

Understanding Organizational Reforms

The Corporatization of Public Hospitals

April Harding and Alexander S. Preker

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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Understanding Organizational Reforms *The Autonomization and Corporatization of Public Hospitals*

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This paper will appear in a modified version as Chapter 1 a forthcoming book:
Harding A, and AS Preker, AS. 2002. "A Conceptual Framework for Organizational Reforms in the Hospital Sector." In AS Preker and A Harding. Eds. *Innovations in Health Service Delivery: Volume I – The Corporatization of Public Hospitals*. World Bank: Washington.

Abstract: Heavy investment over the past 30 years has made the hospital sector the largest expenditure category of the health system in most developed and developing countries. Despite shifts in attention and emphasis toward primary care as a first point of contact for patients, in most countries, hospitals remain a critical link to health care, providing both advanced and basic care for the population. Often, they are the provider "of last resort" for the poor and critically ill. Although, it is clear that hospitals play a critical role in ensuring delivery of health services there is much less agreement about how to improve the efficiency and quality of care provided. With increasing frequency, hospital autonomy, corporatization, and even privatization, are being considered and applied to improve performance of publicly run health services. The objective of this publication is to yield some insights about these popular reform modalities from a review of the literature, reform experiences in other sectors and empirical evidence from hospital sector itself. The review examines: (a) what problems these reforms are attempting to address; b) the core elements of the reforms; and, c) why they are structured the way they are (why their designers think they will resolve certain problems)? While this paper focuses on issues related to the *design* of the reforms, the paper also reports the findings from a larger study that examined the *implementation* and *evaluation* of such reforms so that they will be available to countries that are considering venturing down this reform path.

Keywords: Hospitals, organizational reform, autonomization, corporatization, privatization

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PREFACE

Despite much attention and emphasis on primary care as a first point of contact for patients, in most countries, hospitals remain a critical link to health care, providing both basic and advanced care for the population. Hospitals are often the provider “of last resort” for the critically ill and poor. Yet hospitals also comprise the largest expenditure category of the health system of both developed and developing countries. As a result, although their critical role as an integral part of the health system is well recognized, hospitals are often the target of health sector reforms aimed at efficiency, equity and quality improvements and more systemic reforms in financing and the health care delivery system.

This paper provides some insights about recent trends in the reform of public hospitals, with an emphasis on organizational changes such as increased management autonomy, corporatization, and privatization. The material presented tries to answer three questions: (a) what problems did this type of reform try to address; b) what are the core elements of their design, implementation and evaluation; and, (c) is there any evidence that this type of reform is successful in addressing problems for they were intended)?

Why Look at Autonomization, Corporatization and Privatization of Public Hospitals?

Decentralization, which dominated much of the discussions on structural reforms in the public sector during the 1960s and 1970s in Western Europe, arrived in the developing world during the 1980s. By that time, Western Europe had turned its attention to improving the performance of government-owned services through organizational reforms of the service providers themselves. This included altering the incentive regime that managers within the organizations were exposed to and changing the external policy environment, governance structures, funding arrangements, and competitive pressures.

Reforms of this genre, which are now commonplace throughout the world in the infrastructure, telecommunications and transportation sectors, have included: (a) that increase the management autonomy of the organization (autonomization); (b) transforming the hierarchical bureaucracy into parastatal corporations that are exposed to market-like pressures (corporatization); and (c) outright divestiture of the organizations from the public sector (privatization). They are often referred to as “new public management” or marketizing reforms.

Influenced by the lessons learned from the problems and reforms tried in other sectors, many health care policymakers concluded that the performance problems of public hospitals were similarly grounded in the rigidity of hierarchical bureaucracies, the lack of control by managers over day-to-day operations of their facilities, and absence of performance-based incentives. Having successfully applied new public management techniques and marketizing reforms in other sectors, it was a natural step for policymakers in some countries to consider applying similar reforms to the health sector.

Initially, the reform of choice was to give hospitals some degree of management autonomy. Limited success with this type of reform in some settings led policymakers to go a step further by transforming some of their state-owned hospitals into public corporations. The path breaking reforms of this genre, which occurred through the creation of Hospital Trusts in the United Kingdom and Crown Health Enterprises in New Zealand in the UK and New Zealand, drew world-wide interest. Soon many developing countries such as Hong Kong, Singapore, Malaysia, Indonesia, Tunisia, and Argentina were attempting similar reforms. Often they were accompanied by parallel reforms in the overall health policy framework, provider payment system, and competitive market environment.

The debates surrounding these reforms during recent years have been lengthy, heated, and rarely benefited from evidence gleaned from rigorous evaluation of existing experiences. It is notable much of

this debate entered on whether it is possible for independent hospitals to play a positive role in a well functioning health system. Polemic over this issue obscures the reality that in many OECD countries that from their inception have a tradition of paying for health services through social insurance, inpatient services have always been provided through a mixture of public, semi-autonomous parastatal, non governmental and private hospitals.

The existence and performance of mixed delivery systems that include autonomous, corporatized and private hospitals belies the need to speculate endlessly about the endpoint of reforms that try to introduce more performance-based funding, hospital boards, and regulation of non governmental providers. The hospital sector of all the European countries that use such mixed delivery systems are all part of socially responsible health care systems. The real question that faces most policy makers is therefore not “should they do it” but “how to get from here to there” – *how to get from a rigid integrated delivery system, with dysfunctional hierarchical control of hospitals, to a more performing system that relies on indirect mechanisms to guide substantially more responsive independent service providers*. The research which is presented in this paper was motivated by desire to assemble available information to try to answer this question.

Need for More Research and Analysis

This paper is a first attempt to conduct a systematic, if subjective, review of autonomization and corporatization of public hospitals. It should not be considered a definitive statement on this subject but rather an opportunity to crystallize key questions about objectives, design, implementation, and evaluation of such reforms. It highlights several important areas for further investigation:

- the institutional and contextual requirements for and constraints to “marketizing” organizational reforms (e.g., what works at different income levels, stages of health systems development, cultural settings, market environments)
- a direct comparison of autonomized, corporatized and privatized units to see which reform creates a more workable hospital system in different contexts
- policy options for reforming public hospitals in situations of extreme government failure (is there any evidence that improved management of integrated hierarchical systems do better in this context than if governments were to introduce organizational reforms, complex as they may be)
- the nature of the parallel reforms in resource governance, resource allocation/purchasing arrangements and market environment that are needed for successful reform
- ways to achieve more rigorous and on-going monitoring and evaluation of the reforms to ensure that policymaker will use the lessons learned and that these will be available to countries that have not yet ventured down the organizational reform path.

Research the World Bank is now undertaking in these areas will soon be published as companion volumes to this paper and our forthcoming book on *Innovations in Health Care Delivery*.

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PART 1. UNDERSTANDING ORGANIZATIONAL REFORMS: A CONCEPTUAL FRAMEWORK

A. INTRODUCTION

With increasing frequency, hospital autonomy, corporatization, and even privatization are being considered and applied to improve performance of publicly run health services. The objective of this publication is to yield some insights about these popular reform modalities from developments in the relevant theoretical literature as well as reform experiences in other sectors. We review the literature and the experience to understand: (a) what the reforms consist of; (b) what problems they attempt to address; and (c) why they are structured the way they are (why their designers think they will resolve certain problems). While this paper focuses on issues related to the *design* of the reforms, subsequent research treats issues related to the management and *implementation* of such reforms as well as *evaluation*.

Past Accomplishments

During the past 50 years, many low- and middle-income countries have established publicly funded health care systems with services produced by a vertically integrated bureaucracy in the public sector. These systems were structured this way primarily as a response to market failures and inspired by Western systems such as the New Zealand and British National Health Services.

Often with the help of donors, health sector policies focused on expansion of the underlying human resources and physical infrastructure (clinics, diagnostic facilities, laboratories, and hospitals). Systems were developed to supply drugs and medical equipment and to train staff. Worldwide, the number of hospital beds rose between 1960 and 1980 from 5 million to 17 million, more than doubling the per capita supply. Parallel to this development, the number of doctors increased more than fivefold from 1.2 million to 6.2 million.¹

These input-focused strategies have contributed to many successes including improved equity and access to health care for millions of people as well as the

¹There are major variations in the distribution of these resources across the world and within countries, with the greatest concentration in richer countries and urban areas, Central Europe, and the former Soviet Republics.

control of communicable diseases and other public health activities that respond well to direct government involvement.

Outstanding Problems

These accomplishments are impressive. However, increasingly serious problems in health services are apparent—and many of them origin in the delivery system. Many of these problems have parallels in infrastructure and other segments of the public sector.

Like other public services, a critical problem with publicly delivered health services is technical inefficiency. Resources within facilities are used poorly, often extremely poorly.² At systemic level, allocative efficiency is a severe problem—with resources often flowing disproportionately to urban, curative and hospital-based care.³ Public delivery of services, including health care, obscures awareness of the cost of services. This structural feature minimizes the ability to deliver or even identify cost-effective services.

Although equity is a key motivation for public delivery, distribution of resources in public systems is rarely focused on those in greatest need.⁴ Social services delivered by public providers are notably unresponsive and unaccountable to users. Stories abound of poor staff treatment of patients in government health facilities. Quality is often a problem—both clinical and consumer quality. Equipment is frequently broken or poorly functioning.

² M.A. Lewis, G.M. La Forgia, and M.B. Sulvetta, “Measuring Public Hospital Costs: Empirical Evidence from the Dominican Republic,” *Social Science Medicine* 43 (2): 221–34 (1996).

³ S. Bennett, “Promoting the Private Sector: A Review of Developing Country Trends,” *Health Policy and Planning* 7 (2): 97–110 (1992).

⁴ D. Gwatkin, “Poverty and Equity and Health in the Developing World: An Overview” (Washington: World Bank, 1997).

B. CHANGING VIEWS ON THE ROLE OF THE STATE

“The world is changing, and with it our ideas about the state’s role in economic and social development.”⁵ Reforms in the organization of health service delivery are indicative of fundamental changes in views about the appropriate role of the state in the economy. State-led development is no longer seen as a viable model. Many factors have contributed to this realization:

- the collapse of centrally planned economies
- the fiscal crises in welfare states of advanced, industrial economies, and
- the recent Asian crisis—calling into question the “miracle” of sustainable state-led growth of the East Asian tigers.

In developing countries, overextended governments try to do too much with too few resources and little capability. They often fail to ensure provision of the most fundamental social goods such as basic health and education, property rights, and roads. The growing consensus is that the path to greater state effectiveness and rapid development lies in matching government’s role to its capabilities—getting the fundamentals rights.⁶

Three Phases of Public Sector Reform

Government divestiture of commercial activities has yielded the first and easiest gains on the road to a more focused and effective government. It is clear that cement production, for instance, is not a “fundamental” in which the state should actively play a role. The widespread success of this “first wave” of privatization demonstrated the magnitude of benefits to society from getting the government out of the business of producing private goods and services. Although many governments continue to constrain their countries’ growth through involvement in production of commercial goods, no serious evidence or analysis supports this policy.

Building on this successful privatization of commercial companies, governments throughout the

world have begun to apply these reforms to their public utility services in what may be called the “second wave” of reform. Redefining the role of the state in delivery of infrastructure services has been a more difficult path to navigate. The state clearly has a role to play here, but prevailing wisdom on what that role is has changed substantially.

In these sectors, the long-held view was that the existence of a natural monopoly made it necessary to keep these services in public hands—to capture the scale economies and restrain exploitation of monopoly power. Technological change and, importantly, institutional innovation have made it possible to diversify production and service delivery arrangements—enabling huge improvements in efficiency, quality, and responsiveness of services—not to mention diminishing the fiscal burdens previously associated with operating these services as public sector monopolies.⁷

The magnitude of the gains from moving to diverse structures for service delivery, and including the private sector, has revealed the previously hidden costs of maintaining public monopoly service provision. This has led to a rapid escalation of reforms that have privatized or commercialized (usually through corporatization) the organization of infrastructure services in developing and developed countries.⁸ At this point, very few will argue that the traditional arrangements for public service delivery by a government monopoly department is the best option.

The “third wave” of reforms is now in evidence as many countries experiment with applying these “marketizing” reform modalities from other sectors to

⁵ World Bank, *World Development Report 1997: The State in a Changing World* (New York: Oxford University Press, 1997).

⁶ *Ibid.*, Chapter 3, pp. 41–60.

⁷ Examples of institutional innovations include: unbundling of competitive from monopolistic components of a previously vertically integrated industry, which has allowed competition to replace regulation in many areas; and tendering of concessions, which has brought competitive pressures to bear even on networks—by auctioning off the right to run the network for a period of time, creating periodic competition “for the market.”

⁸ International Finance Corporation, *Privatization: Principles and Practice*, Lessons of Experience Series, No. 1 (Washington: IFC, 1995).

social services (health, education, and pensions).⁹ In the health sector, policymakers are struggling to apply and amend these reforms to address the many problems in health services delivered in the public sector, while preserving social protection and equity.

Theoretical Underpinnings

This section briefly outlines the theoretical advances that have contributed to the new perspectives on the organization of service delivery.

From Neoclassical Economics...

The neoclassical paradigm clearly lays out the potential sources of market failure. The rationale for public ownership has been its effectiveness as a tool for pursuing social objectives in the presence of these market failures. This belief is based on a simple view of the relationship between ownership and control. Privately owned companies are generally believed to be profit maximizers—since by maximizing profits they maximize the benefits to their shareholders (or owners). In some cases, maximizing shareholder benefits is not seen to be maximizing the benefits to society as whole.

Broadly speaking, the two cases are (1) circumstances where competitive solutions do not exist (natural monopoly) and (2) circumstances where they exist but are not efficient (because of externalities, nature of public goods, or significant information asymmetry). In health, this reasoning supports public intervention to address market failures with regard to both equity and efficiency.

Based on these insights, public ownership has been used as a tool to get the organization to replace the narrow interests of owners with the wider interests embodied in the state, to pursue social goals as opposed to private benefit (profit maximization).

...to the Economics of Organizations

Although neoclassical economics clearly lays out potential sources of market failure, the framework is silent on the critical issues of how to structure an

⁹ S. Mathur and G. Torres, *The Third Wave of Privatization: Privatization of Social Sectors in Developing Countries* (Washington: World Bank, 1996).

effective institutional solution. The mechanism by which public ownership is supposed to lead to maximization of social goals is nowhere precisely defined. In fact, neoclassical economics is essentially “institution free.”¹⁰ Recently, this vacuum has been filled, with the development of analytical tools for understanding the effectiveness of different ownership and governance arrangements.

Much progress has been made in identifying the key factors causing wide variations in performance of organizations. The developments most relevant for organizational reform in health come from *principal-agent theory*, *transaction cost economics*, *property rights and public choice theory*. These fields are often grouped together under the title “economics of organizations”—and all deal with considerations of information, motivation and innovation and the implications for how productive activity can best be organized.

The traditional rationale for public ownership was based on a simplistic model of individual behavior—presupposing that the objectives of the government and the objectives of the managers running public organizations were identical. Policymakers assumed that, if managers were told to pursue the public interest, they would be able to determine what that meant and would have the necessary incentives to do it.

In practice, the vagueness of the objectives and the difficulty of precisely determining and monitoring output has proved “inimical to the efficient management of the (sectors) concerned.”¹¹ Public ownership removed the opportunistic profit maximizer—but the civil servant or politician has turned out to be no “high custodian of public interest”; instead, they have tended to pursue their own private benefits.¹² The economics of organization directly addresses the issue of how best to structure organizations that consist of individuals pursuing their own self-interest.

¹⁰ J. Robinson, “Physician-Hospital Integration and Economic Theory of the Firm,” *Medical Care Research and Review* 54 (1): 3–24; discussion 25–31 (March 1997).

¹¹ Organization for Economic Cooperation and Development, *Regulatory Reform, Privatisation and Competition Policy* (Paris: OECD, 1992), p. 17.

¹² Ibid.

Agency Theory

This framework highlights the need to reconcile divergent interests among individuals under conditions of widespread uncertainty and uneven access to information. The key relationship is modeled as occurring between a *principal* and an *agent*. The principal needs the efforts and expertise of the agent but has only limited ability to monitor the agent's actions or evaluate whether the final outcome was satisfactory.

The agency literature surveys the range of contracts, such as payment and monitoring arrangements, observed in the economy as attempts to align incentives and reward cooperation between self-interested but interdependent individuals.¹³ The need for incentive alignment is pervasive in the health sector: the relationship between patient and physician is a classic case of the principal-agent structure. Physicians and hospital managers have divergent interests and different competencies, yet they need each other. Most important for our review is the principal-agent relation between the government owner and hospital management.

Governments, like firms, must design evaluation and reward mechanisms to obtain high-quality performance regardless of whether they are contracting with outside providers/suppliers or with employees. Several studies have generalized the agency insight from the employment context to the full range of relationships that make up the firm—now conceptualized as a nexus of many contracts.¹⁴ This conceptualization has increased the understanding of ownership and governance by clarifying the relationship between suppliers of capital, both equity shareholders and bond debt holders, and the managers of the firm. By illuminating critical elements of relations between owners and firms, this analysis has also improved

¹³ D.E. Sappington, "Incentives in Principal Agent Relationships," *Journal of Economic Perspectives* 5 (2): 45–66 (1991); cited in Robinson, "Physician-Hospital Integration and Economic Theory of the Firm."

¹⁴ E.F. Fama, "Agency Problems and the Theory of the Firm," *Journal of Political Economy* 88 (2): 288–307 (1980); M.C. Jensen and W.H. Meckling, "Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure," *Journal of Financial Economics* 3: 305–60 (1976).

understanding of governance relations between governments and public service providers.

The rise and dominance of the modern corporation is attributed to its successful governance structure. This structure allows professional managers to be assigned decision rights and performance incentives, although they bear relatively little financial risk. At the same time, risk is borne by diversified investors, who need not assume control.

From the perspective of agency theorists, the range of organizational arrangements is interpreted as the outcome of a competitive process in which particular forms survive where they best control the technological, informational, and motivational sources of agency failure. Much of the momentum behind organizational reform of public services is generated by this belief that contractual and governance arrangements developed under the competitive pressures of markets can usefully be applied to public sector organizations.

Another insight from the principal-agent framework relates to moral hazard. *Moral hazard* refers to the inefficient behavior under a contract, arising from the differing interests of the contracting parties, which persists only because one party to the contract cannot tell for sure whether the other is honoring the terms of the contract. For example, in most jobs it is impossible to measure accurately the marginal product of each worker. Employers might attempt to measure employees' output by relying on proxies of performance, such as reports of supervisors. However, this often generates goal-displacing behaviors. Employees focus greater effort on the parts of their work that is rigorously monitored and shirk where monitoring is less rigorous.

This structural problem is particularly prevalent in health, where many of the outputs or features that owners or buyers care most about are unobservable—making it extremely difficult to effectively focus either hospital or employee activities.

Transaction Cost Economics

Transaction cost economics has contributed greatly to understanding alternative governance structures, particularly the differences between the nature of markets (inter-organizational relationships) and

firms (intra-organizational relationships). This contrasts with the agency view of the firm as a nexus of contracts—which downplays the distinctive features of internal organization versus market exchange.

Transaction cost economics emphasizes the limitations of contracts and the need for more flexible means of coordinating activity—that is, internal organization. Because of the cognitive limits of economic agents, their willingness to pursue self-interest, and the unforeseeable changes in the environment, every contract, even the most detailed, is inherently incomplete. None can fully anticipate and accommodate the differing interests of the negotiating parties. Formal contracts need to be supported by organizational means of responding to unforeseen events and adjudicating the problems they create. Integrating activities inside a single organization can bring this about in many contexts.

This theory sheds most light on firm boundaries and the conditions under which it is best to arrange activities within a hierarchy versus interacting in a market with suppliers or other contractors. More generally, vertically integrated organizations, simple “spot” contracts, franchises, or joint ventures are interpreted as discrete structural alternatives—each offering different advantages and disadvantages for effective governance¹⁵

Governance arrangements are evaluated by comparing the patterns of costs generated for planning, adapting, and monitoring production and exchange.¹⁶ Unlike public organizations, private firms have the flexibility (indeed the requirement) to adjust their governance structure to changes in the market environment—making them fruitful targets for identifying “better practices” for governance arrangements.

Vertically integrated (within firm) organization arises as a response to problems with market contracting. The firm substitutes low-powered incentives, like salaried employment, for the markets’ high-powered incentives of profit and loss. Vertical integration permits the details of future relations between suppliers (including employees), producers, and distributors to remain unspecified; differences can be adjudicated as events unfold. Vertical integration (or unified ownership) pools the risks and rewards of various activities undertaken by the organization, and can facilitate the sharing of information, the pursuit of innovation, and a culture of cooperation.

Notwithstanding these positive features, vertical integration suffers from characteristic weaknesses as a mechanism of governance. The two most prominent are the *weakening of incentives for productivity* and the *proliferation of influence activities* (Box 1). The weak incentives come from people’s capturing less and less of the gains of their own efforts as rewards and losses are spread throughout the organization. Despite its focus on the contracting problems that motivate internal organization, transaction costs economics views vertical integration as the governance mechanism of last resort. In most contexts, contractual networks, virtual integration, franchising, or concessioning will outperform unified ownership arrangements.

¹⁵ O. Williamson, “Comparative Economic Organization: The Analysis of Discrete Structural Alternatives,” in *Administrative Science Quarterly* 36: 269–96 (June 1991).

¹⁶ Two useful references include: O. Williamson, *The Economic Institutions of Capitalism: Firms, Markets and Relational Contracting* (New York: Free Press, 1985); and O. Williamson, “Transaction Cost Economics,” Chapter 3 in R. Schmalensee and R. Willig (eds.), *Handbook of Industrial Economics* (New York: North-Holland, 1989).

Box 1: Influence Activities

An important issue related to moral hazard and the structure of organizations is influence activities and the associated costs, known as influence costs.^a Recent analysis has shed much light on the propensity of publicly owned service delivery organizations to capture inordinate portions of the sector budget, as well as on their ability to influence sector policy to their benefit—often at the expense of the public interest.

In the health sector, provider organizations expend effort to affect decisions regarding the distribution of resources or other benefits among providers to their benefit. These “influence activities” occur in all organizations, but countervailing forces are particularly weak in public service delivery structures—and influence costs are one of the most important costs of centralized control. Evidence of such “influence activities” is seen in public utilities where monopolies are often maintained to protect low-productivity state-owned enterprises from competition from more efficient producers.^b In the health sector, the tendency to allocate resources to tertiary and curative care at the expense of primary, preventative, and public health is evidence of similar “capture.”

The costs of these activities includes both the losses associated with the poor resource-allocation decisions as well as the loss associated with the efforts exerted to capture the rents. These costs can be reduced when there is no decisionmaker with authority to make decisions that service providers can easily influence, and this condition can sometimes be brought about by creating legal or other boundaries between the policymaker, the funder, and the service provider unit. Many organizational reforms have attempted to diminish these activities. Examples include reforms separating the policymaker from the payer from the provider in public service delivery, as well as privatization of utilities.

a. P. Milgrom and J. Roberts, “Bargaining Costs, Influence Costs, and the Organization of Economic Activity,” in J. Alt and K. Shepsle (eds.), *Perspectives on Positive Political Economy* (New York: Cambridge University Press, 1990), pp. 57–89.

b. Milgrom and Roberts “Bargaining Costs, Influence Costs, and the Organization of Economic Activity.”

Property Rights Theory

Property rights theory looks at the same incentive issues from a slightly different perspective. Since private ownership appears to have strong positive incentives for efficiency, property rights theorists have attempted to find out why. Explanations have focused on two issues: the possession of residual decision rights and the allocation of residual returns.

Residual rights of control are the rights to make any decisions regarding an asset’s use not explicitly contracted by law or assigned to another by contract. The owner of an asset usually holds these rights—although the owner or the law may allocate many rights to others.¹⁹ The notion of ownership as residual control is relatively clear for a simple asset like a car. It gets much more complicated when applied to an organization

¹⁹ For example, a person may own a house but not have the right to occupy it if he has leased it out. He may own a car but not have the right to transfer it freely if he has a loan secured by the car.

such as a firm. Large organizations bundle together many assets, and who has which decision rights may be ambiguous. For example, do the directors of a firm have the right to accept a takeover offer without soliciting competing bids?

In addition to residual decision rights, an owner holds the rights to residual revenue flows from his assets. That is, the owner has the right to whatever revenue remains after all funds have been collected and all debts, expenses, and other contractual obligations have been paid out. Just as the allocation of residual control can be fuzzy in the case of firms (because rights of control over different categories of decisions may be poorly specified or may lie with various parties), the notion of residual returns is fuzzy as well.

One problem is that recipients of residual returns may vary with the circumstances. When a firm is unable to pay its debt, increases in its earnings may have to be paid to the lenders. In those cases, the lenders are the residual claimant. Firms may pay bonuses, increase workers’ pay, and promote more workers into higher ranking, higher paying jobs when performance is up. So, some of the workers share in the firm’s residual returns. It is the *pairing of residual returns and residual control* that is key to the incentive effects of ownership (Box 2). These effects are very powerful because the decision-maker bears the full financial impact of his choices.

Box 2: High-Powered Incentives of Ownership^a

Suppose a transaction involves several people supplying labor, physical inputs, and so on. If all but one of the parties involved have contracted to receive fixed amounts, then there is only one residual claimant. In that case, maximizing the value received by the residual claimant is the same as maximizing the total value received by all parties. If the residual claimant also has residual control then just by pursuing his own interests and maximizing his own returns the claimant will be led to make efficient decisions. The combination of residual control and residual claims provides strong incentives and

capacity for an owner to maintain and increase an assets value. Firms often attempt to reproduce these high-powered incentives by allocating residual claims in the form of bonuses or shares to key decision-makers in their firm.

Misalignment of residual rights and returns causes serious problems. The residual claimant to the returns from a state-owned enterprise is the public purse, but the residual decision-makers are effectively the enterprise manager, the workers, and the bureaucrats in the supervising ministry. None of these has any great personal stake in the value of the enterprise. The resulting low productivity is well documented. Another example of misalignment comes from the U.S. Savings and Loan industry. Those who had the right to control the S&L's investment also had the right to keep any profits earned but were not obligated to make good on losses. That combination of rights and obligations created an incentive for risk taking and fraud that was not effectively countered by other devices during most of the 1980s.^b

These fields of analysis have led to better understanding of the institutional sources of government failure. The framework has been used to design organizational reforms that seek to allocate to the holders of critical information the authority to make relevant decisions and the financial incentive to do so (in the form of residual claims on the outcome of the decision).

a. Milgrom and Roberts, *Economics of Organization and Management*, p. 291.

b. Milgrom and Roberts, *Economics of Organization and Management*, p. 292.

Political Choice Theory

Political choice theory has strongly influenced organizational reform. A central tenet of public choice is that all human behavior is dominated by self-interest. Individuals are viewed as rational utility maximizers. Public choice theorists apply this model to understanding how individuals will react in different institutional settings with different incentive structures. They also study collective action problems, problems that arise when the pursuit of individual interests produces suboptimal outcomes for the collectivity.

This field focuses on the self-interested behavior of politicians, interest groups, and bureaucrats and studies the implications for effective government and the size of government. Bureaucrats, attempting to maximize their budgets, will acquire an increasing share of national income. As a result, the state will grow well beyond what is needed to deliver its core functions. Powerful interest groups will capture increasing portions of resources. Institutional rigidities develop which

reduce economic growth.²² This analysis has led public choice theorists to support conservative political agendas (minimizing the role of the state).

Below we discuss how these insights on incentives, contracting, and governance have influenced recent reforms in health service delivery.

C. OPTIONS FOR REFORMING DELIVERY SYSTEMS

Organizational reforms such as autonomization and corporatization are usually initiated to address problems in publicly run health services with efficiency, both technical and allocative, productivity, quality, and client responsiveness.²³ However, these reforms are not the only methods used to address these problems. Management reforms as well as reforms of funding or payments arrangements are also commonly used to address these performance problems in publicly run health services. We briefly discuss the first two in this section.

Management Reforms

Many attempts have been made to address the problems in publicly run health care delivery systems through management reforms.²⁴ These reforms have included efforts to strengthen the managerial expertise of health sector managers—both through training of existing staff and through changes in recruitment policies to focus more closely on managerial skills.²⁵ Commonly, efforts

²² Olson, M., *Rise and Decline of Nations* (New Have: Yale University Press, 1982).

²³ *Allocative efficiency* in this context refers to cost-effective use of public resources. In reform programs that emphasized this objective, the organizational reform delinking the funder from the provider was viewed as an instrument for breaking the “provider capture” inherent in systems allocating resources to inputs (hospitals, doctors) rather than population or services.

²⁴ Here we refer only to management reforms within existing organizational structures (nonstructural) to avoid confusion with the structural/organizational reforms we are reviewing in this volume, many of which obviously affect management.

²⁵ Administrators into managers: The emphasis on managerial skills is indicative of a trend to hold those in control of public service organizations accountable for outputs or

are made to introduce improved information systems to facilitate effective decision-making. In addition, in some systems, clinical directorates have been created, and benchmarking of departmental performance has been introduced.²⁶

Many of these efforts constitute part of the growing trend of reform of public hospitals by applying recent “best practice” management techniques from private companies. Frequently, attempts are made to introduce business process reengineering, patient-focused care, or quality-improvement techniques.²⁷ However, attempts to implement these new management practices have been seriously constrained by the public sector context in which public provider organizations operate.

Private sector organizations have introduced recruitment and compensation policies based on the best “personnel management” techniques for finding and motivating high performers. Where attempts have been made to apply these methods to public hospital systems, civil service constraints have blocked or undermined them. A critical barrier to applying “best practice” principles from the private sector is the broad lack of control that public sector managers have over factors of production. Thus, although methods for reinvigorating private organizations have sometimes been successfully transferred to public hospitals and systems, most attempts have been impeded by the common constraints generated by public sector control structures.²⁸ Indeed, the attempts to apply private sector management principles to public delivery of health services has added momentum to the organizational reforms discussed below.

outcomes rather than for administering services in an acceptable fashion.

²⁶ R. Saltman and J. Figueras, *European Health Care Reform: Analysis of Current Strategies* (Copenhagen: World Health Organization, 1997), pp. 213–14.

²⁷ D. Osborne and T. Gaebler, *Reinventing Government* (New York: Plume, 1993).

²⁸ Chapter 7, in J.Q. Wilson, *Bureaucracy: What Government Agencies Do and Why They Do It* (New York, N.Y.: Basic Books, 1989), contrasts the context within which managers manage in public as opposed to private bureaucracies.

Funding/Payment Reforms

Reform of the funding and payment arrangements for public hospitals is another common approach to address problems with productivity, efficiency, quality, and responsiveness.

Problems with *productivity and efficiency* are commonly addressed by altering the structure of funding or payments to providers. These payments reforms usually tighten the link between resource allocation and delivery of specific outputs. Examples include retrospective fee-for-service, per diem, or case-based payments. Some reforms try to encourage efficiency by shifting expenditure risk onto the providers via capitated payments or prospective global budgets.

Different structural changes are made to funding and payments systems to address concerns about *clinical or consumer quality or responsiveness to users*. These payments reforms usually tighten the link between resource allocation and user or payer selection. Examples include limited or fully competitive contracting with providers, fund-holding with patient selection, and demand subsidies (health vouchers to be used with providers or insurers).

None of these instruments is perfect. Each helps achieve one goal at the expense of others. Systems that improve productivity encourage supplier-induced demand. Systems that better contain costs usually encourage shirking and low productivity. The incentives created under each payment structure can be powerful and often create some degree of overshoot that must be addressed. Most systems are not fully understood, nor are measures to compensate for the overshoot, or known disadvantages. This often requires a mix of multiple payments structures, so that the positive incentives of one element of the payment counterbalances the negative features of the other. An example is the frequent combination of capitation elements with fee-for-service in areas where productivity is especially important.

For payments system reforms to achieve their objectives, evidence strongly suggests that reforms must also take place that encourage or enable providers to respond to the new incentives. As discussed below, organizational reforms are more complements to

payments reforms than substitutes. Neither may be effective on its own.

A similar conclusion may be reached regarding management reforms. Much as these management and funding reforms may be needed to improve the performance of health care delivery systems, in themselves they have led to limited results. The general conclusion is that such reforms have often been unsuccessful because they did not get at the roots of the problems of poor incentives inherent in the organization of health service delivery in the public sector. This realization has led to the reforms reviewed in the remainder of this paper.

D. THE NATURE OF ORGANIZATIONAL REFORM

The growing awareness of the structural nature of the problems in public service delivery has increasingly led policymakers in some countries to make organizational reform a core component of health sector reform. These changes are designed to improve the incentive environment by *altering the distribution of decision-making control, revenue rights, and hence risk* among participants in the health sector.

There is a wide range of organizational reforms. Some focus on changing the mapping of functions across agencies, for instance, creating health insurance agencies that collect premiums and purchase health services. Or, endowing providers with “fund-holding” or purchasing authority—thus integrating funding with service provision. Decentralization is another common organizational reform in the health sector, a reform that shifts decision-making control and often revenue rights and responsibilities from central to lower level government agencies.

We will look at organizational reforms that shift decision-making control to the provider organizations themselves—and which attempt to expose them to market or market-like pressures to improve performance. They also attempt to create new incentives and accountability mechanisms to encourage management to use that autonomy to improve the performance of the facility. These reforms may be categorized under three headings: autonomization, corporatization, and privatization.

A word on terminology. Unlike other sectors such as infrastructure, all the health reform modalities

include continued funding, contracting, or purchasing by the government. Therefore, the three reform modalities we are reviewing are often grouped together as “*separation of provider-payer*” reforms. In some cases, reforms on the funding side of moving from budgeting to contracting is emphasized—hence the title “*contracting*” reforms may be used. *Quasi-markets*, *internal markets*, and *regulated competition* are other terms used to describe these reforms when they are applied within the public sector.

Many public hospitals and clinics operate as part of the integrated government structure, usually as a form of budgetary organization (i.e., government department). The reforms applied to such organizations vary in magnitude, depending on how far from “public” toward private the organization is moved (Box 3).

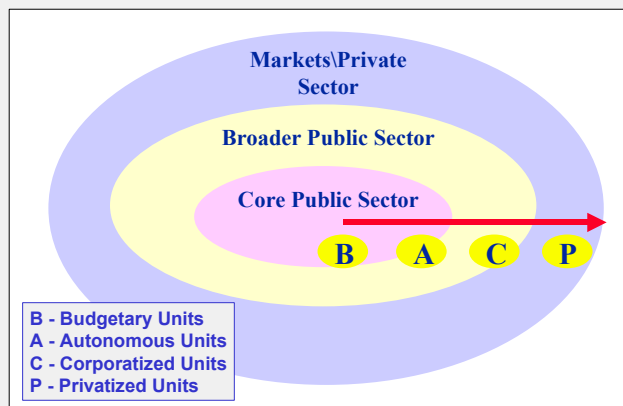
The structure of reforms under discussion and implementation in the health sector are strongly influenced by the development of “new public management,” a set of principles for structuring public sector activities that has gained great currency in the industrial world, and especially in Anglophone countries.³⁰ As noted, they are also influenced by similar reforms undertaken in government-run infrastructure companies and other public enterprises.

Box 3: Incentive Environments from Public to Private

One way to illustrate the differences between reform modalities (autonomization, corporatization, privatization) is to view the possible options for structuring service delivery as a spectrum of incentive environments within which the tasks of government can be performed. The civil or core public service lies at the center (usually constitutional control bodies, line ministries), where the activities of the staff are highly determined. Job tenure is strong.

³⁰ J-E. Lane (ed.), *Public Sector Reform: Rationale, Trends, Problems* (London: Sage Publications, Ltd., 1997).

Incentive Environments



The broader public sector is distinguished by the relative flexibility of its financial management regime and by the greater freedom allowed managers in recruitment and promotion. This may include special purpose agencies, autonomous agencies, and, on the outer limits, state-owned enterprises. Beyond the public sector lies the domain of the market and civil society. Services may be delivered by for-profit, nonprofit or community organizations. The incentives for efficient production are higher as moving outward, and service delivery is often better there.

Many reforms throughout the world have sought to move delivery away from the center of the circle to more arm's length contracts with public and private sector organizations. However, there are constraints to moving delivery outward related to the nature of the outputs and the existence of mechanisms for public sector management of their delivery. Increased autonomy—moving from the center of the circle to the outer limits—requires accountability mechanisms not tied to direct control. These controls, such as contracts, take considerable capacity to write and enforce, especially for services like health services where outputs and outcomes are difficult to specify precisely.

How far countries may go in pushing activities to incentive environments in the outer circles depends on the nature of the outputs (the services involved) and the capacity to create accountability for public objectives through indirect mechanisms such as regulation and contracting.

Source: Adapted from N. Manning, "Unbundling the State: Autonomous Agencies and Service Delivery," draft discussion paper, World Bank, Washington, 1998.

E. DETERMINANTS OF CHANGES IN ORGANIZATIONAL BEHAVIOR

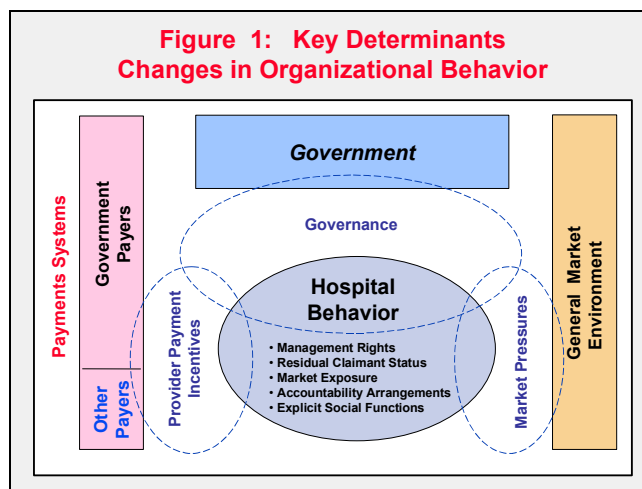
In this section we develop a model encompassing the key determinants of the incentives and behavior of hospitals and other provider organizations undergoing reform. This discussion will help identify the critical elements of organizational reform packages and

the nature of their links to one another. In the following section, we will characterize the reform modalities according to these key determinants.

A large body of literature and empirical experience now indicates that three sets of systemic factors jointly determine the incentive regime and hence behavior of publicly run health service providers undergoing these reforms. These include:

- alterations to the relationship between health care providers and governments (governance)
- the market environment to which such organizations are exposed, and
- the incentives embedded in the funding or payment mechanisms (provider payment systems).

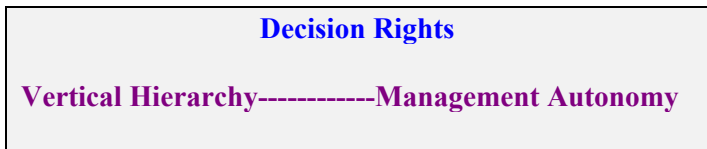
These three factors exert a powerful influence on the behavior of the organizations in question, including its internal management and staff. Below we discuss how these three factors combine to create the critical elements of the incentive regime that the hospitals face: allocation of decision rights, distribution of residual claims, degree of market exposure, structure of accountability mechanisms, and provisions for social functions (Figure 1). These factors are discussed below.



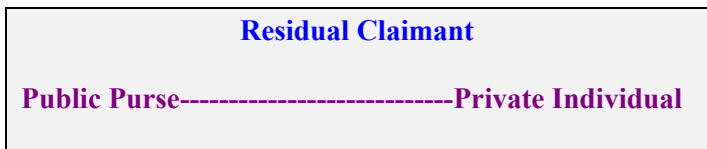
Governance

This section discusses the structural changes made in *governance*, the relationship between the government and the organization, and how these changes contribute to the incentive regime. The organizational forms vary substantially in the *amount of autonomy* given the managers, the *mechanisms used to generate new incentives*, and *accountability*.

Each reform can be characterized by the magnitude of control shifted from the hierarchy, or supervising agency, to the hospital. Critical decision rights transferred to management may include control over: inputs, labor, scope of activities, financial management, clinical and nonclinical administration, strategic management (formulation of institutional objectives), market strategy, and sales (see diagram below).



Giving managers and staff the material incentive to economize is the structural complement to delegating decision-making control to them. As James Q. Wilson queries, “Why scrimp and save if you cannot keep the results of your frugality?”³¹ Therefore, a critical distinguishing feature of the reforms is the degree to which the public purse ceases to be the “residual claimant” on revenue flows. Aligning the revenue flows and decision rights is crucial to get those in the right place to make the right decisions (see diagram below).



The third key element of the high-powered incentives sought in these reforms is the degree to which revenue is earned in a market, rather than through direct budget allocation (see diagram below).



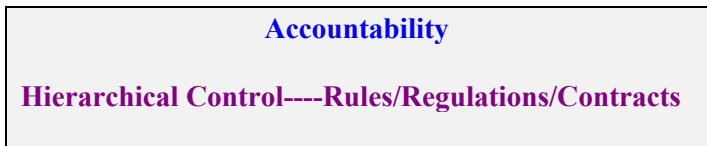
The question is, to what degree is the hospital delivering or selling services to earn its revenue? The first two factors imply that managers will focus more on financial viability. Thus, the issues of which strategies will best generate revenue becomes critical. If delivering

³¹ Wilson, *Bureaucracy*, p. 116.

quality services to patients is the best way to generate revenue, then that strategy will be pursued. On the other hand, if political lobbying, or extracting monopoly rents is the best way to get revenue, then these strategies will be pursued.

The reforms are also characterized by the degree to which accountability for achieving objectives is based on hierarchical supervision of the organization vs. regulation or contracting (see diagram below). As decision rights are delegated to the organization, the government’s ability to assert direct accountability (through the hierarchy) is diminished. Partially, accountability is intended to come from market pressures, since the market is seen as generating a nonpolitical, nonarbitrary evaluation of organizational performance, at least its economic performance.³² If the government is a purchaser, accountability will also be pursued via the contracting and monitoring process.

As we know in the health sector, markets are far from capable of delivering the full range of sectoral objectives—both due to market failures and due to social values. Thus, rules and regulations regarding the operation of these organizations constitute an alternative form of accountability mechanism. Strengthening these mechanisms constitutes a fourth critical element of organizational reforms that reduce the use of traditional, hierarchical accountability mechanisms (see diagram below).



The final critical factor characterizing these organizational reforms is the degree to which “social functions” delivered by the hospital shift from being implicit and unfunded to specified and directly funded.³³

As the hospital is motivated to focus more on financial viability, due to the changes discussed above,

³² Wilson, *Bureaucracy*, p. 117.

³³ By *social functions*, we mean services or products delivered to recipients at a price less than cost—either for distributional purposes or due to externalities in consumption.

management will move to decrease output of services that don't cover their costs. Thus, the financial bottom line undermines the ability to cross-subsidize certain services internally.³⁴ Thus, organizational reforms must create alternative mechanisms to ensure that services, which were previously cross-subsidized, continue to be delivered (i.e., explicit funding, demand-side subsidies, insurance regulation). The issue of necessary complementary reforms to protect non-efficiency sector objectives will be discussed in section F (see diagram below).

Funding or Payments Arrangements

The relationship between the payment arrangements and the new organizational structure directly influences the hospitals' incentives. The governance structure and the payments system jointly determine three of the key determinants of provider behavior: distribution of residual claims; provisions for social functions; and, market exposure.

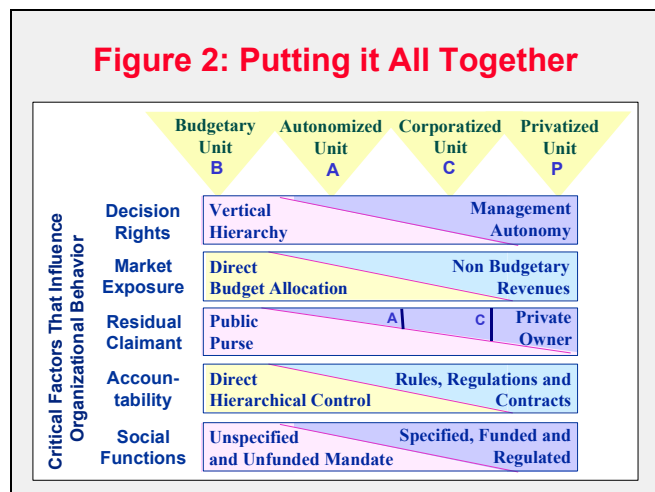
While most organizational reforms endow the hospitals with formal claims to residual revenue in different categories, the structure of the payments system will directly determine whether this claim has any real meaning or incentive effect. If, for example, services must be delivered at prices less than cost, there will be no residual to claim. Thus, the relationship of costs to the price-setting and capital-charging formula in the payments system is a critical determinant of the incentives of the model. The crucial factor is whether *marginal cost-saving effort* on the part of the provider can generate revenue flows that the provider can keep.

As hospital managers start to cost out their activities, the payment system (or price setting or regulation) will determine which services cover their costs. They will reduce internal cross-subsidization where possible. If hospitals have been playing a substantial safety net role, by generating funds from some services to cover costs of services delivered to needy portions of the population, then the payments system will need to take this into account. The payments system will determine the degree to which unfunded mandates based on internal cross-subsidization become explicit, and funded.

Social Functions

Unspecified Mandates---Specified/Funded/Regulated

These elements of the governance arrangements combine to create new incentives for efficiency. However, two external elements strongly influence the new incentive regime: the funding or payments arrangements; and the structure of the market to which the organization is exposed. The influence of these two factors on the five components of the incentive regime is discussed below and summarized in Figure 2.



Box 4: Internal Markets vs. Performance Budgeting: What's the Difference?

Two common funding arrangements used for autonomized/corporatized providers are performance budgeting and purchasing in internal markets.

These funding systems differ in three critical areas: *specificity*, *competition*, and *risk*. *Performance budgeting* is a general agreement for funding in exchange for undertaking to deliver certain services or products—where the funding level is tied to explicit performance results and quality indicators (utilization, average length of stay, staffing ratios, infection rates). Purchasing via internal markets usually entails much greater specificity on what is being purchased (rather than funded)—hence revenue levels are tied to the output levels more directly, although other indicators of performance

³⁴ This movement away from internal, implicit cross-subsidization is often an explicit objective of organizational reforms in other sectors. Some scholars, notably M. Pauly, believe it should also in health services. See M. Pauly, "Health Systems Ownership: Can Regulation Preserve Community Benefits," *Frontiers of Health Services Management* 12 (3): 3–34; discussion 51–2 (Spring 1996).

such as quality are also contracted for. In internal markets, critically, purchasers subject their choice of provider to competition.

The specificity of output contracted for, combined with competition, reduces the ability of the provider to directly pass through all costs and cost increases in their reimbursement. This enables greater shifting of risk for cost of delivery to the provider. While this strengthens the incentive for efficient delivery, it also encourages cream-skimming for low-cost patients.

Perhaps the most obvious behavioral determinant of the reform model influenced by the payments systems is market exposure. When hospital reforms entail a shift to earning revenue by delivering services “in a market,” the issue of what kind of market emerges becomes crucial. Often the government is the largest or only buyer. In this case, the process and terms on which the government purchaser engages providers may well determine the degree of pressure they are under to “deliver the goods”.

In other cases, there may be many purchasers, public and private, individuals or large purchasing agencies. The issue of how much and what kind of competition emerges is critical in creating pressures for performance on the hospital (see next section).

Competitive Environment/Market Structure

The structure of the market to which the reformed hospitals are exposed is a critical influence on their behavior—as it directly determines what strategies will make sense to generate more revenue (Box 4). One of the central arguments in favor of exposing providers to market forces is that in a functioning market, competitive forces will lead to a more efficient allocation of resources than command economy or non-market solutions. Under the conditions of the neoclassical model, a welfare-maximizing outcome can be predicted.

Unfortunately, market structure is a problem in most segments of the health sector. There are two related problems. First, little or no competition may emerge—reducing pressures on the provider to deliver “value for money” in order to maximize profits. Alternatively (or in addition), competition may emerge, but it may be dysfunctional. Both cases are discussed in this section.

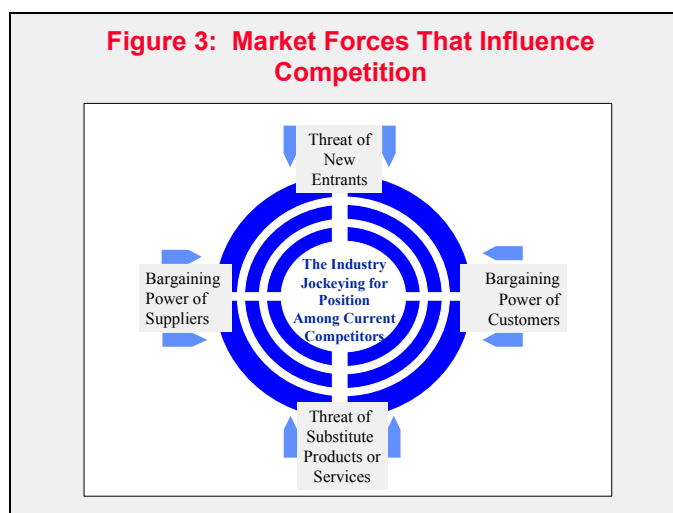
Some health services, especially tertiary and quaternary, exhibit scale economies in production—which relieves incumbent hospitals from pressure from

new entrants. Geographic monopoly over certain services may leave buyers with very little leverage in negotiating with service providers.

Even for services where monopoly power is not an issue, providers may still capture market share or maximize profits through various forms of distortionary behavior. For example, medical treatment is to a large extent a “bundled” good where the seller (doctor) guides patients’ consumption decisions—which hospital to go to for surgery, which lab to use for diagnostic services, and so on. Thus, the provider’s information advantage can be parleyed into control over a rigid and lucrative referral chain. Doctors may “forward integrate” into diagnostic labs or pharmacies and steer patients toward consumption where the doctors have a financial stake. Hospitals may “backward integrate” by creating strong links with doctors, thereby creating a portion of the market in which they experience little or no competitive pressure. Medical professionals are frequently able to create cartels, limiting competitive pressures that strengthen the influence of patients and purchasers.

Since patients and payers know less than the provider about the true value or cost of health services, providers are able to *cream-skim*, select patients whose costs of treatment are lower than those of other patients. Thus, providers can increase their profits, not by delivering better services to capture market share or cutting costs, but by selecting more profitable patients.

In a competitive market, firms seek to maximize their profits, using *whichever method makes sense in that environment* (Figure 3).



In a healthy market environment, they will try to capture market share from their competitors by better pleasing customers, to maximize profits by reducing costs through efficiency gains, and to expand their product lines through imitation or innovation. Wherever possible, however, they will seek to exploit or construct advantages. When they succeed, market-generated pressures for efficiency may be very weak. Distortionary features of health service markets often give providers the ability to: (a) counter the bargaining power of suppliers, patients, or purchasers; (b) ward off the threats posed by new entrants and imitation products; and (c) control a large share of relevant markets.

Ensuring the existence of healthy competition is thus a critical element of the incentive regime created under organizational reform programs.

F. REFORM MODALITIES

We have characterized the incentives faced by the reformed hospital or provider according to five critical elements. This section describes each organizational reform modality according to these features and explains how they fit together.

Budgetary Organizations

For the sake of comparison, let us start our discussion with the case of a budgetary unit, such as a hospital run as a government department. The manager of such a hospital is essentially an administrator. The government's hierarchy of officials and rules controls all strategic issues and determines most day-to-day decisions related to production and delivery of services, for example, staff mix and staff levels, services offered, technology used, accounting and financial management methods, salaries, and so on.

In general, the government determines the revenue of the hospital. Revenues are determined through a direct budget allocation, which is commonly set in relation to historical norms. Other revenues are controlled as well since the government also controls services rendered, patients served, and permissible copayments. Any "excess revenues" generated belong to the public sector—and must either be returned to a superior agency or spent as directed. Any "excess losses" also are covered by the public purse. In this

sense, the public sector is the residual claimant of the hospital operating as a budgetary unit.³⁵

The government's objectives in running the hospitals closely resemble sector objectives and are often unrecorded and unmonitorable. The social functions performed by the hospitals are not distinguished from their other activities—nor are they funded separately. Bureaucrats in the hierarchy are responsible for monitoring hospital and managerial performance, which tends to be tied to input and financial control.

Autonomized Organizations

As noted above, dissatisfaction with the weak performance of such organizations has led to various approaches to reform. Many of the most serious efficiency and quality problems have been seen to be rooted in management's pervasive lack of control over resources (especially labor) and production. Autonomization of such organizations is a reform that focuses on "making managers manage"—by shifting much of the day-to-day decision-making control from the hierarchy to management.

These changes are often accompanied by increasing the scope for generating revenue tied to service delivery. This may be achieved by moving toward funding via performance-related payments, by allowing paying patients to be served or by allowing copayments to be charged. Additional revenue opportunities only motivate if revenue can be retained. Therefore, autonomization reforms increase the scope for retaining revenue in the organization. Often this is partially achieved by moving from a line-item to a global budget, whereby savings in one service or budget area can be shifted to another. In this sense, the hospital or clinic becomes a partial residual claimant on certain savings generated through cost saving or other improvements.

Accountability arrangements still generally come from hierarchical supervision. However, objectives are now more clearly specified. Usually the scope of the objectives is narrowed, and focus on economic and

³⁵ This description does not go into the well-documented cases of retention of copayments or informal payments by employees or management—which makes them also residual claimants, though informally.

financial performance is increased. An agreement between the government and the hospital management may be concluded with monitorable targets regarding performance. Responsibilities for performing social functions may be specified in the agreement.

Implementation of autonomization in the health sector has led to a wide variety of arrangements. The amount of actual autonomy given to the management has varied considerably. Most governments have been unwilling or unable to transfer control over, for instance, labor, recruitment, salaries, and staff mix and have instead left employees in the civil service. In some cases, the organization has been legally established as a new form of government agency—which serves to define the new governance arrangements, secure the changes made, and persuade management that the changes are irreversible. Accountability arrangements have taken many forms—but all of them make some attempt to formally specify performance requirements in advance and to monitor their achievements.³⁶

These performance requirements have sometimes been recorded in a framework agreement or “performance contract.” This mechanism is intended to narrow and clarify the organization’s objectives as well as to formally lay out the criteria by which management will be judged. In a few cases, a board of directors has been established to implement this process of monitoring managerial performance and depoliticizing decision-making.

As noted above, these reforms have often been accompanied by a move to global budgeting or performance-related payments, which leaves some efficiency gains in the hospital.

Corporatized Organization

Corporatization reforms have evolved based on efforts to mimic the structure and efficiency of private corporations while assuring that social objectives are still emphasized through public ownership.

³⁶It is useful to distinguish between ownership accountability arrangements, which are tied to the governance relations between the government and the organization (i.e., corporate plan, performance contract), and *funding or payment accountability arrangements*, which are generated by the structure of the payment or funding mechanisms.

Under corporatization, provisions for managerial autonomy are stronger than under autonomization, giving managers virtually complete control over all inputs and issues related to production of services. The organization is legally established as an independent entity and hence the transfer of control is more durable than under autonomization. The independent status includes a hard budget constraint or financial “bottom-line”—which makes the organization fully accountable for its financial performance—with liquidation at least theoretically being the final solution in case of insolvency. The greater latitude of management is complemented by market pressures as an important source of incentives, crucially including some element of competition or contestability.

These market incentives come from the combination of an increased portion of revenue coming from sales (rather than budget allocation) and increased possibilities for keeping and using extra revenue, as well as a hard budget constraint. The corporatized hospital is thus much more a residual claimant than is the autonomized one—in that it can retain excess revenues, but is also responsible for losses. Accountability is generated on three fronts: direct hierarchical control (or ownership accountability) and funding/payment and regulatory accountability. Ownership accountability is usually narrowed to cover a limited range of economic targets—as part of the effort to mimic the effective governance structures associated with private corporations (Box 5).

However, this emphasis on economic performance necessitates alternative arrangements for ensuring social functions (services previously cross-subsidized) are still delivered. Under corporatization, these are usually pursued through purchasing, insurance regulation, demand-side financing, or mandates that apply to all organizations, rather than simply to public facilities.

In practice, when a hospital is corporatized, it is usually established as a private corporation, although it is still publicly owned.³⁷ The accountability mechanisms are anchored in the creation of a board of directors and

³⁷Reforms that transform hospitals into public corporations—corporations governed by public rather than private, company law—are also used in some cases.

some form of *corporate plan*, which is a binding agreement between the hospital (and the board) and the relevant supervisory agency. This corporate plan contains financial performance targets such as profit or rate of return on assets or equity, dividends and reinvestment policy. These targets usually require the hospital to earn commercial returns at least sufficient to justify the long-term retention of assets in the organization and to pay commercial dividends from those returns.

The reliance on accountability from market pressures to earn revenue has forced governments to establish a functioning framework for direct payment or transfers to reimburse the hospital for the costs of pursuing noncommercial objectives. Instead of forcing hospitals to deliver services below cost to the poor, for example, an appropriate subsidy may be delivered to either the patient or the hospital. Below we will elaborate on the important issues associated with the complementary reforms needed on the funding or purchasing side to support organizational reform.

In a corporatized hospital, directors (board members) usually have absolute responsibility for the performance of the hospital and are fully accountable to the responsible minister. They are sometimes responsible for bringing operation of the hospital into conformance with world best practice (where appropriate, having adjusted for noncommercial government requirements). Reviews, including comparison with this benchmark, are included in corporate plans.³⁸

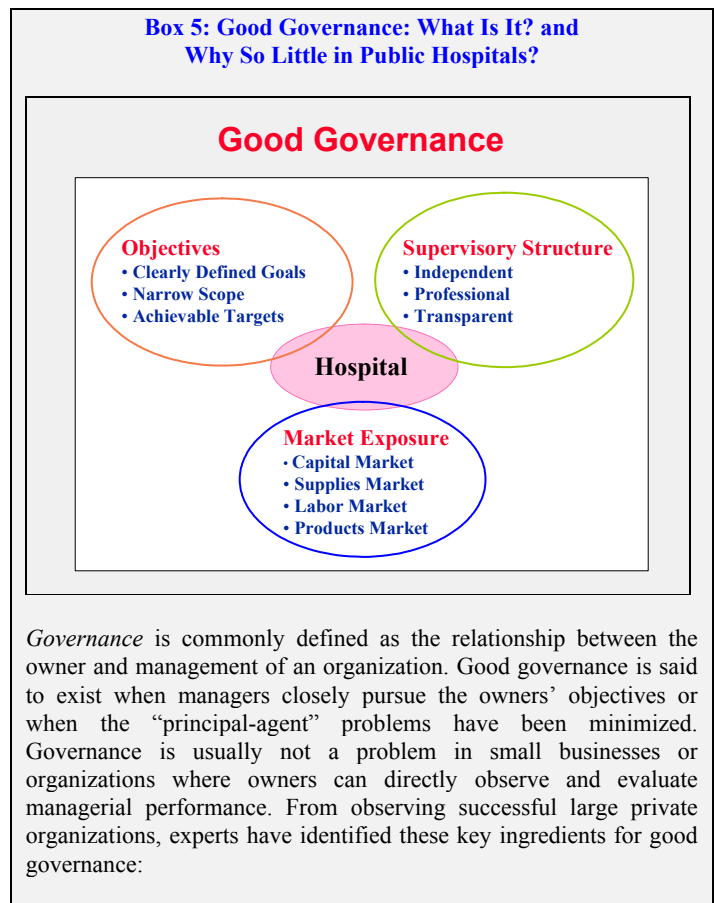
Privatized Organizations

The most extreme version of “marketizing” organizational reforms is privatization. This reform entails transferring a public hospital to private ownership, either as a for-profit or nonprofit organization. Nonprofit privatization is conceptually quite distinct from for-profit privatization and will be discussed separately below.

Privatization naturally removes the hospital from all direct control of the hierarchy of government officials

³⁸ Benchmarking is also an important tool for purchasers to help them set reimbursement by diminishing the informational advantage of hospital management through comparison with similar institutions.

or public sector rules. The organization is thus fully independent of the hierarchy, although the management is likely quite constrained by the new owners. All incentives come from opportunities to earn revenue, and the incentives are relatively strong, since private owners or shareholders now are the residual claimants on extra revenues, now called “profits.” It is the combination of these two forces that drives the high-incentive features of this model—complete exposure to a market to earn revenue and owners who are strongly motivated to capture the revenues and monitor the management.



- *Objectives.* Narrow, clear, nonconflicting objectives of owners translated into narrow, clear, and measurable criteria for management performance. Managers in a private corporation can be monitored relatively easily because owners have two objectives: maximize profits and maximize share price, both observable and measurable.
- *Supervisory structure.* Responsibility for supervising management is vested in an effective, professional body (board of directors) whose members themselves have clear responsibilities and accountabilities.
- *Competitive environment.* A competitive environment eases monitoring and motivates management. Competition in the product, labor, supply, and capital markets promote managerial efficiency by forcing the adoption of the most efficient production arrangements in order to stay competitive and capture market share. Competition in the product market allows owners to compare performance of the firm (and management) with other firms and diminishes monopoly rents, which might be misallocated by management, obscuring weak performance. Ability to monitor performance combined with a competitive managerial labor market allows owners to compare performance of company managers and to motivate managers through rewards and job security. Well-functioning market institutions (e.g., stock markets) and accounting standards drastically reduce the costs of monitoring management. Profits from one company can be easily compared with similar companies in the sector. Share prices can be easily observed.

Why do public hospitals (budgetary organizations) have bad governance?

- *Problems with objectives of public hospitals.* Hospital goals are not well-defined, and may conflict. Hospital goals are not differentiated from sectoral goals (may include delivery of quality health services, efficient use of government resources, poverty alleviation (equity), and delivery of “social” goods).
- *Problems with supervisory structure.* Accountability mechanisms are weak and input control focused. Objectives are not usually translated into narrow, clear performance criteria for management. Often no effective structure is in place for monitoring managerial performance. Politicians and bureaucrats involved with supervision have latitude to pursue their own (non-health related) agendas—including employment generation, sinecures for loyal supporters, and the like.
- *Problems with competitive environment.* Even when formal managerial performance criteria exist—monitoring may be hampered by the lack of competition or other external institutions (like equity or debt markets) that function to generate information about relative performance.

How do the reform modalities of autonomization, corporatization, and privatization address the governance problems of public hospitals?

- *Objectives.* These reforms are designed to address governance problems by narrowing the range of objectives for which managers are accountable. The objectives are translated into measurable performance criteria.
- *Supervisory structure.* Organizational reforms often include the creation of a professional organization (agency or board) vested

with responsibility for monitoring achievement of performance targets. Frequently individuals are recruited on technical or professional bases. Usually the objectives are narrowed to focus on *economic efficiency*—which is more easily monitored than other objectives. However, this requires the development of alternative mechanisms to pursue other sector (social) objectives.

- *Competitive environment.* Organizational reforms sometimes include provisions for product market competition or benchmarking to help the government-owner judge managerial performance. Capital funds may be allocated on a competitive basis to encourage accountability in financing improvements and repaying debt. Management employment and salary may be tied to performance.

What are the biggest problems in trying to improve governance through organizational reforms?

- *Continued politicization of decision-making and opaqueness of intervention.* Failure to establish an oversight structure that ensures accountability for the narrowed range of goals; failure to develop or ensure the use of other mechanisms to achieve key sector goals (related to access and equity for example)—usually results in continuation of old habits of informal intervention by “owners” in operation of the hospital.
- *Failure to hive off or ring-fence “social” goods.* Governments often experience difficulty in clarifying which services they wish to ensure delivery of and targeting subsidies effectively. Often, these objectives end up relying on cross-subsidization inside the hospital. Management then may make reference to the *ad hoc* interventions, unfunded mandates and the associated cost to justify poor economic performance, which reduces the ability of the owner to hold the manager accountable for the economic or other performance targets.

Why these failures?

- *Internal stakeholders disagree.* Defining narrow objectives is hard in health because there are multiple interests in government who may not agree on what the key objectives are or ought to be. Government-owners may have many objectives in the sector and do not know their key objectives or their relative priorities.
- *Clear objectives and priorities reveal trade-offs.* Specifying objectives and priorities can make explicit what is not a priority and what is not going to be delivered/funded by the state. This is often politically costly.
- *Challenging new tasks for bureaucrats.* Creating alternative mechanisms to pursue other sector objectives (besides organizational efficiency) is hard because it requires governments to engage in more complex activities (like contracting, purchasing, and regulation). Under an integrated public system (budgetary organizations), governments can functionally pursue sector objectives through implicit understandings that they would transfer resources of x-amount and the hospitals would provide services in some form or another to the population that comes through the door. Under an organizationally reformed system, the government would have to identify what services would be delivered to the poor (for example) and purchase (or sometimes mandate) their delivery.

- *Bureaucrats prefer direct control and discretion.* Even when alternative accountability mechanisms exist, politicians and bureaucrats will usually prefer *ad hoc* direct interventions with fewer constraints on their relations to the hospitals. Lack of constraints on these interventions creates many problems.

Governments that are trying to improve governance through emulation of the corporate model will need to enhance their capacity to develop and implement sector policy through indirect mechanisms such as contracting and regulation. They must create structures for administering the new accountability arrangements—and for restraining *ad hoc* intervention by politicians and bureaucrats.

a. These mechanisms include accountability mechanisms stemming from funding/payment arrangements and regulatory mechanisms.

The owners of a privatized hospital have at their disposal the full range of institutions that have developed to ensure good governance or monitoring relations between the owner and manager in private corporations.⁴⁰ Dissatisfied owners can voice their views—through selection of board members or, more commonly, by divesting. Observation of share prices or dividend performance can alert owners or boards to poorly performing management. The market for managers also pressures management to perform well to maintain their reputation and employment.

Anticipation of problems in dealing with profit-maximizing providers is leading many countries to explore nonprofit privatization as an alternative. This consists of transferring or converting a public hospital to a nonprofit, and this significantly alters the “model.” The ownership is private, so the hierarchy does not directly control the hospital in any way. However, in some countries, regulatory requirements to maintain nonprofit status and hence subsidy eligibility mean that the government retains certain “control” rights.

Governance of privatized nonprofits conceptually resembles that of corporatized hospitals more than privatized for-profits for two reasons. First, through nonprofit regulation, the government exerts a strong but indirect “voluntary” control. Second, there are no private residual claimants on left-over revenues.

⁴⁰ For an overview of the key ingredients for good governance in private companies, see Ira Millstein, “The Corporation as an Ownership and Management Structure,” paper written for the World Bank Private Sector Development Forum, 1998.

In a privatized hospital, pressures from the market complement the performance pressures from owners. Owners want profits, and the only way to generate them is to succeed in the market, competing with other hospitals for increased sales, making changes that decrease costs, and so on.

Even more than in the case of corporatization, privatization requires a host of systemic reforms to complement organizational reforms—to ensure that such social objectives as access, equity, and clinical effectiveness are not sacrificed in the name of efficiency and consumer quality. In particular, reforms to increase regulatory capacity and to establish effective purchasing arrangements are needed and will be discussed below.

G. RESULTS AND LESSONS FROM OUTSIDE HEALTH

Although such organizational reforms have only recently been applied to health service delivery, a review of the relevant experience from other sectors provides valuable insights (Box 6).

Autonomization

In the case of public agencies producing unspecifiable or unsaleable outputs such as policy advice or policy implementation—autonomization has improved performance in some cases, but it requires fairly sophisticated institutional arrangements for effective operation.⁴¹

In other cases of production and service delivery organizations outside the health sector, the results of autonomization reforms have been disappointing. In many cases, management has not been given sufficient control over production to enable or encourage these organizations to respond to the newly created rewards for performance.

In other cases, substantial autonomy was given, but accountability arrangements were ineffective. A comprehensive review of performance contracts

⁴¹ N. Manning and David Parker, “Nationalization, Privatization and Agency Status within Government: Testing for the Importance of Ownership,” in Peter Jackson and Catherine Price, *Privatisation and Regulation* (London: Longman Group Ltd., 1994).

throughout the world found that they had a weak and often negative influence on performance.⁴² The key reasons cited were:

- The informational advantages of managers over government officials enabled them to negotiate contracts which didn't require high performance (that is, they were able to maintain organizational slack).
- Contracts rarely rewarded or penalized managers or staff for effort.
- Governments often reneged on their promises to the organizations' management by formally or informally retaking control, thereby interfering with management decisions.

In practice, autonomization outside the health sector usually failed to introduce durable changes in incentives, either because the reforms were not fully implemented or because they lacked internal coherence. Frequently, alternative accountability arrangements were never realized, encouraging reversion to previous mechanisms.

For these reasons, in the case of commercial companies and infrastructure, the preferred organizational reforms have been corporatization and privatization.⁴³

Corporatization

Corporatization has also had mixed results when applied to commercial and infrastructure enterprises (see Box 6).

⁴² World Bank, *Bureaucrats in Business: The Economics and Politics of Government Ownership*, World Bank Policy Research Report (New York: Oxford University Press/World Bank, 1995).

⁴³ Critical factors to consider in determining which services can be shifted to the high-incentive environments of corporatized or privatized entities, and under what conditions. See N. Girishankar, "Reforming Institutions for Service Delivery," *World Bank Policy Research Working Paper*, no. 2039 (Washington: World Bank, 1999); R. Gregory, "Accountability, Responsibility and Corruption: Managing the Public Production Process," in J. Boston (ed.), *The State Under Contract* (Wellington: Bridget Williams Books, 1995).

In some cases, performance has improved.⁴⁴ But often these improvements have not been sustained. In other cases, failure to implement key aspects of the model has led to poor results. In all cases, effective corporatization appears to be an institutionally intensive organization reform in that it necessitates a sustained, complex, and politically challenging, role for government agencies and officials.⁴⁵

The main problems with corporatization are rooted in the failure to effectively depoliticize decision-making in a sustainable way. First, the board or management have not often been given responsibility for fulfilling a sufficiently narrow and clear set of objectives.

Second, financial accountability has not been created, partly because managers are simply more informed about costs and turnover. This problem has been exacerbated in the many instances where enterprises have continued to be responsible for delivering some goods or services without remuneration. Reference to this unfunded mandate often provides an excuse and refuge for poorly performing management, since it makes it impossible to benchmark its performance with other providers not carrying that burden.

In most cases, governments have been unable or unwilling to truly expose corporatized enterprises to competition. Nor have they been willing to limit capital funding to what can be obtained commercially, instead giving ad hoc capital injections to troubled enterprises. This has substantially reduced market pressure. Governments have rarely succeeded in removing various systemic privileges for corporatized enterprises. Beneficial regimes for price setting, capital allocation, purchasing, and tax provisions all have undermined the creation of a level playing field. In most cases, market

⁴⁴ I. Duncan and A. Bollard, *Corporatization and Privatization: Lessons from New Zealand* (Auckland, N.Z., Oxford University Press, 1992).

⁴⁵ A. Schick, "No Leapfrogging," presentation made at the World Bank, 1998. (Draws on his paper, "Why Most Developing Countries Should Not Try New Zealand's Reforms." *World Bank Research Observer*, 13: 123–31 (February 1998).

forces have not been allowed to play their full role in creating accountability under this type of reform.

Box 6: Key Lessons from Other Sectors

- Organizational reform must directly and contemporaneously address labor issues—you cannot leave labor for later. Many of the most serious efficiency and performance problems are rooted here.
- Institutional innovations can allow organizational reform to be applied to new areas. Unbundling can enable market forces to be brought to bear in many areas previously thought to be natural monopolies. For example, concessions can create competition “for the market” when competition in the market is not possible.
- Intermediate reforms of autonomization and corporatization are more institutionally intensive—they imply a more sophisticated role for government—because government must utilize indirect disciplining forces rather than simpler instruments of direct control (as in a budgetary organization) or market forces (as in a privatized organization).
- A supportive external competitive environment must accompany reforms in internal incentives. If this environment is not present, systemic reforms may have to be implemented before organizational reforms can work.

While a lack of competition has muted pressure to improve performance, corporatized enterprises have also suffered from constraints inherent in public sector ownership. Rules limiting individual access to loans are one such constraint. The inability to raise capital for service expansion and capital renovation based on their business plan or project viability is often mentioned as a key problem by management. This limitation is also used to explain failure to improve.

Privatization

Privatization of commercial and infrastructure enterprises has generally led to good results. Reforms have usually led to improved productivity and wage growth as well as increased generation of tax revenue for the government. Subsidies were able to be cut, thereby reducing the fiscal drain associated with the enterprises when under public control. In infrastructure, quality and availability of services has generally improved.⁴⁶

⁴⁶ A. Galal, L. Jones, P. Tandoon, and I. Vogelsang, *Welfare Consequences of Selling Public Enterprises: An Empirical Analysis* (New York: Oxford University Press, 1995).

Competition faced by enterprises is a key determinant of performance, perhaps even more so than privatization itself. However, even enterprises privatized in markets with little competition have improved their performance.⁴⁷

H. A COHERENT APPROACH TO ORGANIZATIONAL REFORM AND ALTERING INCENTIVES

Coherence of Reform Package

Based on this discussion, it would be useful to keep in mind several points related to the design of organizational reforms while reading the case studies.

Both the theoretical literature and the real experience in applying these reforms to other sectors point to *critical linkages among the important elements of these reforms*. Governance reforms must be aligned with each other. For instance, managers given incentives to cut costs must have the ability to alter the use of the key cost drivers, including labor.

In addition to being internally consistent, the governance changes must also be aligned with critical elements of the external environment. The design of the governance reforms should therefore take into account key features of the existing institutional and market environment. As discussed above, the governance reforms must be complemented by the incentives created by existing or new funding arrangements and market structure if strong (and not dysfunctional) incentives for efficiency are to result. The next section will discuss the most relevant aspects of the institutional and market environment in designing these organizational reforms. Following that, we discuss the complementary reforms needed to ensure the maintenance of key sectoral objectives.

Incorporating the Institutional and Market Environment

In addition to matching each other, the key elements of the organizational reform package must also be consistent with the institutional and market environment.

⁴⁷ B N. Boubakri and J.-C. Cosset, “The Financial and Operating Performance of Newly Privatized Firms: Evidence from Developing Countries,” *Journal of Finance* 53: 1081–1110 (June 1998).

Capacity of Public Institutions

Organizational reforms will reduce the government's direct control over the provider organizations. Therefore, indirect control mechanisms become doubly important. In particular, the soundness of the government's capacity regarding budget management, procurement (contracting), and auditing will play a crucial role in encouraging the reformed organizations to respond to their new freedoms productively. Reform packages may thus need to include measures to strengthen the public sector functions identified as most critical to the new incentive and monitoring regime.

Structure of Market and Functioning of Market Institutions

Under these reforms, markets are relied upon to create pressures for improved performance. While health services present the unique challenges discussed above, the generic prerequisites for functioning markets are required as well. Competition must exist among providers. Contracts must be enforceable. The legal and judicial framework to review anticompetitive practices and enforce consumer protection will play a heightened role.

To a certain degree, these institutional weaknesses can be addressed using the instruments discussed below. In general, though, the capacity of most institutions should be taken as given and the hospital reforms designed with these limitations in mind.

Complementary Reforms and Sector Objectives

The organizational reforms we are discussing move health services progressively closer to a market environment and encourage providers to focus on their financial viability or even on generating profits. When service delivery is undertaken by a government department, sector objectives can be pursued through direct control of the providers. However, as providers respond more to market incentives, critical sector objectives may be threatened, including quality, cost control, and access for the poor. In these areas, the government must make up for lack of direct control through better information disclosure and the creation of an effective regulatory and contracting framework for health services.

Access and Equity

As providers become increasingly concerned with their financial viability or profit maximization, they will be more reluctant to provide non-remunerated (or not fully remunerated) care. Internal cross-subsidization among patients or services will cease to be a viable mechanism for ensuring access to important services or services for needy members of the population. Problems of equity and access for the poor will emerge, unless the government addresses these problems through other mechanisms. Alternative mechanisms for encouraging their delivery must be developed.

Where the government initially ensures universal access to services through direct control of delivery, it may now have to contract for delivery of these services. This will require development of new skills for contracting or purchasing on the part of public servants, but it may also provide a strong instrument for cost control through the existence of a national global cap on expenditures.

Where the government is not directly the sole or primary funder of health services, effective regulation of purchasers or insurers is needed in addition to whatever contracting the government undertakes. Government contracting, subsidization, or mandates on coverage for services delivered to the poor is critical—especially if public hospitals and clinics have been playing a “safety net” role previously.

As the organizational reforms shift more risk for cost of services onto the providers, the usual tendency to engage in cream-skimming will emerge. Thus, regulation and monitoring of such practices is a critical element of the reforms.

Quality and Cost Escalation

Quality problems will arise from the well-known principal-agent problem involved in the doctor-patient relationship. Patients must rely on doctors to make clinical and therapeutic decisions on their behalf. In so doing, the doctor and the patient may have different objectives. Doctors may prescribe a particular treatment regimen because they can earn more money from it, even though it could cost the patient more or may not be

the most effective method of treating the patient's condition.

Profit maximization is a strong motivating force. However it also encourages service providers to behave opportunistically, that is, to take advantage of their information asymmetry vis-à-vis patients and purchasers and skimp on non-observable quality features of care. Effective mechanisms to enable monitoring of quality are required to ensure that the providers are motivated to provide high quality and clinically effective services. Prescriptive quality regulations can be complemented by information to support patient regulation (as individuals or through consumer groups) and effective government contracting for quality services.

Profit-maximizing providers can be pressured to provide quality and keep prices down by market forces. But many providers wield market power to block the development of competition. Pro-market regulations and regulatory capacity must also be put in place to restrain such anticompetitive behavior.

Moral hazard problems also occur in the doctor-patient relation because health care is often paid for by a third party (government or insurer), leaving neither the doctor nor the patient with any incentive for cost economy. Thus, additional cost-escalation pressures are likely to occur when more providers move to market incentives.

A critical element of the organizational reforms is thus to ensure that government contracting or purchasing is sufficiently effective to pressure the providers to deliver quality services—both in terms of responsiveness to patients and clinical effectiveness.

A discussion of effective regulation of various forms of health insurance goes beyond the scope of this paper, but organizational reforms to make government providers efficient and responsive will not work if their “customers” aren't pressuring them to deliver low cost, high quality services.

Nonprofit Regulation

If conversion of public facilities to nonprofit organizations is implemented, this will create a separate set of regulatory challenges related to the unique nature of nonprofit organizations providing services of “public

benefit.”⁴⁸ To support the delivery of social services, governments commonly bestow financial benefits such as tax exemptions and tax deductibility of contributions to nonprofit organizations. Effective targeting is crucial to ensure that these forgone revenues are well spent. It is important that such support flow only to non-governmental institutions whose primary activities are delivering care benefiting the population.

Verification of the social benefit nature of non-governmental activities to qualify for preferential treatment is a critical feature of an effective regulatory framework for nonprofit organizations. In addition, transferring public assets to the nonprofit sector usually entails a concessionary price based on the understanding that these assets will continue to be used for public benefit.⁴⁹ Thus, the government must create regulations, monitoring, and enforcement capacity to ensure that the value of these assets is not dissipated by the new owners for private gain.⁵⁰

For some goods and services, there are few serious problems related to market failure, including most factor inputs (other than labor), medical goods and supplies, and nonprescription drugs. In these cases, the only needed complementary reforms may be to improve information disclosure to help purchasers make informed choices.

⁴⁸ World Bank, *Handbook on Good Practices Relating to Non-Governmental Organizations* (Washington: International Center for Nonprofit Law, May 1997).

⁴⁹ J. Casagrande, “Social Sector Privatization in Mongolia: Concepts Learned through Experience,” Private Sector Development Department, unpublished paper (Washington: World Bank, 1999).

⁵⁰ Ibid.

PART 2. SUMMARY OF EMPIRICAL EVIDENCE:

BASED ON A REVIEW THE LITERATURE, TWO REGIONAL STUDIES AND EIGHT COUNTRY CASE STUDIES

A. BACKGROUND

This section provides a summary of key findings from our forthcoming volume, A.S. Preker and A. Harding, eds. *Innovations in Health Service Delivery: Volume I—The Corporatization of Public Hospitals*. Washington: World Bank, 2002.

Part 1 of this volume provides a conceptual framework for understanding organizational reforms, their design, implementation challenges, and monitoring and evaluation of impact based on a global review of the literature. Part 2 provides a cross-cutting analysis of empirical data from a global review of selected countries and two regional assessments of “marketizing” reforms in the hospital sector—Eastern Europe and Latin America. Part 3 of this volume presents the results from nine case studies.

Part 1—Conceptual Framework

By reviewing the literature on institutional economics and organizational theory in its application to a wide range of sectors, Chapter 1 of the volume identifies five areas in the incentive regime of hospitals and three critical factors in the external environment that need to be carefully coordinated during organizational reforms. The cross-country analysis and case studies show that countries encounter problems when parts of the hospital’s incentive regime—such as decision rights, market exposure, residual claimant status, accountability arrangements, and explicit policies and reimbursement of social functions—are unbalanced or out of sync with each other.

For example, even with extensive decision rights over areas such as strategic planning, financial management, and procurement, hospital managers will find that efficiency and productivity improvements elude them, if they do not also have control over labor. Many countries yielded to the demands of powerful stakeholders and did not transfer control over labor to the reformed hospitals.

But even consistent changes of the hospital’s incentive regime under these five categories is often not enough. Success and failure depend equally on

underpinning these reforms with broad changes in the external policy environment to ensure the hospital’s payment system and market environment work to promote improvements.

For example, hospital reforms designed to take advantage of efficiency gains prompted by competition will not work if the factor markets (e.g., pharmaceuticals, labor, or custodial services) or product markets (e.g., hospital services) are allowed to manifest monopolistic behavior. Likewise, parallel changes in funding arrangements and the provider payment system is often a particularly critical element of marketizing organizational reforms.

Even with extensive changes in decision rights and accountability arrangements, the behavior of hospital managers is unlikely to change significantly if hospital funding continues to rely on historical patterns with soft budget constraints. And reforms that create hard budget constraints are likely to impair equity unless parallel financing reforms ensure that the subsidies for poor patients are in line with the unit cost of their treatment.

Chapter 2 highlights the importance of the political economy, context, and process dimensions of reforms like autonomization and corporatization of hospitals. Even a well-designed reform will fail without the political consensus to implement it, or if strong vested stakeholders such as the medical profession or labor unions are not brought on board, or if the political cycle is too short, and subsequent governments reverse or dilute the reform policies. Compromises on labor reforms and political interference with decision rights and accountability arrangements were among the most damaging of such compromises observed in many countries that attempted but failed to successfully introduce organizational reforms.

Powerful medical groups that see their incomes or clinical autonomy threatened by the reforms can easily frustrate implementation. Hospital managers that see their informal discretion over the hospital reduced through new accountability mechanisms may equally resist the reforms. Winning support from the medical profession and hospital management was, therefore,

critical to the more successful reforms. Lack of such support contributed to failure.

Likewise, vocal groups in society that have deep-rooted, “antimarket” value systems can poison the reform environment, especially in the case of complex reforms, aimed at efficiency gains without easily identifiable “short-term wins.” Even without being elected, opposition parties that seize the opportunity to exploit such negative reactions can pressure policymakers into compromises that weaken the needed coherence and complementarities among the different reform elements.

The context in which reform takes place can sometimes be as important as the design of the reform itself. Many public sector reforms in the late 1980s and early 1990s, including the autonomization and corporatization of hospitals, were motivated by similar problems of public institutions’ poor performance during fiscal crises. Yet the context for the reforms was often very different. It is particularly important to examine what is already going on in the private sector as an important predictor of what might be feasible after corporatization of public hospitals.

For example, country “X” might have a high level of informality, corruption, weak contract/company law, low general “rule of law,” no purchasing of services by any organized purchaser (often the case in low-income countries). Country “Y” might have a small informal sector, little corruption, strong contract/company law, high “rule of law,” organized public purchasing, and other “quasi-public” organizations already in existence. Even if both countries had the same policy objectives and everything else was the same in the rest of their health systems, the feasible and advisable and design for each of them would have to be very different.

The speed of reform and extent of changes is also significant. The “big bang” approach runs the risk of outstripping a country’s implementation capacity. The “incremental approach” runs the risk of going off course over time. For example, if country “Y” had a strong central government, parallel public sector reforms, and significant institutional capacity in the health sector, it might be able to jump directly into hospital corporatization under a “big bang” reform. Country “X” most likely could not. The chances of success in Country

“X” might have been enhanced by a more incremental reform process. This might consist of first passing through a learning phase, using more limited hospital autonomy or piloting a limited number of hospitals. Provider payment reforms could slowly progress from funding based on inputs/historical resource use, to global budgets based on inputs, to partial funding/bonuses based on some performance indicators (benchmarking), to funding tied to outputs, to noncompetitive purchasing of outputs, to competitive/selective purchasing.

Chapter 3 demonstrates just how difficult it is to monitor and evaluate the impact of reforms in a complex, multiproduct organization like a hospital. Surprisingly, none of the case-study countries developed an evaluation strategy in advance. In the United Kingdom, a deliberate attempt was even made to avoid examining performance during the first phase of its introduction for fear that evidence of failure early in the experimentation period might bolster opposition to the reform. In every case, the limited evaluation carried out later lacked a clear baseline and focused only on target hospitals, missing the opportunity for comparison, using nonreformed hospitals as a control.

The limited evaluation that was possible highlighted several important problem areas. First, reform objectives often were not clearly stated, making it difficult afterward to assess successes and failures in achieving the objectives.

Second, the main reform levers—altering the incentive regime of the organization and the external environment—must lead to changes in the behavior of providers and patients before their net effect shows up in final impact indicators in terms of health outcomes, efficiency, equity, and quality. Changes in the behavior of providers and patients provide proxies for impact.

Third, without explicitly anticipating some of the potentially negative consequences of the reform (such as the financial burden of user fees on the poor) and introducing mitigating policies (such as subsidies or exemptions), the corporatization of public hospitals runs a high risk of being associated with some serious health, efficiency, equity, and quality trade-offs. Many of these negative consequences could have been avoided by looking at the impact of the corporatization of hospitals on the overall structure of the health system and making compensating adjustments in its structure.

Finally, many of the desired effects of organizational reforms—such as efficiency gains and improvement in consumer responsiveness—are subtle, and hence, not easily perceived by the public. Little credit will be given for valid efficiency gains in managing hospital resources and activities if the public sees long waiting lists, drugs less available in dispensaries, and overworked and rude staff. In all the countries examined, too little attention was given to ensuring high-visibility “quick wins” that would increase public confidence in the reform process.

Part 2—Cross-Cutting Analysis

Part 2 of the volume includes a cross-cutting analysis of the global experience with organizational reforms and two regional cases studies (Central Europe and the former Soviet republics, and the Southern Cone of Latin America)

Chapter 4 presents a cross-cutting analysis of the design and implementation of marketizing organizational reforms, based on data drawn from the two regional reviews and eight case studies. The first section assesses the hospital reforms according to their effectiveness in achieving stated objectives, how well they stayed on track, and their overall coherence. Against these criteria, the authors find that Singapore, Hong Kong, Malaysia, and Tunisia were “more successful”. They find the UK reform “partially successful” and New Zealand and Indonesia “less successful.”

The authors then apply the Gill Walt political economy framework to characterize the common elements among each group of reformers. Clear patterns emerge in terms of the success in dealing with implementation challenges. The more successfully implemented reforms dealt more pro-actively with the powerful stakeholders that are usually mobilized by these reforms, including public sector unions and professional associations. Reformers in these countries also dealt more effectively with the significant political demands these complex reforms generate. Finally, the more successful reforms included efforts to address the changed and increased demands on hospital management.

Given the dearth of serious monitoring and evaluation associated with marketizing organizational

reforms, the authors are tentative in outlining a number of hypotheses explaining the success or lack thereof. Helpfully they also outline some of the most successful “mitigating strategies” applied to address common problems confronted in implementing these reforms.

Organizational changes in the hospital sector were a common component of health system reforms throughout Central Europe and the former Soviet republics during the 1990s. Chapter 5 selectively reviews these reforms, focusing on the countries where reforms progressed farthest.

Among these countries a clear pattern or reform package of health system changes emerged. Most countries, in keeping with their desire and self-perception of moving toward Western Europe in their values and institutions, chose to establish a social insurance-based funding system. Underlying this establishment of a social insurance agency (or agencies) was the perception that a more active funder or purchaser would be instrumental in improving provider incentives. Hence the economy-wide move toward market-based incentives was reflected in hospital reforms as well. On the service delivery side, the rejection of central planning the economy as a whole, led to devolution of ownership of hospitals to local governments.

Although many countries pursued rational arguments for both of these changes in the funding and service delivery arrangements, the end result did not add up to a coherent reform package. The governance arrangements that emerged from hospital devolution themselves were inconsistent and problematic. Local governments often provided insufficient funding to cover the unit cost of the patients that they had to treat and less than full control over all the major cost drivers such as labor and pharmaceuticals. The social insurance funds that did take tentative steps toward active, output-based funding, found the hospitals generally unresponsive, owing to the weak governance and accountability arrangements.

The authors conclude that most countries that have introduced marketizing organizational changes in the hospital sector in the ECA region will have to revisit these reforms in the near future, if desired performance improvements are to be achieved.

Hospital organizational reforms were also common in the Southern Cone of South America during the 1990s. Chapter 6 reviews the reform experiences in Argentina, Chile, and Uruguay.

In Argentina, the national government was committed to these reforms, and it attempted to motivate the provinces (as hospital owners) throughout the country to “buy in” to the reform model. The Argentinean model was designed to implement autonomy at the level of the individual hospital. In contrast, Chile opted for a vertically integrated “network” model, in “autonomizing” their regional health administrations. Uruguay, after failing to introduce a nation-wide reform, pushed forward with four pilot hospital autonomization programs.

Although all three countries sought to implement modest autonomization reforms in their hospital sector, they nevertheless intended to create indirect accountability mechanisms that are often associated with substantially greater hospital autonomy. In addition to creating boards in the reformed hospitals, all three countries also tried to establish contracts with hospital managers in an attempt to sharpen management focus on performance.

This regional case study underscores the implementation challenges that almost always emerge during organizational reforms, especially in countries where labor interests hold significant power. With a few exceptions in some Argentinean provinces, political and institutional problems substantially blocked reforms in all three countries. The relative success in Argentina illustrates the importance of support during implementation at the hospital level where the required organizational changes are significant but where opposition from vested interests is also the greatest.

Part 3—The Case Studies

The United Kingdom (UK) introduced several reforms that decentralized and regionalized the hospital sector during the 1970s and 1980s. But it was not until early 1990, after a major organizational reform and privatization of public infrastructure and utilities, that the UK that the UK government decided to apply in earnest a marketizing organizational reform model and to introduce market-like pressures on the hospital sector (Chapter 7). Although the original corporatization model

for the health sector was inspired by the managed care movement in California and initially piloted in Sweden, it was its introduction by the government in the UK that sparked a global fascination with this type of reform.

At the time that the UK introduced its reforms, the hospitals that were targeted for change by the government functioned as virtual government departments. The hospitals selected by the government for the first wave of reform were intended to take on a radically different governance structure, including establishment of independent legal status (Trust), greater control over the employment and management of staff, and many other important decision rights that had previously been in government hands. Newly created hospital boards were to be modeled on commercial boards and to provide oversight of the Trusts’ management and operation without day-to-day government intervention. And new purchasers were to generate performance pressures in their selective purchasing, hence exposing the Trusts to considerable market pressures.

In practice, a number of these elements were left out during implementation, and the real forces for accountability continued to be exercised administratively through the Department of Health and the NHS Management Executive. Paradoxically, instead of increasing hospital autonomy, the reforms ended up increasing the influence of central authorities over the hospital sector. The UK reforms, therefore, underscore the distinction between formal governance structures and actual governance practices. While it is clearly important to put in place organizational arrangements that support desired governance processes, this change is not sufficient in itself. Structures that are developed to support enhanced autonomy can end up serving as a vehicle for more centralized administration. Beyond this mismatch between governance practices and structures, a broad range of other factors discussed in the volume also contributed to the disappointing results associated with the UK reforms.

In 1993, New Zealand became the second industrial country to implement a hospital organizational reform modeled on structural reforms originating in the state-owned enterprise sector (Chapter 8). Like the enterprises that remained state-owned, the reforms were intended to expose hospitals to market pressures in order to improve performance.

As in the case of the UK, the New Zealand hospitals were converted to legally independent entities (Crown Health Enterprises, or CHEs), with associated changes in decision rights and accountability mechanisms. In contrast to the UK, however, New Zealand's public hospitals already had substantial day-to-day autonomy from the central government. As in the UK, the 1993 reforms in New Zealand ended up increasing rather than decreasing the hospitals' reliance on direct accountability mechanisms with the central government.

Despite this paradoxical nature of the reform model and an implementation process that vacillated in response to political pressures, New Zealand witnessed improvement in some performance indicators (allocative efficiency, cost transparency, and enhanced equity in access). On the whole, the reforms were not, however, viewed as successful. As a result, the government that came to power in 2000 substantially reversed the reforms. This lack of success is largely attributed to fundamental alterations made in the financial regime of the reform model as well as weaknesses in the implementation process.

The 1995 hospital reforms in the State of Victoria in Australia were driven by a desire to increase efficiency, and the recognition that this would require substantial rationalization. This reform is presented in Chapter 9.

Rather than having a government-driven rationalization plan, the reforms were designed to enable this process to occur in a decentralized manner. Thus, the reforms integrated groups of metropolitan hospitals (and subsidiary providers) into several networks, which could then compete with each other.

As in the case of New Zealand, the hospitals in Victoria were already fairly autonomous. Hence, the reforms did not focus on enhanced autonomy, but instead concentrated on introducing more corporate-like operation at the network level. Many of the desired improvements that took place, including rationalization, resulted from the combined influence of the hospital reforms and a Diagnostic Related Group (DRG) performance-based provider payment system. The driving force behind the rationalization that took place appeared to be the organizational reforms that set up the network hospital structure rather than changes in

decision rights or other incentives of any individual hospital.

In 1991, Hong Kong policymakers believed the biggest problems in their hospitals related to rigidity and lack of management expertise. They designed their reforms to address these issues (Chapter 10).

New incentives were not a central element of their organizational reform introduced in Hong Kong, perhaps because of the generally well-performing government apparatus that already existed. In particular, the Hong Kong reform was not designed to rely on markets or market-like pressures to enhance performance. Rather, policymakers created a single new corporatized Hospital Authority which was granted significant autonomy and enhanced administrative accountability arrangements.

The reform integrated all public and publicly funded hospitals, constituting almost 90 percent of beds, into this newly created autonomous legal entity. The Hospital Authority was encouraged to undertake managerial and structural changes that would make it function like a corporation. The reforms gave the Hospital Authority a great deal of day-to-day freedom, relying on annual performance targets for accountability.

The Hong Kong reform was relatively successful on a number of fronts but of mixed success in improving quality. Consumer responsiveness and queues, in particular, remain issues. Accountability relied virtually entirely on the effectiveness of the performance-measurement system, since there were no other sources of performance pressure, such as output-related payment, hierarchical control, or consumer choice. Evidence to date shows that this system is improving, yet still falls short of making the Hospital Authority truly accountable for performance. As yet there appears to be no penalty for failing to meet performance targets.

In 1992, Malaysia reformed its newly built National Heart Institute, using a corporatization model that had been applied to other state-owned enterprises in that country (Chapter 11). As in many other countries, difficulties arose during implementation, when the original design of the reform was scaled back in a number of areas. The resulting model had some elements that were more reminiscent of enhanced hospital

autonomy than the more complete corporatization originally envisaged. But since the re-imbursement system was not designed to fund specific services, or services for targeted individuals, the reform went as far as it could toward establishing “market-like” incentives and performance pressures, given this constraint.

Not surprisingly, as a result of the funding system, the Heart Institute did shift toward providing more services to private patients that could pay for their treatment. To make up for these structural problems, the Malaysian authorities made some provisions to deal with the resulting negative impact on equity. These provisions included: funding coverage for a portion of needy patients, ensuring that other hospitals continued to provide cardiac services to the poor, and mobilizing additional funding to cover losses associated with services to the poor.

Initiated in 1985, the Singapore hospital reforms were the first to combine autonomy with reliance on market-based performance pressures (Chapter 12). As in Australia, the reform was implemented in a group of hospitals or “network,” rather than to individual hospitals. Unlike Australia, however, the model did not envision competition among public entities, since the group of hospitals integrated into the network constituted most of the public hospital system.

Singapore’s experience is instructive in illustrating the strong reliance of marketizing organizational reforms on a complementary financing system to create the needed incentives for productivity as well as accountability. In addition to its hospital reform, Singapore simultaneously undertook far-reaching reforms in its system for financing health care. This resulted in Singapore’s unique system of Medical Savings Accounts that allows individuals to generate performance pressures on participating hospitals through consumer choice, while retaining protection against financial risk and constraints on overall expenditure.

In the early 1990s, Tunisia undertook a multi-faceted hospital reform of its 22 teaching hospitals (Chapter 13). The reform is viewed largely as a success in the country and has proven sustainable. The Tunisian program is notable for pursuing changes on the technical, managerial, and organizational fronts simultaneously. The organizational changes were, however, relatively modest, with the endpoint

arrangements falling closer to a budgetary than an autonomous entity.

As observed in some of the other case studies, the reform ended up paradoxically increasing the central authorities’ administrative influence over hospitals. The Tunisian reform, therefore, once again underscored the distinction between formal governance structures and governance practices. While it is clearly important to put in place organizational arrangements that support desired governance processes—it is not sufficient. In Tunisia, as in the UK, structures developed to support enhanced autonomy ended up serving as a vehicle for centralization.

Marketing organizational reform of hospitals is a complex and challenging means of addressing problems in the sector. Consequently, it is rarely done unless there is a strong driving force. Serious fiscal problems are one of the most common motivating factors. The hospital reforms in Indonesia were clearly driven by the fiscal crises of the late 1980s and early 1990s, and the resulting desire to reallocate budgetary expenditure from hospitals to facilities delivering ambulatory care (Chapter 14).

The government opted for a version of autonomization applied to individual hospitals rather than a fully blown corporatization model. Given the focus on reducing expenditure, it is somewhat surprising that the Indonesian reforms did not directly deal with labor management. This constrained the eventual efficiency gains that were possible through the reform. Instead, reformed hospitals were encouraged to earn more private revenue in an attempt to decrease the needed budgetary support. While there were indications of improvements in both efficiency and quality, provisions to protect the poor against fees and cost increases were weak and often not implemented. In the final analysis, the reforms did not enable the government to decrease its hospital funding and are therefore not viewed as a success.

Building on previous efforts, the government that took office in August 1998 in Ecuador began to attack the most critical bottlenecks in the Ecuador health care system (Chapter 15). First, constitutional changes opened a “window of opportunity” for pushing forward a modest reform agenda. This included: (a) a strengthening in the policymaking and regulatory role of

the central Ministry of health; (b) deconcentration or delegation of administrative and financial function to peripheral branches of the public bureaucracy; and (c) decentralization of a range of political, economic, administrative and financial functions.

Although not all the reform envisaged were implemented due to further changes in the government in January 2000, several changes in the incentive regime of the hospital system are now well under way. This has included: (a) changes in the organizational and governance structure of public hospitals; (b) greater decision rights by hospital managers over planning, financial management, cost recovery policies, and financing capital investments (civil works, equipment maintenance, and some aspects of human resources management (training, performance incentives and career development); (c) introduction/increase in some user fees; and (d) safeguards to protect poor households from the negative impact of user fees such as discounts and exemptions. Finally, participating hospitals now use “shadow prices” to gradually acquaint managers to an output based financing system.

It is too early to know the full impact of these reforms on the performance of the Ecuador hospital sector. As in other countries around the world, success will depend as much on the politics of implementation as it will on the technical soundness of the design.

B. A FEW NOTEWORTHY THEMES IN CONCLUSION

In conclusion, two major lessons learned from the topical chapters, regional reviews, and case studies deserve highlighting.

Lesson 1— If reforms are too complex to fully design in advance, go with the broad-brush or blueprint and be prepared to adapt as you go along—but maintaining overall policy coherence.

As would be expected, the case studies demonstrated that trial-and-error experimentation has marked the early generation of “marketizing” organizational reforms of hospitals. There are both striking successes and dismal failures. Many of the lessons learned through similar reforms in sectors such as transport, infrastructure, and telecommunications were not well understood by policymakers; others did not directly apply to the health sector.

For example, much has been learned about the need for special techniques such as performance benchmarking and long-term contracts when public firms are transformed into entities that end up with a natural monopoly. This is especially true in the highly specialized hospital sector and in rural areas, where overheated competition among overlapping units may be undesirable since it can lead to wasteful duplication of capacity and an expensive “medical arms race” for the latest technology.

Yet lessons from other sectors in this regard do not apply directly to a multiproduct organization such as the hospital, where output and health-outcome performance indicators are much more difficult to define and monitor than, for example, kilowatt consumption in the energy sector. Much more refined instruments are needed to guide the behavior of substantially independent hospitals, such as case-mix adjusted payments that are data intensive and require sophisticated patient records and accounting systems. Much new learning has, therefore, had to take place as the principles of “marketizing” organizational reforms were applied to the health sector.

Lesson 2— Organizational and marketizing reforms are systemic in nature—they cannot be introduced in the hospital sector alone without parallel reforms in other parts of the health system.

This volume also shows that organizational reform of hospitals is a multidimensional reform that requires coherent changes in a number of critical factors, not just the appointment of a management board or placing the hospital within the remit of company law. Reforms that are introduced in isolation in the hospital sector almost always led to an incoherent policy framework and had many adverse effects on other part of the health sector.



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