounts, and can be used for facility development. The remaining 25% can be distributed as incentives among the staff of the health facility, if the facility management so decides. Besides this, such facilities are eligible to get a higher budget in the following year by virtue of their achievement, which provides them with more funds that they can use for infrastructure upgradation and improvement of services. Facilities that gain accreditation are required to apply for recertification every three years, which keeps the momentum going and directs efforts towards continual improvement.

A separate program called *Kayakalp* (rejuvenation) uses a similar process of continuing assessment and peer review to focus on cleanliness of healthcare facilities. It recognizes and incentivizes facilities that confirm to prescribed hygiene and infection control standards and are top performers among similar facilities. However, unlike the process for NQAS, where rewards are assured if accreditation is obtained, *Kayakalp* awards are adjudicated through a competition where facilities with the highest scores at each level get the awards. There is again a considerable financial reward for health facilities that win the competition, which is split between the facility and staff (75:25). What is perhaps a more effective motivation is recognition within the fraternity, and appreciation and respect from society and the leaders from the local communities for contributing to social good.

A far more passive and poorly institutionalized process for quality improvement is the star ratings system. Assessments of performance are carried out through monthly scorecards that give star ratings to public health facilities based on data collected through the Health Management Information System (HMIS). Data is collected for 20 indicators across the following categories –

human resource, infrastructure, drugs and supplies, service availability, client orientation and service utilization. A minimum score across certain critical variables is necessary for facilities to receive any rating. The scores serve as a basis for course correction and provide a benchmark against which subsequent assessments can be compared to measure improvement. There is a budgetary provision for disbursement of a sizable incentive in NHM funds to states based on the cumulating ratings of their facilities, to encourage states to monitor their performance. However, there are no institutionalized processes for feedback to health facilities, and action and follow-up. Rather, the ratings serve as a source of information that is often used (albeit arbitrarily) by district nodal officers, to identify poorly performing facilities and their issues, and then follow up with them. This makes the process relatively top-down and passive in its orientation, and lacking in the motivational components that other continuing improvement programs exhibit.

7. Future directions for research and policy implications

Based on the above discussion, and in the backdrop of the proposed conceptual model of organizational reform, this section tries to piece together an agenda for future research. Such research is critical to further our understanding of the effects of various kinds of policy instruments on health system performance, and to indicate the types of reforms that are required to optimize the functioning of public health facilities, and motivate public healthcare providers to produce performance that is both effective and consistent with the ideals of the public sector. A number of interesting insights can be possibly gleaned from the results of such research, providing supporting evidence to current policy debates or pointing to new lines of enquiry.

Firstly, research can help ascertain whether public hospitals are prone to the same set of issues as private hospitals, despite differences in orientation. For example, if there were evidence to suggest that demand-side financing encourages perverse behavior among public healthcare providers, just like private providers, it would raise serious concerns about the suitability of such instruments, and the need for stronger administrative accountability in the public sector. It would also bring into question a lot of what is known about the unique motivations of public sector workers and the primacy of PSM, and highlight the detrimental effects of extrinsic inducements on public values and public ethos. On the other hand, if such programs nudge public providers to upgrade service quality and administrative capacity in order to attract and better service insurance clients, without the associated moral hazard problems, it would strengthen the case for the adoption of such instruments in the public sector.

If no improvements are observed, it might point towards certain structural constraints that could be hindering performance improvements. Limited autonomy is one such impediment. While recent reforms have provided public hospitals with more autonomy for need-based development and the resources to effect change, there is concern among hospital managers and healthcare providers that the decision space that has been given, may not be sufficient for bringing about significant or meaningful improvements. Besides, there are concerns about whether supply-side subsidies from the government in addition to demand-side financing, places public hospitals at a comparative advantage as compared to private hospitals that only rely on market mechanisms. Conversely, there is likelihood that dual sources of financing create complacency among public hospitals, as they are less dependent on markets for their sustenance, and do not face the same pressures from consumers that would otherwise push them to improve their performance.

Systemic bottlenecks, as well as differences in motivation and work culture, might also limit the effectiveness of demand side strategies in the public sector (La Forgia and Nagpal, 2012). In comparison, if quality improvement programs are able elicit better and more sustained improvements, it would reinforce the effectiveness of intrinsically oriented instruments in the public sector context, and make the case for adopting a more holistic approach to reform.

One other possibility exists. Critics have questioned the sustainability of RSBY-type programs and the wisdom of channeling vast public finances mainly into private hospitals, further entrenching the role of the private sector in India's health system. Researchers have flagged the idea that reform instruments that encourage competition, and position public hospitals in a free market context, might eventually lead to further dilapidation of the public health system through 'exit' of patients to the private health sector due to the existing quality differential (Reddy and Mary, 2013; Selvaraj and Karan, 2009; Vasan et al., 2014). There is little evidence about whether this is actually happening, but if future research finds indications of this, it would raise questions about whether this is a thoughtful strategic choice that policymakers have made in keeping with the systemic efficiency argument, or whether the implications of private sector provision and adverse effects on the public health system (and its ethos) have been overlooked. Such evidence might be valuable, and could provide a basis to argue for the need to reconsider some of currently popular approaches to health system reform.

8. Conclusion

The core message of this paper is that of caution about the perils of disregarding the inherent differences between the public and private contexts, when borrowing solutions from one sector

and applying it to the other. Reforms are typically intended to deploy mainstream instruments to replicate conditions that are known to influence private organizations (and their employees) to improve their performance. However, there are important differences between notions of performance in public and private organizations. Public and private sector goals are distinct and sometimes incompatible. The internal and external environments that determine how the organizations respond to similar instruments are also different. The objective of organizational reform in the public sector is not to eliminate the public-private distinction and make public organizations more like private firms. While the application of private sector instruments might still be beneficial in public organizations and may indeed help boost performance, applying the right mix of instruments and providing the necessary conditions to allow them to be effective, is essential for organizational reform in the public sector to deliver the 'right' kind of performance.

References

Adcroft, A., & Willis, R. (2005). The (un) intended outcome of public sector performance measurement. *International Journal of Public Sector Management*, *18*(5), 386- 400.

Adsul, N., & Kar, M. (2013). Study of Rogi Kalyan samitis in strengthening health systems under national rural health mission, district Pune, Maharashtra. *Indian Journal of Community Medicine*, *38*(4), 223.

Allison, G. T. (1986). Public and private administrative leadership: Are they fundamentally alike in all unimportant respects. *Leadership and organizational culture: New perspectives on administrative theory and practice*, 214-222.

Asfaw, K., Bumpus, M., Coen, T., Edelstein, C., Rojas, A. L., Mendieta, C., ... & Vidarte, R. (2014). *Health Service Delivery in Punjab, India*. Woodrow Wilson School of Public and International Affairs, Princeton University.

Babajanian, B., Hagen-Zanker, J. & Holmes, R. (2014). *Can social protection and labour programmes contribute to social inclusion?* Shaping policy for development, odi.org, briefing no. 85.

Bali, A. S., & Ramesh, M. (2015a). Health care reforms in India: Getting it wrong. *Public Policy and Administration*, *30*(3-4), 300-319.

Bali, A. S., & Ramesh, M. (2015b). Mark Time: India's March to Universal Health Care Coverage. *Social Policy & Administration*, *49*(6), 718-737.

Behn, R. D. (1998). The new public management paradigm and the search for democratic accountability. *International Public Management Journal*, *1*(2), 131-164.

Besley, T., & Ghatak, M. (2005). Competition and incentives with motivated agents. *American Economic Review,* 95(3), 616–636.

Bhate-Deosthali, P. and R. Khatri (2011). *Private Health Sector in Maharashtra: A study of private hospitals*. Mumbai: Centre for Enquiry into Health and Allied Themes.

Bloom, N., Homkes, R., Sadun, R., & Van Reenen, J. (2010). Why good practices really matter in healthcare. *London, VoxEU.org, Centre for Economic Policy and Research.*

Bogue, R. J., Hall, C. H., & La Forgia, G. M. (2007). *Hospital Governance in Latin America*. Washington DC: World Bank, 536.

Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. *Social science & medicine*, *47*(10), 1513-1527.

Boyne, G. (2002). Public and private management: what's the difference?. *Journal of management studies*, *39*, 97-122.

Brinkerhoff, D. (2003). Accountability and health systems: overview framework and strategies. Abt associates.

Canton, E. (2005). Power of incentives in public organizations when employees are intrinsically motivated. *Journal of Institutional and Theoretical Economics JITE*, *161*(4), 664-680.

Cerasoli, C. P., Nicklin, J. M., & Ford, M. T. (2014). Intrinsic motivation and extrinsic incentives jointly predict performance: A 40-year meta-analysis. *Psychological Bulletin*, *140*(4), 980.

Chaix-Couturier, C., Durand-Zaleski, I., Jolly, D., & Durieux, P. (2000). Effects of financial incentives on medical practice: results from a systematic review of the literature and methodological issues. *International Journal for Quality in Health Care*, *12*(2), 133-142.

Coursey, D., Yang, K., & Pandey, S. K. (2012). Public service motivation (PSM) and support for citizen participation: A test of Perry and Vandenabeele's reformulation of PSM theory. *Public Administration Review*, *72*(4), 572-582.

Das, J., Holla, A., Mohpal, A., & Muralidharan, K. (2015). Quality and accountability in healthcare delivery: audit evidence from primary care providers in India. *World Bank Policy Research Working Paper*, (7334).

Desai, S., Sinha, T., & Mahal, A. (2011). Prevalence of hysterectomy among rural and urban women with and without health insurance in Gujarat, India. *Reproductive Health Matters*, *19*(37), 42-51.

Devasenapathy, N., Jerath, S. G., Allen, E., Sharma, S., Shankar, A. H., & Zodpey, S. (2015). Reproductive healthcare utilization in urban poor settlements of Delhi: Baseline survey of ANCHUL (Ante Natal and Child Health care in Urban Slums) project. *BMC pregnancy and childbirth*, *15*(1), 1.

Dixit, A. (1997). Power of incentives in private versus public organizations. *The American Economic Review*, 378-382.

Duggal, R. (1997). Health care budgets in a changing political economy. *Economic and Political Weekly*, *32*(20-21), 1197-1200.

Dur, R., & Zoutenbier, R. (2015). Intrinsic motivations of public sector employees: Evidence for Germany. *German Economic Review*, *16*(3), 343-366.

Eldenburg, L., Hermalin, B. E., Weisbach, M. S., & Wosinska, M. (2004). Governance, performance objectives and organizational form: evidence from hospitals. *Journal of Corporate Finance*, *10*(4), 527-548.

Exworthy, M., Wilkinson, E. K., McColl, A., Moore, M., Roderick, P., Smith, H., & Gabbay, J. (2003). The role of performance indicators in changing the autonomy of the general practice profession in the UK. *Social Science & Medicine*, *56*(7), 1493-1504.

Favero, N., Meier, K. J., & O'Toole, L. J. (2014). Goals, Trust, Participation, and Feedback: Linking Internal Management with Performance Outcomes. *Journal of Public Administration Research and Theory*, doi: 10.1093/jopart/muu044.

Field, J. M., Heineke, J., Langabeer, J. R., & DelliFraine, J. L. (2014). Building the case for quality improvement in the health care industry: A focus on goals and training. *Quality Management in Healthcare*, *23*(3), 138-154.

Frey, B. S., & Jegen, R. (2001). Motivation crowding theory. *Journal of economic surveys*, *15*(5), 589-611.

Georgellis, Y., Iossa, E., & Tabvuma, V. (2011). Crowding out intrinsic motivation in the public sector. *Journal of Public Administration Research and Theory*, *21*(3), 473- 493.

Gunningham, N., & Sinclair, D. (1999). Regulatory pluralism: Designing policy mixes for environmental protection. *Law & Policy*, *21*(1), 49-76.

Gupt, A., Kaur, P., Kamraj, P., & Murthy, B. N. (2016). Out of Pocket Expenditure for Hospitalization among Below Poverty Line Households in District Solan, Himachal Pradesh, India, 2013. *PloS one*, *11*(2), e0149824.

HLEG (2011). *High Level Expert Group Report on Universal Health Coverage*. New Delhi: Planning Commission, Government of India.

Holdaway, E. A., Newberry, J. F., Hickson, D. J., & Heron, R. P. (1975). Dimensions of organizations in complex societies: The educational sector. *Administrative Science Quarterly*, 20(1), 37-58.

Hsiao, W. C. (1994). 'Marketization'—the illusory magic pill. *Health Economics*, *3*(6), 351-357.

Jacobs, J. (1992). Systems of survival. A dialogue on the moral foundations of politics and commerce. *London: Holder & Stoughton*.

Jørgensen, T. B., & Bozeman, B. (2002). Public Values Lost? Comparing cases on contracting out from Denmark and the United States. *Public Management Review*, *4*(1), 63-81.

Khan, M. E., Mishra, A., Sharma, V., & Varkey, L. C. (2008a). *Development of a quality assurance procedure for reproductive health services for district public health systems:*

implementation and scale-up in the state of Gujarat. Washington, DC: Population Council, USAID, UNFPA.

Khan, M.E., Mishra, A., Sharma, V., & Sharma, R. (2008b). *Institutionalization of quality assurance within district health management: Experiences from Maharashtra and Karnataka,* FRONTIERS Final Report. Washington, DC: Population Council.

Khan, M. E., Mishra, A., & Sharma, V. (2006). *Scaling up of Quality Assurance Measure in the 25 Districts of Gujarat State: Initial Observations,* OR Summary 15. New Delhi: Population Council.

La Forgia, G., & Nagpal, S. (2012). *Government-sponsored health insurance in India: Are you covered?* Washington DC: The World Bank.

Larbi, G. (1999). The New Public Management Approach and Crisis States. *United Nations Research Institute for Social Development Discussion Paper*, (112).

Lemieux-Charles, L., McGuire, W., Champagne, F., Barnsley, J., Cole, D., & Sicotte, C. (2003). The use of multilevel performance indicators in managing performance in health care organizations. *Management Decision*, *41*(8), 760-770.

Loayza, N., & Soto, R. (2003). On the measurement of market-oriented reforms. *World Bank Policy Research Working Paper*, (3371).

Mattei, P., Mitra, M., Vrangbæk, K., Neby, S., & Byrkjeflot, H. (2013). Reshaping public accountability: hospital reforms in Germany, Norway and Denmark. *International Review of Administrative Sciences*, *79*(2), 249-270.

MoHFW. (2016). Rashtriya Swasthya Bima Yojana website, http://www.rsby.gov.in/Overview.aspx, Accessed 10th September 2016.

MoHFW (2011a). *Annual Report to the People on Health*. New Delhi: Ministry of Health and Family Welfare, Government of India.

MoHFW (2011b). *5th Common Review Mission Report*. New Delhi: Ministry of Health and Family Welfare, Government of India.

MoHFW (2007). *Select health parameters: a comparative analysis across the National Sample Survey Organization (NSSO) 42nd, 52nd, and 60th Rounds*. New Delhi: Ministry of Health and Family Welfare, Government of India.

MoHFW. (2005). *National Rural Health Mission: Framework for Implementation (2005-2012)*. New Delhi: Ministry of Health and Family Welfare, Government of India.

Moynihan, D. P. (2010). A workforce of cynics? The effects of contemporary reforms on public service motivation. *International Public Management Journal*, *13*(1), 24- 34.

Moynihan, D. P. (2006). Managing for results in state government: Evaluating a decade of reform. *Public Administration Review*, *66*(1), 77-89.

Moynihan, D. P. (2005). Goal-based learning and the future of performance management. *Public Administration Review*, *65*(2), 203-216

Moynihan, D. P., & Pandey, S. K. (2007). Finding workable levers over work motivation comparing job satisfaction, job involvement, and organizational commitment. *Administration & Society*, *39*(7), 803-832.

Muraleedharan, V. R. and S. Nandraj (2003). Private health care sector in India – Policy challenges and options for partnership. *Health policy research in South Asia: Building capacity for reform*. A. Yazbeck and D. H. Peters. Washington DC: The World Bank: 227-256.

Murray, M. A. (1975). Comparing public and private management: An exploratory essay. *Public Administration Review*, *35*(4): 364-371.

Mutter, R. L., & Rosko, M. D. (2008). The impact of ownership on the cost-efficiency of US hospitals. *Evaluating hospital policy and performance: Contributions from hospital policy and productivity research*, *18*, 113-138.

Organization for Economic Cooperation and Development (2004). *OECD Principles of Corporate Governance*. Paris: OECD.

Parhizgari, A. M., & Gilbert, G. R. (2004). Measures of organizational effectiveness: Private and public sector performance. *Omega*, *32*(3), 221-229.

Perry, J. L., & Wise, L. R. (1990). The motivational bases of public service. *Public administration review*, *50*(3), 367-373.

Peters, D. H. and V. R. Muraleedharan (2008). Regulating India's health services: To what end? What future? *Social Science and Medicine*, 66(10): 2133-2144.

Planning Commission (2012). *Report of the Steering Committee on Health for the 12th Five Year Plan*. New Delhi: Health Division, Planning Commission, Government of India.

Power, M. (1994). *The audit explosion* (No. 7). Demos.

Rainey, H. G., Backoff, R. W., & Levine, C. H. (1976). Comparing public and private organizations. *Public administration review*, *36*(2), 233-244.

Rainey, H. G., & Bozeman, B. (2000). Comparing public and private organizations: Empirical research and the power of the a priori. *Journal of public administration research and theory*, *10*(2), 447-470.

Rajasekhar, D., Berg, E., Ghatak, M., Manjula, R., & Roy, S. (2011). Implementing health insurance: the rollout of Rashtriya Swasthya Bima Yojana in Karnataka. *Economic and Political Weekly*, *46*(20), 56-63.

Ramesh, M. (2008). Autonomy and control in public hospital reforms in Singapore. *The American Review of Public Administration*, *38*(1), 62-79.

Rathi, P., Mukherji, A., & Sen, G. (2012). Rashtriya Swasthya Bima Yojana: evaluating utilisation, roll-out and perceptions in Amravati district, Maharashtra. *Econ Polit Weekly*, *47*, 57-64.

Reddy, K. N. and V. Selvaraju (1994). *Health care expenditure by Government of India: 1974-75 to 1990-91*. New Delhi: Seven Hills Publications.

Reddy, S., & Mary, I. (2013). Aarogyasri scheme in Andhra Pradesh, India: some critical reflections. *Social change*, *43*(2), 245-261.

Robbins, W. A., & Taylor, G. (2014). Corporate Governance Practices: an Exploratory Study of the US Nonprofit Healthcare Sector. *American International Journal of Social Science, 3*(3), 1-10.

Rodrik, D. (1996). Understanding economic policy reform. *Journal of economic Literature*, 34(1), 9-41.

Rogge, K. S., & Reichardt, K. (2016). Policy mixes for sustainability transitions: An extended concept and framework for analysis. *Research Policy*, *45*(8), 1620-1635.

Saltman, R. B., Durán, A., & Dubois, H. F. (2011). *Governing public hospitals*. Copenhagen: WHO.

Savedoff, W. D. (2011). *Governance in the health sector: a strategy for measuring determinants and performance* (No. 5655). The World Bank.

Selvaraj, S., & Karan, A. K. (2012). Why publicly-financed health insurance schemes are ineffective in providing financial risk protection. *Economic & Political Weekly*, *47*(11), 61-68.

Selvaraj, S., & Karan, A. K. (2009). Deepening health insecurity in India: evidence from national sample surveys since 1980s. *Economic and Political Weekly*, 55-60.

Sharma, S., & Hotchkiss, D. R. (2001). Developing financial autonomy in public hospitals in India: Rajasthan's model. *Health Policy*, *55*(1), 1-18.

Sheikh, K., P. Saligram, et al. (2013a). What explains regulatory failure? Analysing the architecture of health care regulation in two Indian states. *Health Policy and Planning*, doi:10.1093/heapol/czt095: 1-17.

Sheikh, K., P. Saligram, et al. (2013b). *Mapping the regulatory architecture for health care delivery in mixed health systems in low- and middle-income countries*. Melbourne: Nossal Institute for Global Health.

Shrivastava, S. R., & Bobhate, P. S. (2012). Implementation of Rogi Kalyan Samiti (RKS) at Primary Health Centre Durvesh (2009–2010). *TAF Preventive Medicine Bulletin*, *11*(3), 307-314.

Silverman, E., & Skinner, J. (2004). Medicare upcoding and hospital ownership. *Journal of health economics*, *23*(2), 369-389.

Singh, C. M., Jain, P. K., Nair, K. S., Kumar, P., Dhar, N., & Nandan, D. (2008). Assessment of utilization of untied fund provided under the national rural health mission in Uttar Pradesh. *Indian journal of public health*, *53*(3), 137-142.

The World Bank (2001). *India. Raising the sights: Better health systems for India's poor*. Washington D. C.: Health, Nutrition, Population Sector Unit, India, South Asia Region, The World Bank.

Vandenabeele, W. (2008). Government calling: Public service motivation as an element in selecting government as an employer of choice. *Public administration*, *86*(4), 1089-1105.

Van der Wal, Z., De Graaf, G., & Lasthuizen, K. (2008). What's valued most? Similarities and differences between the organizational values of the public and private sector. *Public administration*, *86*(2), 465-482.

Van der Wal, Z., Huberts, L., Van Den Heuvel, H., & Kolthoff, E. (2006). Central values of government and business: Differences, similarities and conflicts. *Public Administration Quarterly*, 314-364.

Van Thiel, S., & Leeuw, F. L. (2002). The performance paradox in the public sector. *Public Performance & Management Review*, *25*(3), 267-281.

Vasan, A., Karpagam, S., & Seethappa, V. (2014). Design, Implementation, and Patient Experiences of the Rashtriya Swasthya Bima Yojana and Vajpayee Arogyashree Scheme: A Qualitative Study from Bangalore District, Karnataka. *India Social Development Report 2014,* 173-184.

Willems, T., & Van Dooren, W. (2011). Lost in diffusion? How collaborative arrangements lead to an accountability paradox. *International Review of Administrative Sciences*, *77*(3), 505-530.

Williamson, J. (1990). What Washington Means by Policy Reform, Chapter 2 in John Williamson (ed.), *Latin American Adjustment: How Much Has Happened?* Washington: Institute for International Economics.

Wu, X., & Ramesh, M. (2014). Market imperfections, government imperfections, and policy mixes: policy innovations in Singapore. *Policy sciences*, *47*(3), 305-320.