

# Better Hospitals, Better Health Systems, Better Health

A Proposal for a Global Hospital Collaborative  
for Emerging Economies

Report of the Center for Global Development  
Hospitals for Health Working Group



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# Acknowledgments

This document is the final report of the Hospitals for Health Working Group, chaired by Amanda Glassman in collaboration with Gerard La Forgia and Maureen Lewis. It was written by a team at the Center for Global Development, including Rachel Silverman, Amanda Glassman, Yuna Sakuma, Kate McQueston, and Jenny Ottenhoff. The report also draws on background papers prepared by Maureen Lewis, Anna Bonfert, Michael Erickson, Shawn Magnusson, Sarah Mintz, Elizabeth Nardi, and Wouter Takkenberg. Contributions from Eric de Roodenbeke, Joseph Ichter, Gary Filerman, Jack Langenbrunner, Joseph Rhatigan, and Juan Pablo Uribe are particularly appreciated. All errors and omissions are our own.



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# Preface

Hospitals are central to building and maintaining healthy populations around the world. They often serve as the first point of access for acute care, offer access to specialist treatment, and influence standards for national health systems at large. Despite their centrality, however, hospital policy has remained a fringe issue on the global agenda for health systems strengthening, with most national and global policymakers instead focused on access to primary healthcare and the control of specific diseases. Only a small minority of hospitals in emerging economies<sup>1</sup>—mostly private facilities serving higher income groups—meet global standards. Still, even low-performing hospital systems require significant resources, consuming up to 70 percent of government health budgets.

Both public and private payers are seeking greater value for money from their investments in hospitals—yet emerging economies have only scant evidence on how they can improve the efficiency, safety, effectiveness, and impact of hospital care. While Organisation for Economic Co-operation and Development (OECD) countries offer relevant experience, more attention to fundamentals is needed before OECD innovations can be adopted at scale in most low- and middle-income countries.

During 2014, the Center for Global Development (CGD)—a think tank based in Washington, DC—convened the Hospitals for Health Working Group to consider performance gaps in emerging-market hospitals and to brainstorm constructive recommendations for a path forward. This report reflects the expertise, experience, and deliberations of Working Group members—experts in hospital management, health economics, and health policy.

Recognizing that emerging-market hospitals are underserved by existing knowledge sharing and evidence-generating institutions, the Working Group recommends establishment of a Global Hospital Collaborative (‘the Collaborative’ or GHC)—that is, a network of individuals and institutions dedicated to fostering improved policymaking, investment, and management for emerging-economy hospitals. The Working Group also helped shape its proposed strategic vision: to improve hospital performance in emerging economies while strengthening integration of hospitals into the broader health delivery system.

With the global community mobilizing to achieve universal health coverage, adequate, efficient, and evidence-based investments in hospitals must be a cornerstone of efforts to build sustainable and effective health systems. For those aiming to improve population health, the role and performance of hospitals can no longer be ignored.

Amanda Glassman  
Chair, Hospitals for Health Working Group  
Director of Global Health Policy, Vice President for Programs, and Senior Fellow  
Center for Global Development

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1. Throughout this report, emerging economies refers to low- and middle-income countries as well as a subset of high-income countries or regions therein where lingering hospital-sector performance gaps require greater policy attention.



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# Fast Facts on the Proposed Global Hospital Collaborative

## Why hospitals?

- Hospitals are necessary for the provision of emergency and specialist care, and thus an essential component of universal health coverage.
- Though data are poor, existing evidence suggests that many emerging-market hospitals have significant performance gaps, compromising patient safety and the efficiency and effectiveness of care.
- In many countries, the hospital sector is a leading driver of overall health expenditure, sometimes consuming up to 70 percent of government health budgets.
- Yet despite hospitals' centrality and importance in low- and middle-income countries, the external global health community provides them with scant technical support, financial resources, or policy prioritization.

## Why now?

- Epidemiological and demographic conditions are changing rapidly; most emerging-economy hospitals are unprepared to coordinate with the broader delivery system and address challenges related to noncommunicable diseases and aging populations.
- Many emerging-economy hospitals are ill equipped to provide emergency care and treat the critically ill during a crisis, as demonstrated by the Ebola outbreak in West Africa.
- Despite the increasing needs for hospital-based care, many emerging-market hospitals are costly and inefficient—stretching health system resources and requiring large out-of-pocket payments from households.

## What is the vision for a Global Hospital Collaborative (GHC)?

- To create a world where low- and middle-income populations in emerging economies have access to high-performing, affordable hospitals
- To integrate these facilities into universal health coverage, strengthen health systems, and generate better health outcomes

## What is the proposed GHC mission?

- To provide a global knowledge exchange platform for hospital-related policy, data, research, and best practices

## Whom would the GHC serve?

- All stakeholders engaged in the management of underserved secondary and tertiary hospitals, which usually have limited access to advisory services. These include policymakers, investors and donors, payers, suppliers, governance bodies, hospital managers, and clinical leadership.

## What could the GHC do in the short term?

- Collect and disseminate evidence from and the experiences of hospitals in emerging economies
- Benchmark hospital performance, management practices, and governance arrangements in a small subset of countries, helping inform efforts to improve efficiency, quality, and coordination
- Create a web-based knowledge clearinghouse on hospital-relevant themes
- Pilot tailored technical assistance to a small number of target countries

## What could the GHC do in the long term?

- Establish peer-to-peer advisory services for hospitals or groups of hospitals
- Develop a standardized and accessible data reporting system on inputs, quality, outcomes, and other performance measures
- Launch synthesis briefs and innovation review series
- Establish an operational research program

## Next steps: What's needed to make the GHC a reality?

A number of activities are needed to support the development and launch of the GHC:

- Identification of seed funding to support the development of a constitution and web presence and to hire a small staff
- Establishment of physical premises
- Outreach to in-country stakeholders to develop the network
- Production of key products

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# I. Hospitals: The Center of Health Systems, the Periphery of Health Agendas

Hospitals are central to building and maintaining healthy populations around the world. They serve as the first point of care for many, offer access to specialized care, act as loci for medical education and research, and influence standards for national health systems at large. Yet despite their centrality within health systems, hospitals have been sidelined to the periphery of the global health agenda as scarce financial resources, technical expertise, and political will instead focus on the expansion of accessible primary care.

As a result, many hospitals in low- and middle-income countries have failed to evolve and modernize, both in operations and infrastructure, while the knowledge base on hospital effectiveness and efficiency remains small and inadequate. In turn, the standard of care and efficiency achieved by these hospitals has stagnated. The gap in treatment capacity and quality between wealthier and poorer countries—and between hospitals serving wealthier and poorer populations—is widening, just as emerging economies are poised to expand the range and depth of healthcare through universal health coverage.

Basic care services are essential and too often insufficient in low- and middle-income countries, but even the best primary care cannot substitute for functional, efficient, and accessible secondary and tertiary care. As low- and middle-income countries experience longer life expectancy and an increasing burden of noncommunicable disease, the number and proportion of critically ill individuals demanding and requiring more advanced inpatient care—surgeries, cancer treatment, and hospice care—will continue to increase.

## Box 1. What Is a Hospital?

Not all “hospitals” are the same. Hospital roles and functions vary considerably across countries according to history, governance model, and ownership—but existing definitions or classifications systems fail to account for this diversity.<sup>a</sup> A 10-bed building without running water in a Siberian village, a Kenyan district hospital near the outskirts of Nairobi, and a major South African tertiary facility in Johannesburg all

qualify as hospitals yet provide a vastly different range of services.<sup>b</sup>

Though no consensus exists on the definition of a hospital, this report uses the following standard:

Hospital: a healthcare facility that provides inpatient health services with at least 10 beds and operates with continuous supervision of patients and delivery of medical care, 24 hours a day, 7 days a week.<sup>c</sup>

a. de Roodenbeke (2012).

b. McKee and Healy (2002).

c. American Hospital Association (2014).

## Why Are Hospitals Important?

*“Power cuts and water shortages in hospitals kill thousands of patients each year, and emergency operations on pregnant women are sometimes carried out by the light of torches made from burning grass. A decade ago, the UK government funded the construction of scores of new hospitals, but the Ugandan government neglected to staff them.”*—Murder in Uganda, Helen Epstein<sup>2</sup>

As in wealthier countries, hospitals in low- and middle-income countries are the most visible symbol of care for the sick, particularly in rapidly expanding urban areas. They are the destination for a huge share and broad range of health services—everything from childbirth to appendicitis and trauma to cancer—and they are essential to the care of critical illness and emergencies. The hospital is often the first stop for citizens of low- and middle-income countries when seeking resolution to a major illness episode, and the last stop for patients whose diagnostic and treatment needs cannot be met through primary care services alone.

Beyond their role in diagnosis and treatment, hospitals often multitask as teaching institutions, centers of biomedical research, and testing grounds for pharmacological and technological innovations. They are major employers of healthcare professionals; and in small, low- and middle-income countries, a single hospital may account for a high proportion of the national health workforce.

Yet multiple mandates come at a high cost, and hospital spending can overwhelm a health system if left unchecked. In low- and middle-income countries, hospital spending often accounts for more than half of total health expenditure and sometimes as much as 70 percent.<sup>3</sup> These funds are often drawn from public coffers, making it imperative that they are spent efficiently and equitably. Too frequently, hospital budgets are seen as fiscal “black holes” by policymakers who cannot account for the end use of funds. In wealthy countries—and in some populous middle-income countries—hospitals have become big business, comprising ever-growing shares of national economies. In the United States, for example, the hospital sector accounts for 5.6 percent of GDP—a larger portion than construction, agriculture, and automobile manufacturing combined.<sup>4</sup>

Absent increased efficiencies, the growth in hospital spending risks crowding out the delivery of cost-effective primary and public health interventions.

Yet hospital-centric systems are the common model for healthcare delivery, and they are likely to persist as low- and middle-income countries become wealthier and experience a growing burden of noncommunicable diseases. And hospital-delivered care—especially surgery—can be necessary: according to a recent report from the Lancet Commission on Global Surgery, “143 million additional surgical procedures are needed each year to save lives and prevent disability.”

*“A collaborative to bring together buyers and sellers is needed; without it, hospital managers have had to rely on the ‘I know a guy’ model to access knowledge for improvement.”*

— Steven Thompson,  
Brigham & Women’s Healthcare

*According to a Pew Research Center survey, a median of 76 percent of people across six countries in Sub-Saharan Africa say that building and improving hospitals and healthcare facilities should be a priority for the national government.*

— Pew Research Center (2014)

2. Epstein (2014)

3. World Bank (2007).

4. Gaynor and others (2015).

Fortunately, in the right context, some forms of hospital-delivered care can also be highly cost-effective. In low- and middle-income countries, the cost-effectiveness of common procedures such as orthopedic and general surgery, hydrocephalus repair, cleft palate repair, and cesarean deliveries compares favorably to common medical or public health interventions (e.g., antiretroviral treatment for HIV, aspirin and beta blockers for ischemic heart disease, and BCG vaccine for tuberculosis prevention).<sup>5</sup>

Ensuring access to high-quality and affordable hospital services is a prerequisite for patients' survival, long-term health, and protection against catastrophic health spending. Further, universal health coverage cannot exist without an effective and affordable hospital system capable of addressing critical illness, trauma, and specialist care. Understanding the impact of hospitals on a country's health outcomes and financial position is thus a necessary starting point for any efforts to undertake health system improvements or reforms.

*“Most private hospitals are moving towards tertiary care because it is most profitable. The private sector is failing to provide equitable care. Could we do better?”*

— Hasbullah Thabrany,  
Center for Health Economics and  
Policy Studies at Universitas Indonesia

## Quality Information on Hospitals Is Hard to Find

Data on hospital capacity, case mix, expenditure, and performance in emerging economies is difficult to find and in many cases simply nonexistent. For example, less than a third of low- and middle-income countries have data on average length of stay; just 18 percent report hospital spending as a percentage of total health expenditure; and only 13 percent provide data on bed occupancy rates.<sup>6</sup> Indicators on hospital safety and outcomes—i.e., nosocomial infections, avoidable morbidity and mortality, and surgical complications—are even less commonly collected and almost never made publicly available. Most countries do not know how much is spent on hospitals, nor the distribution of inputs—such as services or interventions—purchased with those funds.

Systematic hospital research is rare, and what does exist is often purpose-built and proprietary. Donors and development banks have at times financed hospital upgrades, infrastructure, and management reform, but their support has been inconsistent and without an overarching and sustainable strategy. Data collection and analysis has been similarly ad hoc, often responding to the immediate requirements of project preparation. Even in the few countries where high-quality data are regularly collected, the data may not be shared or systematically applied to improve hospital performance. For example, Brazil conducts a regular facility survey, but the results are rarely used for further analysis or to inform policy changes.

At the same time, hospital problems and innovations in Organisation for Economic Co-operation and Development (OECD) countries have not been systematically documented or distributed, limiting international learning from OECD experiences. The end result is that hospital policy in low- and middle-income countries lacks needed evidence, without necessary reference to global experience and best practices.

*“Afghanistan has made significant progress in increasing access to primary health care in the last decade ... It's now the time to focus on improving secondary care and tertiary health care.”*

— Suraya Dalil,  
Afghan Minister of Public Health

5. Meara and others (2015)

6. Lewis (2015).

The absence of data and research prioritization on hospitals is a self-perpetuating problem. In the absence of good data or pressure from external donors, country-level policymakers face few incentives to improve hospital quality or efficiency. In turn, these institutions generate little demand for improved data collection. Finally, few researchers specialize in low- and middle-income country hospitals, creating a dearth of expertise and influence within donor and private organizations and universities—itsself leading to a lack of funding and prioritization.

## The Role and Context of Hospital Care Is Changing

The burden of noncommunicable diseases—most importantly, cancer, cardiovascular disease, and chronic conditions such as diabetes—has eclipsed the toll of communicable diseases in many countries. Even in Africa, cancer now affects more lives than AIDS, tuberculosis, and malaria combined.<sup>7</sup> This new reality requires a paradigm shift in how health systems approach treatment and continuity of care, integrate with communities, and address prevention.

The role of hospitals in industrialized countries has shifted over time—a sea change that is likely to occur in low- and middle-income countries as well. Whereas OECD hospitals once primarily offered episodic care for acute illness and injuries, advances in medical treatment and technology coupled with the growing burden of chronic disease have contributed to an evolution in how services are delivered. “People-centered” and “coordinated” care delivery models are emerging in high-income countries, seeking greater linkages between hospitals and delivery systems to facilitate chronic disease and population health management. Increasingly, hospitals in high-income countries are providing a greater share of services through ambulatory care or scheduled preventive procedures—all while coordinating with other providers along the continuum of care. At the same time, some countries are experimenting with innovative financing mechanisms such as global budgets, pay-for-performance mechanisms, and capitation to help align incentives between patients, practitioners, and hospitals, with the aim of achieving better health outcomes at lower cost. Emerging economies will likewise need to adapt to their populations’ changing profiles and needs but currently have few resources to inform the planning and implementation of this shift.

## Why a Center for Global Development Working Group

The Center for Global Development (CGD) is a “think and do tank” that channels rigorous research into specific, practical policy proposals. CGD research focuses largely on global or cross-cutting issues where market failures or other systemic weaknesses have negatively affected the lives of the poor in low- and middle-income countries.

In this case, low- and middle-income countries have not yet been able to systematically modernize and upgrade their hospitals and improve on quality and efficiency; donors and international organizations have failed to constructively engage in a dialogue about the role, functions, and design of hospital facilities; and markets have not incentivized the production of global public goods related to hospitals. These failures should be of grave concern to the international community: universal health coverage has been widely proposed as a core component of the post-2015 UN Development Agenda yet cannot be achieved without increased attention to the essential role of hospital services within health delivery systems and, ultimately, meeting population health needs.

CGD convened the Hospitals for Health Working Group to examine the root causes of these failures and offer specific policy proposals in response. These problems are global and systemic, crossing borders including the public, private, and nonprofit sectors and global, national, and local

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7. Institute for Health Metrics and Evaluation (2013).

governance systems. Donors, development banks, and multilateral institutions—CGD’s primary audiences—must play a central role in addressing the present situation. Private-sector investors, producers, and providers also need to be engaged beyond their product lines to address widespread hospital performance issues.

We view hospitals as critical to the continued development of the emerging economies and an opportunity for concerted global action and knowledge sharing. The Working Group has drawn upon a broad range of expertise from global leaders in hospital management, health and hospital policy, and health economics. Through this report we aim to galvanize renewed attention and prioritization to hospital performance, leading to a more evidence-based and coordinated international response.



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## II. The Tragedy of Neglect: Performance Gaps in Hospital Care

Years of global neglect have taken their toll on emerging-economy hospitals. All too often, desperate patients in low- and middle-income countries arrive at a facility that is inefficient, unsafe, unaffordable, unaccountable, and/or operating in isolation from other components of the health system.

Hospitals must be understood in terms of their role within, and contribution to, the broader health delivery system. A well-defined continuum of care—with effectively functioning referral chains—is essential to achieving the objectives of primary, secondary, and tertiary care. Often, hospitals in low- and middle-income countries are stand-alone facilities without linkage to the rest of the health system. In some emerging economies, the district-based health system has helped hospitals integrate into the overall network.

Nonetheless, most governments have struggled to maintain hospitals that keep up with their populations' changing epidemiology, demographics, and expectations. This challenge is particularly acute in low- and middle-income countries, where the public sector is often ill equipped to spearhead the reforms necessary to adapt to the evolving context. These governments lack necessary expertise, information, and resources to effectively oversee, manage, and regulate the hospital sector. Low- and middle-income country hospitals thus largely operate within an accountability vacuum (Box 2).

### Box 2. Emerging-Economy Hospitals in the Headlines, 2013

- Hanoi Doctors to Re-operate Boy Suffering from Bladder Removal by Surgical Mistake<sup>a</sup>
- In Violent Hospitals, China's Doctors Can Become Patients<sup>b</sup>
- Los errores hospitalarios, más peligrosos que las carreteras<sup>c</sup>
- [Uganda] Hospitals Are Death Traps, Report Says<sup>d</sup>
- India Baby Deaths Spark Calcutta Hospital Negligence Row<sup>e</sup>
- Dr. Death? Brazilian Doctor Killed Patients to Free Up Hospital Beds<sup>f</sup>

a. Quoc (2013).

b. Langfitt (2013).

c. "Los errores hospitalarios, más peligrosos que las carreteras" (2012).

d. Lanyero (2013).

e. "India baby deaths spark Calcutta hospital negligence row" (2013).

f. "Dr. Death? Brazilian Doctor Killed Patients To Free Up Hospital Beds, Police Say" (2013).

## Gaps in High-Level Planning and Strategy

At the root of the problem is the absence of high-level strategic thinking about the role, structure, distribution, and organization of hospitals within low- and middle-income country health systems. Without a big-picture vision for their development and evolution—and without external support or pressure to drive major reforms—most emerging-economy hospitals are stuck on autopilot, operating under antiquated models and decaying infrastructure.

While no precise data exist regarding the exact distribution of development assistance for health (DAH), the Institute for Health Metrics and Evaluation estimates that in 2010, only 5.3% of allo-

*“There are currently limited incentives to improve quality care. For example, accreditation began in Brazil in 1999, but only 3 percent of hospitals are accredited. It’s often too expensive for hospitals to do this, so only elite private hospitals become accredited.”*

— Laura Schiesari,  
Hospital Sírio-Libanês, Brazil

cable DAH was spent on health-sector strengthening<sup>8</sup>—and it is safe to assume that only a small portion of that amount was spent on hospitals. The United States Agency for International Development’s (USAID’s) Global Health Strategic Framework mentions the word hospital only three times within 43 pages,<sup>9</sup> while hospitals are completely missing in action within the UK government’s 2011–2015 global health outcomes framework.<sup>10</sup> Even where donors do address hospital issues, their support may be limited to specific components. For example, the World Bank claims a comparative advantage in infrastructure development, health-sector financing, and governance but notes its limited expertise in stewardship of the health sector (i.e., regulation, oversight, and strategic planning), hospital management, and micro-level human resource policy.<sup>11</sup>

At the country level, hospital construction, modernization, and integration has not kept pace with demand. Poor access to capital in emerging economies limits the construction of major facilities, as does the general perception among policymakers—reinforced by donors—that hospitals are a relatively low priority. Meanwhile, existing individual facilities often lack budgetary authority to modernize and invest in new equipment (discussed in more detail below) or face limited incentives to do so.

Some global health funders have made significant investments to support hospitals (see Box 3). In Afghanistan, for example, many well-intentioned parties form public-private partnerships (PPPs) with the Ministry of Public Health to build hospitals; over the last decade, several facilities have been built across the country, and as of late 2014 up to 10 PPPs are in the pipeline. Yet too often the donor efforts end there. Only when the buildings are built do people realize that the country does not have the capacity to run the facilities, and the hospitals quickly slide into disuse and disrepair. With no viable options at home, thousands of Afghans turn abroad seeking high-quality care in countries like India, draining \$285 million from the Afghan economy each year.<sup>12</sup> Such missed opportunities could be avoided if the donors and ministries collaborated early on in strategic, coordinated hospital planning—for example, ensuring that all facility construction was accompanied by the requisite long-term human resource and financial planning.

8. Among DAH that could be assigned to a specific category. See: Institute for Health Metrics and Evaluation (2012).

9. United States Agency for International Development (2012).

10. United Kingdom (2011).

11. World Bank (2007).

12. Islamic Republic of Afghanistan Ministry of Public Health (2013).

### Box 3. Examples of How Donors Are Supporting Hospitals

#### Partners in Health

Partners in Health (PIH), a nonprofit organization, helps establish and manage hospitals, health centers, and networks of frontline public health workers in low- and middle-income countries.<sup>a</sup> In Haiti, PIH built and operates Hôpital Universitaire de Mirebalais (University Hospital), a 300-bed hospital with six operating rooms, a neonatal intensive care unit, and a CT scanner.<sup>b</sup> In Rwanda, PIH helped build and now helps operate Butaro Hospital, a 150-bed facility built in collaboration with the government and now home to the first comprehensive cancer facility in East Africa.<sup>c,d</sup> In Malawi, PIH operates Neno Rural Hospital and 10 other rural health centers, serving more than 100,000 people.<sup>e</sup> And in Lesotho, PIH works with the Ministry of Health to operate and support the Botsabelo Multi-drug-Resistant Tuberculosis Referral Hospital.<sup>f</sup>

a. GiveWell (2010, 2012).

b. Partners in Health (2015).

c. Partners in Health (2012).

d. Partners in Health (2011).

e. Global Health Corps (2014).

#### International Finance Corporation

Addressing regulatory, financing, and implementation barriers to better health is one of five strategic priorities for the International Finance Corporation (IFC),<sup>g</sup> an arm of the World Bank that supports and finances private investment in low- and middle-income countries. Between 1998 and 2013 the IFC committed more than \$1.9 billion to help improve health services and more than \$2.7 billion for health and life sciences,<sup>h</sup> supporting 77 healthcare companies in low- and middle-income countries. As of 2007, hospitals represented the most significant category of IFC investments, with projects concentrated in Asia, Latin America and the Caribbean, and Europe and Central Asia.<sup>i</sup> IFC adds value through its extensive experience in emerging markets, in-house health specialists, wide variety of financing options (including equity, debt, and structured finance), and longer time horizons than other financial investors have.<sup>j</sup>

f. Partners in Health (2014).

g. World Bank Independent Evaluation Group (2009).

h. International Finance Corporation (2013).

i. World Bank Independent Evaluation Group (2009).

j. International Finance Corporation (2014).

## Deficiencies in Hospital Governance

As a result of policy-level disengagement, many emerging-economy hospitals operate in an environment of weak or nonexistent governance. National and local governments may set formal regulations but have limited capacity and resources to ensure compliance, and they typically do not demand and review data to monitor hospital performance. Voluntary accreditation systems are also rare. Even where they exist, few hospitals participate. As a result, substandard facilities face little external financial or regulatory pressure to increase efficiency and improve the quality of care.

The lack of effective and proactive governance structures represents a missed opportunity to improve hospital performance. For example, a substantial body of evidence suggests that increased financial and managerial autonomy can drive sizable improvements in the efficiency and quality of hospital services<sup>13</sup>—but only when accompanied by strong accountability mechanisms<sup>14</sup> and

13. Harding and Preker (2003), Bogue and others (2007).

14. Wagstaff and Bales (2012).

robust oversight practices.<sup>15</sup> In countries such as China,<sup>16</sup> Vietnam,<sup>17</sup> and Senegal,<sup>18</sup> poorly governed experiments with greater hospital autonomy resulted in higher costs, catastrophic out-of-pocket spending, and perverse incentives for overtreatment. In contrast, excellent performance at autonomous public hospitals in Brazil was credited to careful performance management by a state government, including performance-based purchasing mechanisms, well-monitored and enforced contracts, and a focus on data and information systems.<sup>19</sup>

## Challenges in Hospital Management, Finance, and Operations

Without strong governance and accountability mechanisms, hospital performance largely depends on facility-level managers. Yet these managers typically do not have the authority, incentives, capacity, and knowledge to improve.

Hospital management is a complex and difficult task under the best of circumstances, but it can be even more trying in low- and middle-income countries and particularly in public hospitals. In many cases, no one stakeholder—let alone the hospital manager—has control over all major operational decisions, such as budgeting or human resource policy. Budgeting and procurement are frequently handled within ministries of health (often poorly), and hospital managers have minimal influence over the process. When the staff is composed of professional civil servants employed by the government and sometimes appointed by a ministry of higher education, managers have little control over staff hiring, remuneration, and discipline. Physicians, nurses, and administrators become accountable to ministries rather than the hospital, the community, or patients—although a potential solution can be found in the emerging role of the hospitalist (see Box 4). As the distance between provider and employer becomes increasingly long, real accountability disappears and managers become unable to motivate better performance from hospital staff.<sup>20</sup> This issue becomes even more complex when health service delivery is devolved to lower tiers of government.

Often, hospitals' financial incentives are misaligned. While a few countries are pioneering innovative payment systems, most public hospitals in emerging economies are still financed by traditional line-item budgets. Budget-based financing does theoretically force managers to cap spending—at least from the public purse. But cost containment in the absence of performance incentives is often achieved by indiscriminate cutbacks rather than increased productive efficiency. At the other extreme, private hospitals overwhelmingly operate under fee-for-service models. This could potentially lead to high-quality treatment—but only for the few who can afford the spiralling cost of care.<sup>21</sup>

Finally, despite their many differences, public- and private-sector managers face a shared lack of incentive to collect and apply rigorous data on costs and efficiency. Public-sector managers and their respective facilities are seldom rewarded for prudent fiscal management, and their governments rarely demand detailed reports on where the money goes. In the fee-for-service private sector, financial incentives run directly counter to efficiency objectives. Providers in the private sector are financially compensated for inefficient treatment and directly benefit from additional tests,

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15. Harding and Preker (2003), Ramesh (2008), Lemièrè and others (2012).

16. World Bank and Ministry of Health—Vietnam (2011).

17. World Bank and Ministry of Health—Vietnam (2011), Wagstaff and Bales (2012).

18. Lemièrè and others (2012).

19. La Forgia and Couttolenc (2008).

20. Lewis and Pettersson (2009).

21. Schneider (2007), Moreno-Serra and Wagstaff (2010).

## Box 4. The Role of Hospitalists

Hospitalists—generalist physicians who specialize in inpatient care and hospital systems—are playing an increasingly important role in the development of hospitals. Hospitalists add clinical value as a primary care provider for inpatients, systems value as stewards of change in the healthcare system, and educational value

as teachers to medical students and residents. Though awareness of hospitalist models is low outside of the United States, a few examples show that the model can help drive better physician and patient satisfaction and decreased length of stay, readmission, and mortality.<sup>a,b</sup>

a. Shu and others (2012).

b. Eymen and Jaffer (2013).

drugs, and procedures. Because costs are borne by the patients, there is little need for them to be systematically measured and controlled. As a result, useful data on hospital spending or costs in low- and middle-income countries is difficult to find.

We know from anecdotal evidence that management and financial reforms can substantially improve the efficiency, timeliness, and effectiveness of facilities. In Brazil, an experiment to contract out service delivery at 17 Sao Paulo hospitals resulted in facilities that were more efficient, less costly, and safer than their traditional counterparts.<sup>22</sup> In US and UK hospitals, improved management practice led to significant reductions in mortality and corresponding gains in patient satisfaction.<sup>23</sup> Comparative research from Argentina, Brazil, Colombia, and Mexico has shown that greater managerial autonomy is linked to gains in production, efficiency, and quality.<sup>24</sup> In Lesotho, a partnership between the government and the private sector has led to much higher quality of care and better patient outcomes—but not without a major downside: higher costs to government,<sup>25</sup> leading to budgetary and staffing cuts in periphery facilities and district referral hospitals.

## Box 5. The Ethiopian Hospital Management Initiative

Many see the training of hospital managers as equally important as the training of physicians. Several efforts of the Ethiopian Hospital Management Initiative, launched by the Yale Global Health Leadership Institute in partnership with the Ethiopian Ministry of Health, the Clinton Health Access Initiative, and Jimma University, have led to the improvement of hospital-based care, including the implementation of the

master's in hospital administration (MHA) program with 55 hospital leaders within the Ethiopian Ministry of Health.<sup>a</sup> A quality improvement initiative in which 24 mentors worked side-by-side with hospital management teams led to improvement in 45 of 75 (60 percent) key management indicators in 10 months.<sup>b</sup> Due to the initiative's success in Ethiopia, lessons learned are being applied to opportunities in Rwanda.

a. Kebede and others (2010).

b. Bradley and others (2008).

22. For a detailed analysis of the experience in São Paulo, Brazil, see: La Forgia and Couttolenc (2008).

23. Bloom and others (2015).

24. Bogue and others (2007).

25. Vian and others (2013).

These experiences can be instructive for other low- and middle-income countries, as can the many successful hospital reforms that were never systematically documented. But in order to learn from others' success, hospital-related data and research in emerging economies must be more common, more rigorous, and more freely available.

## Patients Pay the Price

Ultimately, it is patients who pay the price for systemic failures in the hospital system. In emerging economies, the total cost of hospital care often includes catastrophic out-of-pocket spending, poor patient experiences, and preventable morbidity and deaths.

A visit to the hospital—whether public or private—can spell financial ruin for the poor. Globally, an estimated 81.2 million households incur catastrophic medical expenses each year due to the direct and indirect costs of accessing surgical procedures.<sup>26</sup> In India, it has been estimated that hospitalized patients spend 58 percent of their annual household income on out-of-pocket medical expenses and that a quarter of hospital patients fall into poverty as a result of their medical bills.<sup>27</sup> In Thailand, despite the recent expansion of universal health coverage, a hospital visit almost doubles the risk that a household will incur catastrophic health spending.<sup>28</sup> In 14 of 15 countries in Sub-Saharan African countries, total out-of-pocket expenses for inpatient care exceeded those incurred by outpatients—sometimes by a factor of 4 to 1 (Kenya).<sup>29</sup>

Some of the few studies that have systematically examined patient perceptions of low- and middle-income country hospitals have noted patients' distrust in public facilities and their tendency to

### Box 6. Selected Vignettes on Preventable Complications

#### in Emerging-Economy Hospitals<sup>a</sup>

“A 20-year-old woman who was four months pregnant and had had recent outpatient treatment for malaria was admitted to hospital with symptomatic anemia and palpable splenomegaly. There was a delay in reporting of her low hemoglobin concentration, and her condition deteriorated, requiring urgent transfusion. This was performed without blood grouping or cross-matching. The patient died soon after from transfusion reaction.”

“A 34-year-old patient developed tetanus after a previous admission to a local hospital with traumatic frontal

head injury, without assessment of tetanus status or immunization. The patient died from tetanus and its complications.”

“A 50-year-old woman with diabetes was readmitted two days after discharge after laparoscopic cholecystectomy. Biliary peritonitis was diagnosed and she was transferred to intensive care. She died some days later.”

“A 60-year-old man with history of ischemic heart disease with atrial fibrillation was admitted with acute pulmonary edema. He arrested after bolus intravenous injection of morphine 10 mg and hydrocortisone 200 mg, and died the same day.”

a. Wilson and others (2012).

26. Meara and others (2015).

27. Peters and others (2002).

28. Somkotra and Lagrada (2009).

29. Leive and Xu (2008).

go to private facilities domestically or abroad in search of safe, high-quality care. The few studies that do directly investigate patient attitudes tend to find significant dissatisfaction related to waiting times, hygiene/cleanliness, staff attitudes, and the perceived quality of care. In many cases, negative patient perceptions can become a barrier to health service utilization. For example, one qualitative study of pediatric wards in Tanzania's district hospitals found that delays in bringing ill children to a facility were in part driven by mothers' fears of unsanitary hospital conditions.<sup>30</sup>

While poor patient satisfaction is undesirable, the most severe hospital failures are those that result in preventable patient morbidity and mortality. Unfortunately, many hospitals in emerging economies are poorly equipped to handle patients' emergencies and serious illness. A 2001 Lancet study of 21 hospitals in seven less-developed countries found that two-thirds "lacked an adequate system for triage" and that "adverse factors in case management, including inadequate assessment, inappropriate treatment, and inadequate monitoring occurred in 76 percent of inpatient children." Many of the hospitals were missing essential supplies, and the vast majority of doctors in district hospitals did not have adequate knowledge to treat conditions such as pneumonia, malnutrition, and hypoglycemia.<sup>31</sup>

At times, hospital care can harm the very people it is meant to help. Nosocomial complications are common in wealthy and emerging-economy hospitals alike but have reached crisis levels in many low- and middle-income countries. Recent estimates suggest that 22.6 million disability-adjusted life years (DALYs) are lost each year to unsafe hospital care, and two-thirds of that burden occurs in low- and middle-income countries.<sup>32</sup> Likewise, a 2012 BMJ study of 26 hospitals in eight emerging economies (Egypt, Jordan, Kenya, Morocco, Tunisia, Sudan, South Africa, and Yemen) found that 8.2 percent of all patients experienced at least one complication, of which 83 percent were preventable and 34 percent resulted from "therapeutic errors in relatively noncomplex clinical situations" (see Box 6 for selected vignettes). The observed adverse events ranged from minor issues to major complications: while 32 percent of patients recovered in less than a month, 14 percent of adverse events resulted in permanent disability, and 30 percent contributed to the death of the patient. Put differently, 1 in 50 patients entering these hospitals died as a result of preventable complications—a rate of roughly one preventable death per day per facility.<sup>33</sup> Yet preventable complication rates vary significantly by country,<sup>34</sup> as do observable dimensions of hospital quality.<sup>35</sup> This suggests that even resource-limited settings can see substantial improvement in hospital outcomes if the right policies and incentives that promote timely, safe, and effective clinical service delivery are put in place.

*"The use of hospitals by patients rises with economic gains. People will use health services if they are available, but often they not affordable."*

— Narottam Puri,  
Fortis Healthcare Limited

*"We need to tackle the issue of scalability. The problem facing hospitals is bigger than any one institution."*

— Steven Thompson,  
Brigham & Women's Healthcare

30. Mwangi and others (2008).

31. Nolan and others (2001).

32. Jha and others (2013).

33. Wilson and others (2012).

34. Wilson and others (2012).

35. Nolan and others (2001).

## Is an Adviser in the House?

Currently, few publicly available resources exist to help emerging-economy hospitals move past the status quo. While many institutions work on hospital-related issues in some capacity, policymakers, investors, and hospital managers still often struggle to identify and access timely and relevant guidance on improving hospital performance. In wealthy countries, this problem is largely managed through a cornucopia of hospital associations, journals, other vendors, and a heavy reliance on consulting firms. Indeed many programs, initiatives, and partnerships already exist with the intent of improving aspects of hospital quality and performance—but most importantly, these efforts are not coordinated for greatest impact.

*“This is a space that has lots of players, but the problem persists. Knowledge products are important, but having practical experience solving problems in limited resource settings is also needed.”*

— Kedar Mate,  
Institute for Healthcare Improvement

However, with the exception of some elite facilities, most emerging-country hospitals cannot afford advisory services from consulting firms, are not affiliated with relevant networks or associations, and do not participate in international meetings or conferences on hospital issues. Although they can occasionally access technical guidance from international consultants or donor agencies/development banks, this support is unpredictable and ad hoc. Missing from the healthcare ecosystem is a “one-stop shop” for producing, compiling, and sharing essential knowledge about what works in hospitals.

# III. Closing the Knowledge and Performance Gap: How Can the Global Hospital Collaborative Help?

In the face of rapid demographic, epidemiological, and economic transitions, the global community must actively engage to develop and implement a more strategic view of the role of hospitals as a component of health production. We know gains in hospital performance are possible—but more effective information gathering, evidence generation, and knowledge sharing are needed to harvest unrealized potential.

Donors, technical agencies, and country governments must acknowledge that demand for hospital care is increasing and must respond appropriately. Private investors are already seizing upon the opportunity to target healthcare markets outside of wealthy countries, and private insurance coverage is expanding in low- and middle-income countries. These can and should be positive developments that improve population health, but for the most part emerging economies are ill equipped to adapt to these changes. The public sector is lagging in its adaptation to the new environment and is often unprepared to compete with private providers.

In sum, governments and donor agencies are *reacting* to changes in the health sector; going forward, they must *lead and guide* evolution in hospitals in line with a comprehensive long-term strategy for health systems development.

## Box 7. Mexico's FUNSALUD

Mexico's FUNSALUD (the Mexican Health Foundation) has developed the design of a project on comparative analysis of hospital performance with the support of the Ministry of Health. The project compares indicators across hospitals with similar levels of complexity and other characteristics (such as the number of

hospital beds, number of hospitalizations, etc.) and intends to give awards of excellence. Similar constructs could be created on the international and national levels to identify best-performing hospitals and share their processes.<sup>a</sup>

a. Author contact.

## Recommendations for Action

While governments, investors, suppliers, and agencies can take independent action to improve efficiency and performance, need is still unmet for multi-stakeholder forums to generate, broker, and exchange knowledge. To address this gap, the Hospitals for Health Working Group offers two recommendations:

- 1. Support local efforts directly.** Donors, development banks, technical agencies, country governments, private healthcare organizations, and investors in hospital services should strengthen ongoing efforts to collect, monitor, and analyze hospital data; to benchmark performance; and to foster stronger coordination with other providers. Donors and development banks should consider devoting greater financial and technical assistance resources to hospital strengthening in the context of overall health-sector development.
- 2. Create a collective platform.** Global health donors, multilateral institutions, and private industry should support a collective organizational platform and infrastructure—the Global Hospital Collaborative (GHC). The GHC should foster commitment to a set of knowledge-related public goods with the goal of promoting improved hospital performance and the integration of hospitals into the health delivery system.

In the remainder of this section, we describe how the proposed Collaborative could address existing knowledge and performance gaps, helping hospitals fulfill their potential as a core contributor to population health.

## Mission and Structure of the Global Hospital Collaborative

The mission of the GHC would be to **provide a global knowledge exchange platform for hospital-related policy, data, research, and best practices**. The Collaborative would focus on underserved secondary and tertiary facilities and their role in producing population health. GHC clients could include a diverse array of stakeholders within those hospitals and the broader health sector, including policymakers, investors, payers, suppliers, governance bodies, hospital managers, and clinical directors. It would assist its clients in overcoming existing barriers to accessing knowledge and advice, with the goal of improving the performance of hospitals and facilitating their effective integration into the broader health services delivery system.

To do so, the GHC would have a two-pronged functional focus (Table 1). First, it would address macro-level problems affecting the external policy, institutional, and investment environment. Second, it would assist hospitals at the facility level with solving problems and reforming their internal governance, management, and service provision strategies.

The organizational structure of the Collaborative could take many forms depending on client demand and interest among partner institutions. However, the GHC's legitimacy would depend upon its perceived independence—both organizationally and financially. It is thus the opinion of the Hospitals for Health Working Group that the stand-alone model, i.e., a new entity with an independent board of directors, is the most appropriate governance model for the Collaborative. The GHC could potentially be hosted by another institution and/or operated in concert with a broader partnership but should remain as a stand-alone model within the partnership.

*“A hospital collaborative should offer knowledge and facilitation to underserved or underrepresented hospitals to improve their performance.”*

— Juan Pablo Uribe,  
Fundación Santa Fe de Bogotá

**Table 1. Functional Areas Addressed by the GHC**

<p><b>Focus Area 1:</b> <b>Macro-Level Environment</b></p> <ul style="list-style-type: none"> <li>■ Hospital payment mechanisms</li> <li>■ Payer purchasing strategies</li> <li>■ External governance arrangements</li> <li>■ Data and information environment</li> <li>■ Quality improvement and monitoring architecture</li> <li>■ Regulatory environment</li> <li>■ Hospital rationalization, substitution, and dimensioning</li> <li>■ Capital financing, planning, and investment strategies</li> <li>■ Integration or care coordination processes, especially with ambulatory providers</li> </ul>	<p><b>Focus Area 2:</b> <b>Micro-Level Operations</b></p> <ul style="list-style-type: none"> <li>■ Decision-making authority and leadership</li> <li>■ Strategies and methods for improving quality, patient safety, patient experience, efficiency, and productivity improvement</li> <li>■ Performance measurement, review, and use</li> <li>■ Essential management functions (human resources, IT, financial, supply chain, etc.)</li> </ul>
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## Core Functions of the Global Hospital Collaborative

The GHC would facilitate a united network of individual and institutions dedicated to fostering improved policymaking, investment, and management for emerging-economy hospitals. It would act as a “doorway” organization to hospital-related expertise, brokering interactive knowledge sharing and partnership among underserved hospitals facing similar challenges.

The Collaborative would offer two work streams (Table 2). First, it would directly provide publicly available knowledge products to all interested stakeholders. These services and products would primarily aim to build an accessible foundation of knowledge on hospital-related issues by compiling and synthesizing data, evidence, and best practice. The GHC’s overarching goal under this work stream would be to become a one-stop shop for promoting evidence-based policy, finding relevant

**Table 2. Potential Service Areas and Products**

<p><b>Work Stream 1:</b> <b>Public Goods</b></p> <ul style="list-style-type: none"> <li>■ Knowledge clearinghouse</li> <li>■ Data repository</li> <li>■ Hospital twinning/match service</li> <li>■ Forum newsletter</li> <li>■ Synthesis briefs and innovations’ reviews</li> <li>■ Conferences and webinars</li> <li>■ Technical assistance database</li> <li>■ Discussion paper series</li> <li>■ Case studies on performance excellence (featured hospitals)</li> </ul>	<p><b>Work Stream 2:</b> <b>Tailored Assistance</b></p> <ul style="list-style-type: none"> <li>■ Diagnostic surveys</li> <li>■ Strategic planning</li> <li>■ Operational research</li> <li>■ Technical assistance on specific areas (e.g., management, performance monitoring)</li> <li>■ Practitioner-to-practitioner knowledge exchange</li> <li>■ Data measurement and analysis</li> <li>■ In-country forums</li> </ul>
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## Box 8. Potential Products

### Short Term

- Technical overview of evidence and experience of hospitals in emerging markets and developing countries
- Benchmark hospital performance, management practices, and governance arrangements in a small subset of countries with the intent to assist stakeholders in determining a path toward improving efficiency, quality, and coordination with other providers
- Create a web-based knowledge clearinghouse on hospital-relevant themes
- Pilot tailored technical assistance to a small number of target countries

### Long Term

- Establish practitioner-to-practitioner advisory services for hospitals or groups of hospitals
- Develop standardized data-reporting systems with accessible data on inputs, quality, outcomes, and other performance measures
- Launch synthesis briefs and innovations review series
- Establish an operational research program

data and research, and accessing best practice evidence—that is, a forum for connecting the evidence with the people who need it.

The GHC's second work stream would offer tailored, on-demand assistance to individual countries or facilities. Assistance would include knowledge generation (i.e., diagnostic surveys and operational research) and technical support (i.e., strategic planning and help implementing a performance-monitoring framework). Based on country demand, the Collaborative could broker practitioner-to-practitioner technical assistance; undertake high-quality operational research, diagnostics, and performance benchmarking; and leverage state-of-the-art management techniques

## Box 9. A Potential Engagement Strategy in Nepal

Nepal's Ministry of Health and Population recently launched a Hospital Management Strengthening Program aimed at improving the management and leadership within its own district hospitals. The program is funded and supported by Nick Simons Institute (NSI), a nonprofit working to train and support rural health workers for Nepal ([www.nsi.edu.np](http://www.nsi.edu.np)).

Key to the program is the agreement of a set of minimum service standards covering all clinical and support functions in the district hospital. These have been endorsed by the ministry and are being introduced to individual hospitals through a series of workshops. NSI and ministry staff help hospital teams identify where they are not meeting the standards and develop action plans.

During the design phase of the program, the team from NSI did extensive research to identify examples of where similar work was being undertaken. Their task would have been made far easier by a central repository of information about previous initiatives and their outcomes. A forum for discussing issues relating to hospital improvement would also have proved very useful, allowing Nepal to benchmark its performance against other countries. Facilitating exchange visits or twinning arrangements between countries attempting similar reforms would also be of value. A GHC would provide a platform from which Nepal could share its experiences and learn from others.

and technologies to improve internal processes and system-wide integration. In addition to benchmarking and other comparative exercises to evaluate hospital performance, the GHC would help formulate pragmatic, organizational next steps to improve on priority indicators. (See Box 9 for how the Collaborative could contribute in the Nepalese context.)

## **Getting the Global Hospital Collaborative Up and Running: Financing, Roll Out, and Engagement**

The GHC could be financed by a mix of grants, membership dues, and revenue-generating activities such as tailored technical assistance and conferences. Getting it started would require incubation and seed money to draft a constitution, to build a web presence, to secure physical premises, to hire staff, to reach out to in-country stakeholders (e.g., policymakers, hospital associations, accreditation and quality improvement agencies), and to begin producing key products. Later on, the Collaborative could transition to a more diverse financial support base that will be less dependent on donors and ultimately self-sufficient. Membership fees would be modest and proportionate to facility size and resources; the GHC could also offer group or national memberships, for example, all district hospitals within a particular region.

A first priority would be to forge strategic partnerships with a small subset of countries and demonstrate rapid impact. While gradually building out the “public good” work stream and resources, it could begin pilots of its tailored technical assistance to a small number of target countries. The Collaborative would deploy a wide range of tactics to attract membership and demand in target countries, including linkages with in-country hospital associations, partnerships with accreditation organizations as well as provincial and district health secretariats, and endorsements from development banks and other stakeholders. Together, these strategies should generate sufficient interest to begin pilots, allowing the GHC to demonstrate its value and secure interest from a broader set of potential clients.



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# Appendix I. Hospitals for Health Working Group

The Center for Global Development convened the Hospitals for Health Working Group in the fall of 2013. Working Group members serve on a voluntary basis in an individual capacity. Their affiliations are listed for purposes of identification only.

**Lawton Robert Burns**, Wharton School, University of Pennsylvania  
**Ian Chadwell**, Nick Simons Institute  
**Anita Charlesworth**, The Health Foundation  
**Victoria Fan**, University of Hawai'i at Mānoa  
**Gary L. Filerman**, Atlas Health Foundation  
**Gerard La Forgia**, World Bank  
**Amanda Glassman**, Center for Global Development  
**Frederico C. Guanais de Aguiar**, Inter-American Development Bank  
**Frédéric Goyet**, The Global Fund to Fight AIDS, Tuberculosis and Malaria  
**Arian Hatefi**, University of California San Francisco  
**Bruno Holthof**, Oxford University Hospitals NHS Trust  
**Joseph Ichter**, Palladium  
**Nandakumar Jairam**, Columbia Asia Hospitals  
**Maureen Lewis**, Georgetown University  
**Miguel Ángel Lezana**, Comisión Nacional de Arbitraje Médico  
**Kedar Mate**, Institute for Healthcare Improvement  
**Mead Over**, Center for Global Development  
**Giota Panopoulou**, Ministry of Health, Mexico  
**Alexander S. Preker**, Health Investment & Financing Corporation  
**Joseph Rhatigan**, Harvard Medical School  
**Eric de Roodenbeke**, International Hospital Federation  
**Narottam Puri**, Fortis Healthcare  
**Jim Rice**, Integrated Healthcare Strategies  
**Laura Schiesari**, Hospital Sírio-Libanês, Brazil  
**Hasbullah Thabrany**, Universitas Indonesia  
**Steven J. Thompson**, Brigham and Women's Healthcare  
**Juan Pablo Uribe**, Fundación Santa Fe de Bogotá



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Report of the Center for Global Development Hospitals for Health Working Group

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ISBN: 978-1-933286-91-4

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