Unregulated commercialization & Public Private Partnership (PPP):

Case of hospital reform in Brazil and China

Global Health History Seminar
9 May 2012 WHO

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Topics presented

• Concept
  – What matters and why?
  – Institution and incentive

• Reaction, debate, and actors
  – Who is doing what?

• Hospital reform in Brazil and China

• A snapshot on evolution of theories

• Conclusion: Contract and/or trust
Defining "commercialized" health care

Provision of services through market to those able to pay; investment in, and production of, those services, and of inputs to them, for cash income or profit.

Machintosh (2005)
Health Systems and Commercialization: In Search of Good Sense
Defining unregulated commercialization

Unregulated fee-for-service sale of health care, regardless of whether or not it is supplied by public, private, or NGO providers

What matters

• Major threat
  – Affects a larger population

• Negative consequences
  – For people: health impoverishment
  – For health system: trust and macro economy
  – For social institution: institutionalizes inequality and de-legitimizes the State
Paradigm shift

• Development in the 1980s: from public paradigm to the New Public Management, and the marketization

• Ideological justification: less state is better

• Generalization into health sector
  – Change at the macro level, and consequences at the meso, and the micro level
    • Coping in the 1980s
    • Harnessing, partnerships, engagement…

• The problems with institution and incentive..
Institution and incentive
Effects on service delivery

• Low growth economies:
  – Fragmentation: adapt to donor funding
  – Individual coping strategies
    • Commercialization – no quality "floor"
    • Dangerous "care" – "safari" surgery

• Transitional economies: commercialized care
  – Inverse care: people with more means consume more
  – Misdirected care: primary care neglected
  – Fragmenting care: profitable services increase
Institution and incentive
Effects on institution and governance

• Low growth economies:
  – Institutional inflation follows donor money
  – Strategic discussions replaced by individual donor-client relations

• Transitional/emerging economies:
  – A passive state with less financial leverage
  – Illumination for "competition" for efficiency yet without the functioning market
  – Institutional survival strategies dominate
Reactions

Opinions: mixed
  – Mainstream health economists
  – Academia
  – Global health
  – Health authorities
  – Public

• Evidence: mixed
  – Varied practice with/without donors

• Institutional actors…. 
The debate

• IFC 2007. The business of Health in Africa: Partnering with the Private Sector to Improve People's Lives
  – Harnessing private sector in health

• IFC 2011. Healthy Partnerships: How governments can engage the private sector to improve health in Africa

• Oxfam International 2009. Blind Optimism
  – Calling for public service provision for the poor

• In conclusion: Search for evidence/performance
WHO work on non-state sector, including PPP

1. PPP in the TB program
2. PPP in the Reproductive health
3. Regulating medical technology
4. Service delivery & the role of the private sector
5. PPP and Contracting
6. Moonlighting and human resources
7. Alliance for Health Policy and Systems Research
8. Good Governance for Medicines Program
Agencies/groups working on non-state sector

- Centre for Global Development.
- DFID. Civil Society Challenge Fund.
- Health Alliance International. The NGO Code of Conduct for Health Systems Strengthening.
- Karolinska Institute, SIDA. Private Sector Programme in health
- OECD, WB, IFC, DFID – Public Private Dialogue
- USAID. Private sector partnerships for better health
- World Bank. Knowledge Services for Private Sector Development.

- Medicines Transparency Alliance. Annual Report
- Transparency International: Global Corruption Report
- Health Action International (HAI) Rational Use of Medicines
- Oxfam International. Blind optimism
- Public Services International (PSI)
- Consortia: The Role of Private Sector in Health
- Results for Development Institute: The Private Sector in Health Systems in Developing Countries (Sponsored by The Rockefeller Foundation)
- Health Market for Innovation: Study on Informal Provider
- UCLA. Study on franchise of healthcare
Assessment of public hospital reform:
Unregulated commercialization in China and
public private partnership (PPP) in Brazil

Data on Brazil is from Gerard La Forgia and April Harding, 2009
Data on China is from Hongwen Zhao 2005
Public hospital reform in Brazil and China

<table>
<thead>
<tr>
<th>Sao Paulo state in Brazil</th>
<th>Tertiary care in China</th>
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<tbody>
<tr>
<td>The decentralized Unified Health System (SUS) since late 1980s</td>
<td>Public-integrated model (service, finance and admin) since 1950s</td>
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<tr>
<td>Public hospitals under direction administration</td>
<td>Public hospital under direction administration</td>
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Pre-reform issues:
- Incentives and accountability
- The problem of direct contracting with private hospitals:
  - Agreement (weak contract) poorly managed
  - Political link with public system
  - Indicators: service volume for government payment

Pre-reform issues:
- Obsolete medical technology
- Long queues
- Public sector inefficiency
### Public hospital reform in Brazil and China

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<td><strong>Reform:</strong> PPP model through a non-profit operator</td>
<td><strong>Reform:</strong> Fiscal decentralization</td>
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<tr>
<td>Select private non-profit operators through open competition in late 90s</td>
<td>Create &quot;self-governed&quot; hospitals by reducing government budget since 1985.</td>
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<tr>
<td>- Five year operating contracts</td>
<td>A &quot;purchaser&quot; established in 1997, yet without enough financial leverage</td>
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<td>- Performance specification</td>
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The non-profit operators (OSS) as "public interest" organization created by law in 1998.
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<tr>
<td><strong>Accountability mechanism:</strong></td>
<td><strong>Accountability mechanism:</strong></td>
</tr>
<tr>
<td>• Types of services</td>
<td>• Less specified between hospital and health department</td>
</tr>
<tr>
<td>• Quality assurance process</td>
<td>• Focused on financial audit</td>
</tr>
<tr>
<td>• Reporting: specified</td>
<td>• Appointment of President</td>
</tr>
<tr>
<td>• Contracting inputs, including personnel.</td>
<td></td>
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<tr>
<td><strong>Payment mechanism:</strong></td>
<td><strong>Payment mechanism:</strong></td>
</tr>
<tr>
<td>• 90% payment links to production</td>
<td>• The &quot;purchaser&quot; paid on claims</td>
</tr>
<tr>
<td>• 10% links to reporting and quality</td>
<td>• FFS for bulk of private patients</td>
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## Public hospital reform in Brazil and China

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<td><strong>Incentives:</strong></td>
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<tr>
<td>• Limited market exposure</td>
<td>• Wider market exposure</td>
</tr>
<tr>
<td>– No competition for selling services in a market</td>
<td>– Volume competition between hospitals and with primary care</td>
</tr>
<tr>
<td>– No fees charged to patients</td>
<td>– Can charge fees</td>
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<tr>
<td>• Residual claim rights</td>
<td>• Residual claim rights</td>
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<tr>
<td>– Only for service improvement</td>
<td>– Bonus pay</td>
</tr>
<tr>
<td>– Hard budget constraints</td>
<td>– FFS on private patients</td>
</tr>
<tr>
<td>– Less than 70% of budget on payroll, subject to audits</td>
<td>– Can invest for service improvement</td>
</tr>
<tr>
<td>• Capital investment</td>
<td>• Capital investment</td>
</tr>
<tr>
<td>– No depreciation</td>
<td>– Yes, staff can hold share</td>
</tr>
<tr>
<td>– Negotiating with state</td>
<td>– Loan from public or private entities</td>
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<tr>
<td>Governance arrangement</td>
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<tr>
<td>• Financial management:</td>
<td>• Financial management:</td>
</tr>
<tr>
<td>Standardized cost-accounting system in all PPP hospitals:</td>
<td>Financial audit to &quot;self-governed&quot; hospitals</td>
</tr>
<tr>
<td>• Contract management unit in the health secretariat</td>
<td>• Market inspection unit in the health department</td>
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<tr>
<td>– Contract term enforcement</td>
<td>– Limited tools</td>
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<td>– Arms-length governance</td>
<td>– Unclear governance arrangement</td>
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<td><strong>Key ingredients:</strong></td>
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<tr>
<td>• Autonomous authority</td>
<td>• Autonomous authority</td>
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<tr>
<td>• Flexible HR management</td>
<td>• Flexible HR management but less used</td>
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<tr>
<td>• Strategic purchasing: contract</td>
<td>• Strategic purchase: financial leverage less effective</td>
</tr>
<tr>
<td>• Contract enforcement</td>
<td>• Largely, FFS payment</td>
</tr>
<tr>
<td>• Information and transparency: benchmarking for budget negotiation</td>
<td>• No information framework across hospitals</td>
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Hospital sector in China: "Public identity, private behaviour" 1985 - 2009

- The issues associated with private market in health
  - Market segmentation: benefit the richer segment
  - High OOP: reduced access for the poor

- Blurred distinction between public & private sector
  - Perverse incentives: induced demand under FFS payment method
  - Lack of quality benchmark and price signal that truly reflect the cost

- The commercialized health care needs to institute effective regulatory regime
A snapshot on evolution of theories I

The market failure in health:
• Risk of uncertainty and information asymmetry. Arrow 1963
• Restoration of the market: to establish professional ethical code so to establish reputation and trust. Arrow 1972

The state:
• To promote self-regulation/co-regulation for safety, cost and quality
• To redistribute for access

The new institutional economics: use theories of property right, agency-principal relation, and transaction cost for private health sector development in transitional economies in the 1990s

Balance the state and the market needs new paradigm. Jacobson 2001

Partnership: mutual cooperation (coordination and collaboration) and responsibility for achieving specific goal
A snapshot on evolution of theories II

A new framework: towards new social contracts in LMIC

- Unorganized market: informal and unregulated
  - Not legally recognized, and without the reach of state law enforcement

- Evolving social institutions and actors are in the gradual formation of new social agreement/contracts, formal or informal

- A reiterative process to generate rule-based activities in which reputation-based trust and market-based contracts may operate more effectively

Gerard Bloom et al.
Markets, information asymmetry and health care: towards new social contracts. 2008
Governing healthcare market in the transitional China. Hongwen Zhao, 2005
Searching for good sense: contract and/or trust

• Medicine as science and art:
  – Professional autonomy challenged by organized market

• Economics approach:
  – Distributional equality with respect to exercise of individual liberty through market mechanisms for “both that equality of welfare is impossible and that the market has an ethical base are, in fact, false.”
    – Ronald Dworkin, Law’s Empire

• Legal approach:
  – Governing requires not only technical but also moral competence
    – Kenneth Winston, Do legal institutions require virtuous practitioners

• Sociological approach:
  – Spread of reputation-based trust mechanism rooted in the community, as an alternative of contract used in the PPP, may lead all members a happy life
Thank you