Public Hospital Autonomy
Global Experience

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Hospital CEO Forum, 2018
Creating Excellent Outcomes in the Philippine Healthcare System

Asian Development Bank
July 19, 2018
Summary

• Rationale: Challenges facing public hospitals
  – Performance, governance, management

• Reforms
  – Framework;
  – Operational models and features
  – Impact
  – Short case study from Brazil

• Lessons Learned
Rationale
Public Hospital Managers Face Many Conflicting Interests and Pressures

- Medical Staff
- Suppliers
- Non-medical Staff
- Unions
- Politicians
- Payers/Insurers
- Government Policy makers & Regulators
- Patients and their families
- Consumer Groups
Global Experience: Focus Groups with Public Hospital Managers in Latin America

Public Hospitals: Common Challenges

✓ Strong social symbolism; face of the health system
✓ Fragmented silos inside the hospital
✓ 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
Why Autonomy Reforms for Public Hospitals?

- Poor quality care, inefficiency, low productivity and patient dissatisfaction
- Hierarchical bureaucracy and limited decision-making authority
- Inflexible human resource and procurement policies
- Political and bureaucratic interference in HR processes and selection of managers
- Evidence from other sectors of benefits of delivery model
  - Incorporating and/or building on private sector incentives
  - New public sector management
Can managers manage under these conditions?

Does it matter if managers are able to manage?

“I would like you to be more self-reliant, show more initiative, and take greater personal responsibility — but check with me first!”
World Health Survey: Hospital Management Practice Domains

1. **Standardizing Care & Operations**
   - Hospital layout & patient flow
   - Patient pathway management
   - Standardization & clinical protocols
   - Good use of human resources

2. **Performance Monitoring**
   - Continuous improvement
   - Performance tracking, review, dialogue
   - Consequence management

3. **Target Management**
   - Target balance & interaction
   - Clarity, comparability of targets
   - Time horizon of targets
   - Target stretch

4. **Talent Management**
   - Rewarding/promoting high performers
   - Removing poor performers
   - Managing, retaining, attracting talent

Source: Bloom and Van Reenen (2007)
World Management Survey Results:
Comparative hospital results show that India is lagging, and poor management permeates both public and private sectors (India, 2011)

Notes: 1,971 acute care hospitals with a cardiology and orthopedics department
Source: Bloom, Sadun & Van Reenen (2013)

India sample. N=449; median 100 beds, and 140 employees
Source: Lemos and Scur (2012)
Hospital Management Matters:
A one point increase in management practice is associated with...

**UK Hospitals**
- **Health:** 6.5% reduction in risk adjusted 30 days AMI mortality rates
- **Financial:** 33% increase in income per bed
- **Patient:** 20% increase in above average patients satisfaction

**US Hospitals**
- **Health:** 7% reduction in risk adjusted 30 days AMI mortality rates
- **Financial:** 14% increase in EBITDA per bed
- **Patient:** 0.8 increase in % people would recommend the hospital

Improving Public Hospital Performance
The Roads Taken

• Autonomy Reforms
  • Governance + Management + Finance: Transferring decision-making authority from government administration to the hospitals

• Management interventions
  • Managerial capacity building

• Finance interventions
  • Pay for performance
Autonomy-based Reforms
Global Experience
Framework for Developing and Analyzing Public Hospital Reforms

Authority/Decision-rights
How much effective decision-making autonomy is allowed?

Managerial and Technical Capacity
Do hospital directors have the managerial skills/tools to implement authorities and respond to accountabilities and incentives? What is the extent of technical competence to provide services of acceptable quality and efficiency for the patient caseload?

Accountabilities
What mechanisms exist to ensure hospitals perform well? Are they effective?

Incentives
To what degree are hospitals and/or managers motivated to perform well?

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Main Messages

• **Uncertain Impact** – Evidence is hard to find
  • Limited range of well-designed scientific evaluations; much of the work is of a case comparison type
  • Some successes, but also a number of less successful efforts

• Despite variable record, **hospital autonomy remains on the policy agenda**

• **Raising revenue is not a good rationale** (e.g., China, Vietnam)

• **Accountability is the Achilles heal of autonomy models**
  • Financial performance, access/social functions, quality of care, patient safety, professional competence, ethical conduct
  • Requires strong government/bureaucratic capacity

• **Incentives matter**

• **Human resource issues should be addressed openly prior to implementation**

• **No quick fixes**
  • Design and implementation: long, complicated and highly politicized process
  • Local context matters (even within a country)
  • Need to consider upfront investments and “transition costs”
## Organizational Models for Autonomy-Oriented Reforms: Global experience – What are the choices?

<table>
<thead>
<tr>
<th>Autonomization</th>
<th>Corporatization</th>
<th>Public-Private Partnerships (contract management PPPs)</th>
</tr>
</thead>
</table>
| • 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 | • 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 | • 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) |

Authors’ elaboration
## Public Hospital Autonomy 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           | Autonomization, PPP   | • Public corporations,  
                            • Foundations, consortia  
                            • Administrative concessions (to private firm)                                         |
| Singapore       | Corporatization       | • Private company solely owned by government                                               |
| Sweden          | Corporatization       | • Public-stock corporations                                                               |
| UK              | Corporatization       | • Self-governing trusts  
                            • Foundation Trusts                                                                      |
| Hong Kong       | Corporatization       | • Public Authority                                                                       |
| New York City   | Corporatization       | • Public Authority                                                                       |
# 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>NGO Board</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>
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<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>
</tbody>
</table>
| UK: Foundation Trusts | Board of Governors & Board of Directors | At least one hospital                                     | **BOG**: patients, citizens, staff  
**BOD**: Hospital CEO, executive directors, BOG representatives |
# Examples of Accountability Mechanisms

<table>
<thead>
<tr>
<th>Model</th>
<th>Types of Accountability</th>
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</table>
| **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: Hospital 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** | • Hospital payment partially linked to basic quality targets  
|                    | • External performance and financial monitoring |
Human Resource Options

• Transfer
• Attrition (and replace)
• Transitioning civil servants to alternative (private) labor contracts
  • Grace period
  • Temporary placement elsewhere with reentry guarantee
• Performance incentives
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>
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<td>Brazil (OSS)</td>
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<td>Spain (Alzira)</td>
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Social Health Organizations (OSSs) in Sao Paulo, Brazil [Corporatized PPP model]
Sao Paulo, Brazil: Accountabilities, Incentives and Managerial Know-how

- Performance-based contract
- Performance-based global budget
- Cost-based budgeting
- Robust monitoring and benchmarking
- Vigorous contract enforcement
- Good and experienced managers

Source: La Forgia and Couttolenc, 2008)
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
Sao Paulo, Brazil: OSS hospitals found to be:

- **Significantly more productive and efficient than comparators**
  - Use of beds, operating theaters,
  - Lower ALOS, higher bed turnover and substitution rate
  - Cost per discharge:
    - OSS -- R$ 2,900 vs. Dir. Adm.-- R$ 4,300
  - Regression analysis: 1% increase in spending would result in 0.47% increase in discharges in OSS-managed hospitals compared to 0.22% increase in matched hospitals.
    - OSSs use one-third fewer physicians and one-third more nurses

- **But quality was also higher**
  - Lower Mortality rates
    - No evidence of cream skimming or patient dumping
    - No evidence of treating less severe patients
Global Experience
Lessons Learned
# Reasons for Limited Success of Some Reforms

<table>
<thead>
<tr>
<th>Location</th>
<th>Key Challenges</th>
</tr>
</thead>
</table>
| Hong Kong: Hospital Authority | - Reforms led to transfer of authority from one bureaucracy to another (the HA)  
                        |  - Minimal accountability & poor incentives                                    |
| Portugal: PEEHs   | - Persistence of central control                                               
                        |  - Lack of transparency                                                        
                        |  - Uncoordinated & inconsistent accountability efforts across facilities       |
| UK: Foundation Trusts | - Limited financial and managerial independence                                  
                        |  - High government interference                                                 |
| China Vietnam     | - Focus on increasing financial autonomy and hospital revenues without corresponding emphasis on accountability and incentives for performance, social functions and public objectives |
# 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
Concluding remarks

• Autonomy is often a prerequisite for improving management because it empowers managers to manage.

• 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.

• Any incentive embedded in a provider payment mechanism, contracts or regulations requires autonomy to empower hospital managers to respond to the incentive.
Thanks

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