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Case Studies – White Paper on Hospital Autonomy Potential in India

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Global Cases

São Paulo, Brazil
Administrative Concession: Health Social Organizations (OSSs)

Policy and Legal Framework

The push for greater public hospital independence in Brazil coincided with broader federal government reforms during the 1990s. At that time, excessive bureaucracy plagued Brazilian public administration, leading to inefficiencies and rigidity in the entire system. National leaders recognized the need for loosening control over public agencies to permit greater flexibility in management. To this end, a constitutional amendment was passed in 1998 granting "managerial, financial and budgetary autonomy to indirect and direct administration entities." This amendment served as a basis for Federal Law 9637, which established the framework for "social organizations." These non-governmental non-profits can be contracted by the government for the provision of social services, but are not subject to the civil labor and procurement laws that bind traditional publically administered bodies.

Later that year the state government of São Paulo seized upon this new federal legal environment to create social organizations specifically for hospitals. Established by Law 846, health social organizations (*organizaçaões sociais de saúde*, OSSs) directly provide health care services to the public. While they are incorporated under civil law, these are legally independent, private non-profit organizations that the São Paulo state government contracts to manage one or more publicly owned hospitals, largely in poor urban communities. Contracts last for five years, with the option for renewal if the OSS meets quality and performance targets outlined in its contract with the São Paulo Secretary of Health.

Organizational Forms and Governance Structures

OSSs are legally required to have a governance board, whose members are mainly civil society representatives. This board serves as the ultimate authority of the organization and ensures the hospital(s) under its oversight complies with its contractual terms. Hospitals choose their own CEOs, and management carries out all hiring and firing of medical and non-medical staff independently of government. Additionally, hospitals set their own compensation levels, the only major restriction being that no more than 70 percent of the hospital budget may be spent on payroll. While management receives a fixed salary, staff members are eligible to receive bonuses on top of their salaries as determined by OSS hospital management.

Autonomy

OSSs are contracted by the São Paulo government to run public hospitals, and therefore the hospital facilities and all equipment remain property of the government throughout the contract period. Additionally, while hospital management generally has control over purchasing and how it allocates its budget, it must seek government approval for major purchases such as new infrastructural projects or expensive equipment. OSS hospitals have complete flexibility in hiring and day-to-day operations, however.

São Paulo legislation characterizes OSSs as nonprofit social organizations "of public interest"; as such, they tend to be established within vulnerable communities and are obligated to serve the

public. Accordingly, they must provide a specific basket of services as stipulated by the government and the government must sign off on any major shifts in the types of services provided.

The hospital can retain any surpluses it might have at the end of the year, but these may only be invested in health-related activities. OSS hospitals are financially responsible for their debts and deficits, and can borrow commercially to cover operating deficits. Any capital investments have to be financed by the government, however, and are negotiated annually.

Incentives

A contract management unit within the São Paulo State Health Secretary (SES) negotiates annually with OSS hospitals to reach a global budget for the facilities. The allocation of this budget is divided into two parts. The first 90 percent is disbursed in monthly payments that are linked to volume targets established in the contract. The remaining 10 percent is distributed quarterly and linked to efficiency and quality performance. Portions of both allotments can be withheld if hospitals fail to meet specified targets related to volume, efficiency or quality. Thus, the payment system is intended to incentivize both greater efficiency and quality of care.

Given their social mission, OSS hospitals provide services free of charge to the public; consequently, the hospitals cannot receive payments from individual patients. However, recent policy changes allow them to enter into contracts with private insurers.

Accountability

Given the freedom and flexibility each OSS has in its day-to-day operations, the São Paulo state government has imposed a number of accountability mechanisms to ensure contractual compliance and to maintain indirect oversight of OSS facilities. Written into the OSS management contracts are specific data reporting requirements regarding services provided, quality and finances. Requirements vary by contract, but generally include statistics on at least: production, costs, payroll, spending, results of spot surveys on patient satisfaction, infection control, mortality rates, length of stay, and readmission rates. Given the quantity of data reported, the SES installed a standardized information and cost accounting systems linking all OSS facilities with the management unit of the SES to aid its monitoring efforts. To maintain transparency, the SES publishes the data reported by OSS facilities on its website.

Hospitals' reported performance data and financial statements undergo internal audits by the SES and external audits by the State's Comptroller General. The SES also created an Independent Review Commission to conduct "social audits", which are used to assess whether facilities are fulfilling their social obligations as public hospitals, such as not charging for services and not denying care. This commission consists primarily of civil society representatives. If an OSS facility fails to meet its agreed-upon benchmarks regarding performance, volume, reporting requirements or quality, the hospital management can be let go. In cases of consistent underperformance, the state government has the right to terminate the OSS contract and issue a new tender—a right it has exercised in the past.

Management Capacity

Hospital management is chosen based on merit rather than through political appointment or other opaque mechanisms. Concrete management experience is a key qualification, and has contributed to the high managerial capacity of OSS facilities and their ultimate success.

Lessons Learned

The OSS hospital network has been expanding and operating in São Paulo for over 20 years. A rigorous evaluation of 12 OSS and 12 matched publicly managed hospitals shows OSS hospitals consistently outperformed the publicly administered hospitals in quality of care, efficiency, productivity, cost management and patient satisfaction (see Table A). A number of factors contributed to the success of this model. Managerial autonomy, manifested in the ability to hire and fire personnel as needed, was a key driver of quality gains, particularly when coupled with a salary scheme that rewards staff for good performance. Minimal political interference in hospital operations further strengthened managers' authority and independence. The government's strong contract enforcement mechanisms were also critical. The decision to allocate funding based on outcomes provided an incentive for hospital management to meet agreed-upon quality, efficiency and volume targets. The use of information technologies facilitated the collection and analysis of data, leading to evidence-based enforcement. Finally, the government's ability to terminate contracts with consistently underperforming hospitals, and its proven willingness to do so, provided the ultimate motivation for OSSs to meet contractual obligations.

Table A – Brazil OSS hospitals comparative performance

Brazil OSS hospitals comparative performance

	12 contracted-out public hospitals	12 traditional public hospitals
Quality	**median**	**median**
General mortality	3.3	5.3
Surgical mortality	2.6	3.6
Clinical mortality	11.6	12.0
Pediatric mortality	2.8	2.6
Efficiency: Descriptive Statistics		
Bed turnover rate	5.2	3.3
Bed substitution rate	1.2	3.9
Bed occupancy rate	81	63
ALOS	4.2	5.4
ALOS surgery	4.8	5.9
Technical Efficiency: (discharges/bed)		
General	60	46
Surgical	71	44
Clinical	86	53
GYN/OB	96	58
Annual Spending (in R$000)		
Expenditures/bed	177	187
Expenditures/discharge	2.9	4.3

Source: Adapted from La Forgia and Couttolenc (2008).

Hong Kong
Public Authority: Hospital Authority (HA)

Policy and Legal Framework

Hospital reform in Hong Kong was driven primarily by health authorities and the government to address numerous structural deficiencies in the health care network. Public facilities suffered from overcrowding, disparities across hospital types, and frequent financial debts. Further, hospital governance was divided between the government's Health and Welfare Branch and the Medical and Health Department, leading to system fragmentation. To unify the system and improve efficiency in resource use, the government created the Hospital Authority (HA) to serve as the single governing body for the hospital sector and also introduced sweeping managerial reforms. The 1990 Ordinance of the Legislative Council provided the basis for the legal framework of the HA.

Organizational Forms and Governance Structures

The HA is a nonprofit public corporation responsible for the management of all of Hong Kong's publicly funded hospitals, including both government-owned facilities and non-profits providers receiving public funding. A governing board of community leaders and government representatives oversees the chief executive of the HA, and is accountable to the government. The CEO of the Hong Kong Special Administrative Region (HKSAR) appoints the board's chair; the HKSAR CEO also approves the selection of the HA CEO and its principal managers.

The HA has considerable autonomy in managing and overseeing the hospitals within its network. It controls staff planning, service coordination, and monitoring and evaluation. In addition, HA leadership is responsible for business planning and strategic management. At the facility level, each hospital has a Hospital Governing Committee (HGC) that oversees the hospital's chief executives.

Autonomy

While the 1990 reforms transferred significant autonomy to the HA, individual hospitals actually lost some of their managerial independence in the process. Hospitals' operational rules and plans must be approved by the HA, and in some cases are even defined by the HA, reducing the weight of managers' input. The HA can retain up to 5 percent of its annual recurrent budget, but use of these revenues and reserves is subject to government approval. In the event of any projected budget shortfalls, hospitals must notify the HA, as they cannot take on their own debts.

Hospitals must work with the HA to make decisions regarding capital investments as well, which are then submitted to the government for final approval. In terms of services, hospitals must consult with the HA to develop an agreed upon list of services and programs to be provided by the facility. The government, HA board, HGCs, HA service coordinating committees and the community all provide input regarding the volume and mix of services provided at HA hospitals.

Individual hospitals also have limited autonomy over staffing. Senior management teams are selected by a board of HGC members and then appointed by the HA. Hospital CEOs are responsible for appointing the remainder of staff, but must seek authorization for any increases in senior management positions or medical and nurse specialist staff. Additionally, job requirements are defined by the HA. When reforms were implemented, about 25 percent of existing hospital staff chose to remain in the civil service regime, while 75 percent switched away from it. The terms of employment for non-civil service staff are set by the HA.

Incentives

Hospitals' budgets are calculated annually based on the previous year's budget, adjusted for expected changes in service patterns, recurrent costs of new projects, and the government's fiscal situation. While reforms initially empowered the HA to set prices for its services, the government revoked this authority in subsequent years due to strong opposition to the policy. As a result, user fees now account for a minimal portion of hospital revenues.

Accountability

Accountability mechanisms throughout the HA are minimal, and those that exist are largely administrative and hierarchical (such as hospital CEOs' accountability to the HA and HGC, and the HA's accountability to the governing board). Compensation of upper management is not performance-based, and there are no punishments for poor performance. Some degree of performance accountability is enforced when hospitals are evaluated against their annual plans, but this accountability is based mostly on input indicators rather than outputs, and is therefore quite weak. HA oversight of hospitals is further limited by weaknesses in the information systems used for monitoring and evaluation.

The only area of relative strength in the accountability of the HA network is in financial assessments, as the government evaluates individual hospitals' budgets annually. The HA then needs the Legislative Council's approval to overspend its budget.

Management Capacity

The government appoints the HA CEO, who in turn appoints the chief executive of each hospital. Initially, these hospital management positions were filled by in-house staff (usually doctors) who lacked managerial experience. As a result, the HA had to invest heavily in training these hospital executives to try to generate managerial competence. Today, the decision-making authority of hospital managers is heavily restricted by their dependence on the HA.

Lessons Learned

In principle, the creation of the Hong Kong HA dramatically increased hospital autonomy as governance authority passed from the government to the independent HA. In practice, however, the reform merely resulted in a transfer from one bureaucracy to another, while maintaining similarly minimal accountability mechanisms, incentive systems and levels of competition as in the traditional public sector. While the underlying problems that catalyzed reform efforts—such as overcrowding and patient and staff dissatisfaction—were addressed and improved, evidence regarding improvements in efficiency and quality of care is mixed. The HA case therefore demonstrates that the expected gains in efficiency and quality from increased hospital autonomy should not be assumed nor are they automatic; rather, they are dependent on the proper consideration and balance of the different dimensions of autonomization, including strong (rather than formal) governance, real autonomy, clear accountability, adequate incentives, and strong contracting and oversight capacity.

Portugal
Public Company: Public Enterprise Entity Hospitals (PEEHs)

Policy and Legal Framework

The 1979 Portuguese Constitution established the National Health Service (NHS) as a universal health care provider. However, rising costs, inefficient resource use, inconsistent benchmarks, and stagnant quality of care in hospitals threatened the system's success.

In 2002, the Social Democratic party in power addressed these issues with Law No. 27/2002. Through this law, public hospitals could become "public companies" (*Hospitais S.A.*), with greater financial and managerial autonomy. This first wave of hospital corporatization (2002 – 2005) aimed to pay hospitals for actual service delivery, increase resource efficiency, improve quality of care, boost hospital access, and introduce managerial autonomy and accountability. By 2003, around half of all public hospitals had adopted this "public company" status.

In 2005, the Socialist party came to power and initiated a second wave of reform. The party, concerned that increased hospital autonomy may lead to privatization, passed Decree-law No. 233/2005. This law reiterated that "public companies" are not private hospitals and renamed them "public enterprise entity hospitals" (PEEHs) (*Hospitais EPE*). This new legislation aimed to expand PEEH status, better concentrate and integrate care, and further encourage managerial autonomy, especially within hospital management boards.

Organizational Forms and Governance Structures

Each PEEH operates under an internal management board called a Hospital Administration Board (AB). ABs determine hospital regulations, supervise daily activities, set up clinical trials, and approve operational proposals from the hospital director or executive team. These boards include up to seven members, three of whom must be the AB President, a clinical director (physician), and a nurse director (nurse). Municipalities can also nominate one non-executive member to ABs. The Ministry of Health (MoH) and the Ministry of Finance (MoF) jointly appoint all AB members (except the non-executive member) from a pool of candidates meeting certain qualifications.

In theory, incentives hold AB members accountable for low performance and non-compliance. The government can dismiss AB members for: substantially deviating from budget and implementation protocol; failing to meet quality targets; or violating the National Framework Contract Programme (NFCP), an annual contract between the government and PEEHs. In practice, however, the government dismisses AB members for political (rather than operational) reasons. Thus, ABs experience high turnover rates.

Autonomy

PEEHs have considerable autonomy in operations. Although the MoH directly nominates hospital directors, the AB appoints other hospital leaders like department directors and committee chairs. The AB selects these leaders from a pool of qualified candidates. Hospital management – rather than the government – controls the hiring, firing, promotion, and replacement of staff.

Hospitals have less authority over wage-setting and service provision, however. The government regulates wages, although hospitals can influence some cases. Without permission, ABs cannot create new hospital services that deviate from the Hospital Referral Network (HRN) set by the MoH.

Furthermore, PEEHs must obtain approval from the MoF and the MoH to invest more than 2 percent of statutory capital, borrow more than 10 percent of statutory capital, and take out loans. Hospitals can retain surpluses, however.

Incentives

PEEHs receive around 80 percent of their annual funds from the MoF, and the NCFP determines the conditions of this payment. Historically, annual funding amounted to the previous year's funding plus inflation. However, Diagnostic-Related Groups (DRGs) and outpatient volumes now determine increasing proportions of this annual state funding. In other words, payments to hospitals increasingly reflect the case mix of patients and the actual cost of care.

PEEHs receive the remaining 15-20 percent of annual funds from special services, private insurance revenue, flat-rate user charges, private donations, and grants. PEEHs do not charge patients because they cannot set up co-payments.

PEEHs have limited ability to allocate financial resources. Hospitals under the PEEH model must obtain approval from the MoF and the MoH for: budget plans; accounting documents; new financial incentives; and the purchase or sale of hospital buildings or equipment.

Accountability

PEEHs must use the Official Accounting Plan of the MoH and must annually submit: the AB report; the multi-annual investment plan; the balance sheet and income statements; the cash flows and loans statements; and the audit report. These reporting requirements, along with the performance standards in the NFCP, aim to hold hospitals accountable for using resources efficiently and providing high quality care. The NFCP mandates that hospitals must meet national and regional standards of production and quality. Additionally, contracts require hospitals to record and analyze indicators like the re-hospitalization rate, the number of discharges, and the average patient delay. Reporting requirements like these incentivize quality service and efficient resource use while discouraging unnecessary hospitalization.

Despite requirements, data reporting does not necessarily serve as a strong accountability mechanism. In practice, reporting efforts are uncoordinated and difficult to analyze.

PEEHs don't appear accountable for patient satisfaction. Although patients can give input or issue complaints, there is no evidence that hospital management addresses complaints or uses input to inform practices.

Management Capacity

The MoH directly nominates hospital directors. There are no formal requirements for hospital directors, so appointment and qualification is largely up to the MoH.

Lessons Learned

Comparisons of PEEHs and traditionally administered public hospitals are largely inconclusive. Some studies find that hospital corporatization resulted in positive changes, including increased hospital efficiency, improved billing processes, more effective hospital management and planning

approaches, and greater transparency through information networks. Many studies, however, find no significant difference between PEEH performance and traditional hospital performance. These studies conclude only that converting to the PEEH model doesn't *decrease* efficiency, access, or quality of care.

The Portuguese Observatory of Health Systems finds that the government is involved with ABs. Even with new legislation in 2002 and 2005, hospitals have struggled to escape centralized networks of hospital governance. By 2010, the MoH recognized the need to reevaluate the PEEH model. It organized a commission to compare the PEEH model and other hospital management structures. The commission report concluded that the PEEH model lacks accountability and transparency mechanisms like addressing patient feedback or a standard evaluation of AB performance.

Valencia, Spain
Administrative Concession (AC): The "Alzira Model"

Policy and Legal Framework

The decline of authoritarian rule in Spain led to a nationwide push for the decentralization of power, culminating in the 1978 Constitution. This document gave new power and authority to the regional governments, including the ability to manage their own health care networks. The 1991 Abril Report commissioned by Parliament found that the National Health System continued to suffer from excessive rigidity in administration and centralization, leading to high costs and low efficiency. The report catalyzed new national legislation—Law 15/1997—establishing that the private sector could be involved in the provision of public health services, but it left to the regional governments the job of determining how to structure any new partnerships. In this environment, different models for hospital autonomy developed in different parts of Spain, supported by a number of specific legal frameworks and statutes.

One of the most well known models originated in Valencia. Under this system, commonly called the "Alzira model", an administrative concession is awarded to a private company (or consortium of companies) to build and operate a publicly funded hospital. The key elements of this PPP model are public ownership and financing and clear accountability, but private management of facilities. The pilot facility—La Ribera—expanded in 2003 to integrate the provision of primary and secondary care.

Organizational Forms and Governance Structures

Each concessionaire is required to have a Board of Directors (BOD). BOD members are primarily company representatives, though the regional health administration has a non-voting representative. This structure ensures that the government's views are considered without directly limiting boards' independence. The regional health administration also has an indirect say in the choice of hospital CEO. The concessionaire can appoint (and remove for poor performance) the CEO, but only with the approval of the regional health authority. Once appointed, the CEO is responsible to the BOD, the shareholders of the concessionary company and the Joint Commission (JC), a body made up of representatives of the concessionary company and regional health authority. The JC meets three times per year to verify the concessionaire's compliance with its contract.

Contracts for administrative concessions last for 10 to 15 years, with the possibility of extension. In the case of new hospitals, the concessionaire funds the initial investment in the hospital infrastructure, shifting the financial risk from the government to the private sector. The facility becomes government property at the end of the contract period, however. A similar procedure applies to the procurement of all medical and non-medical equipment. The concessionaire must submit an initial investment plan to the regional government regarding the purchasing of infrastructure and equipment, which is revisited by the government every five years, but beyond this oversight the concessionaire has the freedom to purchase as management sees fit (with all remaining equipment transferred to the public sector at the close of the concessionary period). To offset these losses and protect shareholder wealth, a reversion fund is established at the beginning of the contract period. Over the life of the contract the hospital contributes a portion of its profit annually to the fund, so that at the close of the contract the value of the fund is equivalent to the net value of the assets handed over to the public sector.

Autonomy

This autonomous decision-making capacity extends to the provision of services and hiring of staff as well. Since staff are not civil servants, management can set hours and compensation. Most facilities have adopted performance-based schemes in which up to 20 percent and 10 percent of doctors' and general practitioners' salaries, respectively, are contingent on meeting specified targets. In La Ribera hospital, existing staff could either switch to the new payment scheme or remain civil servants; about 70 percent opted to change. All new staff are hired as non-statutory workers, with their pay set by the concessionaire.

Incentives

The payment system used in this model was designed to incentivize efficiency and high quality care. The hospital is paid on a capitation basis, meaning that the concessionaire receives a fixed annual sum per patient within its catchment area. This fee must cover all expenses incurred in the provision of services, from amortizations to consumables and utilities to payrolls. The payment covers all services provided in the network, which include primary care. Therefore, the concessionaire has an incentive to provide appropriate care at the appropriate facility, thereby reducing overuse of the hospital.

The amount allotted per patient was initially about one third less than that at traditionally run public hospitals; today, this gap has closed somewhat, but concessionary facilities still receive less than their public counterparts. Yet the regional government added a mechanism to prevent the quality of care from decreasing along with costs. While each concessionaire is responsible for providing care to a specific number of patients within its geographically defined catchment area, patients can attend hospitals outside of their region if unsatisfied. To ensure concessionary facilities are providing quality care and to garner patient loyalty, the concessionaire is obligated to pay 100 percent of care costs for patients from its catchment area who seek treatment elsewhere. Meanwhile, the concessionaire is reimbursed 80 to 85 percent for patients it treats from outside of its catchment area, encouraging concessionaires to prioritize the treatment of those within their region.

Accountability

The government maintains a direct presence in the hospital itself. A delegate of the Ministry of Health (and an accompanying staff) is embedded in the facility and has the authority to inspect all aspects of the hospital—including ensuring accurate billing, approving treatment of patients not in the catchment, monitoring patient satisfaction, and tracking hospital activities and financial performance—and apply sanctions for non-compliance with contractually agreed upon terms.

Accountability is ensured through data reporting requirements, in addition to the oversight provided by government representatives in the hospital and on the BOD and JC. The concessionaire must report its business and financial records, as well as provide clinical reports that give statistics related to wait times, clinical outcomes, and patient experience, among other indicators. These data are audited by both an external auditing company and the auditing unit of the regional government.

Finally, the concessionaire is responsible for its debts—adding an additional layer of financial accountability—and can retain and invest at its discretion up to 7.5 percent of profits over the concession period (with any additional surpluses being returned to the regional health authority).

Management Capacity

Merit criteria factor greatly into the hiring of hospital management teams. While the regional health administration has an indirect say in the choice of hospital CEO, managers are nonetheless hired based on their abilities and experience and can be fired for poor performance. Robust management has contributed to the continued success of the model.

Lessons Learned

Despite strong political support for La Ribera when it was founded in 1997, by 2002 the facility was no longer financially viable. In the face of its inevitable closure, the government opted to "rescue" the hospital rather than let it go under. It legally terminated its contract with the concessionary company, and then retendered the contract to that same company under new terms. In 2003, La Ribera began operating under the new contract, which is still in force today.

The second contract had two important modifications that helped account for the subsequent success of La Ribera. First, it covered primary health care in addition to hospital services, allowing the concessionary company to integrate both services. This expansion translated to significant gains in efficiency. Second, the government increased the value of capitation payments (in part to finance the added costs of primary care for patients) and linked their annual rate of change to the percentage increase in the Valencian health care budget, rather than the Consumer Price Index (CPI) as stipulated in the original contract. Because the health budget rose at a much faster rate than the CPI, the concessionaire's annual budget increased dramatically, generating improved cash flows to repay debts and cover contributions to the reversion fund. Since these changes were enacted the hospital's network has expanded and it no longer faces issues of financial solvency.

Spain's experience with the concessionary model offers important lessons for how to structure hospital autonomy reforms. Elements key to the model's success included: the autonomous management and decision-making capacity of hospital leaders; the noted lack of political interference in facility operations; well-designed incentive systems; clear and consistent accountabilities enforced by the government and informed by data; and finally the government's willingness to learn from its experiences and improve the model as problems arose, as exemplified by the retendering of La Ribera under better terms. Taken together, these factors have enabled concessionary facilities to provide good access to quality care for patients, all at a lower cost than at traditional public facilities.

England, UK
Public Benefit Corporation: NHS Foundation Trusts (FTs)

Policy and Legal Framework

The UK National Health Service (NHS) was established in 1948 on five principles: universal access, funding by general taxation, free health services, appropriate compensation to doctors, and centralized health care administration. These principles persevere, even as successive governments debate the level of central control.

Until 1989 government supervised health authorities controlled NHS hospitals and other health care providers – Thatcher's reforms then allowed hospitals to apply for self-governing status. In 1997 a Labour government reversed most of the freedoms given to these hospitals.

In 2002, Labour Secretary of State for Health Alan Milburn visited semi-autonomous hospitals in Spain and Sweden and concluded that these hospitals overcame the deficits of centrally governed health systems. His government's Health and Social Care Act of 2003 allowed and encouraged NHS Trusts, which provided health care services, to transition to legally independent "public benefit corporations" called NHS Foundation Trusts (FTs). To transition, Trusts first obtained the support of the Secretary of State for Health, and then applied to a new independent regulator – the Monitor.

Unlike Trusts, FTs have a Board of Governors (BoG) – a Chair, representatives of local authorities, and elected members from the FT membership community that comprises patients, citizens, and staff. With a BoG, FTs aimed for greater accountability of health care providers to local people, decreased central government control, higher quality and efficiency. Problems ensued. By meeting stringent financial targets, hospitals compromised quality of care. The BoG role was confusing, overlapping with existing public participation forums. Politicians still tried to exert control over hospital operations.

In 2012, a Conservative government passed the Health and Social Care Act of 2012 to minimize political intervention in the health care system and encourage competition among health care providers at fixed prices. The Act restructured the NHS: Local Clinical Commissioning Groups (CCGs) – composed of General Practitioners – commissioned and planned area health care services. CCGs purchased services from Trusts and FTs on the market. All Trusts were to transition to FTs. Today, there are 156 FTs out of 257 acute trusts, mental health trusts, community providers, and ambulance trusts.

In 2016, the government gutted the 2012 Act, reasserting central control over FTs, de-emphasizing quality, competition, and autonomy. Their finances constrained, FTs are now effectively again Trusts.

Organizational Forms and Governance Structures

FT governance seeks to balance community interests against professionalism. One person chairs both the Board of Governors (BoG), and a Board of Directors (BoD). The BoG consists of appointed members who join elected representatives from the community: patients, citizens and staff and it further elects and sends representatives to the BoD. The BoG theoretically provides accountability, legitimacy and policy guidance to the BoD. In practice, the BoG voters rarely represent the community, BoG sizes are invariably large and unwieldy, and any BoG advice on long-term strategy, and approving accounts and reports is rubber-stamping.

The BoD possesses real decision-making and management power, and comprises the chair, hospital CE, professional executive directors, and BoG appointed non-executive directors. Each BoG and BoD determines their working relationship: BoG members may attend all or no BoD meetings depending on the FT.

Externally, FTs were initially accountable to three bodies: the Care Quality Commission (CQC), the NHS Commissioning Board, and the Monitor. The CQC evaluates clinical performance, while the NHS Commissioning Board sets tariffs for the CCGs and coordinates with the Monitor, which evaluated FTs for both financial and clinical performance. In 2016 the Monitor was absorbed into NHS Improvement, which is mandated with constraining FT financial autonomy. Both the Commissioning Board and NHS Improvement exert financial influence on FTs.

Autonomy

FTs were under central control from the start. Hospital CEs followed directions from Monitor, which could end their careers while FT governors could not. Consequently, CEs looked to London instead of to their membership communities, negating the point of FT reform. The Commissioning Board pushed tariffs low, CCGs withheld funding and even well performing FTs breached Monitor's financial rules, unable to fill the gap between funding and cost.

The new NHS Improvement asserts more central control. FTs are subject to financial controls and have no flexibility on managing basic issues like annual leave and deferred income. Even FTs with surpluses cannot apportion them as they wish. The previous emphasis on quality – gauged by staffing levels – and on autonomy, now shifts to finances and to national control.

Incentives

The NHS Commissioning Board defines units and sets tariff prices for hospital services. Hospitals receive fixed payments for units of care, eliminating any incentive for doctors to unnecessarily order expensive treatment. This payment system, called Payments for Results, is the NHS's version of Diagnostic-Related Groups (DRGs).

The NHS also pays hospitals via locally negotiated contracts. Hospitals receive £70 billion in NHS funds: £30 billion via Payment by Results and £40 billion via locally negotiated contracts. Beyond NHS funds hospitals can receive up to 49% of their total incomes from private patients, but these patients only amount to 2% of hospital income.

Accountability

The NHS holds FTs accountable for performance via the CQC and the Monitor (now NHS Improvement). The CQC inspects clinical performance annually and publishes ratings aimed at patients. Inadequate facilities are re-inspected and face notices, warnings, and can be shut down. 2.5% of hospital income is linked to meeting basic quality standards. The Monitor evaluates FTs for quality as well as financial performance, and can place FTs under 'special measures,' can escalate to 'special administration' under government control, or to outright dissolution. Government policy now puts FT finances front and center at the expense of quality. FTs are subject to new financial controls in 2016, and have no flexibility on managing either income or surpluses. The latest NHS guidelines move money around the health system for sustainability.

Management Capacity

Hospitals have the power to hire and fire Hospital CEs and do so based on technical skills and merit, rather than political connections. Turnover rate can be high, with one third of CEs having held their posts for less than a year in 2015.

Lessons Learned

The original policy to autonomize FTs and so drive innovation, efficiency and quality, and to increase accountability has failed. FTs were subjected to central government price mechanisms, their executives feared central government regulators more than their boards, and they relied heavily on government investment and support in crises. Consequently, FTs were unable to create sufficient distance between a single payer and providers.

FTs were also given the option to merge with existing Trusts and other FTs. These mergers resulted in very few efficiency gains and were instead used to cover financial shortfalls within one of the merging organizations. Such mergers led to trouble later on.

The UKs decreasing finances have driven commissioning prices down and FTs into deficits. Any pretense towards quality has now been abandoned in favor of a centrally controlled arrangement that strips FTs of their financial independence. The UKs experience illustrates that even under the guise of autonomy, the government failed to create local accountability and influenced the market via price setting. The politics of the UK promise more debates on levels and levers of centralization down the road.

New York City, US
Public Authority: NYC Health + Hospitals (HH)

Policy and Legal Framework

In the years preceding the creation of New York City Health + Hospitals, the city's public hospitals and ambulatory care network suffered from poor working conditions and outdated facilities, staff shortages, uncompetitive pay scales, over-specialization, and excessive bureaucratic red-tape, all of which contributed to poor quality service provision overall. In the 1960s, actual strategic decision-making and control had been transferred from the NYC Department of Hospitals to a system of affiliated voluntary hospitals acting as private contractors, but this change did little to solve the system's myriad problems. Under increasing pressure to improve quality, in 1970 the NYC legislature created HH, formerly the NYC Health and Hospital Corporation, to allow greater managerial flexibility throughout the network.

Today, HH is the largest municipal health care system in the US, serving over 1.4 million patients within a network of 11 acute care hospitals, 5 nursing homes, 6 large diagnostic and treatment centers, over 70 community-based clinics and one home care agency. Additionally, HH provides a low-cost health insurance program that has over 420,000 enrolled members. The system is divided into 7 regional vertically integrated health care networks.

Organizational Forms and Governance Structures

HH is a public benefit corporation (or public authority), an autonomous entity exempt from the budgetary and fiscal constraints that apply to traditional government entities. A Board of Directors (BOD) chaired by the NYC Health Services Administrator is responsible for strategic planning and oversight of the HH President. BOD members are primarily appointed by the Mayor, Health Services Administrator or the City Council, and most are members of the NYC administration. The BOD is accountable to the Health Services Authority. Another layer of oversight is provided by the New York State Public Authority Control Board, which oversees all public authorities. Finally, HH hospitals are affiliated through service contracts with several medical and academic institutions and these exert considerable influence in HH operations. Given the multitude of players involved, there is considerable fragmentation of authority and control between NYC authorities, the BOD, and affiliated hospitals, which has proved a challenge to accountability.

The BOD appoints the HH President, who in turn chooses hospital CEOs. HH and the NYC administration collaborate on strategic planning, while hospital management has autonomy in day-to-day operations and reports to the HH.

Autonomy

HH buildings and certain equipment are owned by the city. While HH can issue its own debt for capital financing, this capability is constrained by its dependence on the Health Services Administration and the complex division of authority over the corporation. Additionally, the mayor must approve any large capital investments or sale of large assets. In terms of procurement, the corporation is responsible for procuring all goods and services to its facilities.

HH medical staff are predominately employed by its affiliated university hospitals. All other staff are employed by HH under civil service law. Given the civil service status of employees,

management cannot set wages. In the past this has led to HH facilities offering uncompetitive wages.

Incentives

The majority of the corporation's revenue comes from reimbursements by government health insurance plans, specifically Medicare and Medicaid. The remainder of revenues comes from charitable organizations, managed care organizations and other financial pools, and direct patient payments. Most inpatient reimbursements are based on a Prospective Payment System using Diagnosis-Related Groups (DRGs), and outpatient services are reimbursed based on Ambulatory Payment Classifications. Commercial insurers, however, pay based on negotiated rates. HH also receives revenue from the premiums collected from its health insurance program, MetroPlus.

Given the social mission of HH to provide quality care to NYC residents regardless of ability to pay, uninsured HH patients pay for services on a sliding scale based on their income and family size. NYC transfers funds annually to help cover the cost of the uninsured, who amounted to 500,000 patients in 2014.

Accountability

The corporation must submit detailed annual reports on finances and operations to the mayor, the Comptroller, the City Council and the State Comptroller for review, in addition to the following year's budget proposal. Directors also perform routine internal audits at each hospital. Recent improvements have strengthened information systems and performance monitoring, and HH facilities have adopted external benchmarking.

At the facility level, each individual hospital and diagnostic and treatment center has a Community Advisory Board (CAB). These community volunteers meet regularly with health officials to advocate the funding needs of HH facilities, and also perform a key oversight function by anonymously visiting HH facilities to observe waiting times and other areas of concern. CAB members regularly meet with HH staff to report on their findings and any areas of concern, which are passed on to management.

Management Capacity

The BOD chooses the HH management team and the HH President appoints the executive director of each hospital. Managerial skills and experience factor into recruitment decisions, and all managers must abide by the HH Code of Ethics as well as the NYC Conflicts of Interest policy.

Lessons Learned

The HH model faced challenges throughout its first two decades of operation, including lack of fiscal discipline, low staff morale, and low accountability, all of which led to low quality of care at HH facilities. To address these issues, a series of reforms were introduced beginning in 2001 to transform the HH organizational culture to achieve a high-performing integrated delivery system. These innovations successfully improved quality of care and efficiency and were enabled by a strengthening of leadership and revitalized commitment and support from the NYC mayor.

Still, structural problems remain, particularly the fragmentation of hospital oversight, which has resulted in an authority split between city authorities, the affiliated hospitals, and the BOD. As a

result, accountability remains a major challenge. Additionally, the financial crash of 2008 severely constrained HH finances, as the majority of its revenues come from government provided health insurance plans. Coupled with the high number of uninsured patients serviced by HH facilities, the corporation has faced significant budget deficits over the past few years. Thus, while HH quality and efficiency have improved with strengthened leadership, the model's future remains in flux due to its financial instability.

Vietnam
Autonomous Public Hospitals

Policy and Legal Framework

In the late 1980s and early 1990s, Vietnam's broad public shift towards market economy-centered policies spilled over to its health sector. These early policies addressed patient inconveniences including that patients no longer needed referral documents to access certain health care facilities. To alleviate fiscal constraint, new government legislation in 1994 permitted public hospitals to collect user fees for services, and simultaneously decreased state funding. In 1995, the government allowed public hospitals to receive funding from non-public sources.

Subsequent reform measures in the early 2000s – Decree 10 in 2002 and Decree 43 in 2006 – granted public hospitals more financial and managerial autonomy. This reform wave aimed to clarify the regulatory framework, strengthen incentives, establish social health insurance for disadvantaged populations and increase regulation of quality of care. The reforms did not have any explicit objectives for performance improvement.

Currently, public health services dominate the Vietnamese health care sector, as the private sector provides only 7 percent of total hospital beds. Vietnam has better health indicators than other countries with similar income levels, and total health expenditures are relatively low (US$142 per capita in 2014). Vietnam has a large hospital network: 31 urban tertiary hospitals, over 300 provincial and municipal hospitals, and around 600 district-level hospitals. Most hospitals, regardless of type, are small and 95 percent are government-owned.

Organizational Forms and Governance Structures

Hospital boards in Vietnam are responsible for strategic planning, but many oversight roles are still dominated by government at the central, provincial and municipal levels. Additionally, the amount of strategic autonomy granted to hospitals is unclear. The Ministry of Health has created a "referral guide" for roles and functions at certain facilities. It specifies which hospital facilities should be capable of performing what services.

Autonomy

Under Decree 43, public hospitals fall under one of three levels of autonomy: self-financing hospitals, partially self-financing hospitals, and fully-subsidized hospitals (where state funding covers more than 90 percent of hospital expenditures). This decree grants hospitals broad operational and financial autonomy, allowing hospitals to charge user fees, raise and retain their own revenues, decide input mixes, and sell services for a fee.

Hospitals have the full ability to allocate non-user fee revenues, including bonuses to staff (with certain limits). Broad central rules govern the use of user fee revenues: a minimum of 25 percent of net revenues must be used to upgrade facilities while the remaining 75 percent may be used for additional staff incomes, as decided by the hospital director. In practice, central and provincial hospitals are often more able to increase revenues through user fees, leaving district hospitals with fewer funds and greater challenges in attracting high quality staff.

The government owns hospital buildings, but hospitals are able to invest in or buy new infrastructure or equipment using their own revenues as well as independently arrange for repairs

of equipment or infrastructure. The government can also play an integral role in upgrading facilities, and it has used bonds to upgrade disadvantaged district-level hospitals.

Hospitals have limited autonomy in human resources, particularly in recruiting permanent staff. The government must approve major changes in human resources management and investment, and most staff are civil servants over whom hospital managers have little authority. Hospital directors can only hire, fire, and redeploy *contracted* medical and non-medical staff. Government control of human resources management can be positive; for example, the government has instituted measures to ensure hospital staff rotation from the high-quality hospitals attracting educated staff to the lower-quality hospitals serving less affluent communities. This has helped combat systemic issues of inequality in the Vietnamese hospital system.

Incentives

Current payment systems do not strongly incentivize quality services. Hospitals are paid through a mix of line item budget, health insurance reimbursements, and user fees – hospitals rely heavily on fees and reimbursements. District-level hospitals are less able to retain revenues through user fees and thus have less ability to financially reward staff, invest in new equipment and provide services. Social health insurance, established in 2002 to heavily subsidize premium costs for poor and disadvantaged groups, does little to combat this systemic issue.

Accountability

Accountability mechanisms in hospitals are neither emphasized nor strong. Mechanisms aim to link the Ministry of Health to "market competition" via user fees and private hospitals. Data reporting requirements include hospital acquired infection and death rates, which are published and sent to the government.

No national accreditation system exists, and few hospitals have appropriate standards for quality or quality measurement systems in place. In 2015, only 9 percent of hospitals had quality plans and only 5 percent of hospitals adopted quality improvement programs. Even though hospital staff can receive additional income payments based on increased hospital revenues, this has served as insufficient incentive for hospital staff or management to explicitly focus on quality of care; district-level hospitals are more negatively affected.

Management Capacity

Hospital directors and other leadership (vice director, etc.) in public hospitals almost always have medical backgrounds (doctors, pharmacists), but do not undergo any formal training in hospital management. Directors are appointed and promoted by local authorities or the Ministry of Health through standardized procedures. The variety in leadership and technical capacity of hospital directors has translated into divergent outcomes in reform implementation.

Lessons Learned

With reforms public hospitals in Vietnam have achieved more autonomy in managing investments and financing. Further, the hospital network has largely managed to: increase total revenues through user fees and insurance reimbursements; increase admissions; increase medical staff incomes; and reduce average length of stays.

However, implementation largely failed to reflect reform policies and plans. For example, the leadership and technical capacity of local authorities and hospital managers varied widely across hospitals, leaving some facility managers better able to mobilize facility resources and improve hospital operations. Central hospitals were usually able to achieve broader autonomy in these aspects than lower-level district hospitals, leading to uneven reform implementation. These district-level hospitals were more constrained in apportioning funding for their budgets with user fees instead of government funding – since they were operating in less affluent areas – and so were handicapped in increasing staff pay and faced few incentives for health care quality.

Accountability mechanisms remain weak, while unevenly implemented hospital reform lacked appropriate oversight and led to a decrease in quality at some facilities as they simultaneously tried to increase financial autonomy. Central and regional authorities failed to sufficiently invest in bolstering their contracting and supervisory roles. Although the later reform wave (2002 – 2005) partially addressed this by establishing clearer rules and forbidding facilities from discriminating against the poor, problems persist. Studies conclude that increased autonomy has not led to increased hospital efficiency.

Finally, patients are increasingly bypassing lower-level hospitals, total health expenditure is increasing, and out-of-pocket expenditures are persistently high.

India
Selected Short Cases from the Health Sector

All India Institute of Medical Sciences (AIIMS)

Created by an act of Parliament in 1956, AIIMS was established as the premier institution for medical education, research and treatment in India. While AIIMS is not a corporate entity, it has for the most part fulfilled its mandate. Similar to other centrally-funded institutions, it receives funding directly from the central government after approval by the Standing Finance Committee, MOF and MOHFW. As specified in the original legislation, AIIMs is governed by an Institute Body with broad representation from government, universities, the medical and scientific communities, and parliament. The Institute Body appoints a Governing Body, which acts as an executive authority. The Governing Body has a wide representation of directors, staff, faculty and students.

While the original act granted considerable managerial autonomy to AIIMS, personnel management follows civil service rules for "conduct, discipline and penalties" and subsequent regulations mandate greater control by government (MOHFW). Any rules and procedures specified in internal statutes require government approval. Nevertheless, the government appears to grant considerable decision-making authority to AIIMS management regarding appointments of departmental managers, staff postings and compensation, and financial and asset management. AIIMS has established several semi-autonomous (or self-managed) research and treatment centers whose performance is measured through a "results framework." It also introduced a promotion scheme that is partially based on performance appraisal.

Punjab Health Systems Corporation (PHSC)

PHSC was established through special state legislation in 1996 that constituted a public corporation for "establishing, expanding, improving and administering medical care in the State of Punjab." PHSC manages 176 health institutions including 21 district hospitals, 2 specialty hospitals, 34 sub-divisional hospitals and 119 community health centers (rural hospitals). PHSC has been granted limited autonomy in financial management (up to INR 100 crores), but essentially operates like a hospital department inside the public bureaucracy and hierarchically manages the hospitals under its responsibility. The latter have not been granted any decision-making authority. PHSC directors are political appointees. Staff is a mix of government and outsourced staff, and there are different incentives for each set of workers. In sum, there is little if any separation between the PHSC as a corporate entity and government.

Medical Relief and Patient-Welfare Societies

These societies originated in Rajisthan and Madhya Pradesh in the mid-1990s and were rolled out nationally (Rogi Kalyan Samitis -RKS) in the mid-2000s under the National Rural Health Mission (NRHM). RKSs are independent societies registered under the Societies Registration Act. In principle, they consist of a governing body, executive committee and a monitoring committee. In practice, usually a single committee is created and made up of hospital officials (usually the director), district health officers (government officials), local politicians and community representatives. The idea was to decentralize hospital management and MOHFW planners viewed RKS as a platform for transferring decision authorities through a participatory style of management.

However, autonomy appears to be limited to decisions regarding the utilization of a small lump-sum budget allocation, user fees and donations which taken together represent a small portion of a hospital's budget. Evidence suggests that RKSs focus on spending these funds, particularly for equipment purchases, furniture and building maintenance and repairs. Decisions tend to be taken by the medical director in coordination with other district officials. Among RKS members, there is confusion about roles and responsibilities as few received any systematic information or training on the same. There are few guidelines to steer spending decisions. Monitoring, recording keeping, and accountability for use of funds appear deficient.

Emergency Management Research Institute (EMRI)

Founded in 2005, EMRI provides emergency response ambulance services in 15 states and operates a fleet of over 10,000 ambulances. It is a public private partnership model funded mainly by state governments under a contractual arrangement (MoU). The private partner (GVK Foundation) has full autonomy to appoint its own board of directors, recruit and compensate staff, operate its call centers and manage frontline service delivery. Accountability is thus built into a data centric model. The MoU specifies operational guidelines and establishes performance benchmarks that are verified via operation reports, monthly administrative and finance reports, and quarterly fund utilization reports. A third party audits the reports. Indicators of cost per ride, response rates, and beneficiaries per ambulance suggest that EMRI is a high performing program. One problem has been variable government oversight and ambiguity in terms of the MoU.

"Land for Beds" Hospital PPPs

Implemented in several states and municipalities, under this model government enters into a joint venture contract with a private partner—usually a renown, private hospital chain—in which expensive land near city centers is leased or provided at no cost to the partner. The concessional land is the government's equity stake. In all cases, the rationale for this public-private partnership (PPP) was fiscal constraints limiting government's ability to invest in expanding hospital infrastructure. The free or heavily discounted land significantly reduced investment costs by the private partner. In return, the private partner was expected to construct and operate the hospital as well as provide discounted or free care to the poor, usually as a percent of inpatients and outpatients. In practice, the private partner was responsible for any surplus or debts, owned all assets, conducted procurement and expanded services without consulting government. However, these functions were generally not well specified in the lease deed or a contract.

Due in part to imprecise terms of the service contract, ill-defined roles and responsibilities of participating partners, and low oversight capacity by government, particularly in terms of setting and enforcing accountabilities, the model had been criticized because few low-income patients have accessed the hospitals. What is meant by "free" services for the poor was not sufficiently specified in the contracts, leading to differing interpretations by government and private partners. In one high profile case, the Delhi high court has entered into litigation against Apollo Hospitals for charging public patients for drugs and consumables, and therefore limiting financial access to the hospital (Apollo claims that it is abiding by the contract since physician consultations and hotel costs are provided free of charge). Since most low-income patients cannot afford paying for these items, it is estimated that less than 5 percent of hospitals' patient load are "free" public patients, but

the contract states that these patients reach 30 and 40 percent of inpatients and outpatients respectively.

"Contract Management" Hospital PPPs

Under this arrangement, Government sought private partners to operate public hospitals in part to facilitate recruitment of scarce professional personnel, especially specialists. This model has been applied to newly constructed public hospitals in which government enters into a management contract with the private entity. Examples include: Rajiv Ghandi Apollo Hospital in Raichur, Draupadibhai Muralidhar Khedakar-Sahyadri Hospital in Pune, and the BSES Municipal General Hospital in Mumbai. The private partner operates all clinical and non-clinical services and enjoys considerably autonomy over all input management. Some facilities establish management boards with government representation.

This PPP model is considered more functional than the aforementioned "land for beds" arrangement in terms of better definition of roles and responsibilities, decision-making authorities, contractual terms and providing access to the poor. Nevertheless, typical of PPP arrangements in India (and elsewhere), this model is challenged by weak government capacities to enforce accountabilities, monitor performance and manage contractual terms. In some cases, government is overrepresented on a facility's governance board, which tends to lead to administrative and political interference. Contracts contain little detail on performance requirements, sanctions for breach regulations, and reporting requirements.