Hospital Organizational Reform: Distilling Lessons from International Experience

Loraine Hawkins
April, 2010

Outline of presentation

I. Hospital organizational reform in middle and upper income countries:1980's-1990's

II. Evaluation and analysis of reform experience

III. Diversity in hospital policy development in the "noughties"

IV. Relevance of these reform models to issues facing public hospitals in emerging and transitional economies in East Asia

I. Drivers of reform in 1980's-1990's

- Fiscal pressure
- Consumer and voter dissatisfaction with quality of public service delivery
- Market-oriented political philosophies, context of wider public sector reform
- IFI support for developing countries to emulate OECD country public sector reform models

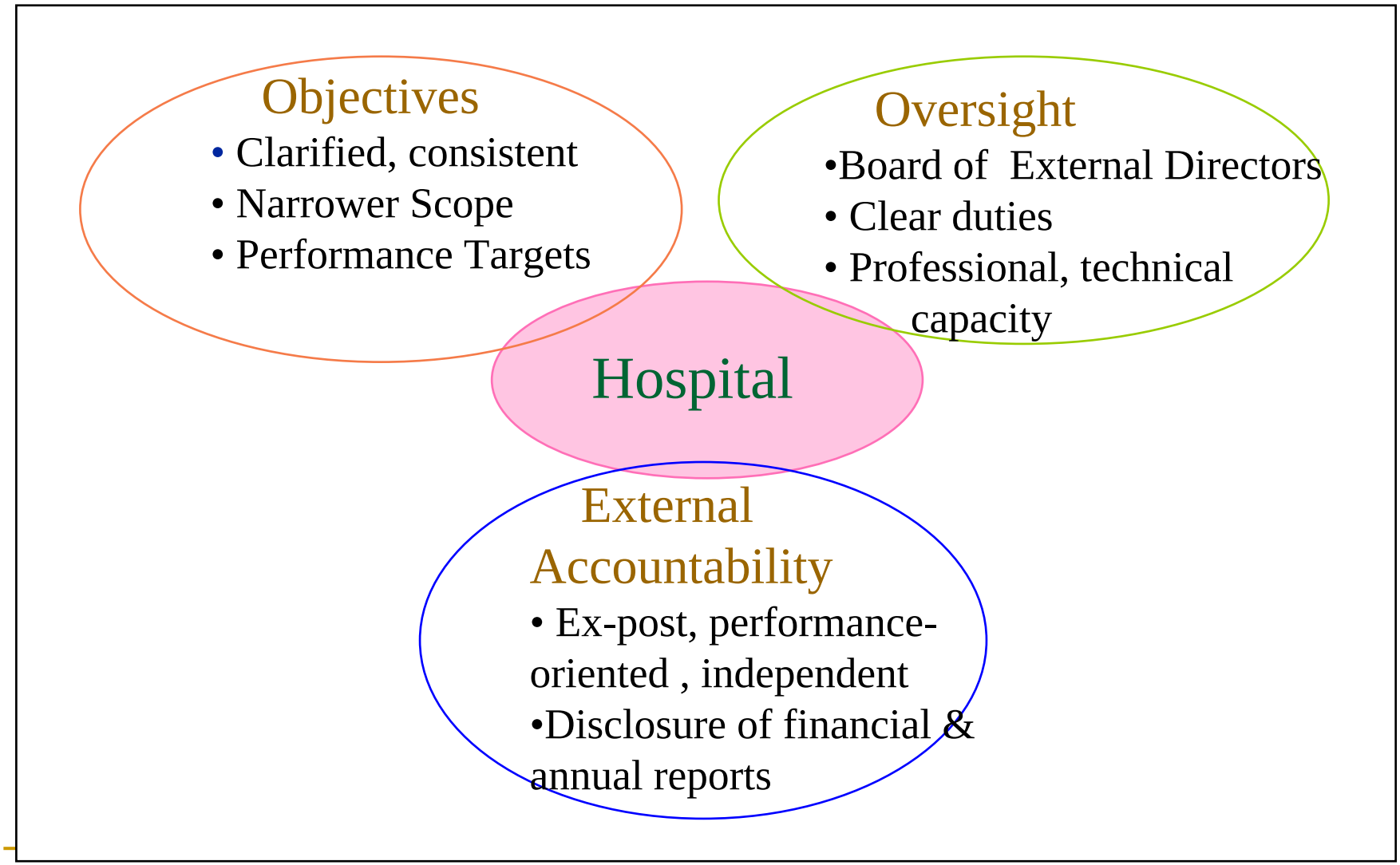
Many regions and countries engaged

- *"Anglo" & EC countries* facing fiscal pressures, under governments with market-oriented political philosophies: UK, NZ, Australian states, US cities, Austrian states, Stockholm...
- *Fast-growing economies* with expanding social spending, and rising urban middle class demand: Singapore, Hong Kong, Malaysia, Thailand
- *Central and Eastern European* countries in post-communist economic transition
- *Other developing countries*: Tunisia, Lebanon, Argentina, Colombia, Brazil, Indonesia...

Elements of comprehensive hospital reforms of 1980's-1990's

- *Internal capacity*: professionalization of management; management systems development
- *External performance drivers*: purchaser-provider separation, contracting and payment reform, competition
- *Institutional and governance reform*: autonomy or corporatization, privatization, private investment, private management
- *Rationalization*: mergers, restructuring

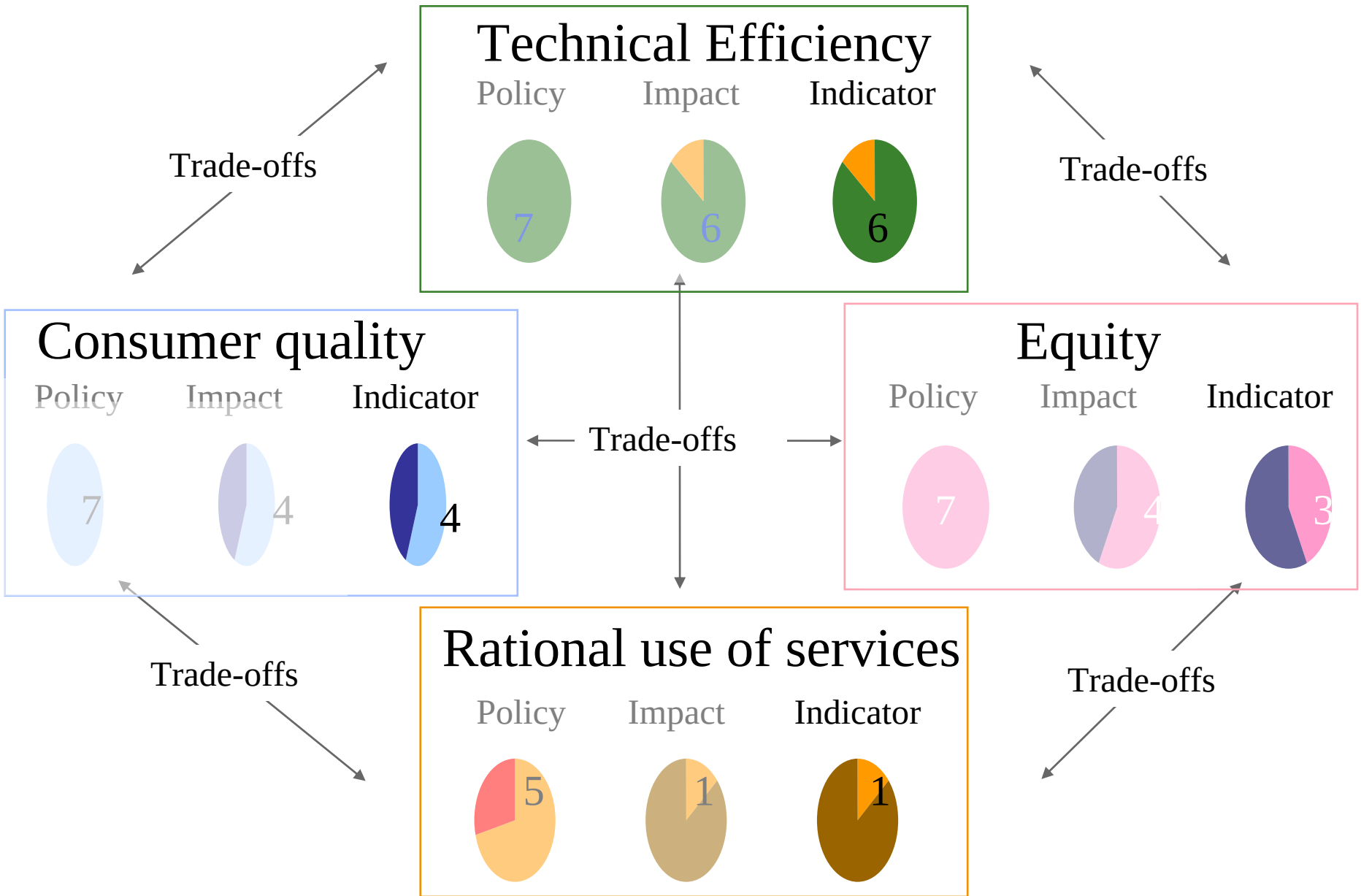
Governance reform in corporatization



II. Evaluation and analysis

- Mostly case studies and before-after studies
- Diversity *within* reforms vexes comparison
- UK and Brazil comparative evaluations – but methodological challenges
  - Efficiency gains; quality improvement from recent UK and Sao Paolo reforms
- Cross Country Studies
  - Harvard School of Public Health 1996
  - World Bank 2003 (UK, NZ, Singapore, Hong Kong, Tunisia, Malaysia, Indonesia)
  - European Health Reform Observatory 2001

Evaluation of seven case studies



Balance among 5 organizational incentives needed

- Management autonomy
- Financial incentives
  - Payment system
  - Surplus retention
- Accountability reform
- Social functions

Income growth
Efficiency
Patient-perceived quality

Equity
Clinical quality
Rational use

Lessons from experience in design of "marketizing" hospital reform

- Planning and regulation tools needed to respond to autonomous hospitals' incentives to:
  - expand/reduce profitable/unprofitable services
  - engage in a "medical arms race" as competition for doctors and patients increases
- Need to fund explicitly "unfunded mandates" (e.g. care for uninsured & refugees, teaching & research) because hospitals are more responsive to provider payment system

Limitations & risks of reform model

- “Cappucino” reforms – applied pressure for change at the top: health care only improves if the front line staff who deliver care work differently
- Need other policy levers to engage with clinical quality, rational use, universal coverage
- Complexity & cost: demand high capacity stewardship, management, information systems
- Reform reversal in countries with bipolar politics where health reform a dividing issue

III. OECD reform in the 'noughties'

- 2nd wave of hospital reform 2000-2010
- diverse – no "blue print"
- countries forging own solutions to own problem-diagnosis
  - stakeholder representation & democracy (UK, Canada)
  - doctor empowerment to tackle HR challenges (France)
- greater emphasis on safety, quality, evidence-based-medicine
- elaboration of methods & institutions for performance assessment & monitoring

Some negative experiences in low and middle income countries

- *Conflicting objectives*: focus on increasing revenue, with unfunded mandate to treat the poor
- *Politicised* or oligarchal control of governance
- Blocking of HR autonomy by unions &/or patronage politics
- Impact of informal payments, dual practice and doctor-ownership of competing businesses
- "*No leap-frogging*" – need "traditional" public administration before "new public management": internal control, public accountability, ethics

Implementation issues: appropriateness to context

- Strategy selected may not be well-suited to every situation: e.g. “market competition” suitable for well-funded, well-informed patients, non-urgent services
- Adequate administrative capacity is essential: e.g. sophisticated performance-related payment methods and staff incentives require good clinical records and independent data validation
- “Fit” with local custom and culture is important: e.g. independence of performance monitoring and supervision difficult in some cultures, prevalence of unofficial practices affects risks of autonomy

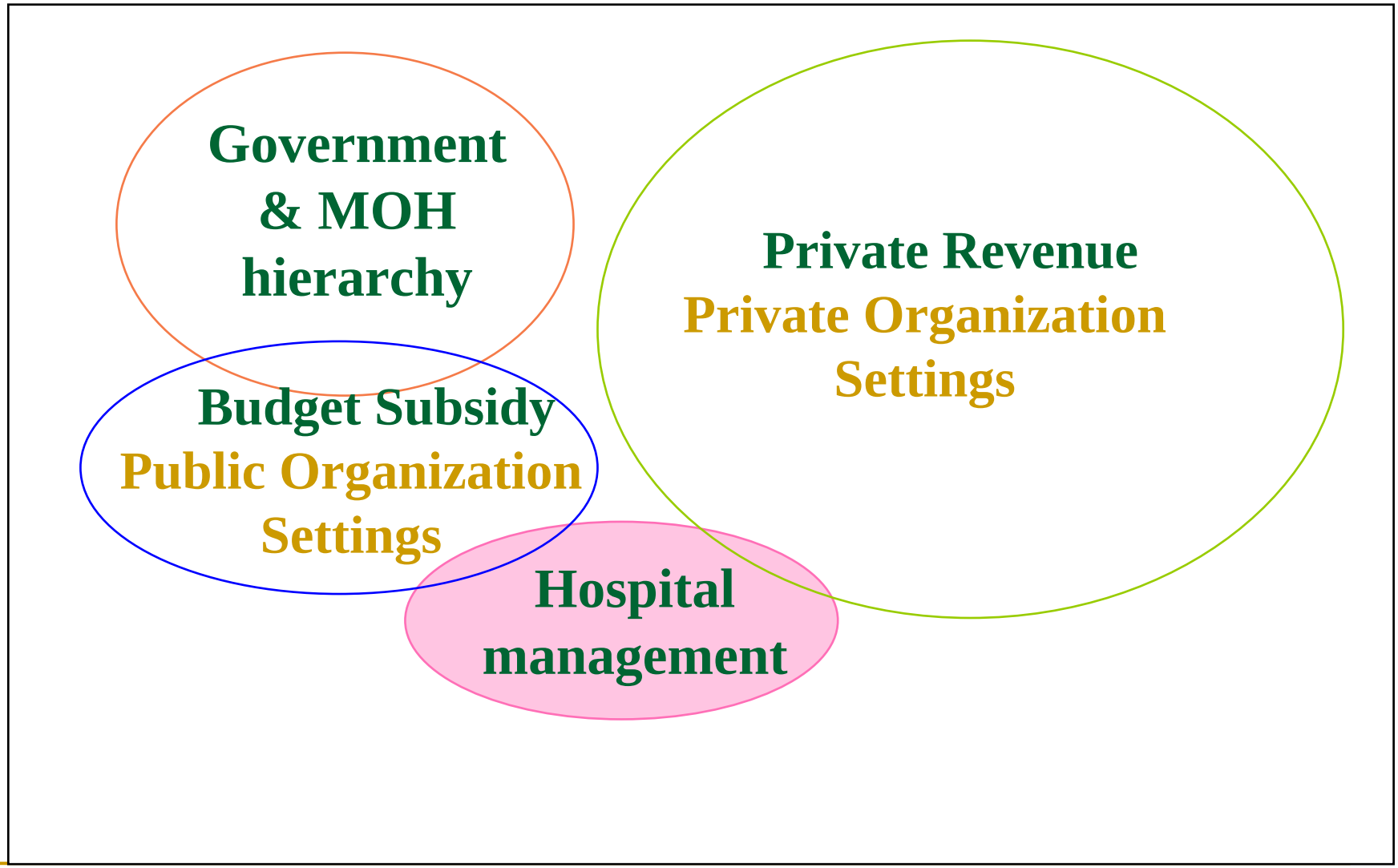
IV. Relevance of OECD experience to low & middle income country hospitals

- Many low or middle income countries with MOH hospital networks have experienced calls for public hospital autonomy, often by doctors, large hospitals
- *Driver for reform:* public hospital system & its doctors want to benefit from rising private demand from urban elite, while improving quality and access for the poor
- *Very different objectives & political economy from OECD*

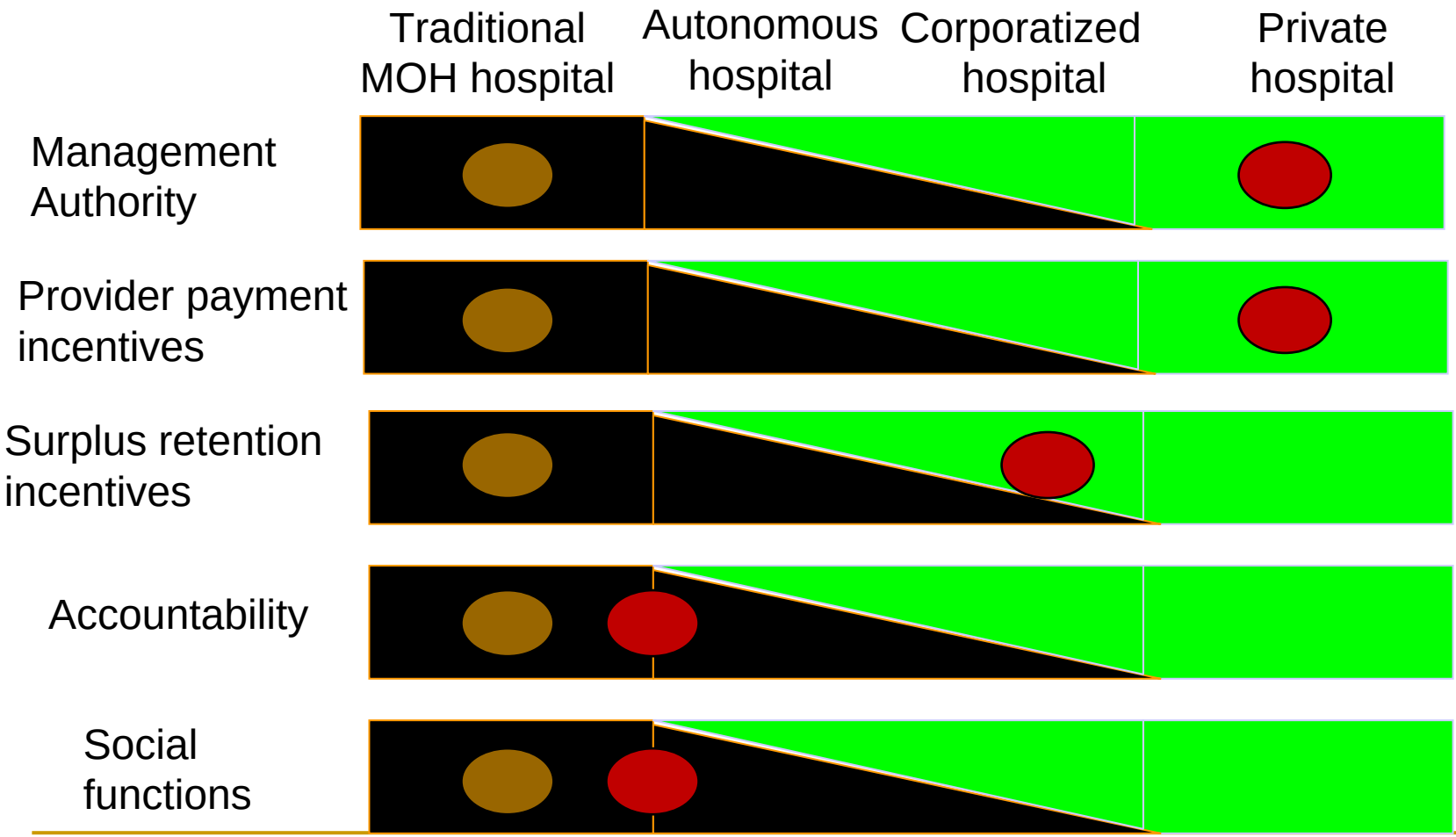
Hybrid organizational settings in low & middle income country hospitals

- Many low or middle income country public hospitals drift into granting hospital autonomy over private revenue, without reform to rules for management of budget revenue
- Private revenue of public hospitals often grows and rules evolve without planned reform:
  - Budget falls &/or middle class demand rises
  - Dual practice, informal payments, drug sales grow
  - Formalization of user fees, private services
  - Gradual expansion of SHI, VHI alongside budget subsidies to cover rising out-of-pocket payment

Hybrid organizational settings



Hybrid organizational settings for budget funds and private revenue



Dysfunctional public-private interface

- Private sector incentives dominate weak incentives and bureaucratic constraints of budget subsidies for the poor
- Doctors and departments retain private revenue from their patients – rapid growth in private services
- Patients unclear about what they should pay for
- Unfunded mandates to provide free/cheap care for the poor leads to implicit rationing &/or lower quality
- Ethics and intrinsic motivation of staff undermined
- Even pro-poor hospital CEOs struggle to manage staff remuneration, capital budgeting and patient processes
- MOFs reluctant to increase public financing or salaries in the face of growth of private revenue and non-transparent use of private revenue

Reasons to replace hybrid hospital settings with comprehensive reform

- Brings all hospital revenues “on budget”
- Integrates financial management and reporting in the hospital
  - Single complete accounting and control over cost of services and hospital revenues
  - Reduced transactions costs of dual accounting
- Introduces incentives for efficient use of budget revenues
- Creates platform for addressing dysfunctional differences in incentives for public and privately financed services

Autonomy: a useful policy tool but of limited relevance to main challenges

- Some hospital autonomy is necessary and important in any health system because the complexity of what hospitals manage is high and most information is at doctor-patient level
- In health systems with insurance or purchasing institutions, some hospital autonomy is necessary to make the “provider payment lever” effective
- But unless government can afford to pay full costs of care for the poor, it will produce a 2-tier system

Relevant evidence on policy options for managing public-private interface (1)

- Costing options for raising revenue while preserving equity in clinical standards for essential services
  - Affordable user fees;
  - Chargeable non-clinical services; charges for choice
  - Explicit clinical rationing
- Making the public-private financing interface clearer to patients:
  - Separate practice or physically separate pathways
  - Transparency on fees & benefits package
- Evidence on externalities of private practice on the public health system and publicly financed services, and policy options for addressing negative impacts (e.g. taxes)

Relevant evidence on policy options for managing public-private interface (2)

- Aligning the incentives of the hospital CEO and senior management team to policy objectives for the poor
  - Professional, full time management
  - Management development and career paths
  - Performance targets, standards with public accountability
  - Provider payment incentives (main tool of “autonomy” model)

- Aligning staff incentives within the hospital:
  - Regulation & management of rights to dual practice
  - Managed “privileges” vs managed part-time employment
  - Regulation of conflicting business interests
  - Credible discipline and sanctions

Hospital reform if a 2 tier system is unavoidable

- Hospitals policy objectives are just as complex: but government is less able to use provide payment tools to achieve multiple policy objectives
- Increases reliance on regulation, management & leadership, mechanisms to build intrinsic motivation of managers & clinical staff, political and social accountability
- Trade-off between intrinsic and external financial incentives harder, but more important