POLICY BRIEF

A Path for Successful Public Hospital Reform:

What the World Can Learn from Brazil

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Key messages:

- Hospital performance depends not only on funding, but also on how hospitals are managed. Improving management can have a significant impact on efficiency and quality of care, and ultimately work to contain costs.

- São Paulo's public hospital reform demonstrates the long-term benefits of a comprehensive management model. Over more than two decades, reformed hospitals have consistently outperformed traditionally managed public facilities.

- The reform combined managerial autonomy, performance-based financing, and strong government oversight. Together, these elements created clear incentives for performance and accountability.

- The model delivered measurable improvements in productivity, lower costs, and better patient outcomes.

- São Paulo's experience provides practical lessons for countries seeking to strengthen public hospital performance while maintaining public ownership and universal access.

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Introduction

Enter a public hospital in many low- and middle-income countries (LMICs), and the challenges are immediately visible: long waiting times, insufficient clinical staff, broken equipment and resources that never seem to stretch far enough. For patients, this often feels like a problem of underfunding. For policymakers, the instinct is often the same: allocate more resources. But what if the problem is not only how much is spent, but how hospitals are managed?

In the late 1990s, the State of São Paulo handed over the management of public hospitals to private non-profit organizations; an approach that many believed would fail. Twenty-five years later, those hospitals are more productive, less expensive, and provide better quality of care than traditionally managed public facilities. What made São Paulo succeed where others have struggled?

Publicly owned and operated hospitals are major actors in the health care landscape in most developing countries. They represent about half of hospitals and 60% of beds, consuming between 40% and 60% of government health spending (see data from Southeast Asia, Latin America, WHO and OECD). Yet despite their importance, these hospitals often struggle to deliver efficient, high-quality care.

Why Many Public Hospitals Underperform

In most LMICs, public hospital systems operate as budgetary units of government in which nearly all inputs and processes are centrally managed by the health ministry or local governments. Hospital managers typically lack authority over staffing, procurement, and resource allocation within the hospital. Incentives for good performance are absent. Civil service regulations make it difficult to hire the right people, and nearly impossible to dismiss poor performers. Managers are frequently political appointees with little experience or training. Performance data, when collected, are rarely used to provide feedback to front-line staff or to inform decisions or accountability.

The result is a familiar pattern: inefficiency, patient dissatisfaction and low quality of care (OECD & World Bank 2023; Roder-DeWan et al. 2020; Huerta-Gutierrez 2019; Bloom et al. 2017; Preker et al. 2003; Tjam et al. 2001).

Why Most Reforms Fall Short

Many LMICs have attempted to improve public hospital performance by introducing isolated reforms; granting partial autonomy to facilities, introducing some limited financial incentives, or strengthening monitoring and oversight. However, these efforts often fail to deliver meaningful results.

Autonomy without accountability can weaken control without improving performance. Performance-based financing without managerial flexibility and capacity may have limited impact. Oversight without clear consequences can lack enforceability.

What São Paulo Did Differently

Brazil faced many of the same challenges. Rather than tinkering at the margins, the State of São Paulo introduced comprehensive reform that reshaped how public hospitals are managed, financed, and held accountable. The state government radically altered nearly all aspects of government-to-hospital and hospital-to-staff interactions and adopted a public-private partnership (PPP) model in which non-profit organizations, known as Social Health Organizations (OSSs), were given responsibility to operate public hospitals. The reform model had following the interlocking features:

- Hospital managers were granted full autonomy over staffing, procurement, internal processes, and the allocation of financial resources.
- A structured and competitive selection process was introduced to identify qualified OSS operators, based on detailed proposals and transparent evaluation criteria.
- Financing shifted to a performance-based model. Hospitals received a global budget, but payments were tied to results: 90% linked to service delivery targets and 10% to quality and efficiency indicators such as infection rates, readmissions, and average length of stay.
- Management contracts defined clear targets, including production volumes, quality indicators, and financial parameters.

At the same time, the government invested in strong oversight capacity, establishing a dedicated monitoring unit with multidisciplinary expertise to track performance, enforce contracts, and take corrective action when needed.

Did It Actually Work?

A growing body of evidence shows that this model translated into measurable improvements:

- **30% higher productivity** across metrics including bed utilization, operating room production, and emergency consultations.
- **20% lower costs** per discharge and per patient-day.
- **Higher quality care** as measured by lower mortality rates, fewer infections, and reduced readmissions.
- **Population health impact** as evidenced by reduced mortality across hospital catchment areas, which was attributed to OSSs addressing previously unmet demand for inpatient care (Coube et al. 2025; Araujo et al. 2019; Tonelotto et al. 2019; World Bank 2018; Mendes et al. 2017; La Forgia et al. 2009; La Forgia et al. 2008).

How Did it Work?

The reforms created a mix of incentives and accountabilities that changed how OSS managers ran their hospitals, which in turn led to changes in how front-line doctors and nurses did their jobs every day. OSSs built a new organizational culture around hitting performance targets, sticking to work schedules, delivering quality care, and solving problems as a team. They became selective about who they hired, favoring well-qualified, often younger clinicians. Staff who couldn't or wouldn't follow the new rules didn't last long. They were either let go or transferred elsewhere.

But this wasn't change imposed from above. OSS managers brought hospital staff into the process, involving them in designing and rolling out improvement plans. They trained department teams in practical tools (such as process mapping, root cause analysis, LEAN methods) to spot bottlenecks, standardize procedures, and improve patient safety. These tools not only improved processes but also improved working conditions and helped build the kind of team-based culture that drives lasting behavioral change.

Why This Matters for Health Systems Reform

São Paulo's success is noteworthy given the limited track record of public hospital autonomy initiatives, and it highlights a critical lesson for countries seeking to improve public hospital performance. Reforms that focus on a single dimension are unlikely to succeed (La Forgia et al. 2017; Wagstaff et al. 2012; Castano et al. 2004; Govindaraj et al. 1996; Kamwanga et al. 2003; Eid 2003). Governments tend to grant partial autonomy to hospital managers while maintaining bureaucratic controls. Also, while some hospital PPP models in LMICs have been successful, political pressures have resulted in backtracking. Evaluations remain scarce.

Granting autonomy alone is insufficient if managers are not held accountable for results. Introducing performance-based financing is unlikely to work if hospitals lack the flexibility and capacity to respond the incentives therein. Strengthening oversight mechanisms will have limited impact without enforceable targets and consequences. The key lesson from São Paulo's experience is that these three have to be harnessed together to achieve real impact.

The Implementation Enablers

Several factors enabled successful implementation:

- **Collaboration:** The government established a consensus-based working relationship with the OSSs. Policy changes are often reviewed with OSS and hospital managers before formal approval. Quarterly meetings with the monitoring and contract management unit enable two-way communication about performance and emerging challenges.
- **Financial reliability:** The state government honored its financial commitments, transferring funds regularly as contracted. Hospitals could plan knowing that resources would arrive on time and in the full amount.
- **Strategic rollout:** São Paulo introduced the model in new or renovated facilities and did not involve OSSs taking responsibility for managing public employees. Of the first 49 hospitals, only 6 involved converting existing centrally-managed facilities. Conversion was a complex process because it required relocating employees unwilling or unable to accept OSS work requirements.
- **Organizational adaptation**: Several strategies emerged from the organizational response to the new incentive environment, including hiring experienced and qualified managers, hiring clinicians who fit a performance-oriented culture, and building as strong organizational focus on quality and patient safety.

Looking Ahead

By 2022, the model had expanded beyond São Paulo to 18 states and accounted for 12% of all public secondary and tertiary hospitals.

The OSS experience offers practical lessons for countries seeking to improve hospital performance without compromising public objectives. For example, all patients receive care free of charge. Public hospitals can deliver efficient, high-quality care, but doing so requires more than incremental change. It requires a deliberate shift in how hospitals are managed, financed, and held accountable, with reforms designed and implemented as part of an integrated whole.

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