Informal Expert Consultation on Hospital Services and Management in the Western Pacific Region

4–5 November 2014
Manila, Philippines
MEETING REPORT

INFORMAL EXPERT CONSULTATION ON HOSPITAL SERVICES AND MANAGEMENT IN THE WESTERN PACIFIC REGION

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NOTE

The views expressed in this report are those of the participants of the Informal Expert Consultation on Hospital Services and Management in the Western Pacific Region and do not necessarily reflect the policies of the conveners.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for Member States in the Region and for those who participated in the Informal Expert Consultation on Hospital Services and Management in the Western Pacific Region in Manila, Philippines from 4 to 5 November 2014.
# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AQS</td>
<td>Access, Quality and Sustainability</td>
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<td>EMR</td>
<td>Electronic Medical Records</td>
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<tr>
<td>FROGG</td>
<td>Financing, Feedback, Regulation, Ownership, Governance, Goals</td>
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<tr>
<td>HAI</td>
<td>Healthcare Accreditation Institute</td>
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<td>HIMSS</td>
<td>Healthcare Information and Management System Society</td>
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<td>HIS</td>
<td>Health information system</td>
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<td>ISO</td>
<td>International Standards Organization</td>
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<td>NEWS</td>
<td>Needs, Evidence, Waste and Safety</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>WHO</td>
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Keywords

Hospital administration / Health systems plans / Economics, Hospital
SUMMARY

Hospitals are key health-care institutions in every country – they have high political visibility and shape public perception of the quality of the health-care system. Health systems are in transition, driven by rapid technological advance and a changing profile of the burden of disease. These shifting contexts require changes in approach to the role of hospital services and the way hospitals are managed.

Meeting objectives:

1) to review how hospital sector challenges are being dealt with in the Western Pacific Region;
2) to identify and prioritize potential areas for intervention for WHO and its partners to assist Member States with the further development or strengthening; and
3) to pinpoint areas for further examination prior to the formal country consultation.

Trends for the future include hospitals becoming part of hospital systems – redefined as hubs of health-care activity. Hospitals take on district-level roles and responsibilities, and develop partnerships with district primary-care providers and the social-care sector.

Governments and regulatory authorities can assign pre-defined levels of autonomy for hospitals for regulatory purposes. Besides funding, governments exert influence through policy levers such as licensing, regulation and accreditation. Policy-makers must ensure policies and financial incentives are coherent and aligned.

Quality and patient safety are big issues for hospitals. A national quality and patient safety programme or framework is useful to encourage a culture of quality improvement and an environment for open-reporting of incidents at the hospital level.

A regional action framework for hospital development may be useful to provide guiding principles. Investing in human resources for health through education and training is also an important focus area. As hospitals grow, management training needs to be strengthened across all cadres. Senior management and chief executives will require training in hospital management, health policy and systems thinking. As hospitals become more complex, the leadership development paradigm must also shift from developing leaders to developing leadership teams.

Hospitals face a multitude of issues and challenges. Hospitals can be analysed against six attributes: goals; regulation; ownership; governance; financing; and feedback. This analysis helps builds understanding of hospitals, and may allow subsequent categorization and benchmarking of hospitals across settings.
1. INTRODUCTION

The Informal Expert Consultation on Hospital Services and Management in the Western Pacific Region was held from 4 to 5 November 2014 at the WHO Regional Office for the Western Pacific in Manila, Philippines.

1.1 Background information

High performing health systems are critical to address health challenges faced by Member States in the Western Pacific Region. Hospitals are key health-care institutions in every country. They provide complex acute medical care, manage medical emergencies, participate in training of health professionals, and are an important part of a national health spending. Hospitals have an important role in shaping public perception of the quality of the health-care system, and have high political visibility. Efficient management of hospitals and hospital organization within a health system are critical policy issues.

WHO acknowledges that attention must be given to all levels of health-care providers, and their coordination and integration. Hospitals are not designed to, and should not, take over the role of primary health care providers. Primary care services are the foundation of health care, administering preventive services, and attending to the everyday needs of the population. An effective primary care system ensures populations are healthy and hospitals services are used appropriately. Patients who can be attended to in primary care settings should be managed by local primary care providers to minimize travel, improve accessibility and optimize cost-efficiency.

Health sectors in the Region are in transition, driven by rapid technological advance and a changing profile of the burden of disease. These shifting contexts require changes in approach to the role of hospital services and the way hospitals are managed. Hospitals require heavy investments and have significant operating costs. Poor management and governance of hospitals can be very costly. Evidence is limited on the right ways to fund hospitals, and how they should relate to other parts of the health system. Diversity between and within countries creates additional complexities – what works in one setting may not be appropriate or relevant in another.

The strategic orientations of a country’s health and hospital policies are dependent on its history, culture, level of development, philosophy and values. A close re-examination of the role and place of hospitals in health systems across the Western Pacific Region is necessary to improve governance and management of hospitals in the Region.

1.2 Objectives

(1) to review how hospital sector challenges are being dealt with in the Western Pacific Region;
(2) to identify and prioritize potential areas for intervention for WHO and its partners to assist Member States with the further development or strengthening; and
(3) to pinpoint areas for further examination prior to the formal country consultation.

1.3 Participants

Sixteen experts in hospital management and health service delivery from the following countries attended: Australia, Brazil, China, Hong Kong SAR (China), Japan, Malaysia, Mongolia, New Zealand, Norway, the Philippines, the Republic of Korea, Singapore and Thailand. The Secretariat for the meeting included eight WHO staff. The list of participants is available at Annex 1.
1.4 Meeting Structure
The consultation included panel presentations, plenary and group discussions. The agenda is available at Annex 2.

1.5 Opening Session
Dr Shin Young-soo delivered the opening address. Dr Vivian Lin then provided an overview of the issues hospitals face in the Region. In health systems discussions, hospitals are often “the elephant in the room” – the challenges they face are at times overlooked, and often ignored. The “elephant” is also a big animal, and when people are standing too close to the elephant, they can only see part of it. Dr Lin expressed her hope that this consultation will broaden the understanding of hospital issues and in time, allow for recommendations and solutions to be proposed.

Dr Laura Hawken provided a technical brief on the roles of hospitals within the health system, and the challenges of managing hospitals as agents within a complex adaptive system. Health systems are increasingly fragmented, contributing to poor integration and quality of care. Quality is an important issue in hospitals, along with macro-policy related issues pertaining to equity and access. To allow hospitals to do the work that they are designed to do, the primary health care sector must be strengthened so that more patients can be treated appropriately in primary care. Human resources for health in hospitals are weak in many health systems; more systematic training and education of hospital staff is critical improve management capacity and the quality of service delivery.

Ms Nuria Toro Polanco provided an update on the WHO strategy on people-centred, integrated health services. Key issues surrounding health services delivery relate to: access, availability, affordability, equity and quality of care. These issues should be viewed against a backdrop of changing disease patterns, lack of empowerment of health service users, inappropriate health service delivery models, and limited coordination across services. The health systems transformation strategy will require a paradigm shift in the way health services are funded, managed and delivered to better support countries aiming for universal health coverage (UHC) in a way that can improve quality, support financial sustainability and be responsive and accountable to the population. The five pillars for action are: empower and engage people, strengthen governance and accountability, reorientate the model of care, coordinate services, and create an enabling environment. The vision for hospitals is for them to be part of a coordinated and integrated health services delivery network – with a central regional budget across hospitals, community and primary care services. This will require hospitals to improve engagement and coordination of care with nearby primary and community care providers. As health networks grow and service delivery is distributed across a wider geographical area, clinical governance needs to be strengthened with a strong focus on quality, safety and people-centred care.

2. PROCEEDINGS

2.1 What is the place of hospitals in the health system?

Dr Lin introduced the session with the following discussion questions:

- Planning: How to reconcile population-based planning (system interests) with institutional-based planning (institutional interests)?
- Public-private mix: How should central planning take into account the private sector, or how might private sector development fit into a planning framework?
- Changing contexts: How can planning take into account the changing expectations pertaining to health-care, and new developments in health technologies?
Dr Shin-ho Lee shared the Republic of Korea’s experience, emphasizing lessons learnt in population-based planning. The Republic of Korea has moved from a highly-regulated and central-planning to a population-based planning approach. The planning paradigm shifted to one where market dynamics strongly influence hospital supply. This approach has resulted in an oversupply of about 30,000 hospital beds. Health-sector planning needs to be more holistic, balancing population- and institution-based approaches. He recommended that governments devolve some health sector planning to the subnational level. The Republic of Korea’s health sector is unique – 90% of services are provided by private sector, hence the lessons learnt may not be generalizable to countries with different distributions of public-private providers.

Dr Erik Normann presented Norway’s experience. In Norway, 90% of health care is provided by the public sector. Norway’s health-sector development is influenced and guided by epidemiological information such as changing burdens of disease. Hospitals have a key role in the attainment of UHC through a paradigm shift that emphasizes a whole-of-systems approach to health service provision. In this new paradigm, the role played by health-care workers within hospitals will also need to evolve. Hospitals play a role in strengthening primary and community health-care providers so that treatment is provided in the community, rather than through admission, where possible.

Key discussion points included:

- Moving to people-centred health care will be challenging as health-care facilities are built and designed around health professionals. It might be useful for different entities in the health system to envision what people-centred health care means to them.
- Evidence and publications on hospital services is inadequate to inform policy. At the macro-policy level, a strong evidence base can provide intelligence to help policy-makers make informed health sector plans and policy decisions
- In Singapore and Thailand’s health systems, hospitals take on a leadership role in building-capacity for smaller health-care providers. This whole-of-systems approach has the potential to strengthen primary care partners, improve the overall health of the population, and reduce the number of patients requiring hospital care.
- The place of hospitals in health systems may be impossible to define categorically because of the heterogeneity of health systems across the world, but having a commonly agreed working definition of what constitutes a hospital is necessary to build a common understanding of the term, and its essential components and functions.
- Health systems are complex adaptive systems, and are resistant to engineering-type solutions. In these complex systems, designing the correct incentive structures may be more effective in driving sustainable changes.
- Developing more hospital capacity may be necessary but it is not sustainable in the long run. A longer-term view of health with emphasis on preventive care will be useful in alleviating health-care demands and costs in the long term, and buffer the exponential demand for hospital capacity.

2.2 What are effective mechanisms for hospital governance?

Dr Dale Huntington introduced the following discussion questions:

- Legislation and Regulation: What should be the relationship between the state and hospitals, and how should it be embodied in legislation?
- Autonomy: Is hospital autonomy a solution to improving efficiency, responsiveness and equity?
- Legal status and ownership: What are successful models of corporatization and corporate governance?
Dr Yingyao Chen shared a study on hospital autonomy as a framework to describe models of governance between the state and the hospitals. This framework has five factors that describe degrees of hospital autonomy: 1) decision rights; 2) market exposure; 3) residual claimant; 4) accountability; and 5) social functions. These factors can be viewed as levers by which states can control the degree of autonomy at the hospital level, and indirectly influence service provision. Applying the framework to case studies of China, Lao People’s Democratic Republic and Mongolia showed that key policy decisions taken longitudinally affect health-care expenditure and consumption patterns. Suggestions were made to strengthen government role in strategic visioning and to establish effective governance structure for public hospitals.

Dr Phua Kai Hong discussed the framework's utility in covering the critical elements of hospital reform, emphasizing the importance of policy and incentive coherence. The corporatization of public hospitals and trade-offs between efficiency and equity; and outcomes and effectiveness can be mediated through the components of hospital autonomy. In Singapore, hospitals were corporatized to improve efficiency. This was followed by a phase of regulatory strengthening to ensure quality and safe provision of public health services. Funding received from government and fees from patients are carefully monitored and deliberated, to calibrate the source of financial incentives, which will subsequently affect hospital’s management and behaviour.

Professor Judith Dwyer summarized the components of hospital governance. Financial incentives are important in influencing the behaviour of health-care providers, as is aligning laws and regulations with policy goals. Health systems and hospitals can consider the principle of subsidiarity: anything that can be competently decided at the hospital level should be, with the exception of things that benefit considerably from national ownership. More context-specific inquiry on the roles of hospitals can be done using a programme logic model, where tasks can be analysed and assigned downstream to the appropriate level of authority.

Key discussion points included:

- The optimal level of autonomy for hospitals is contextual and dependent of the health system. Cultural issues may be as important as structural issues when determining the appropriate level of autonomy. For these cultural issues, planning for development of health systems needs to be guided by a common vision set by the government, preferably with a set of strategic outcomes.
- Government and regulatory authorities must use a mix of market and incentive control, and regulation and hierarchal control – depending on the nature of the issue. Incentive control works well on things that can be measured. For “social function” (as defined by Harding and Preker), since it is difficult to measure, hierarchal control is more suitable. Incentive structures, financial policy and regulatory frameworks need to be aligned. Planning and designing market incentives and regulations are complex processes, and the product and outcome is dependent on the level of competency and capacity at the stewardship level.

2.3 What are effective strategies for financing of hospital services?

Dr Xu Ke introduced the following discussion questions:

- Rules, regulations and enforcement: How to ensure public policy objectives are met when providing hospitals with financial autonomy?
- Incentives: How are provider payment methods aligned with public policy?
- Managerial and technical capacity: How to improve human capacity and information systems for better financial management?

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Dr Bernard Couttolenc discussed the utility of the Harding and Preker framework for determining financing approaches in hospital service delivery. Hospital autonomy, as described by this framework, is a means to an end and not an end in itself. Hospital autonomy must be complemented by the use of contracts to strengthen accountability in hospital service delivery. Public-private mix approaches should be defined by contracts linking provider remuneration to performance, including the achievement of public policy objectives as measured by clearly stated performance indicators.

Dr Stephen Duckett stressed the significance of coherence between the regulatory environment, policy goals and financing approaches. This coherence must also consider the local context (such as population and culture factors). The introduction of market incentives into hospital governance is a key decision that will influence the future options and paths available for policy development and coherence. Market incentives can be introduced for goals such as quality and safety. These incentives require data and measurements. To mitigate risks of gaming of incentives systems, ongoing monitoring and sound feedback mechanisms must be integrated into regular reviews of policy and programme development.

Key discussion points included:

- Health-care financing is a key part of system design, and is heavily influenced by the political and strategic orientations of a country. A country's narrative on whether health care is an essential service that should be provided for by the government, or a commercial service for purchase in a market economy, will heavily influence the model of health-care financing. Lessons learnt from one context cannot be readily applied to another without a good understanding of political and cultural underpinnings.
- Hospitals need to be financially viable, and their income stream is usually a mix of public funds (i.e. tax-funded, mandatory health insurance) or revenue from patient care. The distribution and proportion where the funds come from shape the management and behaviour of the hospitals. Adjustment of this distribution through provision of funds, health-care policy and regulatory frameworks can effect behavioural changes that are more sustainable.
- States and health systems can exert influence on cost-ceilings through centralized health technology assessment, group purchasing, and setting policies on new technologies and pharmaceutical products.

2.4 How can quality and safety be ensured and improved?

Dr Kenichiro Taneda introduced the following discussion questions:

- System architecture: What should be the institutional arrangements be for assuring quality and safety, and should these be regulated via independent authorities or by the government?
- System level strategies: How to improve quality through licensing, accreditation, workforce regulation, feedback mechanisms?
- Institutional-level strategy: What mechanisms within a hospital prevent overuse, underuse or misuse of services, and encourage practice improvement?

Dr Anuwat Supachutikul shared that Thailand’s approach to hospital accreditation takes an educational and self-improvement perspective, rather than being punitive. The process is peer-led, and the intent is to share best practices, learn and improve. Recognizing the importance of quality and patient safety, these topics are now taught in undergraduate programmes. Having the correct approach and perspective for quality improvement is important, but institution-level work processes such as regular reviews need to be present. Well-enforced and evidence-based regulatory measures must be also established. These quality improvement initiatives, accreditation requirements, and regulatory measures must be coherent and well-designed within a broader system architecture, and be considered in subsequent policy and governance development.
Dr Supachutikul shared that change management process needs to closely involve senior management and physician leaders. Scientific processes are often inadequate in effecting sustainable change – story-telling is sometimes better able to transmit values and change culture. The holistic NEWS (needs, evidence, safety and waste) approach to policy assessment involves considering humanistic, scientific, learning and mindfulness and managerial perspectives. The Healthcare Accreditation Institute (HAI) patient safety initiative in Thailand is an example of a successful quality and safety programme achieved through regulatory measures.

Dr Jacob Thomas shared that hospitals in Malaysia undergo voluntary accreditation by the Malaysian Society of Quality in Health. Hospitals have found it useful to undergo accreditation as a benchmarking exercise, but accreditation also provides tangible benefits such as recognition by insurers and helps promote medical tourism. Malaysia’s journey was a step-wise progression, starting with International Standards Organization (ISO) standards 14001 and 15189 before progressing on to accreditation by the Joint Commission International. On safety issues, the Patient Safety Council of Malaysia is chaired by the Director-General of Health and is responsible for the National Patient Safety Goals. Cultural change – including open reporting, setting up feedback systems and building a culture of quality improvement – requires six components: leadership engagement; a culture of continuous learning; systems-based thinking and process-oriented improvement; accreditation; non-blaming culture; and transparent communication.

Key discussion points included:

- Many medical errors may have a system component. When a staff member makes a mistake, a portion of the blame is with the management. For systems to improve, a culture of open reporting and an environment of trust must be present to move to “mistake-proofing”.
- Licensing helps to set minimum standards, and accreditation establishes aspirational standards; both work together to create a floor and ceiling that health-care providers can operate within. States need to create robust licensure institutions, and accreditation can either be voluntary or mandatory. Even if these systems are in place, often there is not enough effort and resources are put into regulation and monitoring of processes and indicators.
- Institutions should ideally participate in and see accreditation as a learning journey. The process of undergoing accreditation helps to shape the thinking for health-care professionals, helping them build a culture of goal-setting, and measure processes and outcomes. Most hospitals report that the process of undergoing accreditation builds capacity in their human resource. Accreditation should not be pursued solely for branding purposes and the process should not be blindly followed like a formula.
- On quality and human resource for health, health workforce regulation and professional licensing is poorly developed in some countries. Licensing for individual health-care providers is an important point of quality control for the state, and specific requirements for specialty accreditation and periodic re-accreditation can be considered.
- Patient education and improved health literacy can have a bottom-up effect on health-care providers. More informed patients may be more discerning about the quality of clinical care received, and may choose hospitals which are accredited over those without accreditation. The more the consumer pays out-of-pocket, the more he will behave like a consumer and be more discerning about the quality of services he receives.

2.5 How can hospital management be strengthened?

Ms Hawken introduced the following discussion questions:

- Management development: How to develop critical hospital management capabilities (human resource, finance, quality, informatics)?
• Corporate governance: What are good models for hospital regulatory authorities, hospital corporate governance, and human resource practices?
• Managing service linkages: What systems are effective for ensuring appropriate referrals and communications amongst hospitals, and with primary care providers?

Dr Rufino L. Macagba shared his experience in managing hospitals. As a physician taking on a leadership role in the hospital, there was no formal management training. It was on his own initiative that he learnt hospital administration and management skills. Health-care leaders and managers can learn lessons from the general management arena. Hospital personnel, at all levels, must undergo regular education and training. In most settings, hospitals can use external vendors to provide training on general matters, such as service excellence. Quality improvement programmes, such as Lean and Six Sigma, are highly relevant to hospital settings.

Professor Jens Mueller highlighted hospital systems where the route to senior management is hierarchical within physicians. Selection criteria may sometimes be based on seniority and tenure, rather than capability. Physicians selected for leadership positions may not have participated in management training. With the growing organizational complexity of hospitals, physicians in leadership roles can be ineffective managers despite their extensive clinical expertise. However, having hospital managers without clinical skills and training can also contribute to poor service delivery. Mixed teams comprising physician leaders and management personnel working together might be a more suitable model. The appointment of senior leadership for hospitals can be selected by an independent board, which can objectively assess the type of leadership needed for the hospital, depending on the challenges the hospital is facing.

Professor Naoki Ikegami shared that in the Asia Pacific region, most hospitals do not have a board or overview committee, instead senior management provides oversight. Adopting the concept of a hospital board may be met with cultural resistance. Physician leadership is still prominent in hospitals in Japan, and many physicians aspire to take on more leadership and managerial roles within the hospital. Any change in hospital corporate governance structures and design needs to take into account the culture and aspirations of staff. Various policy components impact the delivery of hospital services in Japan, a key component being Japan’s fixed fee schedule. Facilitates regulate and control quality because patients know how much to pay, and service providers must meet the level of service provision and quality ascribed by the Government. This centrally controlled fee schedule operates within a national-level budget that helps manage both the over- and under-provision of services.

Key discussion points included:

• Many hospitals in the Region may be operating with more traditional and hierarchical organizational structures, and have varying degrees of receptiveness to recommended practices of management science.
• Hospital leadership and senior management can be either administrators or physician leaders. It is not possible to say which is more suitable – the answer is dependent on context. For example, when selecting a hospital CEO, the selection panel should consider the challenges the hospital is facing and select a candidate whose skillsets match the problems.
• Physicians have the capacity to learn management on-the-go, and are leading small teams. However, more formal leadership and management training should be scheduled if they are taking on senior leadership positions. Training doctors in leadership and management also has its constraints because doctors have many competing demands on their time.
• Big hospitals are run by teams, and it may be feasible to have teams comprising physician leaders and administrators to provide a mix of general skillsets and tacit health-care knowledge.

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Hospital leaders and managers at various levels and functions will require different degrees and types of training. Where possible, regulatory authorities and institutions can draw up a list of desired management skillsets, provide links to accredited training institutions and, where possible, provide funding for personnel education and training.

2.6 How should hospital information systems drive improvements in performance and accountability?

Mr Mark Landry introduced the following discussion questions:

- Performance management: How should hospital performance be measured and what might be core performance indicators?
- Public health responsibility: What should be hospitals’ public health reporting obligations?
- Transparency: Should hospital performance be compared and reported publicly?

Professor Rene Domingo highlighted the challenges in the Region in establishing effective health information systems (HIS) and performance management systems:

1. Heavy reliance on manual methods;
2. Fragmented, incompatible systems within and across hospitals and regulators;
3. Inadequate software and hardware;
4. Lack of HIS expertise;
5. Poor internet connectivity;
6. Case-based rather than patient-based recording;
7. Data not used to improve quality or safety; and
8. Low response rate, selective reporting based on compliance to regulations.

A good HIS enables information tracking and reporting, and can facilitate monitoring of quality and performance indicators. However when HIS are poorly developed, data submission and collection becomes incomplete and of limited utility. Depending on how reported information is used, users might not feel comfortable highlighting perceived poor outcomes for patient safety and quality issues. These developmental limitations must be addressed to enable higher order utilization of health-care data to maximise performance and accountability in the delivery of hospital services.

Dr Clive Tan used the Healthcare Information and Management System Society (HIMSS) Asia Pacific Electronic Medical Records (EMR) Adoption model as an example of how HIS development can be broken down into incremental levels. Such a framework can be useful for needs assessment, benchmarking and measurement of progress – both within a hospital system and at the broader state level. Broad-based adoption of a common model can enable comparability and improve communication about what needs to be further developed. Governments play an important role in adoption of such a framework. This can help to incentivize hospitals to develop their HIS. HIS developments and investments at the hospital-level will translate to easier data collection for the regulatory authorities.

Change requires time, and where possible, should be managed within a broad change management framework, that takes into account human resource development and engagement. Resistance to moving to an electronic system may be due to lack of trust over issues relating to transparency, accountability, remuneration and whether information may be used against those who provided them. Selection of process and outcome measures can reference evidence-based frameworks, such as the

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3 HIMSS Asia Pacific EMR Adoption Model. Available at [http://www.himssanalyticsasia.org/emradoptionmodel.asp](http://www.himssanalyticsasia.org/emradoptionmodel.asp)
ones used by the Joint Commission International. Regulatory authorities should also consider publishing internal or open reports using the data collected, to provide information to internal and external stakeholders. This also signals to institutions that the data collected is important and useful.

Dr Gabriel Leung shared his views that HIS is not an IT system, emphasizing the role of a HIS in providing useful information for monitoring and evaluation. Performance measures and indicators can inform governments and consumers, but more often indicators are selected based on who is the dominant payer.

Interconnectedness across HIS is important, especially when patients are mobile across institutions and in outbreak situations where information needs to be shared rapidly. Legal frameworks also need to align with broader health system goals. For example, legislation and the protection privacy are important enablers for strong and widely-adopted HIS. A well-implemented HIS can have immense translational potential for research and development in other areas.

Key discussion points included:

- Data collected must be put to good use, to provide timely and relevant information for stakeholders. This feedback will let providers see the utility and impact of their data and encourage them to submit data regularly. Where feasible, information that is useful for the patients and consumers should be made available to the media and the public.
- Data can be used to provide information for benchmarking, with the intent to promote self-awareness and healthy competition. For example, information and reports can be anonymized before publication, and outliers can be highlighted with suggestions for improvement from a quality improvement perspective.
- Governments and regulatory authorities should consider having minimum data sets that healthcare providers must submit data on, with institutions like tertiary hospitals reporting on more indicators compared with smaller providers. Regulatory authorities should be tracking both service and clinical indicators, with clinical indicators requiring more technical expertise to select.
- Data collection can be incentivized or enforced, and information processed from submitted data can be used in many ways. The culture of data submission takes time to take root, and is built on trust. If the submitted data is used for punitive measures, rather than quality improvement purposes, the trust between providers and regulatory authorities can be eroded.

2.7 Discussions and summary

Dr Rasul Baghirov summarized the consultation discussions. Governments play an important role in health sector planning, whether directly or indirectly. Health systems are highly interconnected, not just within the health systems, but also connected with other systems (e.g. social, education, trade, etc.). They are complex adaptive systems and because of that, there are limits to what governments can achieve through central planning. One solution is to let regions and local governments take on a strong planning role within an established health systems framework. This will require a stable and coherent macro-policy environment, where the central government is clear on broad ranging issues such as the desired public-private mix, and the overall financing framework. Central government ability to empower regional and local governments with health sector planning may be limited by local government capacity for health policy and planning.

Hospitals are an important part of the health-care system. Health-care resources, expertise and human resources are concentrated in hospitals. Public hospitals often receive a significant proportion of government health budget. Health systems and models of health-care delivery are evolving rapidly, as is the role of hospitals. Trends for the future include hospitals becoming part of hospital systems,

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no longer confined by one premises, but redefined as hubs of health-care and related activity. In this new paradigm, hospitals take on a district-level role and responsibility, and are increasingly active in developing partnerships with district primary-care providers and the social-care sector.

Governments and regulatory authorities can design pre-defined levels of autonomy for hospitals for regulatory purposes. The level of hospital autonomy usually correlates to the level of government funding it receives. This in turn affects the level of control the government has over the hospital and its mission. Aside from funding, governments can influence hospital behaviour through policy levers such as licensing, regulation and accreditation. The level of autonomy for hospitals or the ideal distribution of public and private hospitals will depend on context.

Health systems and hospital reforms are ongoing in many countries, driven in part by ecological issues such as epidemiological transition, and increased prevalence of noncommunicable diseases. Many health-system components may be shifting simultaneously. It is important for the system architect to maintain oversight of reforms to ensure policies and financial incentives are coherent and aligned.

Quality and patient safety are big issues for hospitals. Having a national quality and patient safety programme or framework is useful to encourage a culture of quality improvement and an environment for open-reporting of incidents at the hospital level. It could also encourage hospitals to pursue accreditation and prioritize quality and patient safety training for staff. Licensing, of institutions and individuals, is also an important government lever for quality improvement and assurance.

A good HIS can be an important enabler for many functions of hospitals and the health system in general. However, a good HIS is difficult to develop, and is often costly in terms of time, human and other resources. Establishing a framework for HIS development can be a useful resource and roadmap for this capacity development.

Hospitals face a multitude of issues and challenges. Six topic starting points to analyse hospitals and health systems are: goals; regulation; ownership; governance; financing; and feedback. Participants acknowledged that it was a useful framework for analysing hospitals and health systems, and proposed the mnemonic FFROGG. While certain issues such as human resources for health do not fit under the six headings, the framework was accepted as a good starting point for tackling this multi-faceted issue. This framework could be used in consultation sessions with Member States to initiate a conversation and build an understanding of the state of their hospitals and health system, and possibly categorize and benchmark hospitals. This framework is an important first step towards building a common understanding and designing context-specific solutions for hospitals. The FROGG framework could be further developed through research and practical application. An elaboration of the FFROGG framework can be found in Annex 3.

In terms of working towards UHC, it is important to provide equitable access to good quality health services, while protecting patients from financial hardship. The following guiding principles were re-emphasized:

- Hospital financing with regard to raising capital and regulating expenditure, in private and public settings, must ensure patients do not suffer undue financial hardship when paying for services.
- Access to hospital services should be determined on a needs-basis, with effective referral channels maintained between primary care facilities to ensure all patients receive appropriate care.
- Quality and safety of hospital services should be achieved through a well-trained, motivated and regulated health workforce that provides services based on the best available evidence.
This consultation also highlighted potential areas for further examination:

- **Performance indicators:** What processes and outcomes should be measured to ensure progress for hospitals and health systems?
- **Financing:** What is the evidence base for different financing and ownership models on health outcomes in Member States?
- **People-centredness:** How can health-care professionals, partners, patients and their families shape the provision of health-care services? How can providers, patients and governments co-develop a culture of safety, transparency and accountability?

### 3. CONCLUSIONS AND RECOMMENDATIONS

#### 3.1 Conclusions

In the Western Pacific Region, hospitals face different challenges and require different solutions. A regional action framework for hospital development may be useful to provide guiding principles. WHO can then work with Member States to tailor the framework to their needs.

Changes in macro-policy and financing frameworks can create a favourable environment for change. Investing in human resources for health through education and training is also an important focus area. As hospitals grow, management training needs to be strengthened across all cadres. Senior management and chief executives will require training in hospital management, health policy and systems thinking. As hospitals become more complex, the leadership development paradigm must also shift from developing leaders to developing leadership teams.

To improve service delivery in hospitals, a good approach for regulatory authorities and hospitals is to focus on quality and patient safety. Stakeholders agree – and extensive research supports – the importance of these topics. Quality improvement programmes such as Lean and Six Sigma have been applied to the health-care industry. Accreditation agencies also have frameworks and models for quality and patient safety. Countries with national frameworks or programmes for quality and patient safety can encourage hospitals to prioritize these topics.

#### 3.2 Recommendations

New information and insights gained from this consultation need to be translated to knowledge and impact. The report recommends:

1) Follow up with a formal consultation on hospitals with Member States and discuss the importance and relevance of hospital systems to the UHC agenda.
2) Continue to develop the FFROGG framework as an analysis tool for hospital systems, through partnerships with Member States and practical application of the framework to countries.
3) Develop the evidence base for best practices for hospital governance, management and service delivery, and identify potential WHO collaborating centres for further development of capacity in research, education and training in this field.
Annex 1. List of participants

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Dr Dale Huntington, Director, Asia Pacific Observatory, Division of Health Systems, WHO Regional Office for Western Pacific, 1000 Manila, Philippines

Mr Mark Landry, Coordinator, Health Intelligence and Innovation, Division of Health Systems, WHO Regional Office for Western Pacific, 1000 Manila, Philippines

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Ms Nuria Toro Polanco, Consultant, Services Organization and Clinical Intervention World Health Organization, Avenue Appia 20, 1211, Geneva 27, Switzerland
## Annex 2. Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speakers and Facilitators</th>
</tr>
</thead>
</table>
| 8.00 – 8.30 | Registration                                                           | Ms Ivette Ambrosio  
Ms Cora Ocampo                                                   |
| 8.30 – 8.45 | Welcome                                                                | Dr Shin Young-soo (RD)                                         |
| 8.45 – 9.00 | Meeting objectives and Participant introductions                        | Dr Vivian Lin (DHS)                                           |
| 9.00 – 10.00 | Scoping study on hospital issues in the Western Pacific  
People-centered and integrated services                         | Ms Laura Hawken (WPRO)  
(20 min)  
Dr Nuria Toro Polance (HQ)  
(10 min)                                                      |
| 10.00 – 10.30 | TEA and group photograph                                               | Lawn (or Foyer)                                               |
| 10.30 – 11.00 | Panel 1: What is the place of hospitals in health system?              | Dr Shin-ho Lee  
Dr Erik Normann                                                   |
| 11.00 – 12.15 | Plenary discussion on Panel 1                                            | Dr Vivian Lin                                                  |
| **12.15 – 13.15** | LUNCH                                                                   | Alfresco                                                      |
| 13.15 – 13.45 | Panel 2: What are effective mechanisms for hospital governance?        | Dr Yingyao Chen  
Dr Phua Kai Hong  
Prof Judith Dwyer                                                 |
| 13.45 – 15.00 | Plenary discussion on Panel 2                                            | Dr Dale Huntington                                             |
| **15.00 – 15.30** | TEA                                                                     |                                                              |
**Panel 3: What are effective strategies for financing of hospital services?**

- **Rules and regulations and enforcement:** How to ensure public policy objectives when given hospital financial autonomy?
- **Incentives:** How provider payment methods are aligned with public policy objectives?
- **Managerial and technical capacity:** How to improve human capacity and information system for better financial management?

**Speakers:**
- Dr Stephen Duckett
- Dr Bernard Couttonlenc
- Dr Claude Bodart

**Time:** 15.30 – 16.00

**Day 2 – Wednesday 5 Nov, 2014**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speakers and Facilitators</th>
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<tbody>
<tr>
<td>8.30 – 8.45</td>
<td>Key points from yesterday and focus for today</td>
<td>Dr Vivian Lin</td>
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<tr>
<td></td>
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<td>Dr Rasul Baghirov</td>
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<tr>
<td>8.45 – 9.15</td>
<td>Panel 4: How can quality and safety be ensured and improved?</td>
<td>Dr Anuwat Supachutikul</td>
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<td>Dr Jacob Thomas</td>
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<td>9.15 – 10.10</td>
<td>Plenary discussion on Panel 4</td>
<td>Dr Ken Taneda</td>
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<td>10.10 – 10.30</td>
<td><strong>TEA</strong></td>
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<tr>
<td>10.30 – 11.00</td>
<td>Panel 5: How can hospital management be strengthened?</td>
<td>Prof Naoki Ikegami</td>
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<td>Dr Rufino L Macagba</td>
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<td>Prof Jens Mueller</td>
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<td>11.00 – 12.00</td>
<td>Plenary discussion on Panel 5</td>
<td>Ms Laura Hawken</td>
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<td>12.00 – 13.00</td>
<td><strong>LUNCH</strong></td>
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<td>13.00 – 13.30</td>
<td><strong>Panel 6: How should hospital information systems drive improvements in performance and accountability?</strong>&lt;br&gt;- Performance management: How should hospital performance be measured and what might be core performance indicators?&lt;br&gt;- Public health responsibility: What should be hospitals’ public health reporting obligations?&lt;br&gt;- Transparency: Should hospital performance be compared and reported publicly?</td>
<td>Prof Rene Domingo&lt;br&gt;Dr Gabriel Leung&lt;br&gt;Dr Clive Tan</td>
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<tr>
<td>13.30 – 14.30</td>
<td>Plenary discussion on Panel 6</td>
<td>Mr Mark Landry</td>
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<td>14.30 – 15.00</td>
<td><strong>Recap:</strong> Based on discussions in Panels 4, 5, 6 participants to identify up to 3 critical issues to be addressed to improve hospital performance and how this could be achieved.</td>
<td>Exercise: All</td>
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<td>15.00 – 15.30</td>
<td><strong>TEA</strong></td>
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<td>15.30 – 16.00</td>
<td>Way forward and Next steps</td>
<td>Dr Vivian Lin&lt;br&gt;Dr Rasul Baghirov</td>
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<tr>
<td>16.30 – 17.00</td>
<td>Closure</td>
<td>Dr Shin Young-soo (RD)</td>
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Annex 3. Elaboration of the FFROGG Framework

The secretariat examined issues discussed during the consultation. Moving forward, the FFROGG framework is suggested for use by Member States keen to examine their hospital systems.

Financing

Proper design of funding hospital services in the context of financing health systems forms can drive effective governance and deliver effective health-care outputs. Financing encompasses raising and distribution of capital. In raising capital, UHC can be promoted through social insurance or mandated private insurance purchase complemented by out-of-pocket spending at patient level. In the context of hospital management, the collection of capital was not explored in the consultation. With regards to allocating financial resources, the benefit of a contract design tying performance benchmarking is a focus point that it can incentivize hospitals to align with the goals of attaining target health outcomes set by policy goals. A contract is agreed to be a creative and good purist strategy to enforce governance and accountability, which can be achieved by financing around a set of good key performance indicators. The contract also needs to account or manage the interests of different stakeholder groups, including doctors, nurses and administrators.

Regarding financing a system of hospital ownership (private, public or mix) based on performance, there is little reliable evidence as to whether public or private providers are more efficient. The right incentives paired with effective accountability mechanisms in the contract design naturally drive efficiency targets. The need to consider the specific-country context was emphasized again in this context. Often it is easier to allow privatization to attain efficiency and performance goals than to change the legal and regulatory framework of the national hospital system that applies to public institutions because of complexity and time involved. Based on context, it is also a matter of the health-care culture being used to a private or public system.

In development of a hospital management approach the concept of polarity management must be considered. According to this framework, there is no right predetermined decision. Instead effective control is achieved through maximizing the positives and minimizing the negatives within each option.

In the context of financing, this relates to cases of market failure when a contract is not carefully examined and designed. Priority to financing health-care is also a matter of government design. In the case of Japan, a bigger emphasis on primary education than health-care led to the privatized hospitals funded through social insurance. Unsatisfactory coordination between ministries was cited as an example in China, where health-care decisions are made only by the Ministry of Health without consultation with the Ministry of Social Care, resulting in delays in adjustment of financial distribution.

Feedback

Feedback is the critical component by which hospital systems evaluate alignment of operationalization of hospital service, management and financing functions and the ultimate goal of delivering accessible, quality and sustainable (AQS) health care. Feedback is attained through monitoring and evaluation.

Based on the measurement on service outputs and inpatient health outcomes, hospitals can then be better managed through an evolving regulation or through a financing incentive (contract) to ensure safety and quality care. A benchmark is needed to set targets that will effectively drive hospital performance towards achieving national health policy goals and priorities.
A key component of an effective feedback system is a well-designed health information system (HIS). A technological issue on HIS in the Region is the fragmentation of systems, predominantly between hospitals and regulators/payers, and reliance on manual processes that adds to physician burdens. The added effort to collect data, meant that reporting on compliance becomes selective, and is often carried out by lower-level personnel who may not have sufficient knowledge.

There is a tension between reporting of indicators and their utilization. The ease of collecting information overshadows the understanding of how to effectively use the data collected to derive insight into outcomes and to feed best practice into planning. This internal feedback loop is important to drive better management and financing decisions.

The design and maintenance of good indicators is also a focus area. It is often better to have a good, complete and timely reported set of a few basic indicators, than to have too many indicators that are not measured correctly or submitted on time. One underlying theme when discussing this topic is also that information systems are not the same as information technology (IT); IT is an enabler to allow for information systems to be realized.

Feedback is recognized as vital in enhancing transparency and accountability, and as a way to measure and reward performance (or penalize poor care). But caution is needed for proper design of measurement to avoid gaming, where indicators for reward are over-reported and those for penalty are under-reported. For example, when private hospitals are rewarded based on lowering patient mortality, patients are sent to public providers as a way of manipulating the statistics. This unanticipated negative incentive based on how performance is audited and paid, highlights the importance of harmonizing all policy instruments with overarching policy goals.

**Regulation**

Regulation is a key policy instrument that Member States can use to ensure hospitals and hospital systems act consistently with, and in pursuit of overarching policy goals. Regulatory devices include: professional certification; hospital licensing; and hospital accreditation.

*Professional certification* exists in most countries in the Region. However, in most cases certification is a once-off compulsory mechanism to establish minimum standards. Enhancing certification can help to ensure safe practice and to incorporate ongoing training and education of health professionals.

*Hospital licensing* must be implemented in all hospitals to ensure adherence to minimum standards. Undertaking license renewal procedures on a regular basis ensures ongoing compliance with national and international standards of care.

*Hospital accreditation* is often voluntary and the quality and safety standards required often take on a more aspirational perspective. In several countries, accreditation is done by international bodies (examples include the International Organization for Standardization (ISO) and Joint Commission International (JCI)). Voluntary accreditation in some hospital systems in the Region can serve as a quality indicator and market-incentive to encourage competition.

*Complaints management* and incorporation of *patient feedback* into hospital policy also serves as important regulatory devices.
Ownership

Hospital or hospital-system ownership determines the hospital's mission and strongly influences its behavior. Across the Region ownership differs considerably and can be loosely categorized into four archetypes:

1. **Predominantly public**: capital financing of the institution, service provision and, thus, the continuum of care from financing to delivery is the responsibility of the State. Hospital expenditure is incorporated into national health budgets.

2. **Predominantly private**: hospitals are privately owned and compete with other institutions. Here the cost of services is often determined based on market considerations with funding coming from patient out-of-pocket expenditure. There are, however, models in the Region with majority private providers that through social insurance schemes are still funded by the state. A distinction between for-profit and not-for-profit hospitals is also seen in the Region, for example private institutions run by faith-based organizations that are not profit-driven and thus distinct from other private providers.

3. **Mix between public and private**: hospitals, for example, can be financed by the public health system, but the delivery of service can be delegated to private providers.

4. **Ambiguous ownership between private and public**: the hospital system is defined as public, but the hospitals are run in a private manner. In these settings, the regulatory framework is often weak resulting in a system run differently from what was originally intended. Examples provided from the Region including private hospitals in Mongolia that are run as service delivery centers for a public good, and public hospitals in China that are run with a private, profits driven ethos.

Ownership of hospitals and hospitals system should be planned and aligned with the overarching health goals described by the state. The models being used are context-specific and are adapted to fit the environment, but the tension between planning and implementation can create gaps. Therefore, clear differentiation of the roles of both public and private institutions within the system, regardless of the model, is crucial in order to build a proper regulatory and supporting framework that can maintain accountability and measure performance consistent with the stated policy goals.

Governance

There are two process points in the governance of hospitals: between the State and hospital; and within the hospital.

Between States and hospitals ties in closely with the ownership of individual hospitals. Governance refers to the way the State determines the relationship between the degree and nature of hospital autonomy. The degree and nature of hospital autonomy determines the degree of choice and ownership hospitals have in making decisions.

The ownership structure (predominantly public, predominantly private, predominantly mixed and ambiguous mixed) determines many of the instruments used by the State to establish the degree and nature of hospital autonomy, and subsequently the model and level of governance applied to hospitals.

Across the Region, differing ownership structures, and historical and culture contexts have resulted in diverse autonomy structures that have distinct implications for the achievement of policy goals. Harding and Preker’s (2000) model consisting of five components can be used to describe hospital autonomy (Figure 1).
Governments in the Region choose to locate their institutions at some point on each of the axes in Figure 1. These are the levers the State uses to govern hospitals in order to motivate movement towards particular policy goals. If we consider ownership arrangements, and a hospital’s location on each of these axes, we can understand many of the implications that the extrinsic governance structure can have on the achievement of policy goals.

In the Japanese context, with 90% private provision of hospital services, hospitals are largely corporatized with regard to some internal decision rights (hiring/firing, wage setting, capital investments), however they are restricted through a centrally determined fee-structure and global budget limiting overall spending. The effect of this is that both over- and under-provision of services are deterred, while still allowing for market-incentives (namely reputation and branding) to drive competition. Japan also directs this competition by introducing regulation that limits the services that hospitals provide so they do not duplicate activities undertaken in the private system. This approach functions effectively in Japan but may not work in other contexts.

**Hospital management – internal hospital governance**

Good governance within hospitals means more than just having a governance board. Governance both influences and is influenced by the market environment and payment systems. Throughout the consultation, the panel consistently raised the need for hospitals and health systems to build both management and leadership capacity.

There must be management capacity-building away from the designation of authority via hierarchy, professional background, gender and age to a management structure that emphasizes leadership capacity and capabilities. Management training needs to happen earlier on in a career rather than waiting until people are in positions of authority and can no longer invest time or take responsibility to further develop their management competencies.

Various models for building management capacity are available from focusing on critical performance areas to talent identification and recruitment of managers with transferable skills in complex organizations in other sectors. The distinction must also be made between management capacity and leadership capacity and particularly the importance of governance structures in hospitals exercising leadership and not just management skills.
Additional fundamental challenges to good hospital management include the underdevelopment of information systems needed to accurately measure performance as well as resistant authority structures in hospitals.

**Goals: what are the goals of the hospital / hospital system?**

Hospital and hospital system goals should be guided by universal health coverage (UHC) principles of access, quality and sustainability (AQS):

Access to hospital services involves referral and gate-keeping processes and structures between primary health care and hospital systems. Access also relates to cost and affordability of services, especially when considering the difference between public and private providers. At the hospital-system level, access may be influenced by state-level regulations and finance policies.

Quality of care and patient safety are central to national health goals. Hospital systems should explicitly outline their goals for quality of care and patient safety, so that appropriate emphasis can be placed on measuring safety and quality indicators, to have them drive correct behaviors. Technological advances have resulted in the availability of innovative and more complex treatment modalities. Hospitals must ensure that they do not just provide the latest treatment, but that treatments provided are safe and of high quality.

Sustainability of hospital services is particularly relevant when considering the epidemiological shift to chronic and noncommunicable causes of disease and disability. These conditions often require complex, resource-intensive and expensive care. Cost implications and hospital sustainability must be a fixture of best-practice approaches. Establishing and using sound feedback mechanisms can help to ensure the sustainability of hospital services.

Other goals include: financial sustainability; profit; research excellence; and clinical excellence.
Annex 4. Presentations

**Informal Expert Consultation on Hospital Services and Management in the Western Pacific Region**

**Objectives – Expected Outcomes**

1. To review how hospital sector challenges are being addressed in the Western Pacific Region.
2. To identify and prioritize potential areas for intervention and how WHO and its partners could assist Member States with further development or strengthening of the hospital sector.
3. To identify areas for further examination to be undertaken before a formal country consultation.

**6 key questions**

1. What is the place of hospitals in the health system?
2. What are effective mechanisms for hospital governance?
3. What are effective strategies for financing of hospital services?
4. How can quality and safety be ensured and improved?
5. How can hospital management be strengthened?
6. How can hospital information systems drive performance and accountability?

**Panel 1**

- **What is the place of hospitals in the health system?**
  - Planning: How to reconcile population-based planning (system interests) with institutional-based planning (intrinsic interests)?
  - Public Private Mix: How should planning take account of the private sector, or how might private sector development fit into a planning framework?
  - Changing contexts: How does planning take into account community expectations and changing technologies?

**Panel 2**

- **What are effective mechanisms for hospital governance?**
  - Legislation and Regulation: What should the role and responsibilities of hospitals be, and how should they be embodied in legislation?
  - Autonomy: Is hospital autonomy a solution for improving efficiency, responsiveness, and equity?
  - Legal status and ownership: What are successful models of corporatization and corporate governance?

**Panel 3**

- **What are effective strategies for financing hospital services?**
  - Rules and regulations and enforcement: How to ensure public policy objectives and when given hospital financial autonomy?
  - Incentives: How do provider payment methods align with public policy objectives?
  - Managerial and technical capacity: How to improve human capacity and information system for better financial management?
Panel 4
- How can quality and safety be ensured and improved?
  - System architecture: What should be the institutional arrangements for ensuring quality and safety — through independent authorities or via government?
  - System-level strategies: How to improve quality through licensing, accreditation, workforce regulation, complaints management mechanisms?
  - Institutional strategy: What mechanisms within a hospital prevent misuse, underuse or misuse, and encourage practice improvement?

Panel 5
- How can hospital management be strengthened?
  - Management development: How to develop critical hospital management capabilities (workforce, finance, quality, information)?
  - Corporate governance: What are good models for hospital governing body, hospital corporate status, and employment status?
  - Managing service linkages: What systems are effective for ensuring appropriate referral and communications across hospitals and with primary care?

Panel 6
- How can hospital information systems drive performance and accountability?
  - Performance management: How should hospital performance be measured and what might be core performance indicators?
  - Public health responsibility: What should be hospitals' public health reporting obligations?
  - Transparency: Should hospital performance be compared and reported publicly?

Help us deal with the elephant!
WHO strategy on people-centered, integrated health services

Nuria Toro Polanco

Ongoing health services problems

- Access – only 1/3 of people with mental health disorders in HICs receive treatment
- Availability – just 56% of countries have any palliative care program
- Affordability – health services may be too costly
- Equity – problems among and within countries
- Quality of care – 25% of intensive care patients will acquire an infection during their hospital stay

Emerging challenges for health services

- Changing disease patterns
- Multiple morbidities
- Long term & continuous care
- Lack of empowerment of health service users
- Weak engagement of providers with users and communities
- Inappropriate health service delivery models
- Limited coordination across services

A compelling case for change

Health systems transformation

The strategy on People-Centered and Integrated Health Services represents the need for a fundamental paradigm shift in the way health services are funded, managed and delivered in order to better support countries aiming for UHC to do so in a way that can simultaneously improve quality, support financial sustainability and retain responsiveness to citizens, people and communities

Conceptual framework

5 main pillars

1. Empowering and engaging people
2. Strengthening governance and accountability
3. Rerouting the model of care
4. Coordinating services
5. Creating an enabling environment
Future hospital roles

- Hospital part of a coordinated integrated health services delivery network that balances budget allocations across all care settings
- Service substitution and rationalization of care that promotes alternative ambulatory settings and services when appropriate
- To patient services limited to acute conditions that require highly costly and sophisticated infrastructure and services
- Improved coordination with rest of care providers to ensure continuity of care for patients
- Clinical governance with increased focus on quality, safety and person-centred care
- Greater accountability for population health outcomes and clinical results
- Improved efficiency of the delivery system as a whole by shifting patients and resources to more appropriate sites of care
Main points

- Social-economic status
- Decision rights: centralized in human resources, purchasing
- Market exposure: several health insurance schemes by the government
- Residual claimant: strict budget with item control, no right to deal with surplus
- Accountability: Social functions: quality, efficiency?

Laos: HA undergoing without claims

Degree of decision autonomy in public hospitals in Lao PDR

<table>
<thead>
<tr>
<th>Hospital function</th>
<th>Influence</th>
<th>Degree of autonomy</th>
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<tbody>
<tr>
<td>Financial and budgetary</td>
<td>Government budget plus funds from other sources and financial contributions under government control</td>
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<tr>
<td>Human resource management</td>
<td>Government staff employed by government whose salary normally guarantees and who contracts with the hospital</td>
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<tr>
<td>Procurement</td>
<td>Government procurement through centralized procedures</td>
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<tr>
<td>Market access</td>
<td>Limited to publicly owned and non-governmental hospitals and hospitals for non-governmental and non-profit organizations</td>
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<tr>
<td>Residual claimant</td>
<td>Information, accountability, responsibility for management and for hospitals that have a residual claimant</td>
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<tr>
<td>Accountability</td>
<td>Limited to government control, the government's accountability, especially malevolent government, or public hospitals</td>
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<tr>
<td>Social functions</td>
<td>Viable, unaccompanied by residual social functions</td>
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Free hospital autonomy without control

Policy suggestions

- To strengthen the government role with responsibility for setting a national strategic vision on development of public hospitals.
- To reach the common goal, shared responsibility among different functional government authorities, different levels of the government.
- To make use of insurance authorities to monitor healthcare costs, quality, efficiency and access to care.
Policy suggestions

- To establish effective governance structure for public hospitals:
  - External hospital administration authority
  - Internal governing board

- To highlight control of residual claimant and social function by effective governing approaches, including information and intelligence or transparency.

- To invite stakeholders (especially, patients) participation.

- To re-plot or re-implement the separation of public/private or for-profit/non-profit hospitals.
Hospital Reforms

Prof Phua Kai Hong
The Lee Kuan Yew School of Public Policy
National University of Singapore

What is a Hospital?
- "An institution which provides beds, meals, and nursing care for its patients while they undergo medical therapy at the hands of professional physicians," (Milor 1967)
- Ranges from small acute service to long term care facility, from community hospital to nursing home
- Spreads across many buildings or on different sites (multi-site) or merged into one organizational structure
- Activities undertaken beyond its physical boundaries – vertical integration into pre- and post-hospital care (diagnostic and rehabilitative care), linking outreach services ("hospitals without walls", "hospital at home"), day surgeries in free-standing surg-centres, etc.

Characteristics of a Hospital
- The hospital is a complex organization
- Organizational goals are multiple and conflicting
- Professional groups have specialized knowledge and different values
- Different meanings and functions in various settings
- Structural inflexibility and long time frame contrast with rapidly changing environment
- Resistance to change (structural and cultural) – historical antecedents, traditional practices, professional controls, authority and power

The Role and Functions of a Hospital
- Patient Care – inpatient, outpatient and day patient, emergency and elective, rehabilitation
- Teaching – vocational, university and continuing education
- Research – basic, clinical, health services and educational research
- Health systems support – source for referrals, professional leadership, base for outreach activities
- Societal – state legitimacy, political symbol, civic pride, provider of social care, base for medical power
- Economic – labor employment of health professionals, costs and expenditure of resources, revenue/profits

Types of Hospitals
- Levels of care – tertiary (national/regional), secondary (district) and community (local)
- Specialization – general, single or multiple specialty
- Teaching and research (university)
- Ownership – public/government, statutory agency, joint stock company, private (for-profit), voluntary (non-profit), others (charitable, religious, etc.)
- Financing – tax, subsidized/subvented, fee-charging, charitable
- Organization – autonomous, corporatized, privatized

Types of Hospital Ownership
- Public/Government
  - Federal/national
  - Regional/provincial/state
  - Local government/municipal
- Statutory Agency
  - Hospital authority/corporation/board
  - Social security organization
- Bureaucratic administrative system with budgetary allocation from taxation
Types of Hospital Ownership

Private (for-profit/proprietary)
- Sole proprietorship eg. solo general practice
- Partnership eg. medical group practice
- Limited company eg. doctor-owned/shareholders
- Listed company eg. hospital chains and multinational corporations, public shareholders

Subject to company laws and personal income/corporate taxes

Types of Hospital Ownership

Voluntary (non-profit/charitable)
- Religious organization
- Civic organization
- Employment-related (company/union)
- Cooperative organization
- Community-supported

Usually tax-exempt and subsidized by the government or public fund-raising

Hospital Legislation

General – applicable to all hospitals
Specific – applicable to public/private teaching and research/tertiary
Powers of decision and control – centralized or coordinated by ministries of health/hospital authorities
- Decentralized to local authorities or hospital boards
- Employment terms and conditions
- Salaries and other remuneration, staff benefits
- Financing and payment systems
- Pricing, revenue retention, cost-recoupment, subsidies

Regulation of Hospital Standards

Hospital Licensing
- Standards of hospital construction and operation – physical environment, facilities, sanitation, safety and hazards protection, etc
- Medical staffing and qualifications
- Certificate of need (national health planning and resource development legislation)
- Voluntary accreditation
- Quality certification (eg. ISO)
- Quality of care (JCAHO)

Regulation of Hospital Quality

U.S. example – Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)
- Efficacy
- Effectiveness
- Efficiency
- Appropriateness
- Availability
- Continuity
- Respect and Caring
- Safety
- Timeliness

Organizational Reforms in Hospitals

Governance – ownership and control by hospital board of directors (responsibilities and powers), policies, rules and regulations
- Management – professional hospital administration, separation of clinical from executive functions, business methods
- Human resource – personnel functions, terms & conditions, contractual agreements, performance and incentives
- Financing – taxes, subsidies and pricing, costing and payment methods
**Organizational Modalities in Hospital Reforms**

- **Budgetary Units**
  - Decision rights: Vertical hierarchy
  - Residual claimant: Public funding
  - Market exposure: None, direct budget allocation
  - Accountability: Total ownership and control of government
  - Social functions: Delivered under unspecified, untended mandate

- **Autonomous Unit**
  - Decision rights: Some shifted to management
  - Residual claimant: Public funding, retention of efficiency gains
  - Market exposure: Mainly budgetary, some based on performance
  - Accountability: Mainly through hierarchical control
  - Social functions: Delivered under unspecified, untended mandate

- ** Corporatized Unit**
  - Decision rights: More control to management
  - Residual claimant: Retention of efficiency gains, some limits on use
  - Market exposure: Less budget allocation, more revenue from fees
  - Accountability: Ownership, funding, payment and regulatory
  - Social functions: Largely purchased or funded directly

- **Privatized Unit**
  - Decision rights: Totally removed from hierarchy
  - Residual claimant: Private owner or organization
  - Market exposure: Total
  - Accountability: Funding, purchasing and regulation
  - Social functions: Only purchased or some subsidy
Organizational Incentives for Hospital Reform
- Decision rights
- Market exposure
- Residual claimant
- Accountability
- Social functions

Public-Private Participation in Health Care
- Public Roles
  - Provision
  - Financing
    - tax subsidies
    - user fees
  - Regulation
  - Information
- Private Roles
  - Contracts
  - Cost-sharing
  - Prices
  - Profits
  - Deregulation
  - Marketing

World Bank Study of Organizational Reform of Public Hospitals
Preker and Harding (eds), 2002
<table>
<thead>
<tr>
<th>Budgetary</th>
<th>Autonomized</th>
<th>Corporatized</th>
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<td>New Zealand</td>
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<tr>
<td></td>
<td>Tunisia</td>
<td>Kenya</td>
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</tbody>
</table>

World Bank Study of Organizational Reform of Public Hospitals – Successful Characteristics
- Concurrent incentive regime
- Covered all critical elements
  - Human resource
  - Financing
- Complementary reforms
  - Stewardship
  - Good governance
  - Performance-based purchasing
  - Functioning markets
  - Information
Panel 3

• What are effective strategies for financing of hospital services?
  – Rules and regulations and enforcement: How to ensure public policy objectives when given hospital financial autonomy?
  – Incentives: How provider payment methods are aligned with public policy objectives?
  – Managerial and technical capacity: how to improve human capacity and information system for better financial management?

Panel 3: What are effective strategies for financing of hospital services?

Public policy goals
• Equity in access
• Quality of services
• System efficiency
• Sustainability

Institution and mechanisms
• Rules and legislations
• Inspection (auditing) and enforcement
• Incentives (payment methods)
• Accountability mechanism

Hospital financial autonomy
• Income: retention of user fee revenue;
• Expenditure: use of revenue from user fees and insurance payment; optimal production function; procurement of medicines and supplies;
• Capital investment: mobilize private funding;
• Staff salary and bonus;
• .............
Panel 3: What are effective strategies for financing of hospital services?

Bernard F. Cuatrecasas, MD

HFA framework

Components: HFA framework

HFA elements and links

Framework for hospital performance

Rules and regulations and enforcement

- How to ensure public policy objectives given financial autonomy?
  - Appropriate regulatory framework
  - Clear governance structure and mechanisms (e.g., board)
  - Contracting with clearly specified public objectives and explicit funding
  - Strong IS to support contract monitoring and enforcement
  - Strong capacity for contracting, M&E, at central/ regional level

Incentives structure

- How PPMs are aligned with public policy objectives?
  - PPMs are not intrinsically aligned with public objectives
  - Need to include explicit incentives to protect/enforce them
  - Link provider remuneration to performance, including achievement of public policy objectives
  - Include clear (performance) indicators
  - Do not focus on HFA as self-financing alone
Managerial and technical capacity

- How to improve human capacity and information system for better financial management?
  - Strong M&E capacity at central/regional level
  - Strengthen capacity for resource management, HIS, M&E at facility level – eg. include indicators on information quality & reporting
  - Focus of HIS should be on measuring/monitoring/evaluating performance, not just reporting activities
  - Appropriate indicators to actually measure performance (not means), used in contracting

Example from Brazil: the Social Organizations model

<table>
<thead>
<tr>
<th>Area</th>
<th>Main Features</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership</td>
<td>Public</td>
<td></td>
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<tr>
<td>Management</td>
<td>Private (Non-profit)</td>
<td>Management contract</td>
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<tr>
<td>MMM</td>
<td>Global budget linked to performance; withheld</td>
<td></td>
</tr>
<tr>
<td>Decision rules</td>
<td>High (linked by social function)</td>
<td></td>
</tr>
<tr>
<td>Market presence</td>
<td>Moderate (Budget financed)</td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>High</td>
<td>Surplus/private revenue</td>
</tr>
<tr>
<td>Accountability</td>
<td>High, through performance contract</td>
<td>Strengthened supervision &amp; M&amp;E</td>
</tr>
<tr>
<td>Social function</td>
<td>High, capital</td>
<td>Policies and decisions set by regional health authority, capable of monitoring</td>
</tr>
</tbody>
</table>
How can quality and safety be ensured and improved?

Panel 4
- How can quality and safety be ensured and improved?
  - System architecture: What should be the institutional arrangements for assuring quality and safety — through independent authorities or via government?
  - System level strategies: How to improve quality through licensing, accreditation, work force regulation, complaints management mechanisms?
  - Institutional strategy: What mechanisms within a hospital prevent misuse, underuse or misuse, and encourage practice improvement?

System architecture

HA as an Educational Process
- Not an Inspection
- Core Concepts:
  - Flexible, context oriented
  - System approach, integration
  - Positive approach
  - Evaluation & multiple improvement
  - Special character of healthcare: uncertainty, autonomy & accountability

Accreditation
- Philosophy: learning, positive reinforcement
- Value: external peer review & recognition
- Structure: depend on the country's context
- Autonomous with government support
- Able to cover both public & private sector
- Either MOH or independent body would work
Lesson Learned from Thailand

- Create inspiration from within, story telling or narrative medicine makes people realize their value
- Quality tools is essential as a basic for improvement
- Core values is difficult to understand, but make effective & sustainable improvement
- Balance of everything, e.g. system & culture, process & outcome
- Stepwise recognition works
- Keep on moving to sustain momentum
- Documentation may draw staff from patients
- Optimal financial incentive is important
- Working with physicians: don’t tell, just ask

Some Key Success Factors

- Make it easy and fun for everyone
- Go together, don’t left someone behind
- Don’t hurry to use pass/fail decision, use appreciation at the beginning
- Use peer assist (e.g. local hospitals visit each other) and sharing
- Integrate all concepts and tool of improvement into practice
Informal Expert Consultation on Hospital Services and Management in the Western Pacific Region

World Health Organization

HOW CAN QUALITY & SAFETY BE ENSURED AND IMPROVED?

Dr. Jacob Thomas
President, Association of Private Hospitals of Malaysia
Chairman, Ramsay Sime Darby Health Care

ASSURING QUALITY

Advanced Medical Care

DELIVERY

Both the public and private sectors are important players in Malaysia's healthcare delivery system.

The Malaysian healthcare system, which evolved from the colonial legacy of Britain, is today of International Standards

PUBLIC DELIVERY

70 per cent of healthcare services is in the public sector and is heavily subsidized by the government.

From Rural Care...
...To Modern Paperless Hospitals

The Private Sector
The private sector (30%) offers mainly curative and rehabilitative services, and is financed strictly on a fee-for-service basis.

Our first step in benchmarking....

AWARDS

1995 & 96

1998

1999

2000

2000

2002

2003

2004

2006

Awards
India Medical Excellence Award
Awards
Prime Minister\'s Quality Award
Awards
Schengen QMEA Award
Awards
IQM Quality Award
Awards
NPC Productivity Award
Awards
International Arts Pacific Quality Award
Awards
Stone Derby Quality Merit Award
Awards
Prime Minister\'s Quality Award
Awards
Stone Derby Quality Premier Award

Benchmark
to continually improve
STANDARDS

- Standards (accreditation) are most important when it comes to Quality healthcare.

- Malaysian Hospitals subscribe to the Hospital Accreditation Standards prescribed by The Malaysian Society of Quality in Health (MSQH) (initiated by private hospitals with ACCS support)

- MSQH is an accredited member of the International Society for Quality in Healthcare (ISQua).

- ISQua comprises of representatives from WHO, World Bank, the International Hospital Federation (IHF) and National Accreditation bodies from the US, Canada, Australia, France, UK, Spain, Japan, Finland, Netherlands, Malaysia, South Africa

Vision for Health

A Nation Working Together for Better Health
GOVERNMENT REGULATIONS

Annual Hospital License
Private Healthcare Facilities and Services Act 1998
(Grievance Procedure)
National Specialist Register

GOVERNMENT SUPPORT FOR QUALITY

Hospital Accreditation is currently Voluntary. But the government encourages it by giving:
Tax rebate for amount spent on achieving International Hospital Accreditation

Safety in Hospitals

SARS!
H1N1!

Stringent infection control
“Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous.”
Sir Cyril Chetlet, former Dean Guy’s, King and St. Thomas Medical and Dental school, Lancet 1999

The Rationale for Improving Quality and Patient Safety

The 99.9% Error Rule
- 4000 families per year would leave the hospital with the wrong baby
- 70,000 patients per year would experience wrong site, procedure, patient surgery
- 126,000 missing seat belts per year
- 20,000 computer circuits would not work
- 382 times more air traffic fatalities

To Err is Human

- “Human beings, by their nature, make mistakes, therefore, it is unreasonable to expect error-free human performance.”
- Human error implicated in 60-80% of accidents in aviation and other complex systems
- Causes of errors:
  - Those attributed solely to environmental/mechanical factors greatly reduced
  - Those attributed to human error continue to plague health care

What is a Culture of Safety?

An integrated pattern of individual and organizational behavior, based upon shared beliefs and values, that continuously seeks to minimize patient harm related to high risk processes for delivering care


“People are often afraid to talk to their leaders about problems they encounter, and this fear keeps dysfunctional processes in place. But everyone has the power to impact patient safety. If health executives can build trust with their staff, and encourage them to offer clinical feedback where it’s needed, the hospital will become a much safer place.”

- John Nance, author, Air Force aviator, and former professional pilot

Culture of Silence to a Culture of Safety
Patient safety culture must address

...that healthcare has failed to produce significant patient safety improvement because we have failed to change the culture.

How to Create a Culture of Safety

Basic Organizational Functions
- Leadership engagement
- A culture of learning
- System-based thinking and process-oriented improvement
- Accreditation (JCAHO,MSOH)
- Robust performance improvement

Disturbing Realities

- Doctors are well prepared in the science-base of medicine
- Doctors are well prepared in the skills necessary to care for individual patients
- Few are qualified or trained with the skills to improve care and improve patient safety

Joint Commission International

- Designated as a WHO Collaborating Center for Patient Safety Solutions
- Researches, develops, tests and disseminates solutions to patient safety concerns
- Resources free and available on web site at www.ccforpatientsafety.org

Culture of Patient Safety; Role of Leadership

“Leaders must make quality a core strategy of the organization. That’s probably the most important barrier that must be addressed—a mindset change from “Quality is the job of the quality department” to...

“Quality and patient safety must be a core operational strategy of every executive...”

James Robertson, M.D.

Role of leadership

Create a culture for change
- Non-blaming environment (Just Culture)
- Transparent communication
- Team-based engagement
- Staff empowerment
- Focus on process not people
Patient Safety Council of Malaysia

- Chaired by the Director General of Health
- Aims to Ensure a Safe Healthcare system (sets National Patient Safety Goals)
- Involves MOH, Universities, Private Hospitals, MSON, APHM, MMA, Academy of Medicine, Medical Council
- Meets at least twice a year

Patient Safety Council of Malaysia

The MOH and the Patient Safety Council of Malaysia are committed to the establishment of a safe Malaysian healthcare system. The PATIENT SAFETY COUNCIL OF MALAYSIA aims to:
- Develop National Patient Safety Goals,
- including monitoring and evaluating achievements and progress in attaining targets set for the relevant indicators.

IPSG (WHO)

Summary
5 Steps To Success
1. Keep things simple and clear
2. Consider data your best friend
3. Presume change and manage it
4. Practice the process
5. Set staff expectations

THANK YOU
Complexity & weaknesses of hospital systems

1. Fragmentation of systems
2. Distortions in policies
3. Misallocation of resources
4. Ambiguity of standards
5. Reactive approach

Hospitals and fragmented systems

Root causes
- Low state funding of hospitals
- Poor hospital planning
- Lack of facilities & beds
- Autonomy issues
- Low funding of primary level
- Poor reengineering

1. Fragmented hospital levels
2. Disconnected hospital information systems
3. Over/under regulation
4. Multiplicity of governance

Hospitals and distortion in policies

Root causes
- Low state funding of hospital
- Poor hospital planning
- Lack of facilities & beds
- Autonomy issues
- Low funding of primary level
- Poor reengineering

1. Contracting financing and reimbursement schemes
2. Misguided autonomy policies
3. Contracting licensing and accreditation policies
4. Politicalized hospital policy making

Hospitals & misallocation of resources
Hospitals & misallocation of resources

Root causes Immediate causes Consequences

1. Maldistribution of hospital facilities and supplies
2. Maldistribution of health care workers
3. Inappropriate patient load
4. Misuse of hospital resources

Hospitals and ambiguity of standards

Root causes Immediate causes

1. Lack of quality, and safety standards
2. Unclear hospital financing criteria
3. Inadequate health worker skill standards
4. Lack of hospital information standards

Hospital reactive approaches

Root causes Immediate causes

1. Reactive quality and safety policies
2. Ad hoc capacity planning
3. Unsystematic cost reduction
4. Lack of disaster preparedness

Consequences of hospital complexities

<table>
<thead>
<tr>
<th>Patient</th>
<th>Hospital</th>
<th>Health service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor quality</td>
<td>Overcrowding</td>
<td>Discontinuity of care</td>
</tr>
<tr>
<td>Lower safety</td>
<td>Inefficiency</td>
<td>System-wide inefficiencies</td>
</tr>
<tr>
<td>Higher OOP</td>
<td>Poor staff retention</td>
<td>Fund deficits</td>
</tr>
<tr>
<td>Inequity</td>
<td>Poor image</td>
<td>Poor quality and outcomes</td>
</tr>
</tbody>
</table>

Next slide
Ownership of Hospitals

Types of Ownership:
- Public hospital
- Central government owned
- Local government owned
- State enterprises
- Joint-stock companies
- Private non-for-profit
- Private-for-profit

Freedom & Obligations:
- Legal status
- Rules and regulations
- Tax liability
- Allocation & use of profit

Hospital Autonomy involves ...
- Managers managing
  - Hospital autonomy can be defined as a reduction in direct government control over public hospitals, and a shift of day-to-day decision making to the hospital management teams and
- Government governing
  - Providing leadership
  - Steering and coordinating at the system level
  - Providing system-wide integration and regulation
  - Supervision

Dimensions of hospital autonomy
- Financial:
  - Income: service fees, revenue retention, borrowing, joint-venture
  - Expenditure: choices, processes & controls on spending
  - Accounting and internal auditing
- Capital investment: big equipment, buildings...
- Procurement: medicines, supplies, contracted services
- Organizational arrangement: departments, supporting services, logistic services
- Human resources: positions, hiring/firing, salaries/incentives, career development
- Quality of services: system, recording, reporting, responses
- Monitoring and evaluation: collection and use of information

Continuum of governance strategies

Hospital Autonomy ≠ Public-Private-Partnership
- PPP: collaboration with private sector where the public health system is not immediately able to provide guarantee
- PPP covers a diversity of arrangements from small single product collaborations to large multi-entities involvement
- Contract-in, contract-out, capital investment, training ...
- PPPs are beyond hospitals
- Mutual benefit is the starting point in exploring PPP
- Public sector needs to assess both long-term and short-term impact before engaging in PPP

Why do countries give autonomy to public hospitals?
Context of Hospital Autonomy

- Overall economic and public sector reform
- Fiscal and political decentralization
- Increasing population aging & high cost technologies
- Limited government budget
- Hospital inefficiency
- Lack of incentives
- Lack of flexibility to react to population needs
- Incoherent with other health system reform, e.g., payment through health insurance and performance-based financing

Hospital Governance Features

- Policies
  - Public, institutional management system
  - Accountability
- Decisions
  - Structure
  - Authority over resources
- Management capacities
  - Professional management
  - Use of information
  - Leadership
- External environment
  - Integration & efficiency
  - Quality & responsiveness

International Practices – Asia

- **China**
  - Public hospitals enjoy a wide range of autonomy, but control measures are lacking
  - Hospitals contribute to rapid increase of health expenditure; Public hospital reform aims to help improve this situation
- **Vietnam**
  - Larger hospitals have more autonomy than smaller hospitals
  - Lack of control measures, but more attention now to balance autonomy and cost control
- **Mongolia**
  - Lack of needed autonomy to respond to incentives set by insurance payments
  - Reforms are on going with piloting

Are We Ready?
What Kind of Autonomy?
What kind control measures?
With what potential impacts?

Happy discussions!
Improving Hospital Management and Hospital Design in the Western Pacific Region
Nov 5, 2014
By Rufino L. Macagba, MD, MPH
Chairman and President
Loma Medical Center, Philippines
www.loma.org

Ideas from 50 years of management development experience and visits to 75 countries

Fifty years ago, I was a trained general surgeon who assumed leadership of a 50 bed hospital founded by my physician parents.

- I had no training in management.
- But I wanted the hospital to last beyond my lifetime.
- I decided that I needed to develop management skills to attain this objective.

• I started reading hospital administration literature.
• I did not find them very useful (in the 60's).
- I invited 2 professors from the Asian Institute of Management to spend 5 days visiting my hospital.
- They taught me two things that I still use up to this day.

1. Rotate the chairmanship of meetings
2. Focus on the critical few and the trivial many (20/80 principle)

I started reading Peter Drucker and other management authors.

Monthly Leadership Forum
Two co-chairs rotate monthly

From Peter Drucker:
What do you think of as a manager?
CRITICAL PERFORMANCE AREAS in Management
1. Customers: People you serve
2. Human resources: (managers, professionals and workers)
3. Material resources: (facilities, equipment, tools, supplies)
4. Financial resources: (income, expenditures)
5. Efficiency and productivity (systems, procedures)
6. Outside relationships and environment
7. Innovations / Continuous improvement

The Louis Allen 5-day Workshop
On the Profession of Management
P – Q – L – C / Technical work

Modified 5-day Management Workshop
Management tasks and activities

LEADERSHIP
Toyota Motor Company in most countries can arrange for training of hospital staff to increase their efficiency and effectiveness.

Asian Institute of Management
- Open enrollment programs offer high-impact learning in three days to six weeks. As a participant, you will be able to immediately translate what you have learned back to the workplace.
- Custom Programs meet specific corporate needs and challenges. AIM works closely with companies to develop and deliver results-oriented solutions.

Poor countries in the world today have access to the Internet – they can access the latest developments in the field of health.

“The explosion of advanced technologies means that suddenly knowledge pools and resources have connected all over the planet, leveling the playing field as never before, in such a way that potentially an equal - and competitor - of the other.”

The Philippines is a poor country in Asia ranking no. 130 in the IMF Ranking of 182 countries in the World

Comparative annual GDP per capita (2013):

<table>
<thead>
<tr>
<th>Country</th>
<th>GDP (US$)</th>
<th>Rank</th>
</tr>
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<td>African Republic</td>
<td>$690</td>
<td>No. 182</td>
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<tr>
<td>Philippines</td>
<td>$4,600</td>
<td>No. 130</td>
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<tr>
<td>Italy</td>
<td>$34,500</td>
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<td>France</td>
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<tr>
<td>(Highest) Qatar</td>
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</tbody>
</table>
A hospital that serves the rich and the poor
Lorma Medical Center, Inc.,
San Fernando City, Luzon, Philippines

New developments in Hospital Design and Hospital Management

- A growing movement in US hospitals adopts the Toyota management principles and methods.
- Toyota is number one in the world in car manufacturing, and its management system publications are available on-line from Amazon.com.
- The Toyota or “Lean” Management System reduces waste and operating costs, improves efficiency and effectiveness.

Lean-led Hospital Design

- This is the most exciting new development in hospital design following the “Lean Design” principles of the Toyota.
- The authors report that Virginia Mason Hospital in Seattle, Washington, USA saved millions of dollars after 2 years without laying off staff, solely from elimination waste from its system.

In the Philippines, our new 40,000 sq. ft. annex under construction is using the Lean approach

The trend from doctor centered to patient-centered hospital management

- Doctor-centered hospitals have been the norm, often at the expense of patients and the public.
- Increasing competition for patients has caused a shift to customer-focus prevalent in business organizations.
- Hospital leaders are also learning the healing benefits of patient-centered management on their patients.
Power of the Human Mind

It is now well documented that a positive mental state actually helps the recovery of patients.


The Planetree Movement

- Started in San Francisco. It promotes architectural, environmental and patient care initiatives that promote healing.
- Includes a restful, beautiful environment, natural light, plants, water features, restful music, caring staff, and participation of the family in compassionate care.
- There are now over 13 Planetree affiliated hospitals in the world, including our hospital in the Philippines.

Architecture and Patient Safety

- Standardize patient rooms to prevent falls with hand rails and proper location (same side as the bed) when they go to the bathroom.
- Other features that promote safety:
  - Slip-proof floors
  - Hand rails in hallways and bathrooms, ramps
  - Places for hand washing and hand disinfection throughout the hospital.

Traditional priority domains in hospital design and construction

Preplanning stage
a. Decisions on location, type and size of facility
b. Preliminary discussions by stakeholders
c. Involvement of frontline workers in affected departments

Development of preliminary plans
a. Master plan of future state to allow continuous improvements to take place
b. Multidisciplinary teams use simple models to design how their workflow can be better in the new facility

Toyota or Lean Management System

- Focus on the process of achieving goals.
- Training on the Lean Approach
- Time spent at the worktable to observe where improvements can take place
- Focus on Process improvements:
  - Eliminate waste, such as avoiding too much inventory, reducing number of steps at a time, waiting time, etc.
  - Visual control, to know when something is missing, materials are available when needed, a place for everything and everything in its place, etc.
  - Mirrors perform the procedures to avoid harm or waste
- Frontline workers solve many of the problems themselves
Information/Communication Center

A Key Feature of Lorma Service
Patients' calls are answered in 7 seconds

In-patient calls are answered in 7 seconds (ave.)
Operator has access to intercoms, telephones, paging system and two-way radios.

Only what is needed goes to the patient's room

Welcoming environment:
architecture, interior design, natural light, plants
All suites have 24-hour Internet and Cable TV

Suites have cable TV, DVD player and 24-hour internet included in room rate

Integrated computer system developed in-house serves all departments

The first completely computerized hospital in the Philippines

Out-patient Registration

Corporate services department

Outreach to companies and homes
Endoscopy and minimally invasive surgery

Pass-over patient transfer ledge in OR
Adopted from a New Zealand hospital

Doctor-family meeting room in OR
A Loma innovation

Busy 17-bed Dialysis Center
Separate infectious section has 3 shifts per day
Kidney transplants now available

Ceiling view in MRI room

Loma made systems save money
Piped in oxygen and suction
to OR, ICU, ER and private rooms
Lorma-made headboard
with central oxygen and suction outlets, call button, intercom and telephone

Well-equipped Engineering and Maintenance keeps things running and expenses down

Engineering and Maintenance Department
help in construction projects and keep things running

1. Biomedical/electronic communication and electrical systems maintenance
2. Computer and IT systems maintenance
3. Air conditioning maintenance
4. Welding, Carpentry, Upholstery and Plumbing Sections

Integrative Medicine
Wellness and Integrative Medicine Center

Combines Western with Alternative and Restorative Approaches

Standardized ICU
private room
Family area with bed is standard

ICU PATIENT ROOM FLOOR PLAN
Summary (1)

How do you develop hospital management skills?
1. Management books and publications
2. Visits to other hospitals
3. Relevant workshops and conferences
4. On-line courses (executive MBA, etc)
5. Degree in hospital administration
6. WPFO continuing education on line?

Summary (2)

The book, “Lean-Led Hospital Design: Creating the Efficient Hospital of the Future”, by Naidus Grunden and Charles Haygood, 2012, is the most exciting new development in hospital design that can reduce waste and costs, improve efficiency and effectiveness.

Business and industry, especially the Lean Management System of Toyota has a lot to teach hospitals leaders about management.
Summary (3)
Hospital leaders are learning the healing benefits of patient-centered management on their patients.

It is now well documented that a positive mental state actually helps the recovery of patients.
The Planetree movement started in San Francisco some years ago promotes architectural, environmental and patient care initiatives that promote healing.

The Planetree concept includes:
A restful and beautiful environment, natural light, paintings, plants, water features, restful music, caring staff, and participation of the family in compassionate care.

Summary (3)
The New Lean (Toyota) approach to hospital design:
1. Involve frontline workers in Master Planning the future state of the hospital that will allow continuous improvements.
2. Multidisciplinary teams use simple models to improve their work flow and work area in the new facility.
3. The architectural plans reflect the concepts from the frontline workers.

End
Panel 6 - Prof. Rene T. Domingo

• How can hospital information systems drive performance and accountability?
• Performance management: How should hospital performance be measured and what might be core performance indicators?
• Public health responsibility: What should be hospitals' public health reporting obligations?
• Transparency: Should hospital performance be compared and reported publicly?

HIS Challenges in Western Pacific

1. heavy reliance on manual methods
2. fragmented, incompatible systems within and across hospitals and regulators
3. inadequate software and hardware
4. lack of qualified personnel
5. poor connectivity
6. case-based rather than patient-based
7. not used to improve quality and safety
8. low, selective reporting compliance to regulators

Performance Measurement Challenges in Western Pacific

1. basically input and resource based, with few metrics on process efficiency and outcomes
2. conflicting performance metrics (state, social insurance)
3. weak, voluntary accreditation
4. under and over-reporting of statistics and revenues

Conditions for effective HIS, PMS

1. right metrics
2. right infrastructure
3. right remuneration or incentives
4. use for performance improvement or planning

<table>
<thead>
<tr>
<th>KEY HOSPITAL INDICATOR</th>
<th>PHILIPPINES</th>
<th>VIETNAM</th>
<th>MONGOLIA</th>
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<td>48%</td>
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<td>TERTIARY HOSPITAL AVERAGE BED CAPACITY</td>
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<tr>
<td>PUBLIC HOSPITALS (%) of Total</td>
<td>42% (50%)</td>
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<td>PRIVATE HOSPITALS (%) of Total</td>
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<td>PRIMARY HOSPITALS (%) of Total</td>
<td>80% (50%)</td>
<td>85% (66%)</td>
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CAPITAL CITY HOSPITALS (% of Total)

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<thead>
<tr>
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<th>PHILIPPINES</th>
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<tr>
<td>METRO-NAPOLI</td>
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<td>HANOL KOR</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>UB</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
</tr>
<tr>
<td>Key Hospital Indicator</td>
<td>Philippines</td>
<td>Vietnam</td>
<td>Mongolia</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>Number of Managed Hospitals (HEDS - % of Total)</td>
<td>4% (21%)</td>
<td>4% (33%)</td>
<td>4% (33%)</td>
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<tr>
<td>% of State Health Budget for Hospitals</td>
<td>0%</td>
<td>30%</td>
<td>75%</td>
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<tr>
<td>Public Health Exp. (% of Total Gen. Expenditure)</td>
<td>8.7%</td>
<td>3.7%</td>
<td>9%</td>
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<tr>
<td>Public Health Exp. (% of GDP)</td>
<td>1.3%</td>
<td>2.8%</td>
<td>3.5%</td>
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**Percentage of Medical Personnel**

<table>
<thead>
<tr>
<th>Key Hospital Indicator</th>
<th>Philippines</th>
<th>Vietnam</th>
<th>Mongolia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds per 1000 Population</td>
<td>2.0</td>
<td>2.2</td>
<td>3.5</td>
</tr>
<tr>
<td>Doctors per 1000 Population</td>
<td>2.2</td>
<td>0.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Average Bed Occupancy</td>
<td>77%</td>
<td>13%</td>
<td>80%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>5 Days</td>
<td>7 Days</td>
<td>8 Days</td>
</tr>
<tr>
<td>Average Access to Health Facility</td>
<td>35 Minutes</td>
<td>50 Minutes</td>
<td>24 Days</td>
</tr>
<tr>
<td>Hospital Accreditation Rate</td>
<td>82%</td>
<td>0%</td>
<td>78%</td>
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</tbody>
</table>
Panel 6: How should hospital information systems drive improvements in performance and accountability?

Dr. Claire Tan
clinervan@gmail.com

Improvements in Performance & Accountability: Why?

<table>
<thead>
<tr>
<th>Asia Pacific EMR Adoption Model™</th>
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<tbody>
<tr>
<td>Stage</td>
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<tr>
<td>-------</td>
</tr>
<tr>
<td>Stage 1</td>
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<td>Stage 2</td>
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<tr>
<td>Stage 3</td>
</tr>
<tr>
<td>Stage 4</td>
</tr>
<tr>
<td>Stage 5</td>
</tr>
</tbody>
</table>

Big data and analytics
Performance reports
Regulatory
Upgrading
Fusion: Revenue & Transport
Building in reality / target-to-Process monitoring
Communicating electronically
Data mining
Managing electronically
Send and retrieve electronically

Improvements in Performance & Accountability: How?

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>EMR integration and deployment, with IT support and training</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Implementation and training, with IT support and training</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Rollout of EMR modules, with IT support and training</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Full implementation of EMR modules, with IT support and training</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Performance and accountability measures, with IT support and training</td>
</tr>
</tbody>
</table>

Improvements in Performance & Accountability: But!

Performance
Trust
Transparency
Governance
Accountability

What to measure?

Reporting Performance

<table>
<thead>
<tr>
<th>What to measure?</th>
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<tbody>
<tr>
<td>Stage 1</td>
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<tr>
<td>Stage 2</td>
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<tr>
<td>Stage 3</td>
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<td>Stage 4</td>
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<td>Stage 5</td>
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