Public Hospital Reform: Options, Opportunities and Risks
Global and Indian Experience

New Thinking in Health Policy
Oct 26-27, 2017, New Delhi, India
Summary

• Challenges facing public hospitals
  – Performance, governance, management

• Global experience
  – Framework
  – Lessons learned and examples

• Indian experience

• Proposed co-location PPP initiative
Why Governance/Autonomy Reforms?

- Poor quality care and patient dissatisfaction with public hospitals
- Hierarchical bureaucracy and limited decision-making authority at hospital level
- Inflexible human resource policies
- Political Interference
- Evidence from other sectors of benefits of delivery models incorporating and/or building on private sector incentives
Focus Groups with Public Hospital Managers

Public Hospitals: Common Challenges

- Strong social symbolism; face of the health system
- Fragmented silos
- Consumes largest portion of health investments, but financing is insufficient
- Provides a confusing mix of first, second and third level of care services
- Feeling of being “overwhelmed and alone at the peek of the pyramid” called the health system
- Poorly managed: managers lacking the appropriate competencies
- Too much political interference
- Lack of decision-making authority

Source: Adopted from Holder, 2014
Global Experience
The Roads Taken

- **Reforms**
  - Governance + Management + Finance: Transferring decision-making authority from government administration to the hospitals
- **Management interventions**
  - Managerial capacity building
- **Finance interventions**
  - Pay for performance
Why Autonomy?

• Empowers hospital managers to manage.
• Empower hospital managers to respond to any incentive embedded in a provider payment mechanism, contracts or regulations

BUT . . .

• Autonomy does not mean a license to do what you want.
  – Any reform involving autonomy requires accountability mechanisms and incentives appropriate for independent hospitals.
  – Without such mechanisms hospitals may deviate from public objectives.
## Organizational Models for Autonomy-Oriented Reforms

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
</tr>
</thead>
</table>
| Autonomization            | - Formal institutional grant of autonomy, but actual decision making rights vary considerably  
                           | - May involve creation of governance structure such as a board or council  
                           | - Usually involves a limited number of facilities                                 |
| Corporatization           | - Creation of legalized organizational forms (e.g. trust, foundations, state enterprises, etc.) that are separate from government administration  
                           | - Usually applied to a number of facilities, but may involve single facilities with “own” legislation  
                           | - Ownership remains public  
                           | - Autonomy usually stronger than under autonomization                             |
| Public-Private Partnerships (PPPs) | - Long-term contract between government and a private entity  
                           | - Joint investment in the provision of publicly financed health services  
                           | - Different models: can include or exclude infrastructure, clinical and non-clinical operations  
                           | - Private sector assumes financial risk  
                           | - Ownership usually remains public (not privatization)                            |
## Public Hospital Reforms: Examples of Organizational Models

<table>
<thead>
<tr>
<th>Country</th>
<th>Organizational Models</th>
<th>Organizational Nomenclature</th>
</tr>
</thead>
</table>
| Czech Republic   | Corporatization         | • Limited liability companies  
|                  |                         | • Joint-stock companies                                                                |
| Brazil           | PPP                     | • Social Health Organizations (OSSs)                                                      |
| Estonia          | Corporatization         | • Joint-stock companies  
|                  |                         | • Foundations                                                                       |
| Portugal         | Corporatization         | • Public enterprises                                                                   |
| Spain            | 1. Corporatization 2. PPP| • Public corporations, foundations, consortia  
|                  |                         | • Administrative concessions (to private firm)                                           |
| Philippines      | Autonomization          | • Local government enterprises                                                           |
| Sweden           | Corporatization         | • Public-stock corporations                                                              |
| UK               | Corporatization         | • Self-governing trusts  
|                  |                         | • Foundation Trusts                                                                      |
| **Autonomous Public Body Managing a Hospital Network** | | • Public Authority                                                                     |
| Hong Kong        | Corporatization         |                                                                                            |
Framework Core Components for Developing and Analyzing Reforms Involving Public Hospital Autonomy

- Corporate Governance
- Decision-making Authority
- Incentives
- Accountability
- Provider Payment
- Data
- Benchmarks
- Policy and legal framework
- Performance (Efficiency, Quality, Social Functions, etc.)

Authorizing Environment

Decision-making Authority Management

Framework Core Components for Developing and Analyzing Reforms Involving Public Hospital Autonomy

- Corporate Governance
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- Benchmarks
- Policy and legal framework
- Performance (Efficiency, Quality, Social Functions, etc.)
Lessons Learned: Autonomy/Transfer of Decision-Making Authority

- Legislated governance structure specifying composition, functions and responsibilities
- Formal application & transparent approval process for hospitals to achieve autonomous status
- Transparent arrangement to transition civil servants to alternative labor contracts
- A phased time table for transferring decision authority to hospitals
- Provision of guidelines and technical assistance to help hospitals prepare and implement new decision-making responsibilities
# Examples: Autonomous Hospital Governance Structures

<table>
<thead>
<tr>
<th>Model</th>
<th>Governance</th>
<th>Jurisdiction</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil: OSS</td>
<td>Board</td>
<td>One or more hospitals under OSS contract</td>
<td>Civil society representatives</td>
</tr>
<tr>
<td>Hong Kong: Hospital Authority</td>
<td>Board</td>
<td>All publically funded hospitals</td>
<td>Government representatives &amp; community leaders</td>
</tr>
<tr>
<td>Portugal: PEEHs</td>
<td>Hospital Administration Board</td>
<td>Single Hospital</td>
<td>Medical staff, members appointed by MoH &amp; MoF</td>
</tr>
<tr>
<td>Spain: AC</td>
<td>Board</td>
<td>Network of hospitals &amp; associated clinics under AC contract</td>
<td>Company representatives</td>
</tr>
<tr>
<td>UK: Foundation Trusts</td>
<td>Board of Governors &amp; Board of Directors</td>
<td>At least one hospital</td>
<td>BOG: patients, citizens, staff BOD: Hospital CEO, executive directors, BOG representatives</td>
</tr>
</tbody>
</table>
Lessons Learned: Corporatized Entities

• Legal framework to specify nature of corporate entity & ownership relationship with gov.

• Legislation/regulations can clarify roles and accountabilities, including social functions and composition and authority of governance structures (e.g. boards)

• Board members should receive guidelines & trainings on board roles and responsibilities
Legal & Policy Framework

- Central level framework legislation can provide guidance for state-specific policies/laws
- Avoid facility-specific legislation
- Ensure compliance with existing health laws, labor codes, other regulations
Brazil: Legal Framework for Corporatized Entities/Governance structures ("social organizations")

Central Level

**Framework Law**
(created non-profit "Social Organizations" of "public interest" for the provision of social services)

State Level

**State Laws**
(creating specific service Social Organizations)

Sao Paulo State
"Health Social Organization"
Lessons Learned: Accountability

• Specification and enforcement of rules/reporting requirements for strong accountability to gov. (e.g. audits, contracts)
• Institutional arrangements for gov. monitoring and oversight (new performance monitoring units; contract management units)
• Performance information is collected, analyzed and made public; feedback to hospitals
• Guidelines and advisory programs in support of hospital boards
# Examples of Accountability Mechanisms

<table>
<thead>
<tr>
<th>Model</th>
<th>Types of Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil: OSS</td>
<td>• Contract payments linked to volume, quality and efficiency targets</td>
</tr>
<tr>
<td></td>
<td>• Data reporting requirements</td>
</tr>
<tr>
<td></td>
<td>• Internal and external audits</td>
</tr>
<tr>
<td></td>
<td>• &quot;Social audits&quot;</td>
</tr>
<tr>
<td></td>
<td>• Contract termination/firing of management for consistent underperformance</td>
</tr>
<tr>
<td>Hong Kong: Hosp. Authority</td>
<td>• Financial assessments against annual budget targets</td>
</tr>
<tr>
<td>Portugal: PEEHs</td>
<td>• Annual financial reports</td>
</tr>
<tr>
<td></td>
<td>• Data reporting requirements</td>
</tr>
<tr>
<td></td>
<td>• Government can dismiss board for budget deviations, quality deterioration and contract violations</td>
</tr>
<tr>
<td>Spain: AC</td>
<td>• Penalties for patients seeking care outside of catchment area</td>
</tr>
<tr>
<td></td>
<td>• Sanctions for non-compliance with contract</td>
</tr>
<tr>
<td></td>
<td>• Data reporting requirements (clinical, financial, operational)</td>
</tr>
<tr>
<td></td>
<td>• Internal and external audits</td>
</tr>
<tr>
<td>UK: Foundation Trusts</td>
<td>• External performance and financial monitoring</td>
</tr>
</tbody>
</table>
## Sample Performance Measurement & Indicators from Select Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Financial Indicators</th>
<th>Patient Experience</th>
<th>Efficiency</th>
<th>Quality</th>
<th>Social Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil: OSS</td>
<td>• Audits • Spending</td>
<td>• Patient satisfaction surveys</td>
<td>• ALOS</td>
<td>• Infection rates</td>
<td>• No fees • No refusal of care • All hospitals in low-income areas</td>
</tr>
<tr>
<td>Spain: AC</td>
<td>• Audits • Billing</td>
<td>• Wait times • Patient experience</td>
<td></td>
<td>• Clinical outcomes</td>
<td></td>
</tr>
<tr>
<td>Portugal: PEEHs</td>
<td>• Audits • Cash flows</td>
<td>• Average patient delays</td>
<td>• Discharges</td>
<td>• Readmission rates</td>
<td></td>
</tr>
<tr>
<td>HK: Hospital Authority</td>
<td>• Financial reports</td>
<td></td>
<td>• Input indicators</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Lessons Learned: Incentives

• Align hospital incentives with public objectives and performance:
  – Hospitals at financial risk for noncompliance with performance measures/overruns
  – Payment systems promote cost containment and link payment to quality and efficiency
  – Purchasing systems to enable effective monitoring and data analysis
  – Use of cost accounting systems to set payments and monitor spending
Brazil OSSs in Sao Pablo: Performance-based Global Budget – Two Payment Streams

- 90% (Vol.)
- 10% Benchmarks (retention fund)
- Adjustment
- Monthly allocation against volume targets
- Quarterly allocation against quality & efficiency benchmarks
- Semester Assessment

Source: La Forgia and Couttolenc, 2008
OSS Sao Paulo, Brazil
Performance-based Global Budget: Benchmark Portion

Global Budget (Retension Fund; Stream 2) = Weighted Scores (of tracer indicator compliance) \[\times \] 10% of value of global budget

Weighted Scores:
- Quality
- Reporting Requirements
- Quality of Information
- Efficiency
- Patient Satisfaction

Source: La Forgia and Couttolenc, 2008
Examples of Performance Indicators and Weights Linked to 10% “Retention Fund” of OSS Global Budget

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples of Indicators</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Information</td>
<td>Medical records contain secondary diagnoses Place of residence codes completed in patient records Reason for caesarian sections provided</td>
<td>0.10</td>
</tr>
<tr>
<td>Efficiency</td>
<td>ALOS for specific services (without secondary diagnoses) remain within pre-defined ceilings</td>
<td>0.10</td>
</tr>
<tr>
<td>Quality</td>
<td>Mortality, medical record and infection commissions are fully operational % of deaths analyzed by mortality commission % reduction in hospital infection rates</td>
<td>0.70</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>% percent of patient complaints addressed Realization of patient satisfaction survey</td>
<td>0.10</td>
</tr>
</tbody>
</table>

Source: La Forgia and Couttolenc, 2008
Lessons Learned: Management

- Pilot autonomy reforms in hospitals with capable and experienced managers
- Establish an executive management program to upgrade specific skills
- Create a hospital management benchmarking system to track management indicators (linked to performance indicators)
- Develop a career path for professional hospital managers; integrate managerial competencies into
## What about Impact?

<table>
<thead>
<tr>
<th></th>
<th>Revenue</th>
<th>Production</th>
<th>Efficiency</th>
<th>Quality</th>
<th>Equity</th>
<th>Patient Satis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil (OSS)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Indonesia</td>
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<td></td>
<td></td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Spain (Alzira)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Vietnam</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

# Key Components of Effective Public Hospital Reforms

<table>
<thead>
<tr>
<th>1. Clear policy and legal framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Well-defined and legally constituted governance and corporate entities</td>
</tr>
<tr>
<td>3. Autonomous managerial authority</td>
</tr>
<tr>
<td>4. Incentives for efficiency, cost containment and equity</td>
</tr>
<tr>
<td>5. Government or other authority holds autonomous hospitals accountable for:</td>
</tr>
<tr>
<td>• Financial performance</td>
</tr>
<tr>
<td>• Service quality and scope</td>
</tr>
<tr>
<td>• Contract compliance</td>
</tr>
<tr>
<td>6. Data to tracks hospital performance and financial accounts; strong government capacity to monitor and enforce contracts</td>
</tr>
<tr>
<td>7. Managerial capacity</td>
</tr>
</tbody>
</table>
What do we know about public hospital governance and management in India?
Public Hospitals in India

• Gaps in information base
• 1.37 million beds
  – 61% private; 39% public
• Private sector
  – Mostly small facilities (<20 beds)
• Public multi-tiered system
  – 25,387 Primary care centers w/ beds (6-20 beds)
  – 5,521 Community health centers (30-100 beds)
  – 1,065 Sub-district hospitals (50-100 beds)
  – 773 District hospitals (100-500 beds)
  – 200 Medical colleges (500+ beds)
Public Hospital Performance in India

- Little systematic information on performance
- Microstudies, small surveys and press reports suggest:
  - Shortages in HR and supplies
  - Inadequate and poorly maintained infrastructure and equipment
  - Poor quality of care and patient dissatisfaction
  - Low productivity

Public Hospital Governance in India

• Most public hospitals can best be described as government administrative units:
  – Operated directly by government departments
  – Financed through more or less set line-item budgets
  – Hospital managers have little decision-making authority over inputs, especially HR and financial management
  – Managers are administrative appointees and selection is usually based on seniority
  – Managerial formation and experience are not job requirements
World Management Survey: Comparative Hospital Results

Hospital Management Scores
By country

US: 3.07
UK: 2.07
Sweden: 2.72
Germany: 2.07
Canada: 2.56
Italy: 2.49
France: 2.41
India: 1.62

Average management score

Note: data from the World Management Survey includes hospitals offering acute care and with at least a cardiology and/or orthopedics department.

Source: Lemos and Scur, 2012
World Management Survey: India
Results: Public and Private Hospitals

Source: Lemos and Scur, 2012
Public Hospital Governance
Some Examples of Relevant Indian Experience
## Examples of Organizational Models from India

<table>
<thead>
<tr>
<th>Name</th>
<th>Organizational Model</th>
<th>Legal Basis</th>
<th>Governance structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIIMS</td>
<td>Autonomization</td>
<td>Special Act of Parliament (1956)</td>
<td>Institute Body</td>
</tr>
<tr>
<td>Apollo Hospital (Delhi)</td>
<td>PPP (joint venture)</td>
<td>Land Concession/Contract</td>
<td>Apollo Board?</td>
</tr>
<tr>
<td>Rajiv Ghandi Apollo Hospital (Raichur) Draupadibhai Muralidhar Khedakar-Sahyadri Hospital (Pune); BSES Municipal General Hospital (Mumbai)</td>
<td>PPP (contract management)</td>
<td>Contract with private provider</td>
<td>Board of contracted provider?</td>
</tr>
</tbody>
</table>

**A Public Body Managing a Network of Facilities**

<table>
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<tr>
<th>Name</th>
<th>Organizational Model</th>
<th>Legal Basis</th>
<th>Governance structure</th>
</tr>
</thead>
</table>

**Other Models (probably not “reforms”)**

<table>
<thead>
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<th>Name</th>
<th>Organizational Model</th>
<th>Legal Basis</th>
<th>Governance structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rogi Kalyan Samitis (RKS) (patient welfare societies)</td>
<td>Semi-Autonomization?</td>
<td>Societies Registration Act</td>
<td>Governing committee</td>
</tr>
<tr>
<td>Grants-in-Aid (Gujarat, Kerala, Assam)</td>
<td>PPP (purchasing arrangement)</td>
<td>MOU with NGO/trusts</td>
<td>NGO/Trust Board?</td>
</tr>
</tbody>
</table>
Relevant Indian Experience: Less Successful

Punjab Health Systems Corporation (PHSC)
- Publically run incorporated body
- Essentially run as administrative & budgetary arms of overseeing gov. ministry
- Suffers from: political interference in appointment of key staff; rigid government procurement, personnel and budgetary process; fragmented oversite; weak accountability & incentives

“Land for Beds” PPP Scheme (ex. Apollo Hospital, Delhi)
- Land leased at heavily subsidized/zero cost to private entities (usually for-profit hospital chains); joint venture between gov. & private provider
- Intention: Private entity to provide discounted/free care to the poor (usually as a % of patients)
- Reality: Contracts & lease deeds poorly structured; unclear performance & reporting requirements & sanctions for non-compliance; few poor patients treated
- “Free” services for public patients insufficiently defined
- Litigation: public patients should not be charged for drugs and consumables
Relevant Indian Experience: More Successful

All India Institute of Medical Sciences (AIIMS)
• Unique model: Facility-specific legislation; special relationship with political power center in New Delhi
• Created under a “hands-off” political environment but increasingly under “hands on” administrative control
• Developed performance-oriented internal governance & management culture
• Accountable to government priorities

Hospitals under PPP Contract Management Arrangements
Examples: Rajiv Ghandi Apollo Hospital (Raichur); Draupadibhai Muralidhar Khedakar-Sahyadri Hospital (Pune); BSES Municipal General Hospital (Mumbai)
• Applied to newly constructed public hospitals
• Government enters into management contract with private provider
• Private provider operates all clinical and non-clinical services with considerable autonomy over input management
• Challenged by weak government capacity to enforce accountabilities, monitor performance and specify/manage contractual terms.
Relevant Indian Experience: A Work in Progress?

Public Hospitals Empaneled under Public Insurance Schemes

- Allowed to retain earnings
- Follow allocation formula
- Have they contributed to greater autonomy or managerial capacity?
- Role of Rogi Kalyan Samitis (RKS)?
Number of Public and Private Empaneled Hospitals by Government Insurance Scheme

- **Private Facilities**
- **Public Facilities**
- **Total Empanelled Hospitals/Clinics**

- Mukhyamantri Swasthya Bhima Yojana (Uttarakhand)
- Retired Employees Liberalized Health Scheme (RELHS)**
- Bhagat Puran Singh Sehat Beema Yojana
- Central Government Health Scheme (CGHS)
- Swasthaya Sathi
- Yeshasvini Co-operative Farmers Healthcare Scheme
- Chief Minister's Comprehensive Health Insurance Scheme
- Mukhyamantrigala Santhwana -"Harish" Scheme**
- Employee State Insurance Scheme (ESIS)*
- Indira Suraksha Yojane
- Ex Servicemen Contributory Health Scheme (ECHS)

Rashtriya Swasthya Bima Yojana (RSBY), 2017

*Data for 2010, **Data for 2016
Recommendations

• Newly constructed hospitals
  – Contract management PPP

• Large teaching hospitals
  – Build upon AIMS/state medical college models

• Urban municipal hospitals
  – Independent health authority

• Rural district hospitals
  – Contract management PPP
    – Society/Foundation
Proposed Co-location PPP in India
Emerging Hospital Co-location PPP Initiative in India

• Objectives
  – Improve access to NCD services: oncology, cardiology, pulmonology (OP, ED, IP, diagnostic)
  – Augment hospital infrastructure (district level)
  – Reduce OOP

• Features
  – 50-100 bed facilities
    • Co-located within existing premises of district hospitals
    • 30 year concession
  – Private partner: build/upgrade, equip, staff and operate clinical and non-clinical services (including MIS)
  – Steering Committee, Contract Management Cell, Quality Assurance Cell
  – Monitoring indicators
  – Accreditation in three years
Emerging Hospital Co-location PPP Initiative in India

- **Financial structure**
  - Government viability gap financing (infrastructure)
  - Uniform tariff (FFS)
    - State government reimburses private operator for “government” patients at RSBY tariffs
      - Patients enrolled in GSHISs
      - Patients not enrolled in GSHIS but eligible for full subsidy (but with possible volume cap)
    - Self-paying patients pay OOP
      - Collected by government?
  - Escrow account
    - 3 month balance
Some Considerations on Co-location (Indian Experience)

- Successful “asset-light” dialysis/diagnostic co-location experiences in India
  - Require low management capacity and limited capital and recurrent financing
  - Can these low-complexity models serve as a basis for doing more complex co-location models?
- Risk of delayed or non-payment
- Pricing of services
- Volume control
Some Considerations on Hospital Co-location (Global Experience)

- Not a public hospital reform model – though may be part of broader hospital reform initiative
- Documented benefits in South Africa and Australia
  - Infrastructure/equipment upgrades and equipment for private AND public facility
  - Cross-subsidization - Revenue flow to public partner
  - Staff retention (increased earnings)
  - Service expansion and discounts for public patients
Co-location Hospitals: Lessons learned from South Africa and Australia

- Robust legal and regulatory framework
- Correct incentives - link payment to performance, especially quality
- Strong contract development, management and monitoring
  - Harnessing private sector contract management capacity
- Rigorous performance monitoring
- Avoidance of rigid adherence to administrative processes
- Effective public hospital management (to manage staff and ensure undifferentiated treatment of public and private patients)
- Evaluation – build a knowledge base on what works, where and why
Thank you

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