T17aP11 / Public Hospital Reforms in India, China and South East Asia: Consequences for Accountability and Governance

Topic : T17a / Sectorial Policy - Health

Chair : Rama Baru (Jawaharlal Nehru University)

Second Chair : YINGYAO CHEN (School of Public Health, Fudan Unviersity)

Third Chair : Madhurima Nundy (Institute of Chinese Studies)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

Over the last four decades most low and middle income countries in Asia have introduced a range of reforms in public health institutions, especially hospitals at the secondary and tertiary levels of care. The motivations for reforms in diverse socio-political contexts share some common features with the objective of rationalizing cost and improving efficiency and effectiveness of public hospitals. Some of these shared features include the introduction of user fees; contracting out and in of clinical and non clinical services; casualization of workers to include medical, paramedical and support staff; introduction of paying clinics; autonomisation of public hospitals leading to the redefinition of the ‘public’ in public hospitals.

The main objective of this panel is to invite papers that address the a) the motivation for reforms: fiscal and budgetary pressures prompting governments everywhere to search for ways to improve efficiency and rein in healthcare costs; b) the different ways of pursuing those goals by a mix of strategies and instruments (not just market principles); and c) the consequences of those reforms on hospital workers, patients, management and others.
A number of interesting questions that the papers could address are: (a) whether these reforms have given rise to multiple structures of authority within public hospitals? (b) What are the consequences of fragmentation of authority for the functioning of the hospital? (c) What does contracting in and out of services imply for governance and quality of services? (d) What are the implications of casualization of health workers for governance? (e) Who is responsible and accountable for these workers- the contracting agents or hospital administrators? (d) Is there a potential role conflict between permanent and casualised workers? (e) How do the differential working conditions and wages affect motivation and morale of workers? (f) How does this affect the organizational culture and behavior of health workers towards patients? (g) What are the challenges for governance in the context of fragmented roles, authority and power within a hospital? (h) What are the consequences of these reforms for patient care?

CALL FOR PAPERS

We invite papers that adopt a multi and interdisciplinary perspective that address the complexities involved in governing public hospitals that have introduced reforms. The papers submitted to the panel maybe descriptive and /or analytical that discuss the process, content and experience of public hospital reforms in India, China and South East Asia. These papers could have a country focus or may adopt a comparative perspective between two or more countries of public hospital reforms. The papers must provide broadly a historical overview, content and process of reforms; the role of international agencies (if any) in furthering the reform agenda; restructuring of financing and structures for governance; innovations in regulations for the management of public–private partnerships in the hospital. The papers must reflect on the reform process and the challenges it poses for governance of the hospital. It should broadly address the following questions :

- What are the consequences of these reforms for accountability, quality, management and organizational culture?
- What are the implications of these reforms for patient care?
- How do users of hospitals perceive and experience these changes?
- What were the consequences of these reforms for equity of access?

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Session 1

Thursday, June 29th 08:15 to 10:15 (Block B 3 - Auditorium)

Discussants

Rama Baru (Jawaharlal Nehru University)

An Overview of Public Hospital Reform in China

Shanlian Hu (School of Public Health, Fudan University; Shanghai Health Development Research Center)

Public hospital reform was started in 2009, which are involved multi-stakeholder interests. Along with the universal coverage of health insurance, the medical demands are being increased rapidly. The number of public hospitals and their beds has increased 34.9% and 70.8%; respectively On the contrary, the capacity of primary health care at community level has shrunk. Most of the patient's flows to the tertiary hospitals directly where provide 40% outpatient services and 76.4% hospitalization services. In recent 8 years, the annual growth rate of hospital revenue as high as 15.2%. At present, China has 27,587 hospitals, among them 47.4% are public hospitals. About 2000 county public hospitals and 200 urban hospitals have been carried out national pilot studies. The future direction of public hospital reform is to upgrade the quality of medical services, improve the innovative delivery system.

The paper reviews the main steps of public hospital reform, including building up modern hospital management system, establishing legal hospital governance structure, ownership and autonomy, hiring and firing staff, medical service integration, pay for performance, delink the incentive of drug profit, cost accounting, changing payment system and giving the responsibility and accountability to hospital director, etc.

When conducting reform, China is facing many challenges, such as organizing hospital drug tendering system and GPO, "two-invoice system" in drug distribution channel, drug zero-markup in hospital, price adjustment on medical service items. Chinese government has set the targets: (1) the share of drug income in total hospital revenue should be less than 30%; (2) the cost of medical suppliers should be no more than 20% total medical revenue excluding drug revenue; (3) the annual growth rate of pubic hospital revenue should be less than 10%; (4) the proportion of individual payment should be less than 30% total health expenditure so as to release economic burden for population.

Another public hospital reform fact is to promote the establishment of tiered medical services, cut red tape and enhance coordination among medical and healthcare institution at various levels and different categories. Contracting with family doctor is based on voluntary principle that will play a role as gate-keeper. Government will make favorable policies to support the development of private non-profit hospital from the perspectives of land, taxation, price setting and health insurance coverage. The public-private partnership will be the future tendency.

"Healthy China 2030" emphasizes on deepening health reform in China, the target of equality of basic health service will be accomplished by the year of 2020.

Evolving organisational structures in public hospitals in China: Implications for governance and equity in access

Madhurima Nundy (Institute of Chinese Studies)

Reforms in public hospitals in China have been one of the major health sector reforms. This paper will examine the public hospital reforms in China in phases, post 1978 and study the structural changes and evolution of

hospitals to present entities. Public hospitals deliver 90 per cent of inpatient and outpatient care and garner two-thirds of all health care spending and hence, are quite central to Chinese people's lives. The paper attempts to examine the evolving organisational structures of hospitals and their implications for governance, access and health services in general. The paper is based on secondary literature as well as primary data gathered through interactions and interviews with Chinese public health scholars and practitioners.

The preoccupation with economic reforms that were promoted by Deng Xiaoping as market socialism during the late 1970s led to the complete neglect of the health sector in the 1980s. The decentralisation of power and transfer of profits were the main reform features in the 1990s when incentivising hospitals and doctors was allowed to increase revenues for hospitals. As hospitals were left mostly to fend for themselves and 'autonomised', it led to a system where hospitals were owned by the state but due to major cuts in government subsidies, several market mechanisms were introduced in order for them to stay afloat. These hospitals behaved like quasi-commercial entities.

Since 2009, there have been shifts in hospital reforms. One part of reforms has been introduced to address the social unrest and dissatisfaction of patients due to high costs and overcrowding. This has mainly attempted to break the dependence of hospitals from selling unnecessary drugs and diagnostic services and do away with incentives attached to these. The other part has given emphasis on introducing newer structures by furthering markets in public hospitals. This has involved selling of public hospitals to private investors on one end and on the other, restructuring public hospitals by introducing new forms of partnerships. This has led to the infusion of private capital and expansion of these institutions based on ideas of business and profit models. There are now several models that have been piloted in the first tier cities. These have led to creation of new entities within and outside hospital systems and new governance mechanisms that have in turn created clear separations between ownership, operations, management and supervision. The paper will explore the consequences these reforms will have on governance, equity and on the overall health service system.

Private Sector Solutions to Public Sector Problems: Critical Appraisal of Public Hospital Reforms in India

Altaf Virani (Monash University, Indonesia)

M Ramesh (LKY School of Public Policy, National University of Singapore)

There has been by a progressive shift in how public organizations are managed. Policy literature has identified two distinct strands of this movement. The first is characterized by the infusion of scientific management and businesslike practices in government. The second is rooted in new institutional economics, which exalts the merits of incentives arising from free competition and a focus on citizens as customers, instead of simply consumers of public services.

This paper focuses on health system reform and proposes a theoretical framework within which some of the common reform strategies can be situated and analyzed. It incorporates conceptual elements drawn from both organizational and policy literature that are known to affect an organization's performance. In this framework, performance is affected through complex interactions between the structural environments within which public and private healthcare providers operate (such as the extent of autonomy they have and the nature and strength of accountability mechanisms they are subjected to), and their orientation in terms of values, ethos and motivations. The paper questions the assumption that public and private providers might respond to performance-oriented instruments in similar ways, given their distinct dynamics, structural constraints and unique objectives. It is therefore possible that instruments that are usually effective in improving performance in private healthcare organizations might have ineffectual or even adverse outcomes, in the public sector context.

The paper highlights these challenges using public hospitals in India as examples of restructured public organizations. The National Rural Health Mission (NRHM) in 2005 brought about a slew of management reforms in India's health sector, with greater autonomy to public hospitals at sub-state and sub-district levels, incentives to motivate employees, performance targets, demand-side financing programs, community monitoring and participation and collaborations that aim to leverage private sector capacities towards public objectives. We discuss two interventions that are geared towards leveraging these reforms for improving performance of public hospitals in different ways. The National Health Insurance Program (Rashtriya Swasthya Bima Yojana or RSBY) and similar programs at the state level, create fund generation opportunities for public hospitals and leverage local autonomy for their use through Patient Welfare Committees (Rogi Kalyan Samaitis or RKSs), to get them to compete with private hospitals and improve services. In contrast, Quality Assurance (QA) programs use a target-based approach that drives improvement through team goal setting and recognition for success. We position these programs within the proposed framework and draw attention to some of the opportunities, impediments and ramifications of these reforms. Based on this assessment, the paper examines the question of whether 'public ethos' is likely to be compromised if performance is extrinsically driven and accountability is performance-oriented, than if it is intrinsically motivated and accountability is more democratic. It also sets the agenda for future research that might help understand what kinds of structural reforms and interventions might be

required to optimize the functioning of public health facilities, and motivate public healthcare providers to produce performance that is both effective and consistent with the ideals of the public sector.

Power of data in the governance of public hospitals in China: case of antibiotics control in Shanghai Municipality

Hai Lin (Shanghai Health Development Research Center)

The public sector dominates healthcare provision in many areas in China, including Shanghai Municipality, with a population of 24 million. The resources-wasting pattern of healthcare services provided by public hospitals has been criticized by both academia and decision-makers in the last decade. This pattern is characterized by the mechanism of reimbursing hospitals by surplus from sales of drugs. As a result the average proportion from drug sales accounts for nearly half in the total revenue of each public hospital.

The boundary between the information that should be disclosed and that could be kept within walls of public hospitals is still obscure. It challenges the governance of public hospitals and may risk losing the chance to improve in an era of big data. The case of antibiotics control is about the efforts to contain antibiotic resistance which is of global importance, with the aim of surveillance systems of antibiotic use and resistance. We extracted data from Shanghai Municipal Medical Products Administration Agency, whose database covers 95% of total drug procurements of all public hospitals from 2009, and processed with a method from Europe and recommend by World Health Organization, to get comparable indicators for the level and patterns of antibiotic utilization.

The three-year (2011-2013) national campaign to contain unnecessary antibiotic prescriptions yielded a drop of 31% in the first half of 2011 and the level kept stable until the end of 2014. However the pattern of antibiotic use differentiate any reported areas or countries by preferences for cephalosporins, quinolones, macrolides and injections. In the end of 2016, the annual spending of antibiotic use bounced to a higher level by 0.7 billion RMB (17.5%) compared with the level of 2010, in which increased spending on carbapenems, quinolones, and third-generation cephalosporins constituted the majority. The sales data to monitor antibiotic use is almost real-time within a lag of one week and powerful to inform evidence for further policies and actions, and thus make it promising to improve governance.

In conclusion, the authoritarian centralized political system of China makes it rapid for new decisions and efficient to implement. Nevertheless the medical professionals' involvement is not sufficient to make policy and action sustainable. The governance of public hospitals could be optimized with more power from data accumulated in the healthcare infrastructure investment in China via evidence-informed decision making and researches.

January 13, 2017

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Session 2

Thursday, June 29th 10:30 to 12:30 (Block B 3 - Auditorium)

Discussants

YINGYAO CHEN (School of Public Health, Fudan Unviersity)

How Reforms are Reorienting Public Sector Hospitals in India

Bijoya Roy (CENTRE FOR WOMEN'S DEVELOPMENT STUDIES)

Reforms in public sector health facilities particularly in hospitals in India became widespread mid-nineties onward and have been central to World Bank reforms. Public sector hospitals are facing the challenge of funding and ways to provide new and old clinical and non-clinical services. Increasingly public sector hospitals across the country have been exposed to series of quasi-market reforms arguing that public sector is less efficient and responsive. However, these reforms bear implications the way services are provided, for resource allocation (financial, technological) and workforce. In the recent years with stagnating public expenditure, capital investment in the hospital sector has emerged as an important aspect. The draft National Health Policy 2015 recommended ‘reorienting Public hospitals’ to adapt them to the needs of health insurance and create an environment of competition.

The focus of this paper is on the public sector hospitals since post reform hospitals as institutions have received little attention. This article examines how the dual process of user fees at the point of service delivery followed by Public Private Partnerships (PPPs) are restructuring public sector hospitals and exposing them to privatisation process and creating quasi-market structure.

The first section explores the user fee policies and using regional experiences its exclusionary impact is assessed in terms of access and utilisation. The second section maps the existing PPP models for hospital provisioning, management and construction. It is observed that user fees that was initially for services directly provided by the hospital have now become integral to the PPP based service provisioning even though it was deterred at the policy level due to its negative impact. PPPs have exposed public sector hospitals to complex arrangements with private sector and their associated risks. Even though the PPPs in the hospital sector are at its nascent stage already there are certain concerns related to costs, financing, comprehensiveness, quality, and regulation. Complexity of PPPs bear an impact on public sector hospital’s management, infrastructure and overall functioning. Monitoring and regulation has become more difficult through contractual relationship with diverse set of private sector organisations.

In an overall low resource setting with weak governance like in India, user fees and PPPs in public sector hospitals together have led to change in values and gradually orienting these facilities towards a new culture. Firstly, they have created tiered provisioning of clinical care, fragmentation and monetisation of services that was erstwhile universally free irrespective of the patient’s economic background. Secondly, early studies of these reforms indicate itemisation of each aspect of clinical care, and push for business. Thirdly, over a period of time private sector has expanded its foothold into the public sector hospitals. When commercialisation is gradually stepping into these health care facilities what remains to be seen is whether these hospitals will be able to safeguard the principles of universality, comprehensiveness and quality care.

The Bonus Scheme, Motivation Crowding-Out and Quality of the Doctor-Patient Encounters in Chinese Public Hospitals

Alex Jingwei He (The Education University of Hong Kong)

Public hospitals, as sophisticated health care organizations, constitute complex payment arrangements, which powerfully shape the incentive structure for physicians. Payment system typically includes how hospitals are reimbursed externally and how physicians are remunerated internally. Bonus as a powerful incentive has been widely used in public hospitals to boost staff morale. This may, however, also create unintended consequences. This study analyzes primary data collected from a physician survey in two Chinese provinces and demonstrates that the extensive use of quantity-based bonuses in Chinese public hospitals has significantly crowded out physicians' motivation to improve the quality of clinical encounters. An increase in bonus payment to a physician is associated with a decrease in the length of outpatient consultation and the frequencies of both talking and smiling to patients. This finding is set in the broader context of the Chinese health care system, which has been witnessing a critical deterioration of doctor-patient relationships and a rapid escalation of conflicts and medical disputes. This article demonstrates that perverse bonus schemes do not only lead to the provision of unnecessary care but also crowd out physician's intrinsic motivations, resulting in a decline in the quality of services offered. More appropriate physician remuneration mechanisms must be introduced in China's ongoing public hospital reform.

How patient welfare committees contribute to the governance of district hospitals in Odisha State, India

Bhuputra Panda (Public Health Foundation of India)

Kabir Sheikh (Public Health Foundation of India)

Harshad Thakur (Tata Institute of Social Sciences)

Background

Governance and accountability are a critical but often neglected aspect of public hospital reforms across the globe. Under the auspices of the National Health Mission (NHM), the government of India and state governments have established participatory patient welfare committees or Rogi Kalyan Samitis (RKS) with administrative and policymaking responsibilities. These committees were established with the objective of improving the quality, equity, efficiency and local responsiveness of health services provided by district and sub-district hospitals. The processes of decision-making through these local governing institutions are critical determinants of their performance. This study aimed to assess RKS functioning through analysis of the experiences of RKS members.

Methods

Eighteen focus group discussions (FGD) were conducted at selected district hospitals and community health centres across six districts of Odisha. Total of 109 members participated, with an average of 6-8 members in each FGD. We used an FGD guide and audio-recorded

the proceedings. All recordings were transcribed and translated into English language for analysis. Data were analysed in four domains of composition, governance within RKS, functioning of RKS and supportive environment. Under each domain, results related to specific themes, such as, memberships, meetings, motivation, autonomy, accountability, user fees, local responsiveness, service delivery, quality of care, etc included.

Results

Members reported that the diverse composition of RKS' posed several challenges. Consequently, members were irregular in attending meetings. Interference by elected representatives was cited as an important reason for poor accountability of public hospitals. Role clarity was lacking amongst almost all members of RKS. Most respondents felt RKS had increased autonomy at work, but accountability and local responsiveness were poor, as the understanding of members about their own roles in governing the local institution was poor. Several service quality related functions are now within the mandate of RKS, but powers of recruitment and funds utilization are centralized. Fragmentation of NHM and non-NHM wings, less trust of patients on government-supplied medicines, and hidden agenda of

RKS members were cited as the main barriers to achieving the goals of better governance of public hospitals by RKS'.

Conclusion

Local decision-making has the potential to improve the governance of public hospitals at district and sub-district levels, and advance public health goals. Devolution of more powers to RKS, criterion-based membership, and

capacity-building for key governance functions are critical to improve RKS functioning.

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Session 3

Thursday, June 29th 13:30 to 15:30 (Block B 3 - Auditorium)

Discussants

Madhurima Nundy (Institute of Chinese Studies)

Policy Pilots and Public Hospital Reform in China

Xun Wu (Hong Kong University of Science and Technology)

Qian Jiwei (East Asian Institute, National University of Singapore)

Yifei Yan (University of Southampton)

Policy pilots in healthcare sector have been conducted extensively in China in the last two decades. While these pilots have played an essential role in determining policy measures to reform healthcare system in China, there has been very little research on the design, implementation and adoption patterns of policy pilots. Based on a comparative case study of major policy pilots in reforming public hospitals in China, this paper examines the role of political environment, institutional structure, and administrative incentives in shaping the design, implementation and evaluation of policy pilots. Our analysis shows that, while the intention of central government for conducting policy pilots is to test the technical merits of different reform alternatives, there are strong biases against negative results of these pilots among local government officials who are eager to show that their pilot programs perform better than pilots conducted elsewhere. Our analysis offers valuable insights into mechanisms and measures to improve the effectiveness of policy pilots.

Casualisation of Health workers and the erosion of trust in public hospitals in India

Rama Baru (Jawaharlal Nehru University)

An important feature of health sector reform has been the casualisation of health workers in hospitals. Initially it meant that permanent workers at the lower levels were replaced by contract workers. This then was extended to include paramedical workers, nurses and doctors. Some of these were government contracts while those at the lower levels were contracted in through an intermediary, mostly private contractors. The different work arrangements that included salaried permanent employees; contracted government employees and those contracted through private contractors have differences in job security, salary, benefits and pensions. This potentially creates a splitting of roles of workers, role extension and duplication in the hospital. This results in contradictions and conflicts within and across categories of personnel. Since hospitals are primarily a human service organisation, these conflicts result in frustration and alienation among the workers that robs the team effort that is required for effective patient care. It also poses challenges for administration and accountability in the hospital. This paper will examine how casualisation of the work force contributes to erosion of trust among workers and also with patients.

‘On-Contract’ Healthcare Personnel in Government Services – Issues and Implications for patient care in India

Zafar Seemi (Jawaharlal Nehru University)

The introduction of market reforms in Indian public health sector since 1990s has seen experimentation with many

strategies to provide cost effective healthcare and reduce the government's health bill. One major thrust of these reforms has been efficient human resources management. Historically, the Indian public health sector has been characterized with severe shortages of health care personnel at all levels, and within hospitals the numbers have always been short of prescribed norms for patient care. Under the ambit of hospital reforms, recent recruitment of health workers including doctors, nurses, technical and paramedical staff have largely been on renewable one-year contracts, while permanent selections have been minimal. The entry of contracted workers has helped in alleviating the significant human resource deficit in health systems and overburdening on existing staff, but at the level of operations it has created two parallel workforces within a single institution - one with permanent jobs, better salaries, greater leaves and social security benefits; and the other with one year contracts, dismal pays, fewer leaves, no benefits and no possibility of professional growth - gradually creating a demoralizing effect on contracted employees. This paper delineates the characteristics of contract work in a public health setting and its implication on services delivery, through insights from a qualitative study conducted in a tertiary government hospital in Delhi. Evidences from the study indicate that contracted employees work with a very low morale, feel discriminated, have little association with their roles, face greater work burden, and have no likelihood of promotion, or diversification in role performance. The coexistence of permanent and contract staff side by side creates problems of distrust among coworkers, lack of respect for each other, dispute in assumption of responsibility and accountability, and blame shifting. Such relationship among staff members weakens the organizational culture, and restricts the quality of healthcare being rendered to patients.

Free Medicines in Tamil Nadu: sustainable reforms and effective financial protection

Mukhopadhyay Indranil (School of Government and Public Policy, OP JIndal Global University)

One of the critical implications of the health sector reform policies and cutbacks in public spending on health has been gradual withdrawal of distribution of free medicines in public facilities. Consequences on access to medicine has been quite severe- as much as two third of the out-of-pocket expenditure is due to medicines and as many as 3.4 crores people are impoverished due to the lack of an effective system to deliver these essential inputs to people at the right time and at appropriate cost.

While majority of Indian states were rolling back delivery of health services during 1990s, Tamil Nadu brought in a sustainable reform in the procurement and distribution of medicines in the state to ensure free distribution of essential medicines. The main objectives of the paper had been twofold. First, the authors reviewed the various aspects of reforms brought under TN free medicine scheme and secondly to study the implication of this model in providing financial protection for its population.

Methods: The study uses data and information from multiple sources, including survey of public facilities, unit records of National Sample Survey Organisation data, health system level data and medicine procurement and distribution data. Secondary literature, tender documents and rate contracts have been analysed to study the various aspects of procurement system.

Findings: The Tamil Nadu Medical Services Corporation (TNMSC), set up in 1994, is a pioneer of pooled procurement system in India with considerable autonomy provided to the procurement agency. The centralised procurement system brings about considerable economies of scale with huge cost containment- at rates which are on an average 200% lower compared to market rates.

A passbook with monetary entitlements is provided to all public health institutions that can obtain medicines in the approved list from the available funds. The passbook system facilitates a need based transfer of medicines from one warehouse to another, thus avoiding stock outs. This actually helps overcoming with one crucial limitation of inputs based budgeting system, which is often riddled with allocative inefficiencies.

The study points out that states with centralized procurement and decentralized distribution model have achieved significant efficiencies in terms of lower procurement prices, higher availability of medicines and higher percentage of people receiving free or partially free medicines. Experience from Tamil Nadu suggest that the scheme has succeeded in controlling OOP on medicines as the state has one of the lowest share of medicines in total OOP on health.