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

New Thinking in Health Policy

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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

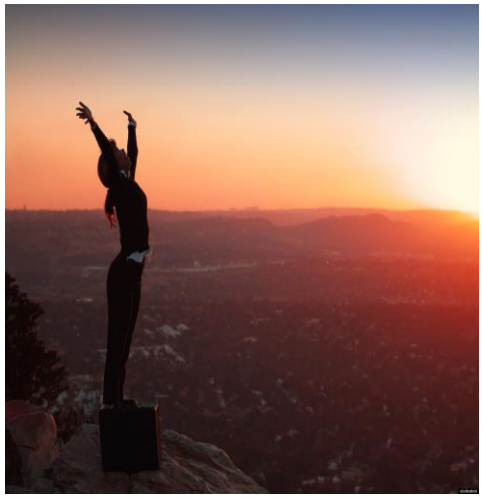
Source: Adopted from Holder, 2014

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

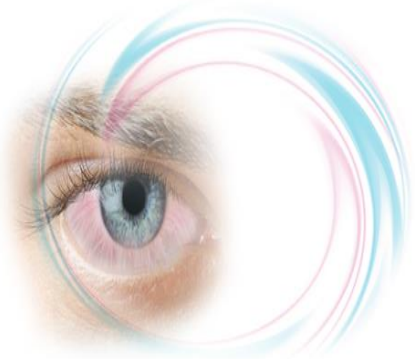
Why Autonomy?

- 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.



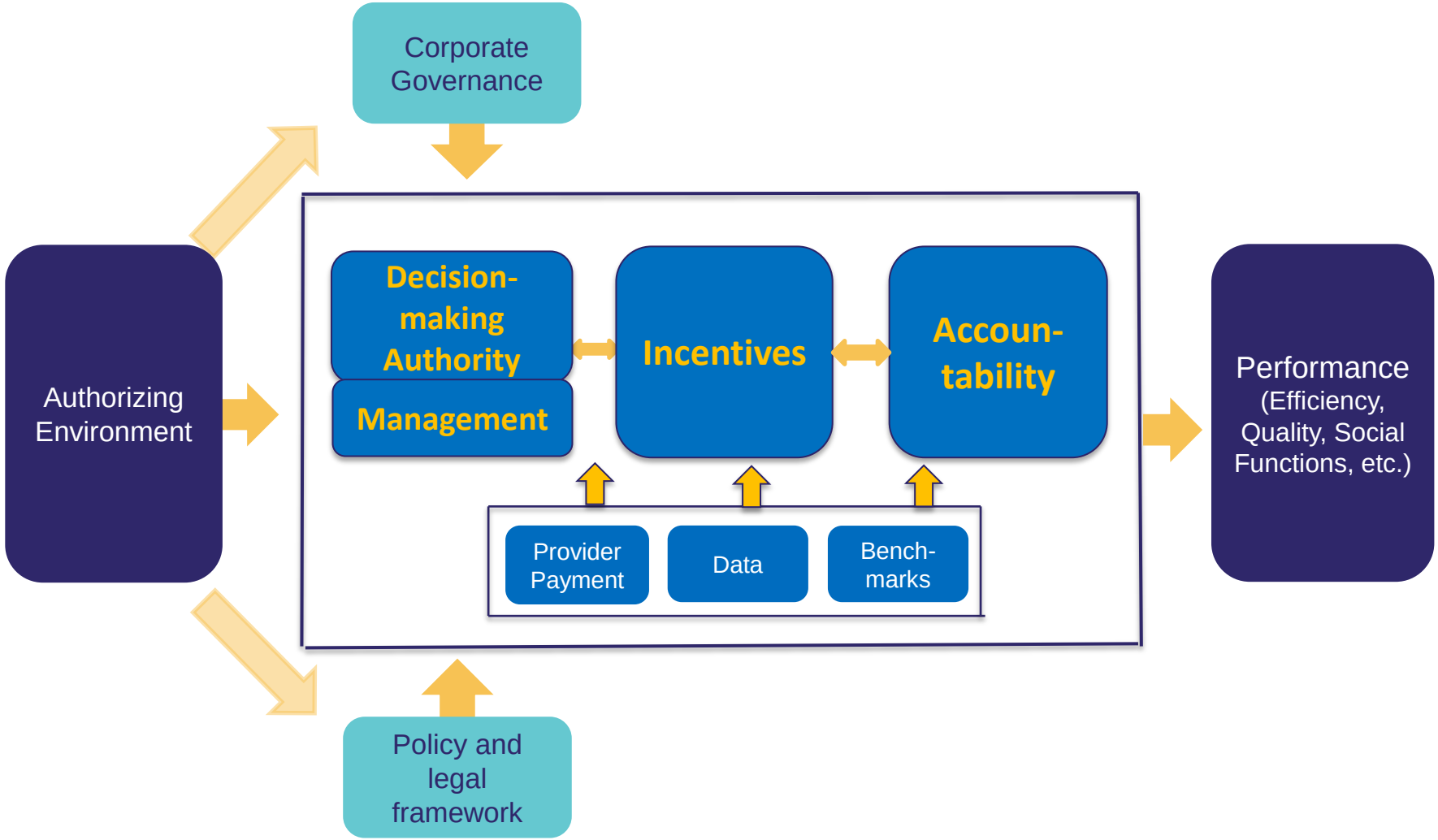
Organizational Models for Autonomy-Oriented Reforms

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

Country	Organizational Models	Organizational Nomenclature
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		
Hong Kong	Corporatization	• Public Authority

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



Lessons Learned: Autonomy/Transfer of Decision-Making Authority

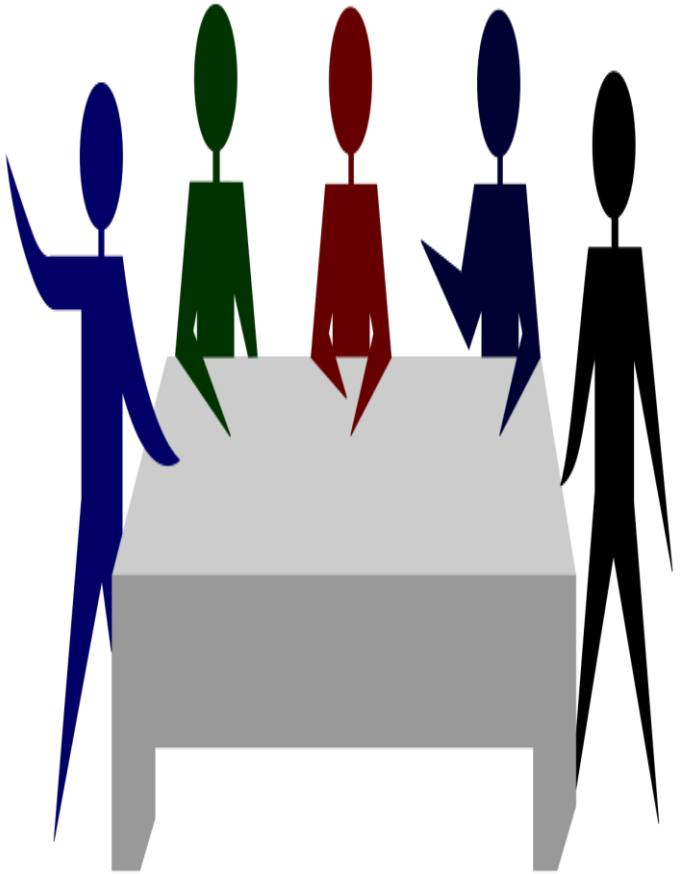
- Legislated governance structure specifying composition, functions and responsibilities
- Formal application & transparent approval process for hospitals to achieve autonomous status
- Transparent arrangement to transition civil servants to alternative labor contracts
- A phased time table for transferring 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

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

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)

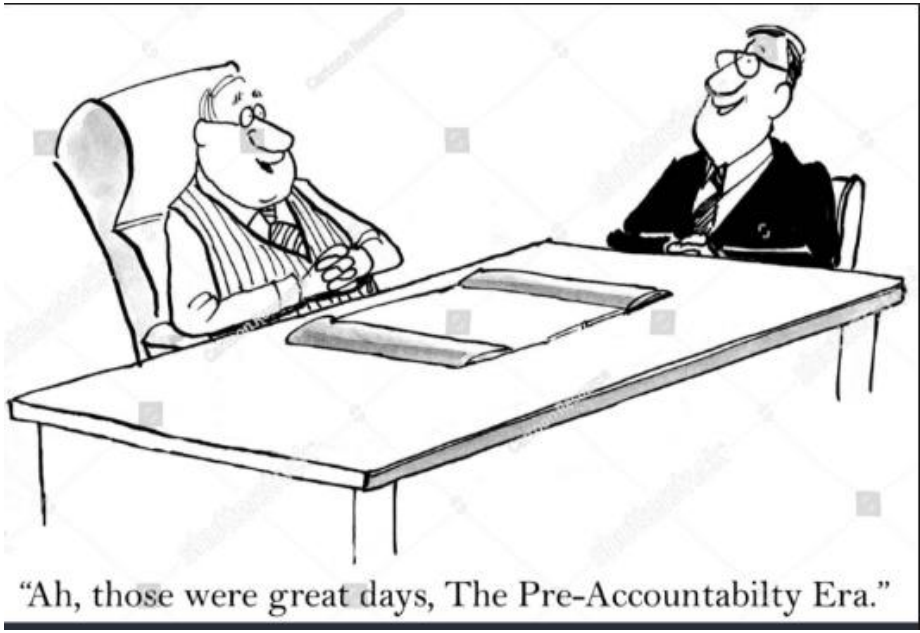
State Level

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


"Ah, those were great days, The Pre-Accountabilty Era."

Examples of Accountability Mechanisms

Model	Types of Accountability
Brazil: OSS	• Contract payments linked to volume, quality and efficiency targets • Data reporting requirements • Internal and external audits • “Social audits” • Contract termination/firing of management for consistent underperformance
Hong Kong: Hosp. Authority	• Financial assessments against annual budget targets
Portugal: PEEHs	• Annual financial reports • Data reporting requirements • Government can dismiss board for budget deviations, quality deterioration and contract violations
Spain: AC	• Penalties for patients seeking care outside of catchment area • Sanctions for non-compliance with contract • Data reporting requirements (clinical, financial, operational) • Internal and external audits
UK: Foundation Trusts	• External performance and financial monitoring

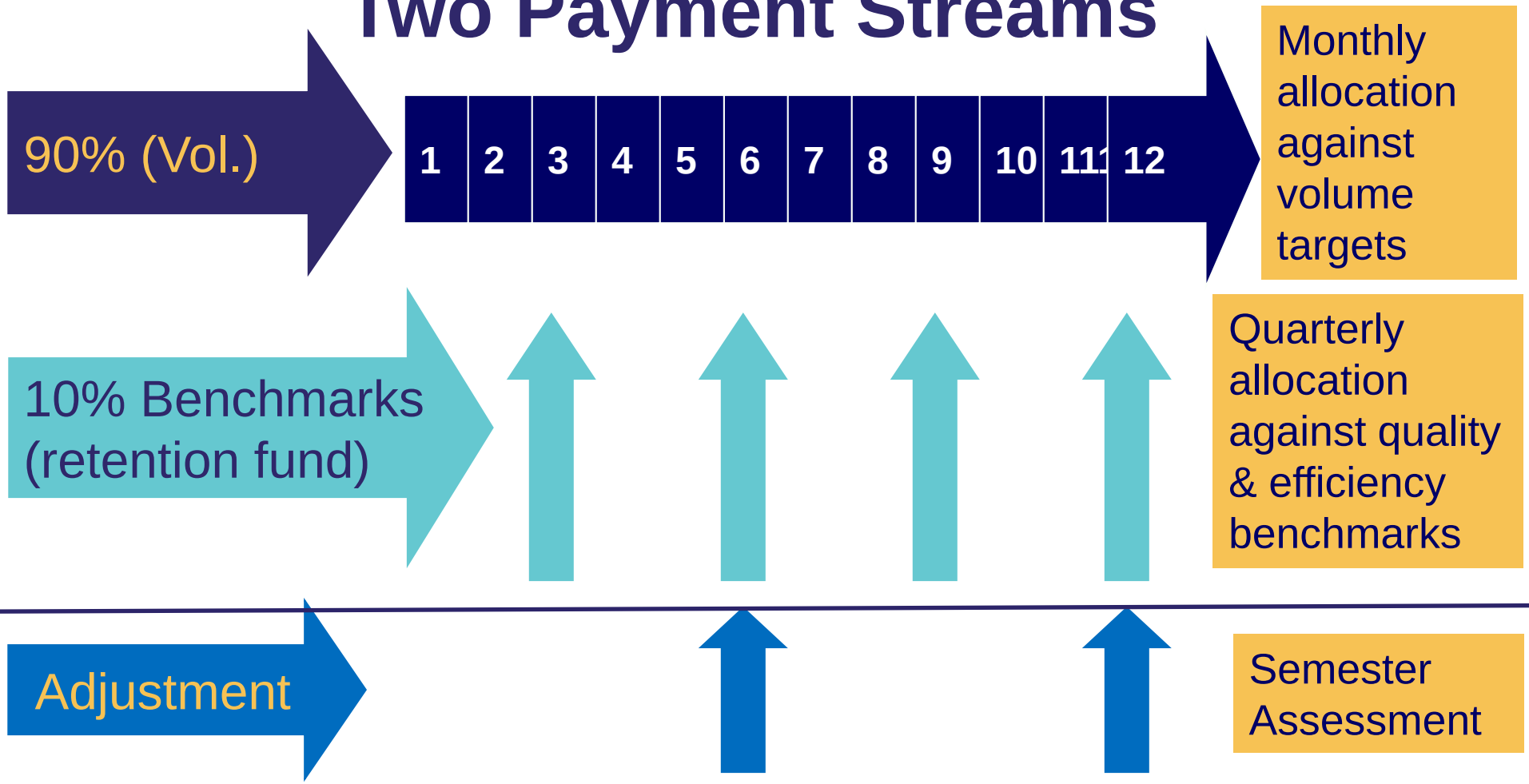
Sample Performance Measurement & Indicators from Select Models

Model	Financial Indicators	Patient Experience	Efficiency	Quality	Social Functions
Brazil: OSS	• Audits • Spending	• Patient satisfaction surveys	• ALOS • Costs per admission	• Infection rates • Readmission rates • Mortality	• No fees • No refusal of care • All hospitals in low-income areas
Spain: AC	• Audits • Billing	• Wait times • Patient experience		• Clinical outcomes	
Portugal: PEEHs	• Audits • Cash flows	• Average patient delays	• Discharges	• Readmission rates	
HK: Hospital Authority	• Financial reports		• Input indicators		

Lessons Learned: Incentives

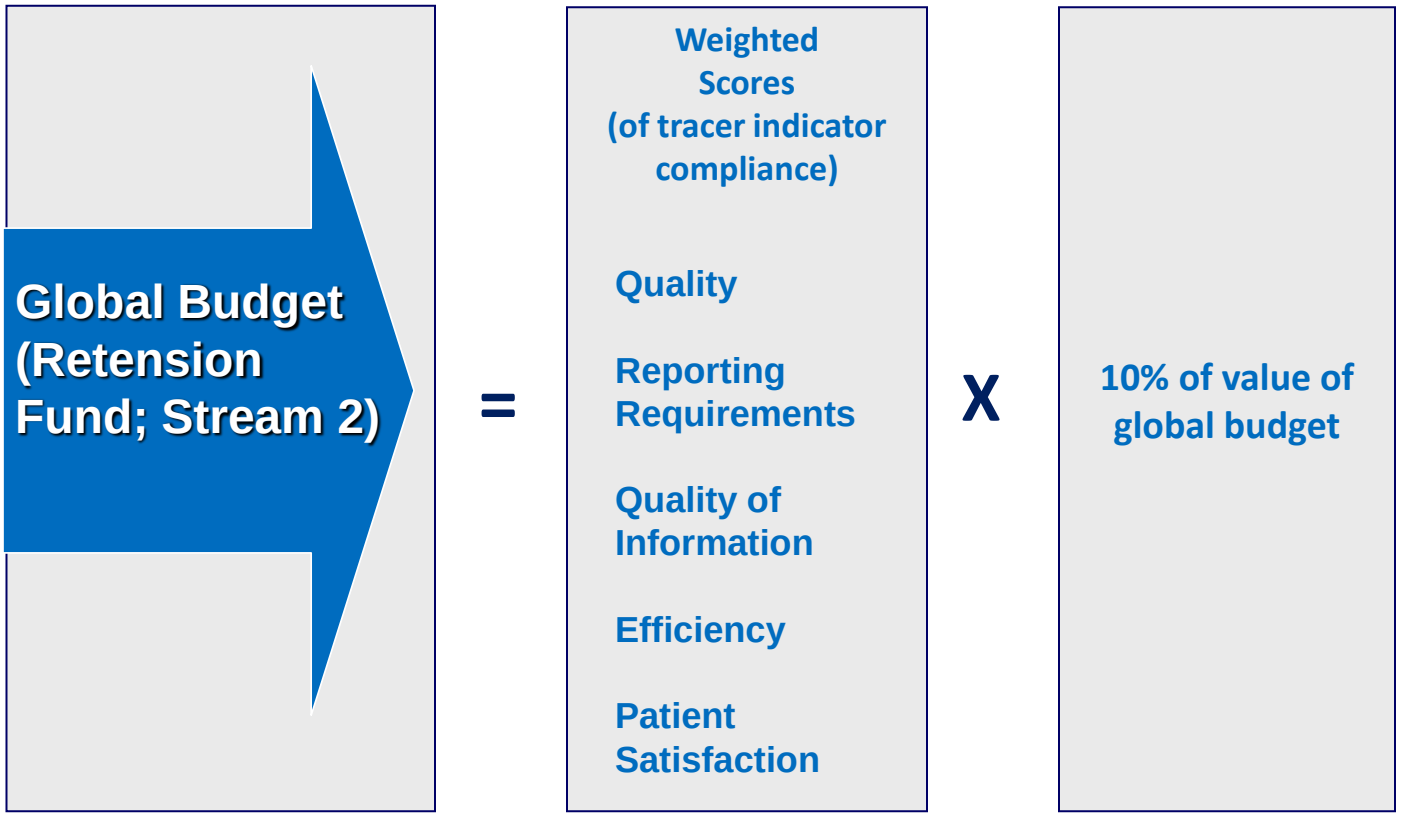
- Align hospital incentives with public objectives and performance:
  - Hospitals at financial risk for noncompliance with performance measures/overruns
  - Payment systems promote cost containment and link payment to quality and efficiency
  - Purchasing systems to enable effective monitoring and data analysis
  - Use of cost accounting systems to set payments and monitor spending

Brazil OSSs in Sao Pablo: Performance-based Global Budget – Two Payment Streams



Source: La Forgia and Couttolenc, 2008

OSS Sao Paulo, Brazil Performance-based Global Budget: Benchmark Portion



Source: La Forgia and Couttolenc, 2008

Examples of Performance Indicators and Weights Linked to 10% "Retention Fund" of OSS Global Budget

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

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?

	Revenue	Production	Efficiency	Quality	Equity	Patient Satis.
Brazil (OSS)	↔	↑	↑	↑	↔	↑
Indonesia	↑	↑	↓	N/A	↓	N/A
Spain (Alzira)	↔	↑	↑	↑	↔	↑
Vietnam	↑	↑	?	?	↓	N/A

Source: Maharani, 2017; Wagstaff and Bales, 2012; NHS Confederation, 2011; London 2013; La Forgia and Couttolenc, 2008

Key Components of Effective Public Hospital Reforms

1. Clear policy and legal framework
2. Well-defined and legally constituted governance and corporate entities
3. Autonomous managerial authority
4. Incentives for efficiency, cost containment and equity
5. Government or other authority holds autonomous hospitals accountable for: • Financial performance • Service quality and scope • Contract compliance
6. Data to tracks hospital performance and financial accounts; strong government capacity to monitor and enforce contracts
7. Managerial capacity

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

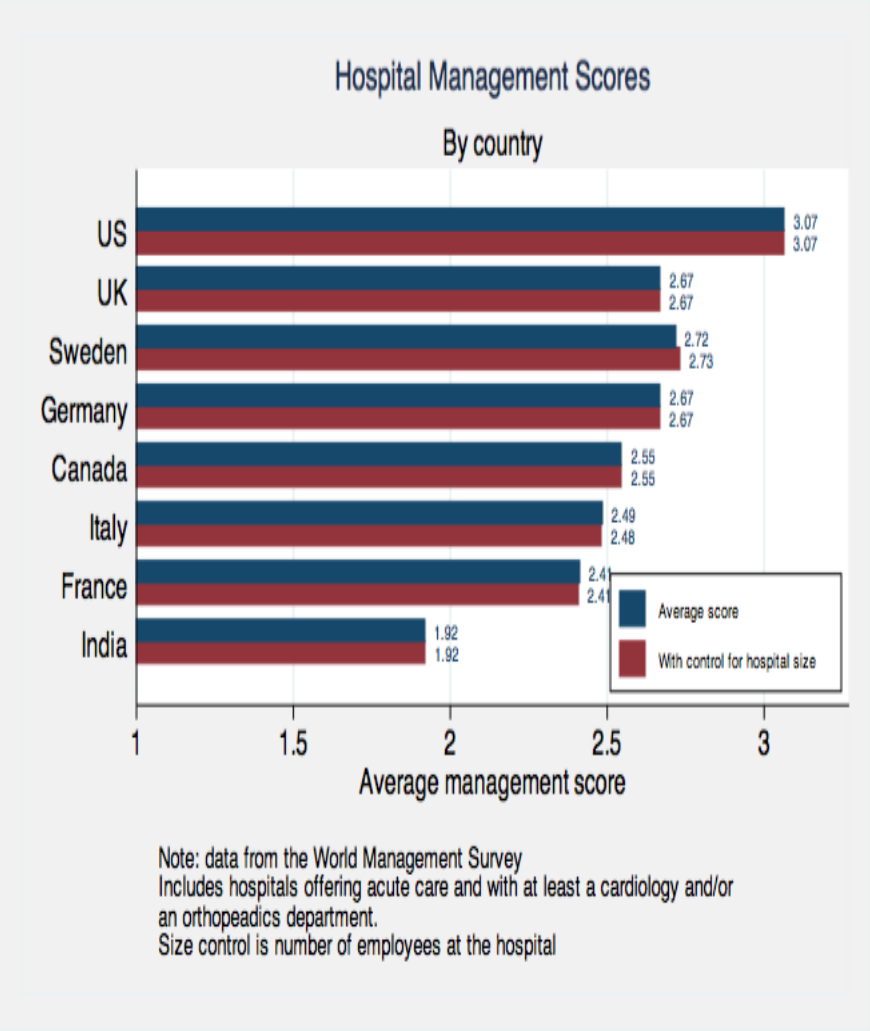
- Little systematic information on performance
- Microstudies, small surveys and press reports suggest:
  - Shortages in HR and supplies
  - Inadequate and poorly maintained infrastructure and equipment
  - Poor quality of care and patient dissatisfaction
  - Low productivity

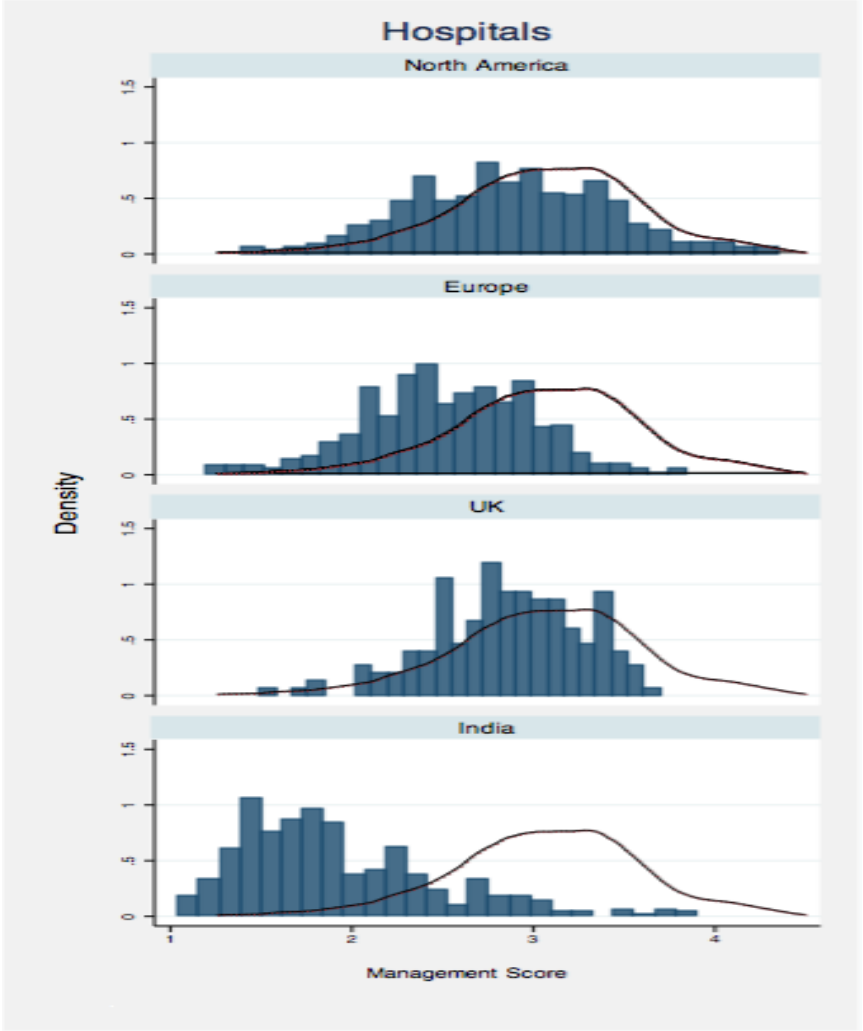
Source: Burns, Srinivasa and Vaidya, 2014; Baipai, 2014, International Institute for Populations Studies; MOHFW, 2005, 2010, 2014; NABH, 2016; National Health Resource Centre, 2009; Lipika, et. al., 2009).

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

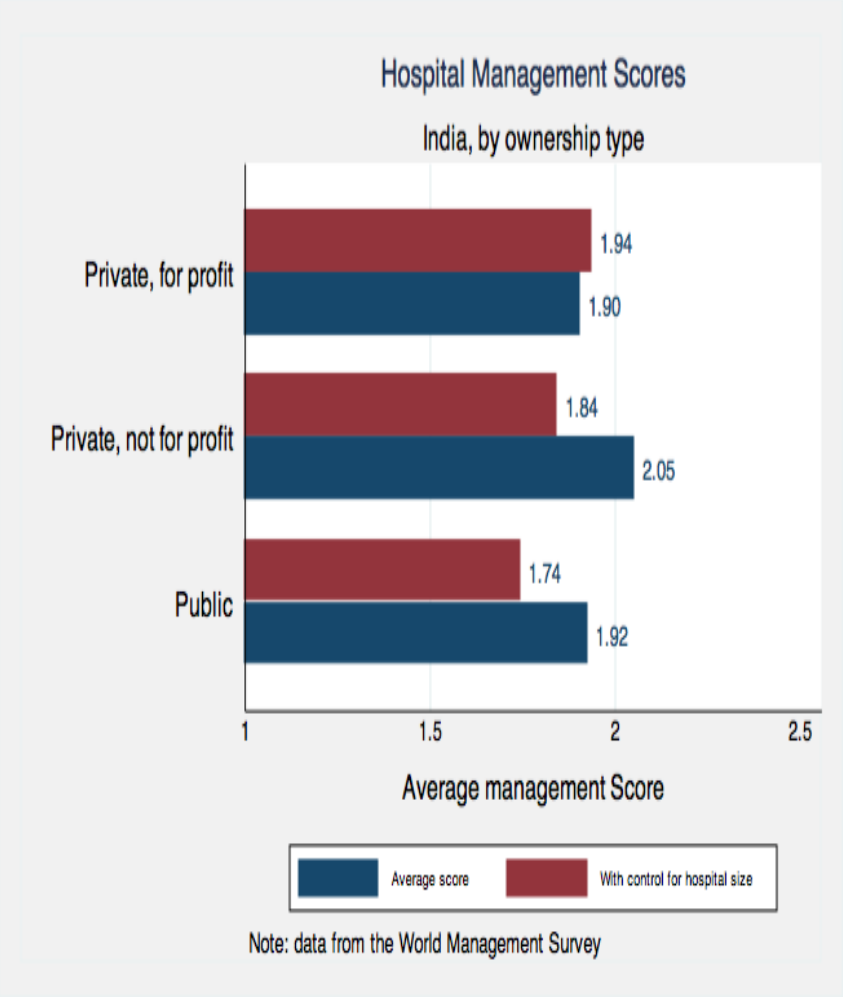
World Management Survey: Comparative Hospital Results

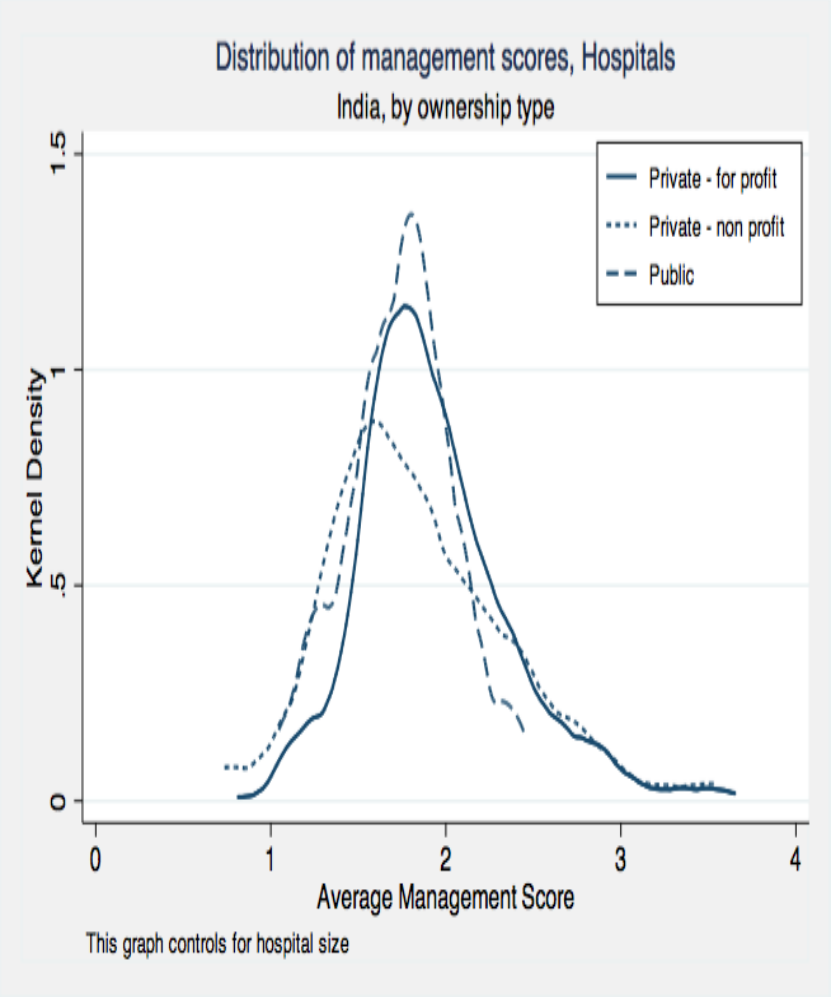




Source: Lemos and Scur, 2012

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

Name	Organizational Model	Legal Basis	Governance structure
AIIMS	Autonomization	Special Act of Parliament (1956)	Institute Body
Apollo Hospital (Delhi)	PPP (joint venture)	Land Concession/ Contract	Apollo Board?
Rajiv Ghandi Apollo Hospital (Raichur) Draupadibhai Muralidhar Khedakar-Sahyadri Hospital (Pune); BSES Municipal General Hospital (Mumbai)	PPP (contract management)	Contract with private provider	Board of contracted provider?
A Public Body Managing a Network of Facilities			
Punjab Health Systems Corporation	Corporatization	State Legislation (1996)	Board
Other Models (probably not "reforms")			
Rogi Kalyan Samitis (RKS) (patient welfare societies)	Semi-Autonomization?	Societies Registration Act	Governing committee
Grants-in-Aid (Gujarat, Kerala, Assam)	PPP (purchasing arrangement)	MOU with NGO/trusts	NGO/Trust Board?

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)

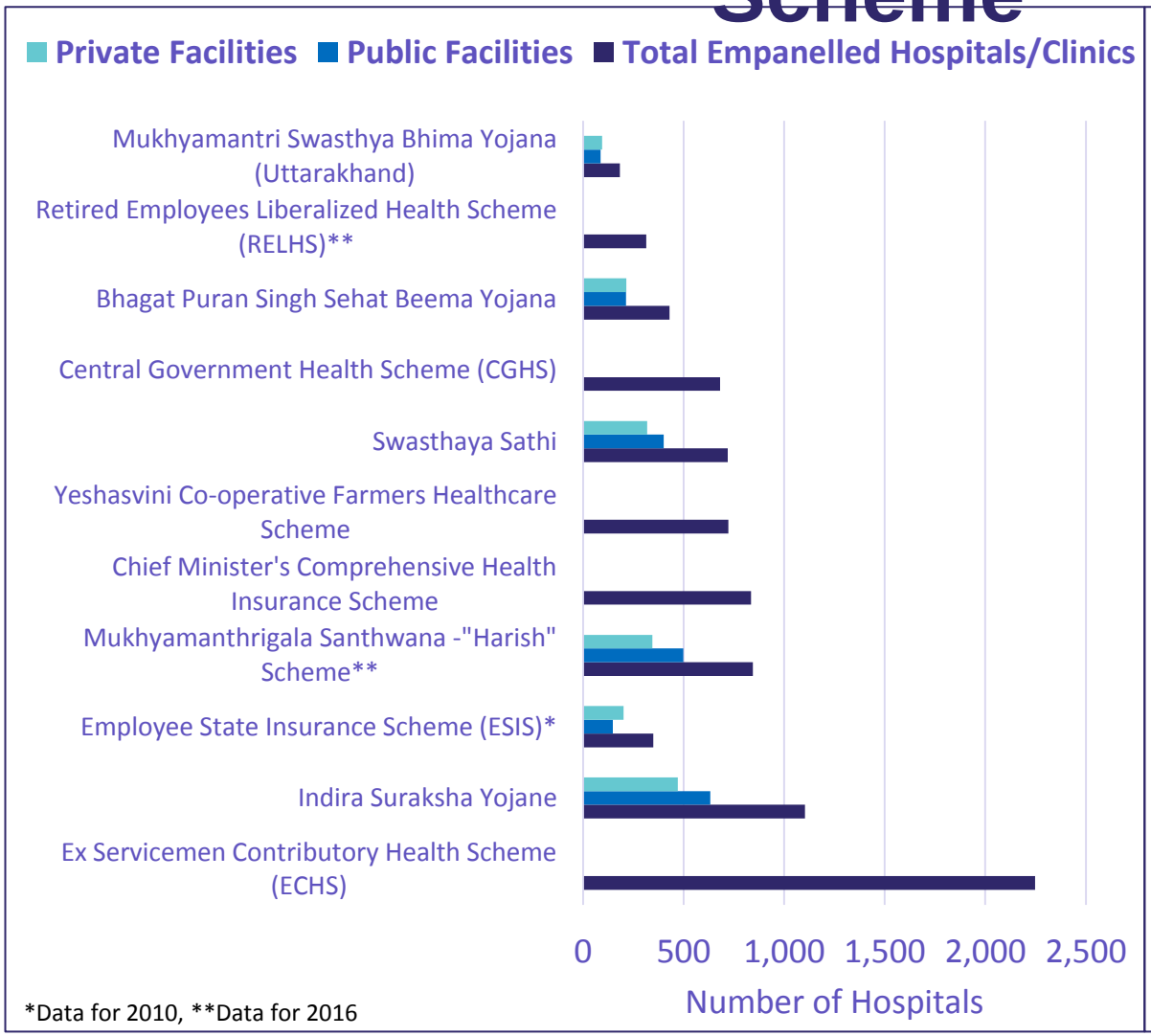
- Applied to newly constructed public hospitals
- Government enters into management contract with private provider
- Private provider operates all clinical and non-clinical services with considerable autonomy over input management
- Challenged by weak government capacity to enforce accountabilities, monitor performance and specify/manage contractual terms.

Relevant Indian Experience: A Work in Progress?

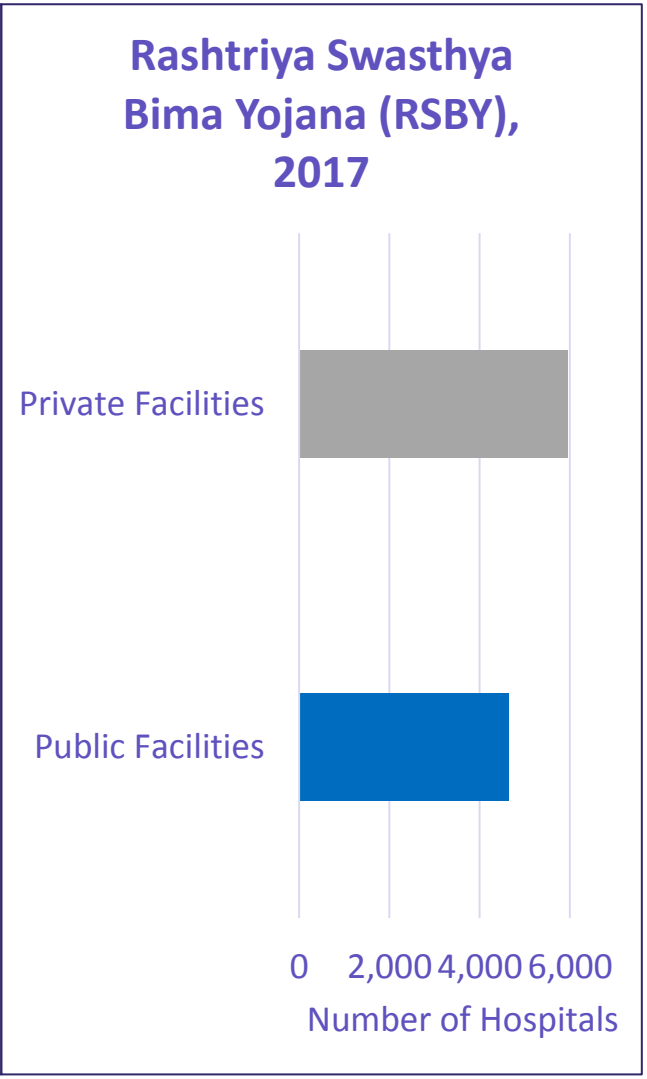
Public Hospitals Empaneled under Public Insurance Schemes

- 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



*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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