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Editorial

Private hospitals and health care
The risks and opportunities of the globalization of health care delivery

Global implications from the US hospitals privatization experience

Collaborating to improve the global competitiveness of US academic medical centers

A zebra or a painted horse? Are hospital PPPs infrastructure partnerships with stripes or a separate species?

The role of Public Private Partnerships: The Brazilian experience of modernizing hospitals in the Sao Paulo Prefecture Health Secretariat

The African Health Fund and Nairobi Women’s Hospital – A successful model for improving access to capital for health businesses

Quality improvement activity in radiology reading and reporting in a rural setting hospital in Indonesia

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Contents volume 48 number 2

03 Editorial
Eric de Roodenbeke and Alexander S Preker

Special feature: Private hospitals and health care

05 The risks and opportunities of the globalization of health care delivery
Steven Thompson and Salim Hasham

08 Global implications from the US hospitals privatization experience
Monte Dube

11 Collaborating to improve the global competitiveness of US academic medical centers
Molly Allen, Andrew Garman, Tricia Johnson, Samuel Hohmann and Steve Meurer

15 A zebra or a painted horse? Are hospital PPPs infrastructure partnerships with stripes or a separate species?
Dominic Montagu and April Harding

20 The role of Public Private Partnerships: The Brazilian experience of modernizing hospitals in the Sao Paulo Prefecture Health Secretariat
Roser Vicente and Joan Castillejo

24 The African Health Fund and Nairobi Women’s Hospital – A successful model for improving access to capital for health businesses
Bernard Goya

26 Quality improvement activity in radiology reading and reporting in a rural setting hospital in Indonesia
Grace Freita, Christlyn Wongso and Marganda Depot Asi Pasaribu

30 Apollo Quality Program
Anupam Sibal, Shaveeta Dewan, RS Liberio, Sujoy Khar, Gaurav Loria, Clive Fernandes, G Yatheesh and Karon Sharma

Reference

35 Language abstracts

40 IHF corporate partners

43 IHF Events calendar

Reference

35 Language abstracts

40 IHF corporate partners

43 IHF Events calendar

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The private hospital sector (nonprofit and for-profit) is playing an increasingly important role in providing health care for both privileged and lower-income populations, even in many emerging economies. Globally, health care spending reached US$6 trillion in 2010, with the hospital sector comprising around 35 percent – US$2 trillion. Spending in developing countries reached US$960 billion. In many countries, the private sector provides as much as 60 to 80 percent of financing and 50 percent of service delivery.

Although the private hospital sector is still small in comparison with out-of-pocket spending on pharmaceuticals and direct payment of health care providers, even these expenditure items are often linked to hospital care delivered in the private sector.

Positive experiences
As demonstrated by the authors who contributed to this volume of the WHHS journal, there are many positive dimensions to the private hospital sector. In many countries, both developing and advanced market economies, the private hospital sector already plays an active role and is the benchmark against which the rest of the curative health sector is compared. Thus, private hospitals are a real option for quality care. Moreover, private hospitals in those countries can provide affordable care even for the poor when coupled with subsidized prepayment mechanisms.

Negative experiences
But the private hospital sector is not a panacea. There are also many problems that better public policies, regulations, and incentives could address. Among these problems are rising cost and financial pressures, often linked to high-end private hospital care. Frequently, inadequate regulation of informal private hospitals leads to poor quality care from unqualified providers, fragmented care, and profit-maximizing behavior. Out-of-pocket charges often pose financial hardship for uninsured or underinsured patients in unregulated markets. Competition with the public sector for publicly trained and subsidized personnel amplifies labor market inefficiencies.

The authors contributing to this issue of the WHHS journal highlight several barriers to improving the performance of the private hospital sector and its potential contribution to broader health care objectives in both developed and developing countries. Foremost among these obstacles are lack of access to capital finance and a lack of financial protection or sustainable financing such as health insurance or other prepayment mechanisms for private hospital care providers. In addition, the policy and regulatory framework of many countries often fails to oversee and enforce quality assurance and improvement processes in the private sector. And skilled health workers (clinical and managerial) are often in short supply.

High-performing health systems are characterized by mixed delivery of services. Yet many countries do not have adequate policies to coordinate public and private service delivery.

The following actions are suggested directly from the problems enumerated above to help governments engage the private hospital sector more effectively in contributing to overall health goals:

- Support responsible and sustainable private sector development by increasing access to finance (both debt and equity).
- Share hands-on experience in providing hospital care between the public and private sector.
- Improve the policy and regulatory environment in which private health care companies operate, with appropriate rules, including quality standards, and enforce them.
- Provide regulators and policymakers with the information they need for informed decision making.
- Expand the pool of well-trained health care professionals by having qualified private hospitals play a role in such training.
- Increase the availability of risk-pooling and other mechanisms that would help stabilize revenue flows and make health care financing more equitable.

The International Hospital Federation remains committed to working with both public and private health care providers in promoting high-quality and affordable care for the population. It recognizes that differences in country situations play a role in the evolution of the respective roles of the public and private sectors. For the International Hospital Federation, it is not an option of more public or more private health care but rather of both sectors’ working together to bring people better care. For this, a positive
dialogue between both sectors, supported by the national authorities, is an essential starting point. Efforts are under way to engage the private hospital sector directly and to make positive experiences, such as some of those highlighted in this volume of the WHHS journal, better known to policymakers and people working in both the public and private parts of the health sector. At the international level, the International Hospital Federation is well placed to offer such a platform for a more effective dialogue between the public and private hospital sectors for the benefit of the population. This edition of the WHHS journal is testimony of this determination to improve dialogue with private sector.

UHC is an alliance of leading nonprofit academic medical centers, which are focused on delivering world-class patient care. Based in Chicago, Ill, UHC fosters collaboration with and among academic medical centers and affiliated hospitals through its renowned programs and services in the areas of comparative data and analytics, performance improvement, supply chain management, strategic research, and public policy. UHC helps its members achieve excellence in quality, safety, and cost-effectiveness. Formed in 1984, UHC’s membership includes United States academic medical centers and international organizations.

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The risks and opportunities of the globalization of health care delivery

ABSTRACT: The pace and scale of globalization in health care services delivery have accelerated over the past decade. There have been numerous collaborations in health care service delivery between the private sector in North America and Europe with public and private entities in various emerging markets. These partnerships can be extremely fruitful, but also carry significant challenges. Johns Hopkins Medicine International (JHI) has been active for more than a decade in supporting international partners in building capacity and improving delivery systems. In addressing the challenges of globalization we have learned a number of lessons and have come up with several innovations to better help providers in emerging markets respond to the health care needs unique to their regions.

Globalization has impacted health care in a fundamental way. Private sector players in emerging markets are consolidating in their regions and expanding into other regions, having built financial and management capacity. Some of these players have developed innovative and efficient models of delivery in specific service lines in their markets, and are now exporting these models with increasing frequency to other parts of the world. At the same time, models of delivery and financing long established in North America and Europe are now being adapted to and implemented in emerging markets, and in this context these models are innovative.

Johns Hopkins Medicine is one of many established institutions adapting its strategies to the evolving globalization in health care. Johns Hopkins Medicine International (JHI) was specifically established to globally implement Johns Hopkins Medicine's tripartite mission of leadership in research, education and clinical services. Our projects with private and public sector partners span more than a dozen countries, with a particularly significant presence in the Gulf Cooperation Council (GCC) region.

Adaptation and flexibility

The nature of our collaborations with emerging country clients has evolved in response to market forces. Some of these partnerships essentially have us providing consulting services focused on specific skill sets and knowledge domains. Other of our partnerships extend into providing onsite management and clinical leadership teams, effective helping to transfer skills and experience in hospital and health-system management. Equity-based ventures and public private partnerships are increasingly common forms of collaborations for us. Many of our partners also have an affiliate relationship with us, so that our name becomes involved in the resulting delivery systems.

The nurses were reluctant to challenge doctors' directives, even when the nurses believed the patients were at risk of harm. In cases like this, we seed the staff with professionals who lead by example
recognizing that different clients are at different stages of development, and thus there will be differences in how fully and rapidly partners can be expected to successfully implement certain changes in the short term. As part of the process, core clinical practices are defined in consultation with the partner, and agreement sought on which of them are inviolate and which of them can be safely modified.

Invariably, projects and cultures will clash at some stage. The first thing we do when confronted with a culture clash, which can manifest in any of many different forms, is determine if there is really a need to challenge the culture at all. We will not compromise on patient safety. However, in many cases we can find new, innovative approaches that to accomplish our patient care goals within the social, corporate and medical governance cultural constraints.

Consider one type of medical governance culture clash. In most developed countries, nurses, junior physicians, and other care providers are now empowered to challenge the decisions of senior physicians or clinical leaders when a patient’s health may be at risk. The basic tenet, sometimes referred to as the “culture of safety,” is that any care provider on the team must speak up if there is a failure to follow practices shown by evidence to significantly improve quality of care. However, in many countries where we work the medical governance culture clings to an outdated model wherein no one openly questions the senior doctor’s judgment, even when it violates that tenet.

That is the challenge we ran into in Singapore (which while not a developing country is seeking to improve its health care delivery) in an oncology clinic we developed in partnership with the government. The nurses were reluctant to challenge doctors’ directives, even when the nurses believed the patients were at risk of harm. In cases like this, we seed the staff with professionals who lead by example. In Singapore we brought in nurses from countries in which nurses have greater autonomy. Their willingness to stand up to senior physicians shocked and initially offended staff. However, when everyone saw the behavior was supported by management and there was a steady improvement in patient outcomes, the staff slowly came around and the culture of timidity receded.

As another example, in some Gulf hospitals the social culture has led to some male patients refusing to see female doctors. As much as our own culture does not have this sort of gender-based bias, a simple solution respected of the local culture was to make sure the patient is aware of the doctor’s gender when scheduling appointments. Similarly, male physicians at some of these same hospitals learned to accept the fact that when treating a married woman they had to conduct all conversation through her husband, even while examining the patient. In both cases, patient safety and quality of care remained uncompromised.

Transforming risk to opportunity

Affiliations involve in part allowing a partner some form of use of an established institutional name, providing partners with brand recognition. It usually also involves providing access to additional management and clinical resources, and to specialized programs. It is important to define clear expectations of such an affiliation early on in the project, and most governance boards of the provider organizations will require assurance that the institution’s brand and therefore its reputational risk is well managed. JHI has over the years been exposed to risk factors over which it has no control, including the sources and sustainability of project financing; regulatory and legal systems protecting contracts, and the ongoing commitment to quality and safety by project partners. The challenge thus becomes determining whether or not the potential benefits of the project outweigh the inevitable risks.

First, determining the fit of the partner and project with our mission is critical. The initial negotiations provide important clues as to the chances of disaster down the road. Partners looking for a quick return on investment, or who appear to be mostly investing in the Johns Hopkins “halo,” or who are able to secure only incremental financing for their project, are not likely to be good choices for us. JHI has learned, after some hard lessons, how to pick up on the subtle signals that partners’ goals are not well-aligned with ours. For example, in the very first meeting we look to a potential partner to focus on a sustainable commitment to quality and patient safety, rather than on financial returns. Largely because of that policy, more than a third of our initial conversations do not lead to a second conversation.

We also walk potential partners through a rigorous and structured process of due diligence, which may involve our working with them to fill in gaps in their project planning and in the resources they have arrayed to support the project. Among the tools we use are the gap analysis and the clinical and management assessment, along with detailed reviews of their business plans. Although this rigor may initially be resisted, the result in most cases is a stronger partnership that mitigates risk substantially and leads to enhanced project sustainability.

Finally, we persuade partners they must undertake the process of seeking and maintaining accreditation. We convincingly argue that doing so helps ensure meeting regulatory requirements, provides a competitive advantage, and tangibly improves service quality and risk management. The private sector in particular tends to be amenable to pursuing accreditation as a strategy for differentiating itself in the market. Our contracts generally require that the facility produced by the project aim to earn accreditation from the Joint Commission International or another accrediting organization that sets an extremely high bar. We find that without this objective assessment leading to a tangible, prestigious outcome, our partners find it a lot easier to shrug off our exhortations for more effective change and improvement. In addition, we find that a written agreement about accreditation goals can serve as the core of the broader agreement presented for acceptance by the boards of directors on both our and the partner’s side.

We are also willing to work with whatever accreditation standards are most accepted in-country, be they from Accreditation Canada, a European Accreditation process, or a different organization. If there is a local accreditation system different than international standards, it is usually possible to carry out a cross walk between them in order to satisfy both.

Building capacity and plugging local gaps

Building the management and clinical capacity of partners is the most important element of our partnerships. But doing so can require some creativity and no small amount of flexibility. In one of our projects with a private non-profit entity in Turkey,
the success of the project depended on putting the right executives in place. These needed to be managers experienced in the complex operational and clinical challenges that all leading hospitals have to get right. JHI was prepared to find suitable individuals from within its own ranks, but Turkish law explicitly prohibits non-citizens from running hospitals. And yet finding the right local executive for the new hospital in Turkey proved impossible.

The solution was multi-pronged. First, we were able to put in a seasoned US manager as chief nursing officer, which is a critical role. That helped raise the partner’s awareness of the advantages of finding the right managers for key roles. More generally, local partners who resist recruiting anyone but local managers usually start to recognize within a year or two that local managers may be unable to provide the needed innovation and culture change, at which point they are likely to ask us to help fill executive management roles. In the case of the Turkish partner, it later enthusiastically agreed to place one of our managers in the number two role, and then it dissolved the top position, leaving our manager in charge while remaining in technical compliance with the law. The project is now thriving.

We do not seek to hold these roles long term. Our managers in the field focus not only on improving operations and clinical practices, but also on mentoring local managers with the goal of preparing them to take over within a specified period of time. In many cases, we rotate key local managers and professionals through our Baltimore base to become familiar with how our facilities operate. We also push to establish local training programs in fields that may lack them, including nursing leadership, hospital administration, hospital financial management, and HR.

Finally, we have set up a strong recruitment pipeline in Baltimore intended to attract more top US talent to the field of developmental health care, to give them special training, and to make sure that an overseas placement is a career boost rather than a career interruption.

In fact, there is a growing trend in some developing regions for private, public and quasi-public institutions to seek out mentoring and coaching relationships in order to build local skills and capacity. That's certainly true in the GCC region. In a current capacity-building project with a Ministry of Health in that region, we are implementing such a program to address both the management and clinical sides. Designed as a five-year project, the program includes rotating in clinical and administrative teams from our home campus in Baltimore focused on providing their local counterparts with knowledge transfer and education. These rotations are supplemented with coaching from clinical and management teams placed onsite longer term.

Lessons Learned

Several key lessons can be extracted from these experiences. Three of the most important are:

- Best practices can be transferred globally and, if properly adapted, can have significant impact in improving patient safety and care quality.
- Cultural clashes in their various forms can, if responded to flexibly, support rather than block improvement in patient care.
- Properly structuring partnerships is critical to successfully building capacity.

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Salim Hasham is Senior Vice President Global Services for Johns Hopkins Medicine International. Mr Hasham has served as President and CEO of a hospital system in Hawaii and has a 30 year history in international health care work. He has a MHA from University of Ottawa and an MSysEng from Clemson University.
Global implications from the US hospitals privatization experience

ABSTRACT: This Article summarizes the US market and regulatory forces which have contributed to – and are expected to accelerate the pace of – “public” or “governmental” hospital privatizations. It also sets forth the rationale for why we can expect to see an increasing number of governmental hospitals worldwide likewise choosing to restructure their governance platforms.

Much to the amazement of the rest of the world, the US spends over US$2.6 trillion annually – or more than 17 percent of its Gross Domestic Product – on health care. A large percentage of these expenditures are devoted to Medicare reimbursement to the nation’s 5,000 general acute care hospitals.

A key component of the US hospital industry is the large, but ever-shrinking component known as the “public” or “governmental” hospital sector. In the almost 35-year period from 1975 to 2009, the number of US public hospitals has decreased from 1,761 to 1,092 (a decrease from 29 percent to 22 percent of all acute care hospitals) (AHA 2010).

This article addresses the following issues: (1) What are the environmental and market factors accounting for this drastic reduction in US governmental hospitals? (2) Why we believe this trend will continue, if not accelerate, in the years ahead? (3) What, exactly, do we mean when we describe this trend as “privatization”? (4) What are the alternative privatization models which governmental hospitals have undertaken, and what are the perceived advantages and disadvantages of each? (5) What contractual protections do governmental bodies obtain in order to ensure that the successor “private” hospital operators abide by state-of-the-art accountability and transparency obligations, and finally? (6) What are the global implications of the US privatization experience for public hospitals internationally?

US governmental hospitals: A snapshot

Public hospitals historically have served a critical role in the US health care delivery system. Governmental hospitals originated soon after the country’s founding almost 250 years ago; the first of such hospitals opened in large cities on the US Eastern Seaboard in Boston, New York and Philadelphia. Such facilities served the poor and dispossessed immigrant populations as public health institutions of last resort. It is worth remembering that in the late 1700s and early 1800s, hospitals rarely possessed any technology, employed precarious few hygiene procedures, and utilized what are now considered barbaric surgical techniques – and all of this before anesthesia and penicillin had been discovered or implemented. The public hospital was where the poor obtained their health care; for the rest of the more fortunate Americans, birth, death and everything in between happened at home under physicians’ care.

Over the centuries, as the US continued to grow westward into both urban and rural agrarian societies, public hospitals burgeoned nationwide. Today’s 1,000+ governmental hospitals vary widely in size and scope and complexity of services provided, from 25-bed, rural, critical access county-owned facilities, to 1,000-bed State owned urban tertiary care academic medical centers.

In addition to their diversity of size and scope, US governmental hospitals are subject to the respective laws of each of the 50 States which “enable” their existence that is to say, a New York municipal hospital is created and is subject to the limitations of that particular State’s “city hospital” enabling statute, whereas a California “district,” “county” or “authority” hospital so exists by virtue of that State’s unique municipal, district, county or authority hospital laws.

Environmental assessment: What accounts for fewer US public hospitals?

As noted in the Introduction, there are almost 700 fewer public hospitals in the US today than there were three decades ago. While some of these hospitals have entirely ceased operations, the vast majority have changed their legal status, and are now operated by non-governmental entities. There are multiple reasons why governmental bodies throughout the US have determined that it was in their stakeholders’ interest to turn over hospital operating responsibility to “private” operators. What follows is a brief summary of the most common reasons:

The Need for Capital – Hospitals are technology-driven institutions. Aging plants and equipment demand capital-intensive replenishment. It is the increasingly rare governmental hospital which can generate the cash flow...
US public hospitals cannot respond as nimbly and effectively to market and health reform demands as can their non-governmental counterparts.

### Forces driving increasing privatization

The pace of privatization is increasing throughout the US. In addition to the competitive and financial market forces described above, the implementation of Health Reform – at both the Federal level by President Obama, as well as at the 50-State “local” level – is accelerating the need for governmental hospitals to operate more flexibly and responsively to payment incentives (and disincentives) to operate more efficiently, to provide better patient outcomes, and to do so at lower cost. Simply put, due to legal, political and practical realities, US public hospitals cannot respond as nimbly and effectively to market and health reform demands as can their non-governmental counterparts. And, even the few public hospital outliers, which have found ways to circumnavigate these problems, often find themselves viewed with disdain by potential partners – especially entrepreneurial physicians – with whom they may desire to more closely align. For all of these reasons, we feel confident predicting that the number of US public hospitals whose governmental owners choose to privatize in the years ahead will greatly increase.

### Privatization: A definition

While “privatization” of any governmental service is a highly politically charged term, the definition we use to describe the phenomenon is, we think, remarkably benign. It is the process by which a governmental body or entity transfers legal authority and responsibility for operation of an existing governmental function or service to a non-governmental entity or person.

Thus, in a governmental hospital privatization, the former public operator of the licensed health care facility “hands over the keys” for the hospital’s operation to a private party. The transferee-operator may be a non-profit corporation, a for-profit entity, or even a joint venture entity co-owned by a private party and the governmental-transferor.

Because a governmental hospital privatization transfers legal authority to operate the licensed hospital to a private party, the governing board of the public hospital – whether they are the governmental officials themselves, or, as in more often the case, their appointees – are no longer empowered or authorized to govern the hospital, which responsibility is passed onto the new private operator-licenseholder. Thus, the following are not privatizations, insofar as the licensed, legally authorized board remains in ultimate control of the public hospital: a management contract, outsourcing – or contracting out – discrete hospital services or departments, or “build-operate-transfer” contracts. In each of such latter situations, the governmental hospital board remains legally in charge of hospital operations and quality.

### Alternative privatization models

There are two primary vehicles through which governmental bodies may choose to transfer the legal responsibility for operation of a public hospital: (a) a long-term operating lease, or (b) an outright sale. The perceived advantage of a lease is often “political,” that is, the leasing governmental body can credibly inform its electorate that, should the private lessee-operator breach its contractual obligations under the lease agreement, the governmental-lessor can “take back the keys” to the hospital. Thus, in contrast to an outright sale, where if the new owner-operator were to breach its obligations under the purchase and sale agreement, the governmental body would be limited to suing
in court for monetary damages or for specific performance of the contracted terms – but it cannot take back operations, which it has irrevocably transferred to the private party.

**Contractual protections**

Whether the privatization vehicle is an operating lease or an outright sale agreement, thoughtful governmental hospital transferors should undertake a detailed process to identify – and then to embed in their transfer agreements – those actions it wants the new operator to commit to undertake and, conversely, those actions it wants to ensure that the private operator does not take, for an agreed-upon period of years post-transfer. So, for example, “wish list” covenants governmental bodies often elicit from new operators include:

- maintenance of certain clinical programs and service lines for a period of years (or establishment of new programs);
- capital expenditure commitments, including, sometimes, a promise to build a replacement hospital, or to invest in electronic health records and related health care IT;
- appropriate treatment – such as continued employment or medical staff credentialling and privileging – of existing employees and medical staff members;
- maintenance of “community benefit” programs, such as continued provision of indigent care, public education and health promotion and disease prevention programs, and the like; and
- budgetary and financial oversight, through periodic public reporting of results of operations (both financial and quality metrics) and ongoing compliance with contractual covenants.

This article does not permit a comprehensive discussion of the innumerable ancillary contractual terms often set forth in state-of-the-art hospital transfer contracts (such as: duration of the lease term, length of the covenants, indemnification rights, or right to assign, sublet or mortgage the underlying hospital real estate). Suffice it to say that detailed contract negotiations are often complex, protracted and absolutely essential in order to protect the financial and reputational status of the governmental-transferor, as well as the community’s stakeholders in the future operation of their precious public hospital asset.

**Implications of the US experience**

In common parlance, “when you’ve seen one deal... one deal.” That said, there are great commonalities among the hundreds of US public hospital privatizations of the last four decades, notwithstanding their great variability in size, complexity and political status. And, while governmental payor systems, access to health care as a legal right, and hospital political realities may vary extraordinarily world-wide, one thing, we believe, is common—that is, whether in the US, Europe, Asia, or the Global South, “health care and politics don’t mix well.” In the decades ahead, better informed consumers of hospital services, including the governmental and private payors which reimburse such services, will be increasingly demanding that pay be linked to performance and evidence-based, medically necessary clinical outcomes, and appropriate, cost-efficient resource utilization. The world’s best hospitals will need, more than ever, to have appropriate governance and legal structures in place in order to Nimby react to market and payment demands, and increasing competition from a highly fragmented marketplace, in which the vast majority of diagnostic and surgical procedures can be safely and effectively performed in non-acute, outpatient (and often freestanding) settings. Because governmental hospitals, unlike their private counterparts, have built-in limitations on their ability to be poised to respond flexibly to such demands, we expect that the years ahead will find hundreds of governmental hospital owners worldwide turning to the private sector to assume stewardship of these essential health care institutions.

Note

Mr Dube has personally advised on the privatization of dozens of US governmental hospitals over the last three decades. While he has first-hand knowledge of the rationale underlying such transactions, his advocacy on behalf of his governmental hospital clients has resulted only following his client’s independent evaluation of the advantages and disadvantages of undertaking such complex business and policy decisions. This article is not intended to present or offer legal advice; readers who are considering undertaking such a transaction should consult their independent advisors and legal counsel for detailed guidance.

Monte Dube has been a law Partner and Head of the Chicago Health Care Department of Proskauer, LLP. For over 30 years, he has counseled US and international health and hospital clients in mergers and acquisitions, joint ventures, restructurings and privatization transactions.

**Reference**

Collaborating to improve the global competitiveness of US academic medical centers

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ABSTRACT: President Obama announced the National Export Initiative in his 2010 State of the Union address and set the ambitious goal of doubling US exports by the end of 2014 to support millions of domestic jobs. Understanding the competitive position of US health care in the global market for international patients, University Health System Consortium (UHC), an alliance of 116 academic medical centers and 272 of their affiliated hospitals, representing 90 percent of the nation’s non-profit academic medical centers partnered with Rush University, a private University in Chicago, IL and the International Trade Administration of the US Department of Commerce International Trade Administration (ITA) to participate in the Market Development Cooperator Program. The goal of this private-public partnership is to increase the global competitiveness of the US health care industry, which represents over 16 percent of the GDP, amongst foreign health care providers. This article provides an overview of the US health care market and outlines the aims of the US Cooperative for International Patient Programs, the end result of the partnership between UHC, ITA and Rush University.

The global competitiveness of US academic medical centers has degraded in recent years due to increased competition from hospitals abroad that cater specifically to international patients seeking the highest quality of medical care. In an effort to bolster the competitive position of the US in the international patient care marketplace and in response to the Obama Administration’s National Export Initiative (NEI), a unique partnership has been formed between University Health System Consortium (UHC), the International Trade Administration of the Department of Commerce and Rush University. The genesis and current disposition of this collaboration are discussed.

Exposition
The U.S. health care industry is one of the largest in the world and represents 16.2 percent of the US GDP. Health care organizations provided 14.3 million jobs in 2008 and are projected to add 3.2 million new jobs by 2018. Twenty of the fastest growing occupations are in health care (http://www.bls.gov/oco/oc005.htm).

“Medical travel” is purposeful travel across country borders for medical care that is more accessible, higher quality and/or lower cost. It is important to differentiate between medical travel and medical care that is incidental to one’s primary purpose for traveling to another country in the context of the global competitiveness of the US health care industry. There is little that US health care providers can do to influence the volume of medical care incidental to the primary reason for travel, because the volume is principally driven simply by the number of foreigners coming to the US for business or personal reasons. US health care providers do directly influence the volume of medical travel exports, however, by providing high quality and cutting edge medical care, thereby encouraging international patients to choose the US rather than other countries for care.

Despite anecdotal evidence that increased competition from abroad has diverted foreign patients from the US to other countries, no current single data source can provide objective data to systematically and continuously measure medical travel or the growth in global competition for medical care exports.

Throughout the 1980s and 1990s, US inbound medical travel saw a significant increase due to the globalization of air travel and growing middle classes in the developing world. Several major trends over the last thirty years have also resulted in increased growth in the medical travel industry by health care providers abroad. While the US is perceived as the leader in high quality
Private hospitals and health care

health care, it is also among the most expensive. US health care prices have spiraled upward and, at the same time, foreign hospitals have improved their quality of care. As a result, the global health care market has become more competitive. As competition has increased, the demand for patients seeking care overseas has increased, increasing the speed of the health care globalization movement.

At the same time, the September 11th terrorist attack created new obstacles in the US for patients coming from the Middle East, the single region with the highest patient exports. As a result, Europe quickly developed international patient programs within their hospitals to meet this demand, creating a quicker and more accessible alternative to medical care that historically had been provided by US academic medical centers.

Finally, a decade of strong global economic growth allowed many developing countries to invest in their own medical infrastructures. Countries like Thailand, Singapore and India have cut deeply into the US market. Brazil, India, Russia, Cost Rica and Argentina are actively developing strategies for building their medical tourism industry. The United Arab Emirates embassy estimates that 90 percent of its citizens seeking care outside of the country go to Thailand and Singapore, with only 5 percent coming to the US and the remainder going to Europe.

International patients who come to US academic medical centers do so because they need care that local providers are either unable to provide at all or are unable to provide at the level of quality desired. Interview research with nationally-ranked academic medical centers that have an international patient program confirmed that growth in international patient revenues was due primarily to an increased demand for high-sophistication services, also referred to as “quaternary care” or complex care (Garman, Johnson, and Clapp 2008).

In addition to the revenues the health care industry receives associated with these patients, other industries in the US also benefit collateral from these exports. Often patients travel with family members and other supports, who will stay locally while the patient is receiving care. Although these “collateral benefits” have not been studied systematically, some estimate that they may add severalfold to the value of these health care exports to the local economies in which they are embedded.

There is clear evidence that the health care export market is undergoing transformative change internationally. Outside of the US, destination brands (e.g., Singapore, India) are becoming as strong, and in some cases stronger, than individual hospital brands. Other countries housing medical travel providers have begun capitalizing on this by collaborating at the national level to “brand” their countries as medical travel destinations. The need for a similarly collaborative approach in the United States is clearly evident.

Researchers at the Rush Center for the Advancement of Healthcare Value at Rush University in Chicago have been forecasting trends in health care innovation and globalization and predicting the ways in which innovations in quality, safety, and efficiency will shape the future of health care. Dr Tricia Johnson and Dr Andy Garman began evaluating international medical travel in 2007 in partnership with the Sloan Foundation. In their work with US health care providers participating in the ad hoc International Health Forum, Johnson and Garman were able to clearly articulate the need for a coordinated effort among US health care providers to “brand” the US as a medical travel destination and work collaboratively to support these efforts nationally. Characterization of inbound international patients was undertaken in collaboration with UHC (Hohmann, 2008, Satjapop 2010). The end result was a partnering with UHC in an application for the International Trade Administration Market Development Cooperator Program. UHC is an alliance of 116 academic medical centers and 272 of their affiliated hospitals, representing 90 percent of the nation’s non-profit academic medical centers. UHC’s mission is to advance knowledge, foster collaboration and promote change to help members successfully compete and succeed in their respective markets. UHC works with academic medical centers to accelerate improvements in clinical and operational excellence, thereby improving their competitive positions within the local, domestic and international markets. UHC collects data from these academic medical centers to facilitate performance improvement related to clinical, operational, financial, patient safety and supply chain areas. UHC programs provide opportunities for knowledge sharing and education across member hospitals. Examples of these programs include benchmarking and improvement services and e-mail listservs that allow members from across the country to share information.

The funds granted by the MDCP have been used to form a new structure within UHC for all US health care providers serving international patients. This partnership has created the infrastructure for academic medical centers to successfully compete with foreign hospitals catering to international patients, formally known as the US Cooperative for International Patient Programs (USCIPP). The USCIPP is currently working with 35 prestigious US hospitals and health care systems to achieve its goals which include: data collection and evaluation on the volume and characteristics of international patients being treated in the US; best practice identification and sharing amongst member organizations; joint promotion of the US health care “brand” to foreign government, commercial and private payers; and strategic relationship building between US providers and foreign stakeholders. The USCIPP is open to all US health care providers serving international patients. Inquiries about membership or general information should be directed to Molly Allen, Program Director at mallen@uhc.edu or +011-312-775-4201.
The US Cooperative for International Patient Programs is working collaboratively with US health care providers to greatly improve the global competitiveness of the US.

Conclusion

The US faces a three-fold challenge with regard to its competitive position in the international medical travel market. First, the US hospital industry loses revenue to other countries when its residents travel abroad to medical care. Evidence suggests that Asia and Latin America are the largest exporters of medical care to US residents. Second, the US hospital industry is losing revenue to foreign patients who select other international providers rather than US providers. Finally, there is a large, untapped market for medical travel to the US that should be systematically developed from the national perspective. It is clear that global competition has arrived in the health care market, and US academic medical centers must proactively tackle this competition. The US Cooperative for International Patient Programs is working collaboratively with US health care providers to greatly improve the global competitiveness of the US in this highly competitive arena by improving data collection, aggregation and valuation of medical care services provided to foreign patients who travel to the US specifically for the purpose of medical care and developing relationships with ministries of health and private payers abroad.

Molly Allen is the Program Director of the US Cooperative for International Patient Programs and the project coordinator for the UHC Market Development Cooperators Program Award from the US Department of Commerce, which seeks to expand the Medical Exports market in the US. Mrs. Allen oversees the 3-year award which is a collaborative effort between the International Trade Administration, UHC and Rush University. Mrs Allen’s previous experience includes work at Rush University Medical Center, Health Care Services Corporation and local government administration. Mrs Allen holds a Master of Science in Health Systems Management from Rush University (Chicago, IL), a Master of Public Administration from Northern Illinois University (DeKalb, IL) and a Bachelor of Arts from the University of Notre Dame (Notre Dame, IN).

Andrew Garman, Professor at Rush University, collaborates with Tricia Johnson in researching and forecasting trends in health services delivery, with a special emphasis on global trends and standards of excellence. He is the author of numerous books and research articles in areas including health care leadership, patient experience and interprofessionalism. He is co-author with Johnson and Tom Royer on the recently published book, The Future of Healthcare: Global Trends Worth Watching (Health Administration Press). In addition to his work with Prof. Johnson, Garman runs the non-profit National Center for Healthcare Leadership (www.nchcl.org), whose mission is to improve population health through the development of health care leaders. Dr Garman received a Bachelor’s in psychology with a mathematics emphasis from Penn State, a Masters in Personnel and Human Resource Development from the Illinois Institute of Technology, and a PsyD in Clinical Psychology from the College of William & Mary. He is also an Illinois licensed clinical psychologist, and a Senior Fellow with the Health Research & Educational Trust.

Tricia Johnson PhD, is associate professor and health economist at the Department of Health Systems Management and director of the Rush Center for the Advancement of Healthcare Value at Rush University in Chicago. Drs Johnson and Garman are leaders in forecasting trends in health care innovation and globalization and predicting the ways in which innovations in quality, safety, and efficiency will shape the future of health care. Johnson has a particular interest the economic impact of international and domestic medical travel on health care providers and the national economy. She is a 2009 Fulbright Scholar in Austria, where she has worked in the Institute for Social Policy at the Vienna University of Economics and Business. Johnson is currently the acting chair of the Department of Health Systems Management at Rush University. Dr Johnson has a PhD in economics from Arizona State University, MA in hospital and health administration from The University of Iowa and BA in economics from Coe College.

Samuel Hohmann is principal consultant – Research for the Comparative Data and Informatics group at University HealthSystem Consortium in Chicago, IL. There he facilitates member engagement in data resources provided by the Clinical Data and Informatics enterprise. His focus is on encouraging the use of UHC data for medical and health services research. Dr Hohmann also provides advice on development of UHC’s integrated data environment, serves as an end-user in testing new software performance, conducts audits of internal data bases, and contributes to UHC’s drive for internal data quality. In addition to his responsibilities at UHC, Dr Hohmann is an Assistant Professor of Health Systems Management at Rush. Prior to coming to UHC, Dr Hohmann was at Loyola University Health System in Maywood, IL, where he was Project Director of the Integrated Advanced Information Management Systems planning grant from the National Library of Medicine. Dr. Hohmann was formerly Vice President of Research and Statistics at QuadraMed, a clinical decision support vendor. Prior experience included tenure at MMI Companies, Inc., a hospital liability insurance company as Executive Director of MMI’s Institute for Healthcare Risk Management Studies. Previous experience included research and development using the Illinois Health Care Cost Containment Council’s hospital discharge database and characterizing patient cohorts receiving care at Illinois hospitals. Dr Hohmann has a Bachelor of Science degree in chemistry from the University of Illinois-Urbana/Champaign, a Doctorate in bioengineering from the University of Illinois at

World Hospitals and Health Services Vol. 48 No. 2
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References
A zebra or a painted horse? Are hospital PPPs infrastructure partnerships with stripes or a separate species?

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ABSTRACT: Public Private Partnerships (PPP) have been common in infrastructure for many years and are increasingly being considered as a means to finance, build, and manage hospitals. However, the growth of hospital PPPs in the past two decades has led to confusion about what sorts of contractual arrangements between public and private partners constitute a PPP, and what key differences distinguish public-private partnership for hospitals from PPPs for infrastructure.

Based on experiences from around the world we identify six key areas where hospital PPPs differ from infrastructure partnerships. We draw upon the hospital partnerships that have been documented in OECD countries and a growing number of middle-income countries to identify four distinct types of hospital PPPs: service focused partnerships in which private partners manage operations within publicly constructed facilities; facilities and finance PPPs, focused on mobilizing capital and creating new hospitals; combined PPPs, involving both facility and clinical operations; and co-located PPPs where privately operated services are developed within the grounds of a public hospital.

These four types of hospital PPPs have differing goals, and therefore different contractual and functional aspects, as well as differing risks to both public and private partners. By clarifying these, we provide a base upon which hospital PPPs can be assessed against appropriate goals and benchmarks.

Public Private Partnerships (PPP) are used for differing reasons across a range of industries. PPPs in the water sector have successfully mobilized private operators to turn around failing public companies and expand access to water services. In the building sector, PPPs have transferred responsibility of construction and estates management to private companies, leaving government departments to focus on their core activities (Grimsey and Lewis 2004). Increasingly policymakers are exploring PPPs as a means to improve their public hospitals. However, the performance goals and policy context for hospitals differ considerably from those in which PPP models evolved (Grimsey and Lewis 2005; Brinkerhoff and Brinkerhoff 2011). Discussions about PPPs in the health care sector are often hampered by confusion about what the term means, with multiple models grouped without distinction on the umbrella PPP term (Field and Peck 2003). Lacking a clear vocabulary, health policymakers find it difficult to sort out what these “imported” models offer and it is difficult to understand which models are likely to address the performance problems for which a specific PPP is contemplated (Ng and Loosemore 2007).

We review the PPP models most frequently applied in other sectors, and increasingly in hospitals, and use configuration analysis to group them into categories with analytically important distinctions among them. We propose a typology of hospital PPPs to permit clearer communication and more sound analysis. Clearer specification of their characteristic mechanisms also illuminates the problems that each PPP type has been “built” to address. Establishing analytically meaningful categories allows researchers to compare “like with like”. We hope that this typology will support much needed evaluative research in this field.

Defining PPPs

PPPs are a form of contract between a government and a private entity in which the private partner undertakes the long-term provision of publicly beneficial services. Initial injection of capital by the private partners is a key component of many, though not all PPPs. What critically distinguishes a PPP from a service contract is the duration and intended distributed benefit.
An important source of confusion about what a PPP is and what it is intended to deliver to the health system derives from the different perspectives of two groups of professionals. One group has a background in infrastructure PPPs – and they seek to bring the benefits of this model to the hospital sector. In infrastructure sectors, PPPs are implemented mainly as a means to mobilize private capital, transfer investment risk, and consolidate the finance, construction, and maintenance activities into a single contract for easy of management by government, with ensuring gains in efficiency by the private operators. Often the advantage of an infrastructure PPP is that financing can be recouped by direct billing of service users, bypassing government budgets entirely. The infrastructure model proponents view the mobilization of private finance as the critical component of a PPP, central to the benefits of the model, and the focal point for contractual attention (Brown 2007).

The second group comes to PPPs from health services and is engaged with PPPs as a means to bring private management expertise, flexibility, and care delivery models to hospital operations. This group focuses on service contracting, responsiveness, and efficiency in both the conceptualization and operations. This group views the incorporation of better management systems and expertise, flexibility, and care delivery models to hospital PPPs as a means to bring private management expertise, flexibility, and care delivery models to hospital operations.

**Table 1: A Typology of Hospital PPPs**

<table>
<thead>
<tr>
<th>PPP Category</th>
<th>Common term</th>
<th>Definition/ Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>Operating contract</td>
<td>A private organization is brought in to operate and deliver publicly-funded health services within a public facility.</td>
</tr>
<tr>
<td>Facility/finance</td>
<td>Project (PFI)</td>
<td>A public agency contracts a private entity to finance, design, build, and operate a hospital facility. Health services within the facility are provided by government.</td>
</tr>
<tr>
<td>Combined</td>
<td>Build-Operate-Transfer (BOT)</td>
<td>A private organization establishes capacity (through new construction or expansion of existing facility) to provide health services under sustained public/social insurance reimbursement.</td>
</tr>
<tr>
<td>Co-location</td>
<td>Co-location</td>
<td>A public agency allocates a portion of a public hospital’s land and/or premises for sustained use by a private organization in exchange for payment and specified benefits to the public agency.</td>
</tr>
</tbody>
</table>

Source: Authors’ analysis

An important source of confusion about what a PPP is and what it is intended to deliver to the health system derives from the different perspectives of two groups of professionals. One group has a background in infrastructure PPPs – and they seek to bring the benefits of this model to the hospital sector. In infrastructure sectors, PPPs are implemented mainly as a means to mobilize private capital, transfer investment risk, and consolidate the finance, construction, and maintenance activities into a single contract for easy of management by government, with ensuring gains in efficiency by the private operators. Often the advantage of an infrastructure PPP is that financing can be recouped by direct billing of service users, bypassing government budgets entirely. The infrastructure model proponents view the mobilization of private finance as the critical component of a PPP, central to the benefits of the model, and the focal point for contractual attention (Brown 2007).

The second group comes to PPPs from health services and is engaged with PPPs as a means to bring private management expertise, flexibility, and care delivery models to hospital operations. This group focuses on service contracting, responsiveness, and efficiency in both the conceptualization and assessment of PPPs. Hospital operation and management experts view the incorporation of better management systems from the private sector as central to improving health services, and as the core benefit, and focus, of a hospital PPP (Dorganet al. 2010). Because of the differing perspectives, the collection of hospital PPPs implemented around the world includes examples that each group view as having been undertaken for the wrong reasons, and often as being inappropriately designated a PPP. As we will explain below, we believe that the commonalities of partnership arrangements and duration of engagement justify the inclusion of partnerships as defined by both groups in the same, shared, PPP designation. That said, we believe it is critical for policy-maker, analyst, and economist to distinguish the structural features and objectives that drive each transaction.

**Hospital PPPs vs Infrastructure PPPs?**

The documentation on infrastructure PPPs is growing, and the models, risks, benefits, contract structures, and financing issues are understood (Brown 2007). Since at least the 1860s, governments have sought to encourage private investment in areas of public benefit through mixtures of land grants or long-term leases (railways, toll highways), monopoly grants (canals), and enduring purchase commitments (water and electricity). The pricing of assets, loans, and share of income or fee waivers have all grown more sophisticated, but an infrastructure PPP today is very similar to those from a century ago. As in the days of railway PPPs, profits are gained largely through better management, use of zero-cost land leases, and monopoly or quasi-monopoly control of a resource used by many purchasers. For the government, these PPPs are attractive because the risk and effort of investment is taken on by a private entity. Society as a whole benefits from the new infrastructure or utility services that otherwise would not exist. The mechanics and sources of gains in infrastructure PPPs translate imperfectly to hospitals and healthcare. Acknowledging the minor variation between hospital PPP models, there are six key issues that are common to hospital PPPs and make them different from their infrastructure homonyms:

- **Government, not individual, is primary purchaser of outputs:** Infrastructure PPPs commonly collect fees from multiple consumers – drivers on a highway, passengers on a railway, factories and homes receiving water or electricity. By contrast, hospital PPPs typically receive nearly all of their income from one government. In the form of a scheduled lease, payments or unit service payments. This simplifies, constrains, and adds risk to the income stream of private operators in hospitals.
- **Partnership risks are political rather than marketplace:** As a result of the government primacy in purchasing noted above, the risks of hospital partnership success are often more due to uncertainty about long-term compliance with payment obligations, than market demand projections. For this reason the borrowing costs for hospital PPPs are usually higher than the cost of infrastructure financing.
- **Measurability of outputs:** Infrastructure PPPs deliver highly measurable outputs, whether power, water, road access, or otherwise. Inpatient services are immensely varied based on the condition, co-morbidities, and patient characteristics and largely unobservable (Preker et al. 2000).
- **Variability of outputs over time:** During the 20 to 30 year life of a typical hospital PPP the population served by the facility can be expected to change in composition, wealth, age, and illness. This is particularly true in low- and middle-income countries (LMICs) where both demographic and epidemiologic transitions may be occurring simultaneously, contemporaneous
with rapid economic development. All of these will affect the medical service mix, or outputs, of the hospital. By contrast, in infrastructure PPPs variation in output volume is normal, but output mix is constant.

**Variability of technology and organizational configuration over time:** The pace of change of medical service delivery is increased every year due to changing regulation, reimbursement systems, technology, and better information. Across the OECD there are large changes each year in the inpatient-outpatient mix, the duration of stay for each service, with new technology leading to changes in diagnostic and treatment protocols, and care shifting from doctors to nurses to physician assistants, and sometimes back in the other direction. The unpredictability of these shifts, together with the high proportion of overall project cost that is due to operations, is unique to hospital PPPs.

**Ratio of investment capital to operating capital:** Over the life of a hospital clinical, laboratory, pharmacy and medical services represent 65 per cent of annual operating costs and ancillary services (food, support, IT) another 17 per cent. Facility maintenance and amortized construction costs are less than one fifth of total budget (EBRD2007). For infrastructure operations, the cost of design, construction, finance and maintenance are the large majority of total costs. This means private involvement in design, construction, and maintenance of hospital entities has a lower potential for efficiency gains than in infrastructure projects. In hospitals, the majority of the potential efficiency gains come from service provision. The implications for governmental obligations and transaction gains or costs are summarized in Table 1.

1. The US Centers for Medicare and Medicaid Services list 998 different diagnostic codes in their most recent guide.

### Table 2: Major differences between hospital PPPs and infrastructure PPPs

<table>
<thead>
<tr>
<th>Government vs Private purchaser of output</th>
<th>Infrastructure PPPs</th>
<th>Hospital PPPs</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Private buyers/payers</td>
<td>- Government does not enter into long-term service purchasing relationship as part of transaction</td>
<td>- Government (or social health insurer) buy all or most services</td>
<td>- Substantial risks to government payer as a result of long-term funding “lock in” obligation</td>
</tr>
<tr>
<td>- Government does not enter into long-term service purchasing relationship as part of transaction</td>
<td>- Government enters into long-term service purchasing relationship as part of transaction</td>
<td>- Substantial political risks to private partners in hospital PPP</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Business risk vs Political risk</th>
<th>Infrastructure PPPs</th>
<th>Hospital PPPs</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Borrowing costs reflect estimated risk of demand for infrastructure services by total market of potential payers</td>
<td>- Borrowing costs reflect risks associated with single or multiple government payer agencies</td>
<td>- Cost of finance (and therefore capital) higher for hospital facility investment</td>
<td></td>
</tr>
<tr>
<td>- Cost of finance (and therefore capital) higher for hospital facility investment</td>
<td>- Cost of finance (and therefore capital) higher for hospitals</td>
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</table>

<table>
<thead>
<tr>
<th>Measurability</th>
<th>Infrastructure PPPs</th>
<th>Hospital PPPs</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Comparators for benchmarking cost of facility availability services are somewhat limited</td>
<td>- Comparators for benchmarking cost of services often extremely limited</td>
<td>- Probability of that payment contract will set excessive rates is higher for hospitals</td>
<td></td>
</tr>
<tr>
<td>- Probability of that payment contract will set excessive rates is higher for hospitals</td>
<td>- Comparators for benchmarking cost of services often extremely limited</td>
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</table>

<table>
<thead>
<tr>
<th>Variability of outputs over time</th>
<th>Infrastructure PPPs</th>
<th>Hospital PPPs</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Products stable over time</td>
<td>- Products highly variable due to volatility in demographics and disease</td>
<td>- Risk to private partners necessitating either higher return contingencies, or flexibility in contract modification</td>
<td></td>
</tr>
<tr>
<td>- Products highly variable due to volatility in demographics and disease</td>
<td>- Risk to government due to “locked in” commitment to hospital/configuration that may not be needed in the future</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Variability of technology over time</th>
<th>Infrastructure PPPs</th>
<th>Hospital PPPs</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Service delivery technology and organizational models change slowly</td>
<td>- Service delivery technology and organizational models change rapidly</td>
<td>- Risks to government and private partners as a result of lost flexibility to adapt service organization; or cost of unpredictable adjustments to technology, systems and staffing</td>
<td></td>
</tr>
<tr>
<td>- Risks to government and private partners as a result of lost flexibility to adapt service organization; or cost of unpredictable adjustments to technology, systems and staffing</td>
<td>- Service delivery technology and organizational models change rapidly</td>
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<table>
<thead>
<tr>
<th>Ratio of investment to operating capital</th>
<th>Infrastructure PPPs</th>
<th>Hospital PPPs</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- High ratio of capital to operating costs</td>
<td>- Low ratio of capital to operating costs</td>
<td>- Efficiency gains from private finance/design/construction and operation of hospital PPPs lower than for infrastructure PPPs</td>
<td></td>
</tr>
</tbody>
</table>

Source: Authors’ analysis
predictable in hospital PPPs than in infrastructure PPPs.

**Typology**

Hospital PPPs range from the health service focused to the infrastructure focused. In many instances PPPs incorporate aspects of both. From our review of documented hospital PPP initiatives, four distinct structures, or types, emerged, distinguished by what the public partner is “buying or selling” from/to the private partner, and the primary objectives of the partnership.

In the first model, “services” are the core of the partnership. In order to improve the quality and/or efficiency of hospital services provision, avviate organization is brought in to operate and deliver publicly-funded hospital services, usually within the existing infrastructure of the government (La Forgia and Harding 2009). The facility may be built by government explicitly in preparation for this model of service PPP.

The second model involves a public agency contracting a private entity to finance, design, build and operate a hospital facility within which a public service is run. We refer to this as the “facilities and finance” model. It is popularly referred to as the PFI model, coming from the name of the “Private Finance Initiative” program which first applied the model in the UK (McKee et al. 2006, Edwards 2006).

Under the third model, a private organization establishes capacity to provide hospital services under sustained public or social insurance reimbursement. We refer to this as the “combined” model, since the public sector “buys” hospital services combined with the underlying facilities and related finance. There are two variants under this model, which merit distinction. In one variant, a public agency tenders to have a private organization build a new facility and provide services; in the second, the private organization takes over an existing facility and services. The former has been applied to add capacity and assure social insurance reimbursement. We refer to this as the “facilities” model. The latter is more politically controversial, but has the potential to harness the private sector to take over existing hospital facilities and turn them around, as has been the case in Germany (Roeder 2012, Coelho and O’Farrell 2009).

Under the fourth model, public agencies do not buy services but rather allocate public hospital real estate for a private service provider to develop services “co-located” within the public facility. The private organization makes payments to the public agency, as well as providing in-kind services. Most often the objective of this kind of partnership is to capture the value of the real assets, and to tap the private operator’s services and expertise for the benefit of public patients. Facilitating dual practice as an incentive to both build and test a model of the criteria that will make a PPP likely to succeed or fail. The typology presented here is an advance towards this goal.

Dominic Montagu is an assistant professor of epidemiology and biostatistics and lead of the Health Systems Initiative at the Global Health Group of the University of California, San Francisco. His work is focused on private delivery of health services in developing countries and on market function for health services and health commodities. He holds Masters degrees in business administration and public health and a doctorate in public health from the University of California Berkeley. Dr. Montagu has worked extensively in Africa and Asia, and teaches on the private sector in developing countries, and on regulation of private hospitals and private public partnerships at UCSF, UC Berkeley and on behalf of the World Bank Institute.

April Harding is an economist and health systems specialist with the World Bank Institute. She is a sought-after speaker, author, and policy adviser on the private health sector, public-private partnerships, as well as hospital reform and governance. April has provided policy advice and analytical support to more than 20 governments of transition and developing countries on these topics. She recently returned to the World Bank from the Center for Global Development, where she undertook research examining five global health programs, child health, TB, malaria, family planning and HIV/AIDS, looking at how these programs interact with the private sector in their implementation, and how this contributes to their success or failure. Her findings are presented in her book “Private Patients: Why Health Aid Fails to Reach So Many, and What We Can Do about It” (forthcoming 2012, Brookings/Center for Global Development). She served as a contributing editor at Health Affairs, where she helped the journal develop their global health coverage. Prior to joining the World Bank, April was a research fellow at the Brookings Institution. She received her doctorate in Economics at the University of Pennsylvania.
Private hospitals and health care

References


http://hansdorns.wathebook.org/19TSA04EST07PMW0812/Resources/MPAccessionSeries MHP12 accessed on 20.03.2009.

The role of Public Private Partnership: The Brazilian experience of modernizing hospitals in the São Paulo Prefecture

Health Secretariat

ABSTRACT: Within the health sector, the aim of the PPP model is to improve management efficiency and innovation in health care services while it also helps to accelerate the modernization of national health systems. Gesaworld’s experience in Brazil, including the modernization of the hospital network of the São Paulo Prefecture, has contributed to improvements in the health of the population by offering better health care facilities. The scope of the project, which is based on the legal model of an administrative concession contract, includes sustainability criteria as part of the project.

Gesaworld is an international consultancy group which was founded in 1999. Its main activities are focused on improving health services and the social sector. Today, Gesaworld is one of the main consultancy companies in the Spanish market for the health and social sectors, and it has become a reference point in its area of expertise at an international level. The international nature of the company can be clearly seen in its list of clients, which include the main actors in the health and social services of several countries as well as international bodies such as the World Bank, the European Union, the United Nations and the Inter-American Development Bank.

Gesaworld projects are guided by its focus on maximum efficiency, client-oriented organization systems, management by objectives, quality management, transparency and efficient information systems. Over the last 12 years, we have carried out more than 200 projects in some of the following areas: strategic consulting for the reform of the health sector, advice on health system performance, the development of health sector strategic plans, functional planning and the management of health institutions, evaluation of public health policies, auditing of health centers and hospitals and the management of public institutions etc.

Gesaworld’s other activities include an awareness of the need to ensure sustainability within the health system, insofar as the health sector has a leading and responsible role to play and it is a driving force behind economic and social development. For this reason, addressing global sustainable development is one of the main branches of Gesaworld’s strategy, which involves integrating the three areas that define management: economic, social and environmental.

Our recent experience means that we can offer sustainability consulting to help health institutions to structure their policies and actions in this area. We focus these efforts on sustainable development throughout the value chain, thereby offering effective and efficient delivery aimed at achieving sustainable solutions.

The Brazilian experience in Public Private Partnership (PPP): More medical effectiveness and long-term sustainability

Project: A Public Private Partnership for the modernization of hospitals in the Health Municipality Secretariat of the São Paulo Prefecture (Prefeitura de São Paulo (2011)). In 2010, Gesaworld was awarded the contract to provide professional expertise for the technical definition of the private public participation (PPP) project for the modernization of the hospital centers of the Health Municipal Secretariat in São Paulo, Brazil. The scope of the project, which is based on the legal model of an administrative concession contract, includes constructing and fully equipping three new hospitals; four diagnostic centers that use reference imaging; the complete renovation of five hospitals; the complete replacement of six existing hospitals and the provision of non-health care services to enable the correct functioning of hospitals both in terms of medical equipment and the provision of proper care for clients. These services are: sterilization, laundry, hospital cleaning, maintenance of medical equipment, computer systems maintenance, building maintenance, hospital catering, admission and reception, telephone and surveillance services.

The project is the first PPP to incorporate sustainability criteria not only in the design, implementation and maintenance works, but also in the management of equipment and non-health care services. As a result, the entire project is focused on attaining
sustainability certification for both the planning and the subsequent management. The new hospitals are designed to incorporate new technologies and the medical advances and services that are necessary to facilitate clinical efficiency.

The São Paulo Prefecture has defined the key objectives of the project:

+ Improve the health condition of the population.
+ Create sustainable protocols while maintaining inputs and obtaining environmental certifications.
+ Improve the comfort and safety of patients and professionals.
+ Modernize the management of health services in hospitals through high-resolution units and ambulatory surgery.
+ Incorporate new technologies such as digital imaging.
+ Incorporate more efficient administrative management practices.
+ Increase and improve the production capacity.
+ Create quality protocols in non-care services.
+ Increase and improve the production capacity.

The project is divided into six phases:

**Needs analysis**
The starting point of the project begins with a needs analysis, based on a diagnosis of the health care situation, considering different variables such as: population pyramid, current demand and supply, bed ratio, care needs in the region, analysis of the main causes of death, maternal deaths, index of aging population, number of infant deaths etc. From the evaluation of epidemiological data and the desires of the population, it highlights the need to construct new hospitals and reform existing ones.

**Supply sizing**
After the needs analysis, supply sizing is required to analyze the portfolio of services and the capacity installed. This includes a physical, functional, and operational diagnosis of the various hospitals in the São Paulo Municipal Hospital Network. The supply sizing process considers different aspects:

- health needs index;
- coefficient of general beds per region;
- characterization of the unit (hospital sector services, specialties of hospitalized patients, emergency sector specialties, surgical center);
- diagnosis of hospital infrastructure;
- support services to be rendered by the public private partnership (non-care services);
- analysis of the regulatory framework related to the project (Federal legislation and state and municipal legislation of São Paulo).

**Functional planning**
The portfolio of services and functional planning is developed on the basis of supply sizing. The functional plan establishes the basis...
of the needs of individuals, allowing the development of a services portfolio. The functional plan of the project, which includes 14 hospitals and four diagnostic centers, covers a total area of 210,000 m² with 21 medical specialties and approximately 2,206 beds provided, which is a 79 percent increase on the current situation. Furthermore, the different functional plans incorporate technological innovations in construction and services (including digital hospital, telemedicine, high-resolution services and environmentally sustainable building etc.). The functional plan also includes a description of the areas and the different health services and places an emphasis on the roles and the specific requirements of each plant in order to provide support for the final architectural design of the hospital.

### Proposed model of hospital

Once the functional plans and the service portfolio have been designed, the General Reference Hospital Model is put forward. This means that the service portfolio includes the hospital’s core areas, which are: hospitalization, outpatient consultations, emergency, and major and minor outpatient surgery. The composition of hospital services is based on epidemiological data and population trends for the region. The model of the hospital proposed allows for an increase in hospital efficiency and the quality of health care.

### Sustainable certification

As we have already mentioned, the project highlights the importance of sustainability in the construction and rebuilding of the different hospitals. Sustainability is considered right from the start of the project and sustainable criteria are incorporated into the functional plans of the hospitals and into technological and health services. There is also an emphasis on the inclusion of sustainability criteria in the construction of new hospitals and reform processes. At this stage, Gesaworld was the first company to collaborate with the health sector in Brazil in achieving a sustainable certification based on the Haute Qualité Environnmentale (HQE) model criteria.

The Vanzolini Foundation is the institution responsible for granting the sustainability certification, through independent face to face audits. The certification is known as AQUA, and it is an adaptation of the standard French HQE model.

### Economic and financial studies

Financial and economic studies were carried out with the aim of analyzing the budget for the construction, equipping and the other services included in the project. The maximum unit cost (i.e. the market cost) was used to perform this economic analysis due to its efficiency compared to the administration cost approach. Using this methodology, purchasing power is increased, and accordingly the cost per volume can be reduced. The Economic Research Institute Foundation (FIPR) conducted the financial modeling on the basis of these economic studies.

The first step in financial analysis and modeling is the gathering and analysis of historical data, including financial and organizational data, operational and technical aspects and other
relevant information necessary to carry out the modeling. In addition to the specific data related to the sector, the collection of macroeconomic variables such as interest rate, inflation, gross domestic product (GDP), exchange rate and demographics (population, growth rates) is also necessary. These macro-economic and demographic changes are needed and are key elements for the calculation of demand, costs, revenues, investments and debt service.

The financial model simulates the financial results of the project by showing cash flows under different scenarios. The model also reflects the risks associated with the project (and the associated capital cost). This financial model allows for a decision-making process based on the project structure and operating environment. The model can simulate construction cost overrun, changes in operating costs, projected changes in demand or changes in inflation or the interest rate. The financial model is used throughout the entire process, as it allows a continuous assessment of the impact of changes in costs, financing and service scenarios used to update or confirm decisions related to the structure of the project.

The analysis of the total investment in infrastructure, equipment, technology and information, amounts to some US$678 million. Similarly, the economic study of non-care services (laundry, equipment and maintenance, reception, security, etc.) amounted to US$67 million by year.

Public bidding process
Throughout this process, Gesaworld has been involved in advising on contractual requirements and the criteria for bid evaluation and public consultation. Gesaworld is also responsible for the preparation of technical annexes and support in all phases of the public bidding process, and it subsequently takes charge of the PPP contract management phase and the monitoring of all stages of implementation.

One of the key elements at this stage is the joint coordination of the various departments of the Prefecture of São Paulo: the Municipal Secretary of Health, the Municipal Department for Legal Affairs, the Municipal Planning and Budget Department, the Municipal economic development and labor department, the Municipal Urban Infrastructure as well as the Public and Private Partnership Society of São Paulo. In this sense, it is important to point out the significant role of the Public and Private Partnership Society, in the work of coordination and quality control of the project.

Conclusion
Gesaworld’s international experience in the health sector has facilitated the design of a private public partnership project to provide the health care services offered by the São Paulo Municipal Secretariat, offering the highest level of excellence ever seen.

The lessons learned highlight the importance of sustainable practices within the scope of the project, and the hospitals concerned were the first Brazilian hospitals to receive Environmental Certification status. The consulting activity of Gesaworld in the social and health care field gives us a privileged view of how sustainable development is taking place in hospitals, primary care and other resources around the world.

In addition to other results, these hospitals will create 4,500 jobs as a result of the economic development in the region driven by the magnitude of this project. Likewise, another achievement is characterized by reduced travel between their residences and the new hospitals for patients and staff.

The Public Private Partnership (PPP) model has provided the following social, health, environmental and economic benefits:

1. Immediate access to new services, in only three years this model has already given a large section of the São Paulo population access to health facilities.
2. Integration of innovation aspects into the organizational, healthcare, technology and communication models, providing high quality standards for clinical practice in a fast and effective way.
3. The accessibility and innovation have resulted in substantial improvements in the health of the São Paulo population;
4. Environmental compliance criteria: the 238,804 m² of the project were designed following the most stringent criteria in order to reduce their environmental impact and provide maximum efficiency solutions;
5. Economic efficiency: thanks to the use of economic variables from the private sector such as lower prices and the ability to group purchase volumes.

The PPP model is a complex process that requires three essential elements in order to guarantee the long term success of the implementation of the project:

1. Political leadership;
2. Technical strength;
3. Project management.

Finally, another key element of a successful PPP model comes from a precise definition of the project, transparency and completeness, the implementation and accountability of a quality model and the ability to achieve financially attractive projects.

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Joan Castilhejo is chairman of the Gesaworld Group and holds a degree in Medicine and Surgery and a Masters degree in Health Economics and Health Management. Dr Castilhejo has acted as an international advisor and consultant to government institutions and multilateral organizations in Central America and Brazil on matters related to the development, implementation and evaluation of health system models.

References
ABSTRACT: Nairobi Women’s Hospital is a private for profit hospital that has been in operation since 2001. Its main target is reaching women and children with affordable high-quality services. Its initial growth plan was stranded by lack of capital. The Africa Health Fund managed by Aureos Capital took a stake in the hospital in December 2009 to provide the needed capital for expansion. The investment has seen the hospital expand rapidly from 57 beds to 226 beds in three campuses. The affiliated nursing school has also opened. Based on its recent successes, NWH is now currently looking at borrowing an additional US$10 million from IFC to expand in the East Africa region.

The Nairobi Women’s Hospital (NWH) opened its doors to its first patient in 2001 with the aim of providing high-quality holistic care to women and children. The business idea was inspired by an incident in which Dr Sam Thenya, the founder and group CEO, was confronted with the case of a poor woman presenting at one of Nairobi’s top private hospitals for emergency obstetrics care. She was, however, turned away by the hospital since she could not pay. When he tried to intervene, Dr Thenya was reminded that the hospital was not for the poor and if he wished to serve the poor, he should open his own hospital. And there and then, the idea of Nairobi Women’s Hospital was born. He subsequently mobilized a group of doctors who pooled resources to start NWH as a private for profit facility that targets middle- to lower-income groups.

At its inception, the hospital’s primary focus was maternal health (obstetrics and gynecology). However, the scope has since been expanded and now it caters for a wider range of patients including most medical and surgical conditions. A nonprofit organization, the Gender Violence Recovery Centre (GVRC), is also based at the hospital. The centre was established as corporate social responsibility arm of NWH to provide medical management, HIV Post Exposure Prophylaxis and psychosocial treatment to survivors of rape and domestic violence.

The hospital which initially had only 57 beds faced a number of challenges in its growth plan. The most critical was lack of access to capital for expansion. This is consistent with the findings of Business of Health in Africa published by the World Bank in 2007 (World Bank 2007). The report identified limited access to capital as one of the barriers to productive growth in the private health sector in Africa.

Collaboration with Africa Health Fund

The Africa Health Fund (AHF), administered by Aureos Capital, is a pilot fund with a specific investment focus on the health care sector across the African continent. The fund, established in June 2009, seeks to deliver social benefits alongside investment returns. It targets businesses that focus on health services provision, distribution and retail, life sciences, risk pooling and medical education. The AHF team pursues this objective by making investments of between US$250,000 and US$5 million in small and medium-sized enterprises. Its main investors are the International Finance Corporation (IFC), the African Development Bank, DEG, Bill & Melinda Gates Foundation, Elma Foundation, Maria Wrigley Trust, ASN Bank and Norfund amongst others. AHF began work at around the same time that the NWH was looking for capital to expand. They approached Aureos and as a result NWH became AHF’s first investment. AHF acquired a stake in NWH by injecting in US$2.66 Million for expansion in December 2009. The Africa Health Fund managed by Aureos Capital took a stake in the hospital in December 2009 to provide the needed capital for expansion. The investment has seen the hospital expand rapidly from 57 beds to 226 beds in three campuses. The affiliated nursing school has also opened. Based on its recent successes, NWH is now currently looking at borrowing an additional US$10 million from IFC to expand in the East Africa region.

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Private hospitals and health care

NWH is a local initiative run by a Kenyan management team. As a business, NWH has remained profitable even during the rapid expansion phase. This is because they are able to address a segment of the market that was largely ignored.

In 2009, the additional capital was to help NWH to open three more campuses in low-income areas and to establish a nursing training school. In addition to financial inputs, AHF provided technical assistance to improve internal operations of the hospital and to improve governance structures for the hospital. According to Dr Thenya, this is one aspect of the funding that separates it from all the other potential sources of funds that they considered. The goodwill from partnering with AHF was also a factor – particularly the profile of the investors into the fund.

The investment has resulted in phenomenal growth for the hospital over the last two and a half years. The number of beds has expanded from the original 57 to 226 spread across the three campuses around Nairobi. Prior to the investment, NWH saw an average of 100 out-patients per day; this has since gone up to an average of 450 patients per day. Average Bed Occupancy Rate (BOR) for the three campuses has increased from 30 percent to 69 percent over the same period. The BOR for the original campus has registered much larger growth with current BOR estimated at more than 90 percent. The School of Nursing has been accredited by all the relevant regulatory bodies in Kenya and admitted the first set of students in March 2012. In summary therefore the hospital has managed to meet its expansion goals while at the same time remaining profitable.

The Gender Violence Recovery Center (GVRC) is funded through profits from the hospital’s private services and private donations. It offers free-of-charge services for AIDS/HIV patients and is believed to be the first Gender Violence Recovery Centre in East Africa. The Center has helped more than 21,000 cases of domestic and sexual violence.

In terms of reaching out to those on low-income, NWH despite being a for-profit-facility still has 60 percent of its clients from the base of the pyramid (BOP). This is in line with their target of reaching the middle and upper lower-income brackets. While investing in NWH, AHF had a similar target of ensuring the investments have a social impact. This target has been independently verified by a study commissioned to Dalberg Development Advisors by Aureos. This performance surpassed the AHF target of having at least 50 percent of people served directly by NWH living in households with a net household member average income of less than US$3000 (BOP 3000) on a PPP basis.

As a result of the phenomenal growth, NWH is now looking to expand in East Africa’s regional market with new facilities earmarked for Kampala (Uganda), Kigali (Rwanda), and Arusha and Dar es Salaam both in Tanzania. They are currently negotiating with IFC Investment services for a mix of debt and equity financing totaling US$10 million.

Conclusion and recommendation

NWH is a local initiative run by a Kenyan management team. As a business, NWH has remained profitable even during its rapid expansion phase. This is because they are able to address a segment of the market that was largely ignored. The lower-middle and upper-level lower-income brackets have the ability to pay for services. However most privately provided services have been priced to high for them to afford. Developing a high quality yet affordable health service is one effective way of addressing this segment of the market. The Nairobi Women’s Hospital is a case study of how the private for profit providers can be used to address the health needs of the base of the pyramid in a profitable way. They have been ranked the lowest priced private hospital in Nairobi by the AoN insurance company – a factor that makes them a hospital of choice for health insurance providers and cash paying clients.

In conclusion, it is possible to reach BOP with privately provided high-quality health services in a profitable way. Similar funding mechanisms should be scaled up rapidly in the continent in order to rapidly improve access to quality health services by the poor.

Dr Bernard Olayo is a Kenyan physician and a public health specialist. He is currently working for the World Bank Group’s – Health in Africa (HIA) initiative project as a policy officer. In this role, he supports the Governments of Ghana, Uganda and South Sudan to improve the investment climate in order to increase private sector participation in delivery of health services and goods through increased investments and Public Private Partnerships.

Reference

PRIVATE HOSPITALS AND HEALTH CARE 26

QUALITY IMPROVEMENT ACTIVITY IN RADIOLOGY READING AND REPORTING IN A RURAL SETTING HOSPITAL IN INDONESIA

ABSTRACT: The Republic of Indonesia is an archipelago country, which is located between Asia and Australia. With a population of more than 200 million people, Indonesia only has about 600 Radiologists, whose majority resides in urban areas. In such a challenging situation, the Siloam Hospitals Group (SHG) established a strategy to improve its remote hospitals’ Radiologists’ quality care standard of patient safety. Although the strategy has produced a positive result, resistance towards cultural change was unavoidable throughout the strategy implementation. By learning from several resources and experiences, SHG’s leaders tried to develop a strategy improvement towards better processes, particularly in recognizing and solving interpersonal conflicts.

Health care Service Organizations (HSO) have given more concern lately toward quality care improvement by making changes that result in better patient outcomes (health), better system performance (care), and better professional development (learning) (Batalden & Davidoff 2007). Patient safety associated with medical errors is one of the quality care improvement’s concerns. Failure to uphold patient safety standards comes down to various factors, such as poor communication, ineffective teamwork, cultural barriers, inappropriate resource or inadequate resource management, and workforce and workload issues (Brathwaite et al. 2007).

Strategy enactment
The Republic of Indonesia, a middle-income country, consists of 17,000 islands located between Asia and Australia. The total area of Indonesia is nearly 1.9 million km² and its population is more than 200 million people (World Health Organization: Country Office for Regional South-East Asia 2007; World Health Organization: Country Office for Indonesia 2008). With such demography and geography, Indonesia only has about 600 Radiologists throughout its archipelago, most of whom live in urban areas.

Hence, as part of developing the quality care improvement of patient safety in its rural-setting hospitals, since August 2011, Siloam Hospitals Group (SHG) has established a strategy towards improving SHG’s General Radiologists’ quality care standard so that it is as good as that of Sub-specialist Radiologists by conducting quality assurance and learning process activities. These activities were implemented by getting comparison radiology reports from external experts, who specialize in reading radiology images, for all MRI and CT scan images produced. Siloam Hospital Jambi’s (SHJ-B) Radiology department was chosen as a pilot trial for this strategy, as SHJ-B is the first rural-setting hospital in our hospital group. MRI and CT scan images were chosen in this strategy as these images are new and sophisticated for rural areas; where the Radiologists have limited experience in reading MRI and CT scan images.

On daily basis, all MRI and CT scan images produced would be sent for external expert reading. The external expert and SHJ-B’s Radiologists would complete their own radiology reports in a timely manner. SHJ-B’s Radiologists would then compare the reports between external expert’s and their own. If there was no discrepancy between the two reports did occur, cases would be documented and reported to Medical Director (Ancillary Medical Affairs, AMA), who would arrange a discussion between SHJ-B’s Radiologists and referring specialists immediately, and as well as applying the Severity Assessment Criteria (SAC) Rating (Figure 1) and acted according to SAC Rating’s actions.

By adopting the Plan-Do-Study-Act (PDSA) improvement cycle, all actions and results from the cases reviewed would be documented by the AMA and would be presented and discussed further in the monthly multidisciplinary Radiology Review Board Meeting (RRBM), which would be attended by AMA, all SHJ-B’s Radiologists, referring specialists, a Senior Radiologist from other SHG, and a representative from Head Office’s
Private hospitals and health care

Management (Figure 2).

Strategy criteria

Several key criteria were formulated to assess the soundness and quality of the strategy enactment (Hambrick & Fredrickson 2005, p.61). As mentioned by Bolman & Deal (2008), “frame” is a mental model of idea, assumption or concept that helps us to understand and what to expect on a particular matter. In order to reflect and resolve multiple difficulties in a strategy, multiframe thinking from structural, human resources, political and symbolic approaches; and the wisdom and ability to match the frame to the situations are crucial (Boiman & Deal 1984 cited in Bolman & Deal 2008, p.14). A strategy is developed to achieve an established goal. The goal set should be in response to demands and/or opportunities and have a shared vision with a clear intention, i.e. to improve rural-setting hospital’s General Radiologists’ quality care standard, in this case is SHJB’s Radiologists, to be as excellent as Sub-specialist Radiologists by conducting quality assurance and learning process activities. The strategy should also be based on the flexibility for the staff to formulate the goals and operational plans, hence to build staff’s commitment and reach best

![Figure 1: Severe Assessment Criteria (SAC) Rating – Radiology Quality Review](image)

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Source: Department of Group Global Quality Development, Siloam Hospitals Group (2011)

![Figure 2: Radiology Quality Activity’s Flow Process](image)

Radiology Quality Activity – Daily

1. Scan patients, enter information into RIS/PACS
2. Create DCDI for all CT and MRI
3. Send DCDI to external expertise and SH Radiologist
4. Distribute report to doctor and patient
5. Complete report

- Acts according SAC ratings action required (template 2)
- AMA, Radiologist, Administration
- Completes report
- Compare external report and SH report
- Is there and discrepancy?
- Create and print patient final report
- Record discrepancies on Radiology report
- Log (template 1)
- Forward discrepancies report to AMA immediately via email, meanwhile preparing final report on the expertise

YES

NO

- Apply SAC rating by discussing and show discrepancy report case with radiologist and referring specialist immediately
- Review radiology discrepancy report from radiologist immediately

Source: Department of Group Global Quality Development, Siloam Hospitals Group (2011)
performance. In addition, the strategy should help towards the goal by recognizing individual capability and its appropriateness to a particular task. The responsibility chart needs to be done as well in order to get a clear picture of framework and roles of each involved member. An ideal strategy should comprise of a good working environment, where staff empowerment is encouraged and an accountability culture is established. Besides that, a good strategy should be able to recognize the possibility of miscommunication among staff that may lead to interpersonal conflict. It also important for a strategy to have a leader that is able to understand the political terrain and be able to communicate and negotiate towards a win-win solution (Burgelman & Grove 1996; Bolman & Deal 2008; UNSW The School of Public Health and Community Management 2011). As stated by Nelson et al. (1998), measurement is needed for improvement to occur. Therefore, a strategy should be supported by accurate data in order to monitor the progress. Additionally, a strategy should allow regular review for individual and organizational learning processes (Mohr 2005, p.42). This review should also obtain external advice to avoid bias and attain a broader systemic view (UNSW The School of Public Health and Community Management 2011). Lastly, to deepen the members’ faith, a strategy should also consist of rituals and ceremonies to celebrate success when it is achieved (Bolman & Deal 2008).

Strategy critique
A clear goal and shared vision for this strategy, i.e. to improve SHJB’s General Radiologists’ quality care standard to be as excellent as sub-specialist Radiologists towards quality care improvement of patient safety has been established. In accordance with the flexibility of the strategy towards member’s participation and learning processes a regular monthly multidisciplinary Radiology Review Board Meeting (RRBM) is carried out to review and discuss the follow-up and actions taken for discrepancy cases, complex and difficult cases faced, strategy’s progress, problems faced, and solution matters (Pronovost et al. 2003 cited in Mohr 2005, p.42). The multidisciplinary meeting is also attended by various medical specialties, junior doctors, and radiologists. This discussion is aimed at increasing physician knowledge, especially junior doctors and radiologists; hence, prevent them from committing unnecessary mistakes. A senior Radiologist from other Siloam Hospitals also attends the meeting to review strategy process regularly and provide expert advice. As part of the strategy’s encouragement, six monthly rewards are also given to Radiologists who has the least prevalence of discrepancy errors, where the appointed Radiologists’ salary will be reviewed.

However, interpersonal conflicts are unavoidable within this strategy enactment, particularly for some Radiologists. These interpersonal conflicts arise in view of miscommunication, which lead to the Radiologists’ struggle over power and pride (Bolman & Deal 2008). Hence, this strategy enactment is being interpreted wrongly as critiques and resulting in intimidation and humiliation feelings by the Radiologists. These interpersonal conflicts has arisen over the divergence between strategic intention and action. Thus, an important question needs to be asked, i.e. how a strategy can survive if the staff are starting to diverge from each other (Burgelman & Grove 1996, pp.15-16). These interpersonal conflicts have also created a political terrain within the strategy, where political tribes among staffs are formed. Moreover, the ambiguity of task responsibilities has caused confusion among the involved staff. Even though, the leader of each discipline involved, i.e. AMA, Head of Radiology department, and Head of Radiographers, have had explained their team members’ roles, it seems that the socialization responsibilities toward frontline staff did not take place properly and resulting in the confusion among staff.

Strategy improvement
There are still much room for improvement in this strategy. It is reflected that staffs interpersonal conflicts are secondary to miscommunication as the major problem in this strategy. This has resulted on the development of unpleasant working conditions and political terrain. Therefore, strategy improvements should aim and focus more on resolving these conflicts. Pronovost et al. (2003) stated that one of the characteristics of a strong safety culture is encouraging and practicing communications and teamwork (Pronovost et al. 2003 cited in Mohr 2005, p.42). Therefore, in order to prevent miscommunication and to create a good working conditions, SHG acknowledges the essential value of the accountability culture, internal dissent and controversy, where staff are liberated to speak their minds without fear of punishment.

However, the implication is difficult as usually the organization is uncomfortable with this disagreement (Burgelman & Grove 1996, p.19). The invention of this condition started from SHG’s leaders who able to overcome the traps in thinking about errors and using errors as opportunities to advance the learning process (Pronovost et al. 2003 cited in Mohr 2005, p.42; Johnson et al. 2008). This is implemented by encouraging staff to learn from their mistakes rather than hide them, and hence, blame free system based on staff competency in a non-punitive environment is finally
established. Leaders have taken into consideration not telling staff to be quiet and conversely, congratulate staff who had a disagreement but were right (Burgelman & Grove 1996, p.19).

The PDCA improvement cycle tool has been applied to encourage staff contribution and empowerment to this strategy. The discrepancy data obtained for analysing is not just merely for the sake of collecting numbers, but can also be used as a vulnerably detector (Mohr 2005, p.42). The data attained also looked at the relationship between causes and errors, such as working environment conditions, amount of workload, communication problems, physical and mental well-being, tiredness and sleep deprivation, and lack of knowledge. As stated by Hambrick & Fredrickson (2005, p.61) that strategy can be dynamic, where evolution and adjustment can be carried out on an ongoing basis. Hence, this data relationship is necessary to function as a reflection tool to facilitate strategy evolution.

Lastly, the confusion caused by the ambiguity of task responsibilities is handled bu using a process map/flow chart. The process map/flow chart is a tool that describes how an individual interacts with the system and with others within the system. It can be used to understand the work process and identify the opportunities for process redesign. Hence, by developing and visualizing a process map, process inefficiency can be identified and the ambiguity of task responsibilities can be clarified (Figure 2) (Johnson 2009).

In conclusion, as suggested by Senge (1990), a good learning organization should master five disciplines, i.e. systemic thinking, personal mastery, mental models, shared vision, and team learning (Senge 1990 cited in UNSW The School of Public Health and Community Management 2011). By mastering these five disciplines, it is hoped that strategy improvement towards better processes, particularly in recognizing and solving interpersonal conflicts can be realized. Although this strategy has been implemented for about six months, there is still some room for improvement. Nevertheless, it never is too late to conduct some strategy adjustment for a better outcome. Late is better than never. Given the outcome of this pilot, Siloam Hospitals as a Group has made a strategic decision to incorporate the model into our routine radiology operation in all our remote (three existing and seven pipelines) hospitals across the archipelago.

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References

ABSTRACT: Ensuring patient safety is a vital step for any hospital in achieving the best clinical outcomes. The Apollo Quality Program aimed at standardization of processes for clinical handovers, medication safety, surgical safety, patient identification, verbal orders, hand washing compliance and falls prevention across the hospitals in the Group. Thirty-two hospitals across the Group in settings varying from rural to semi urban, urban and metropolitan implemented the program and over a period of one year demonstrated a visible improvement in the compliance to processes for patient safety translating into better patient safety statistics.
two patient identifiers; improving communication through the use of read back for verbal orders and for critical lab reports obtained on the phone; improving the safety of high alert medication through segregation, proper labeling and cross checks during administration; implementing the process for preventing wrong patient, wrong side, wrong procedure surgery using preoperative checklists, surgical site marking and time outs; preventing health care associated infections through an effective hand hygiene program and implementing a falls risk assessment and prevention program to prevent patient falls were uniformly implemented across all Group hospitals irrespective of their accreditation status.

Surgical Care Improvement Plan envisaged targeting the major complications in surgical procedures including wrong site, wrong patient, wrong procedure surgery, surgical site infections (SSIs) and foreign body retention during surgery. Definitions, monitoring requirements and steps for preventing surgical site infections through preoperative, intraoperative and postoperative measures were defined. Circumstances increasing the risk for retention of foreign bodies were delineated and preventive measures described.

Steps for moving towards zero medication errors in the current scenario included a comprehensive medication management plan, format for addition or deletion of drugs to a formulary and ensuring prescription audits of all prescriptions including discharge summaries.

The objective was to educate all our hospitals about the importance of patient safety, implement patient safety practices in all our Apollo hospitals irrespective of accreditation status and make care safe for all our patients.

**Implementation**

The plan was sent to all Apollo hospitals for their input, finalized and then implemented across 32 Apollo hospitals. An implementation checklist guided the implementation process. After four months of implementing the process, data collection on the monitoring dashboard was started in April 2011 and analyzed monthly for improvement.

A team of 20 quality representatives from various Apollo Hospitals (the Apollo Clinical Audit Team) was trained by videoconferencing and then sent to other Apollo hospitals to audit the implementation status, the mechanism of monitoring compliance and guide implementation wherever there was a problem. The team also validated the data reported by the hospitals.

**Monitoring**

Monitoring parameters were devised for measuring compliance to clinical handovers, IPSGs, surgical care and medication safety.

**Table 1: Monitoring dashboard Apollo Quality Program**

<table>
<thead>
<tr>
<th>Monitoring parameter</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical handovers</td>
<td></td>
</tr>
<tr>
<td>1 Percentage compliance to completion of in house transfer form before patient transfer</td>
<td>&gt;90% 80-90% &lt;80%</td>
</tr>
<tr>
<td>2 Percentage compliance to use of nursing handover form for patient handover</td>
<td>&gt;90% 80-90% &lt;80%</td>
</tr>
<tr>
<td>3 Percentage compliance to use of physician handover form for patient handover</td>
<td>None 1 &gt;1</td>
</tr>
<tr>
<td>4 No. of instances (per month) where clinical handovers were one of the proximate causes for the adverse clinical events and outcomes</td>
<td></td>
</tr>
<tr>
<td>IPSGs</td>
<td></td>
</tr>
<tr>
<td>5 IPSG 1 Tracker score</td>
<td>100% 90-99.9% &lt;90%</td>
</tr>
<tr>
<td>6 IPSG 2 Tracker score</td>
<td>1100% 99-99.9% &lt;90%</td>
</tr>
<tr>
<td>7 IPSG 3 Tracker score</td>
<td>100% 99-99.9% &lt;90%</td>
</tr>
<tr>
<td>8 IPSG 4 Tracker score</td>
<td>100% 99-99.9% &lt;90%</td>
</tr>
<tr>
<td>9 IPSG 5 Tracker score</td>
<td>100% 99-99.9% &lt;90%</td>
</tr>
<tr>
<td>10 IPSG 6 Tracker score</td>
<td>100% 99-99.9% &lt;90%</td>
</tr>
<tr>
<td>Surgical care improvement</td>
<td></td>
</tr>
<tr>
<td>11 Percentage of patients receiving antimicrobial prophylaxis one hour before surgery</td>
<td>&gt;95% 90-95% &lt;90%</td>
</tr>
<tr>
<td>12 Percentage of patients excluded from SSI calculation due to lack of follow up for the requisite time frame</td>
<td>&lt;20% 20-30% &gt;30%</td>
</tr>
<tr>
<td>13 Number of instances of wrong patient, wrong side, wrong procedure surgery</td>
<td>&lt;2.2% 2.21-2.86% &gt;2.86%</td>
</tr>
<tr>
<td>14 Compliance to communicating sponge and instrument count to surgeon before skin closure</td>
<td>&lt;95% 90-95% &lt;90%</td>
</tr>
<tr>
<td>15 Number of instances of retained foreign body during surgery</td>
<td>None Any</td>
</tr>
<tr>
<td>Medication safety</td>
<td></td>
</tr>
<tr>
<td>16 Medication errors per 100 discharges</td>
<td>&lt;2.2% 2.21-2.86% &gt;2.86%</td>
</tr>
<tr>
<td>17 Medication errors due to sound alike look alike drugs as a percentage of total errors</td>
<td>&lt;2% 2-4% &gt;4%</td>
</tr>
<tr>
<td>Standardization of medical records</td>
<td></td>
</tr>
<tr>
<td>18 Percentage compliance to minimum content of medical records on closed audits</td>
<td>&gt;80% 90-95% &lt;80%</td>
</tr>
<tr>
<td>19 Percentage compliance to minimum content of medical records on closed audits</td>
<td>&gt;80% 90-95% &lt;80%</td>
</tr>
<tr>
<td>20 Accuracy of ICD-10 coding</td>
<td>&gt;95% 90-95% &lt;90%</td>
</tr>
</tbody>
</table>

Source: Apollo Quality Program developed at the Apollo Group Quality Workshop 2010
safer care. To ensure medical records completeness, minimum content of medical records and accuracy of ICD – 10 coding were also included. The 20 parameters together formed a measurable dashboard that is reported by every hospital to the group leadership on a monthly basis. The results for each parameter are color coded as green, orange and red for defined ranges of scores.
The greatest benefit achieved by any hospital was the establishment of processes for patient safety where they were not well-developed earlier. For example, while the bigger hospitals measured SSI for 30 days postoperatively, smaller hospitals did not have a system of following up patients after they were discharged from hospital after surgery. They devised mechanisms for this to get a true idea of their SSI rates. There were hospitals with well-defined mechanisms for the audit of all prescriptions of inpatients, but they missed out on covering the audit of medications prescribed in the discharge summaries. That was initiated by them to discover more medication errors. There were hospitals which did not track the time of administration of antimicrobial prophylaxis before surgery. They initiated this to be able to ensure that the prophylaxis was given within one hour before surgery. Time outs were being practiced mainly by accredited hospitals. They were introduced for all hospitals. International Patient Safety Goals similarly were being followed only by JCI accredited hospitals. They were implemented by all hospitals. It took a great effort to have documented physician to physician handovers. In house transfer forms were introduced at many locations. Patient identification using two identifiers and read back for verbal orders were implemented by many hospitals for the first time.

It has also given us an opportunity to identify the processes where implementation has been difficult and still requires more support. Written physician to physician handovers, following up of patients for 30 days postoperatively for SSI after discharge and hand washing compliance were identified as challenges for bigger hospitals with larger patient volumes, the smaller hospitals had difficulty with medication error rates and implementation of Time Out in the operating theatres. An added emphasis is being given to them.

While achieving the establishment of processes in most hospitals was an achievement in itself, it goes without saying that anything that is measured tends to improve. The monitoring data reflected these improvements in processes and outcomes. Below are a few examples of improvement at different Apollo locations:

**Clinical handovers:** Percentage compliance to completion of In house transfer form before patient transfer at Apollo A increased from 65 percent in April 2011 to 96 percent in March 2012 (Figure 1).

**International Patient Safety Goals:** Compliance to use of two identifiers for patient identification (IPSG 1) on random observation increased at Apollo B from 65 percent in April 2011 to 96 percent in March 2012 (Figure 2).

**Surgical safety:** Percentage of patients receiving antimicrobial prophylaxis one hour before surgery at Apollo A increased from 26 percent in April 2011 to 96 percent in March 2012 (Figure 6).
decreased from 88 percent in April 2011 to 12 percent in March 2012 (Figure 7).

**Medication safety:** Medication errors at Apollo F decreased from 6 percent in April 2011 to 1.39 percent in March 2012 (Figure 8).

**Scoring:** We also analyzed the data to assess an overall improvement in the processes of all hospitals by assigning a score of 5, 3 and 1 to each parameter reported in green, orange and red zone respectively. A parameter not reported was given a score of 0. The average score for all hospitals together increased from 62 in April 2011 to 81 in March 2012 (Figure 9).

We also divided the hospitals into three groups as Group A (bigger hospitals), Group B (medium) and Group C (smaller hospitals) and analyzed the data as a Group. While the Group A hospitals had consistent scores (Figure 10), Group B and C hospitals showed greater improvement (Figures 11 and 12).

**Conclusion**
In the first year of implementation, AQP has brought about improvement in processes for patient safety for thousands of patients visiting Apollo hospitals in varied settings. This is evident in the process indicators of the Apollo Quality Dashboard for almost all locations.

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**References**

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**Figure 10: Average AQP scores of Group A hospitals**

**Figure 11: Average AQP scores of Group B hospitals**

**Figure 12: Average AQP scores of Group C hospitals**
1. Risques et opportunités de la mondialisation des prestations de soins de santé
Résumé: La vitesse et l’ampleur de la mondialisation en matière de prestations de soins de santé se sont accélérées au cours de cette dernière décennie. Dans le secteur des prestations de soins de santé, de nombreuses collaborations se sont nouées entre les secteurs privés d’Amérique du Nord et d’Europe avec des institutions publiques et privées dans diverses économies émergentes. Ces partenariats peuvent être extrêmement fructueux, mais présentent des difficultés importantes. Johns Hopkins Medicine International (JHI) travaille depuis plus de dix ans à aider les partenaires internationaux à accroître leurs ressources et améliorer le système de prestations. En relevant les défis de la mondialisation, nous avons appris un certain nombre de leçons et découvert plusieurs innovations pour mieux aider les prestataires de soins de santé des marchés émergents à répondre aux besoins sanitaires spécifiques à leurs régions.

2. La privatisation expérimentale des hôpitaux américains et ses implications mondiales
Résumé: Cet article décrit le marché américain et les dynamiques réglementaires qui contribuent – et devraient accélérer – les privatisations d’hôpitaux “publics” ou “d’État”. Il explique également les raisons pour lesquelles nous devons nous attendre à un accroissement du nombre d’hôpitaux du monde entier choisis pour étudier également de restructurer leur plateforme de gouvernance.

3. Une collaboration visant à améliorer la compétitivité mondiale des centres universitaires médicaux américains
Résumé: Dans son discours sur l’état de l’Union de 2010, le président Obama a annoncé le programme national d’exportation et fixé l’objectif ambitieux de doubler les exportations américaines d’ici la fin de l’année 2014 pour créer des millions d’emplois nationaux. Consciente de la position compétitive des services de santé américains sur le marché national des patients internationaux, l’UHC, alliance de 116 centres universitaires médicaux et de 272 de leurs hôpitaux affiliés, a été créée et représente 90% des centres universitaires médicaux sans but lucratif de la nation en partenariat avec la Rush University, une université privée de Chicago, IL et l’International Trade Administration (ITA) du Département du Commerce américain, pour participer au programme commun de développement des marchés. Le but de ce partenariat public-privé est d’accroître la compétitivité mondiale de l’industrie médicale américaine qui représente plus de 16% du PIB, parmi les prestataires étrangers de services de santé. Cet article présente un aperçu général du marché américain des soins de santé et des objectifs des programmes collaboratifs américains obtenant les patients internationaux, qui ont abouti au partenariat entre l’UHC, ITA et la Rush University.

4. Les PPP hospitaliers sont-ils des partenariats d’infrastructure ou des entités séparées, ou les deux faces d’une même monnaie ?
Résumé: Les Partenariats publics-privés existent dans les infrastructures depuis de longues années et on les considère de plus en plus comme les moyens de financer, de construire et de gérer les hôpitaux. Toutefois, depuis une vingtaine d’années, la croissance des PPP hospitaliers a entraîné des confusions sur les types d’accords contractuels entre partenaires publics et privés qui constituent un PPP, et sur les principes qui permettent de distinguer le partenariat public-privé concernant les hôpitaux de celui qui s’applique aux infrastructures. D’après l’expérience acquise dans le monde entier, nous déterminons six secteurs principaux dans lesquels les PPP hospitaliers diffèrent des PPP d’infrastructure. Nous nous basons sur les partenariats hospitaliers qui ont été documentés dans les pays de l’OCDE et sur un nombre croissant de pays à revenu moyen pour identifier quatre types différents de PPP hospitaliers: les partenariats axés sur les services dans lesquels les partenaires privés gèrent des opérations au sein d’établissements construits par des entreprises publiques, les PPP établissements et finances, axés sur la mobilisation des capitaux et la création de nouveaux hôpitaux, les PPP combinés, dont les activités portent tant que l’établissement de distinguer le partenariat public-privé concernant les hôpitaux de celui qui s’applique aux infrastructures.

5. Le rôle du partenariat public-privé – L’expérience brésilienne de la modernisation des hôpitaux au secrétariat de la santé de la préfecture de Sao Paulo
Résumé: Dans le secteur de la santé, l’objectif du PPP est d’améliorer l’efficacité et l’innovation gestionnaires dans les services de santé tout en contribuant à accélérer la modernisation des...
systèmes de santé publics nationaux. L’expérience de Gesaworld au Brésil, qui inclut la modernisation du réseau hospitalier de la préfecture de Sao Paulo, a contribué à améliorer la santé de la population en offrant de meilleures installations de soins. Le projet qui est basé sur le modèle légal du contrat de concession de service public impose entre autres des critères de développement durable.

6. Le Fond pour la santé en Afrique et l’hôpital des femmes de Nairobi –Un modèle réussi pour faciliter l’accès aux capitaux des entreprises de santé

7. Mesures d’amélioration de la qualité de l’interprétation des images et des comptes rendus radiologiques dans un hôpital rural d’Indonésie
Résumé: La République d’Indonésie est un archipel situé entre l’Asie et l’Australie. Avec une population de plus de 200 millions d’habitants, l’Indonésie ne compte que 600 radiologues qui résident en majorité dans les zones urbaines. Dans une situation aussi difficile, le groupe hospitalier Siloam (Siloam Hospitals Group, SHG) a instauré une stratégie visant à améliorer les critères de qualité des soins des radiologues pour la sécurité des patients dans ses hôpitaux isolés. Bien que cette stratégie ait donné des résultats positifs, la résistance aux changements culturels est inévitable dans la mise en œuvre de la stratégie. En apprenant d’après diverses ressources et expériences, les dirigeants de SHG se sont efforcés de mettre au point une amélioration stratégique visant un perfectionnement des processus, notamment par la reconnaissance et la résolution des conflits interpersonnels.

8. Programme de qualité Apollo
Résumé: Pour optimiser une issue clinique favorable pour les patients, l’assurance de la sécurité des patients est une initiative hospitalière de la plus haute importance. Le Programme de qualité Apollo vise à standardiser les processus concernant le transfert des soins des patients, l’innocuité des médicaments, la sécurité des traitements chirurgicaux, l’identification des patients, les ordres vitaux, le respect de l’hygiène des mains et la prévention des chutes entre les hôpitaux du Groupe. 32 hôpitaux du Groupe répartis dans des secteurs géographiques ruraux, semi-ruraux, urbains et métropolitains ont appliqué ce programme. Sur une période d’un an, on observait une amélioration tangible des processus ayant trait à la sécurité des patients, se traduisant par une amélioration des statistiques de sécurité des patients.
Resumen en Español

1. Los riesgos y oportunidades de la globalización de la prestación de los servicios de salud
Resumen: El ritmo y la magnitud de la globalización en la prestación de los servicios de salud han acelerado en gran manera en los últimos diez años. Se han producido numerosos acuerdos de colaboración en la prestación de los servicios de salud entre el sector privado de América del Norte y Europa y organismos públicos y privados de diversos mercados en vías de desarrollo. Si bien estas asociaciones pueden resultar sumamente provechosas, también pueden acarrear importantes dificultades. La empresa Johns Hopkins Medicine International (siglas en inglés JHI) lleva más de una década apoyando las sociedades internacionales encaminadas a incrementar la capacidad y mejorar los sistemas de prestación de la salud. Al abordar las dificultades de la globalización, hemos aprendido numerosas lecciones y hemos dado con diversas ideas innovadoras con miras a ayudar a mejor medida a los proveedores de asistencia sanitaria de los mercados en vías de desarrollo, a atender a las necesidades de los cuidados de salud específicas para su región.

2. Repercusión mundial de la experiencia de privatización de los hospitales en los EE UU
Resumen: Este artículo hace un resumen del mercado estadounidense y de los factores reguladores que no sólo han contribuido a la privatización de los hospitales públicos y gubernamentales, sino que además se espera hayan acelerado el ritmo de esa privatización. El informe explica además la razón fundamental por la que es de esperar que cada día haya mayor número de hospitales gubernamentales que sigan este mismo ejemplo y decidan reestructurar su sistema de gobierno.

3. Trabajando para mejorar la competitividad mundial de los Centros Médicos Universitarios
Resumen: Durante su discurso del Estado de la Unión en 2010, el Presidente Obama anunció una Iniciativa Nacional de Exportación y expuso el ambicioso objetivo de doblar las exportaciones de los EE UU antes de finalizar el año 2014, con el fin de respaldar millones de puestos de trabajo en su país. Siendo consciente del lugar tan competitivo que ocupa la atención de la salud de los EE UU en el mercado mundial en cuanto a pacientes internacionales, el informe expone a grandes rasgos los objetivos de los Programas de Colaboración para pacientes internacionales, que es el resultado final que persigue la asociación entre UHC, ITA y la Universidad Rush.

4. ¿Se trata de una cebra o un caballo pintado a rayas?. ¿Son las Asociaciones con infraestructuras público privadas (en inglés PPP) cebra o rayas o se trata de una especie aparte?
Resumen: Ya hace tiempo que las asociaciones público privadas se han convertido en algo frecuente en cuanto a infraestructura y cada día se consideran más como un medio destinado a financiar, construir y gestionar los hospitales. Sin embargo, en las dos últimas décadas el aumento de estas asociaciones hospitalarias ha dado lugar a una confusión sobre qué tipo de acuerdos contractuales entre los socios públicos y privados constituye una asociación público privada y cuales son las principales diferencias entre una asociación hospitalaria público privada y una PPP desde el punto de vista de la infraestructura. Según nuestra experiencia de otros países, hay seis diferencias principales entre los PPP hospitalarios y las asociaciones centradas en la infraestructura. Pongamos como ejemplo las asociaciones hospitalarias que han sido documentadas en diversos países de la OCDE y un número cada día más creciente de países con ingresos medios, con el fin de identificar cuatro tipos distintos de PPP hospitalarios: las asociaciones centradas en el servicio, en las que los socios privados dirigen las operaciones en el seno de instancias construidas con fondos públicos; las PPP basadas en las instalaciones y las finanzas, centradas en movilizar capital y construir nuevos hospitales; las PPP combinadas, es decir, con finalidades mixtas, que se ocupan tanto de las instalaciones, como de las operaciones clínicas; y las PPP co-localizadas en las que los servicios privados tienen lugar en el entorno de un hospital público.

Estos cuatro tipos de PPP hospitalarios tienen unos objetivos diferentes y por lo tanto los aspectos contractuales y funcionales...
son también distintos y lo mismo puede decirse de los riesgos para los asociados públicos y privados. Con esta aclaración, proporcionamos una base sobre la cual pueden evaluarse las PPP hospitalarias contra unos indicadores y metas apropiadas.

5. La función de la sociedad pública privada (en inglés PPP).
El experimento brasileño para la modernización de los hospitales en la Secretaría de salud de la Prefectura de Sao Paulo
Resumen: En lo que respecta al sector de la salud, el objetivo del modelo denominado PPP radica en mejorar la eficacia y la innovación de la gestión en los servicios de la salud, mientras que también ayuda a acelerar la modernización de los sistemas nacionales de salud. Además de modernizar la red hospitalaria de la Prefectura de Sao Paulo, el experimento de Gesaworld ha contribuido a mejorar la salud de la población mediante la prestación de unas instalaciones sanitarias mucho mejores. Entre las posibilidades de este proyecto, basado en el modelo legítimo de un contrato de concesión administrativa, cabe citar criterios de sostenibilidad como parte integrante del proyecto.

6. Fondo africano para la salud y Hospital de la mujer de Nairobi: un ejemplo con buenos resultados para mejorar el acceso al Plan “Capital for Health Businesses”
Resumen: El Hospital de la mujer de Nairobi es un hospital privado con fines de lucro que lleva funcionando desde 2001. Su objetivo principal consiste en estar al alcance de mujeres y niños, ofreciendo unos servicios de alta calidad a un coste asequible. Sus perspectivas iniciales de crecimiento fracasaron por falta de capital. En diciembre de 2009, el Fondo africano para la salud, dirigido por Aurcos Capital, adquirió una participación en el hospital con el fin de proporcionar el capital necesario para su ampliación. Gracias a esta inversión, el hospital ha crecido rápidamente, pasando de las 576 camas con las que contaba, a 226 en tres recintos distintos. Además de esto, se ha fundado una escuela de enfermería afiliada. En base al éxito reciente, en la actualidad el Hospital de la mujer de Nairobi se propone obtener un préstamo adicional de $10,000,000 de la Corporación Financiera Internacional, con miras a ampliar sus actividades en la región del Africa Oriental.

7. Iniciativa encaminada a mejorar la lectura y los informes radiológicos en un hospital rural de Indonesia
Resumen: La República de Indonesia es un archipiélago situado entre Asia y Australia. A pesar de contar con más de 200 millones de habitantes, Indonesia tiene solamente unos 600 radiólogos que en su mayoría viven en zonas rurales. En estas condiciones tan difíciles, el Grupo Hospitalario de Siloam (en inglés SHG) puso en marcha una estrategia encaminada a mejorar el nivel de calidad y, por ende, la seguridad de los pacientes del servicio de radiología de sus hospitales más remotos. Si bien la iniciativa ha dado resultados positivos, es inevitable que haya resistencia a un cambio cultural en los lugares donde se ha puesto en marcha.
Gracias a la lección aprendida por varios recursos y experiencias, la dirección del Grupo Hospitalario de Siloam intentó mejorar su estrategia con miras a perfeccionar los procedimientos, especialmente en lo que respecta a identificar y solucionar los conflictos entre personas.

8. Programa Apolo sobre el control de la calidad
Resumen: Garantizar la seguridad del paciente es un hecho vital para cualquier hospital en lo que respecta a la consecución de unos resultados clínicos óptimos. El Programa Apolo sobre el control de la calidad tiene por objetivo la normalización del sistema de traspasos clínicos, la inocuidad de los medicamentos, la seguridad quirúrgica, la identificación del paciente, las instrucciones verbales, el cumplimiento de normas en lo que respecta al lavado de manos y la prevención de caídas en todos los hospitales pertenecientes al Grupo. Este Grupo, integrado por 32 hospitales de zonas geográficas que van desde zonas rurales, a semi urbanas, urbanas y metropolitanas pusieron en práctica el Programa Apolo y en un año mostraron una mejora muy notable en cuanto al cumplimiento de los procedimientos destinados a garantizar la seguridad del paciente, lo que se tradujo en mejores resultados estadísticos sobre la seguridad del paciente.
Who We Are

Founded in 1947, the IHF is the premier worldwide body for hospitals and health care organizations. It represents national hospital associations from around the world and its members come from close to 100 countries. IHF develops and maintains a spirit of cooperation and communication among its members and other stakeholders with the primary goal of creating an environment that facilitates the exchange of information and ideas.

The IHF’s founding philosophy is that it is the right of every human being, regardless of geographic, economic, ethnic or social condition, to enjoy the best quality of health care, including access to hospital and health care services. By promoting this value, the IHF supports the improvement of the health of society.

The role of the IHF is to help international hospitals work towards improving the level of the services they deliver to the population regardless of that population’s ability to pay. The IHF recognizes the essential role of hospitals and health care organizations in providing health care, supporting health services and offering education. The IHF is a unique arena for all major hospital and health care associations to cooperate and to act upon their critical concerns.

What IHF Accomplishes

- The IHF engages in projects that support hospitals and improve health care.
- The IHF pursues all possible avenues of collaboration with governmental and non-governmental organizations for developing health systems. This has resulted in research projects aimed at improving the quality of hospital and health care services.
- The IHF is a “knowledge hub,” working through international conferences, management training courses, information services, publications and consultations.
- The IHF is an official partner of the World Health Organization (WHO) and is strategically positioned as a bridge between IHF members, the United Nations and other international organizations.
- The IHF serves as a global facilitator for health care delivery.

What Is the Corporate Partnership Programme?

The present participation opportunity is being offered to major corporations who seek to join with IHF members to work to improve hospital performance around the world.

The IHF partnership package provides year-long access to decision makers from around the world. The Corporate partnership will provide an exclusive opportunity for relationship building and sharing ideas and experiences between corporate leaders and executives in the hospital sector. These discussions will ultimately issue in new ideas and expand knowledge in emerging markets.

Affiliation with this partnership programme also gives a strong signal to the global community that the corporation is a major world player in the hospital sector.

The benefits of the programme allow maximizing possible interaction with actual and potential clients through a “one-stop shop” approach. Its package of benefits distills more value and achieves better targeting than ordinary marketing and advertising.

The programme is open to a limited number of corporations that are fully engaged in the global health sector and have a good reputation as providers.

Becoming a Corporate Partner: Application

For additional information, please contact the IHF in Switzerland to further discuss becoming a potential Corporate Partner.

Letter of Agreement

The International Hospital Federation (IHF) will enter into a partnership with organizations upon signature of a letter of agreement by representatives of both the International Hospital Federation and the partner.

Contact Details – Secretariat

c/o Hospital de Loëx, 151 Route de Loëx, 1233 Bernex, (Canton de Genève), Switzerland
Tel: +41 (0) 22 850 94 20; Fax: +41 (0) 22 757 10 16
E-mail: corporate@ihf-fih.org; Web site: www.ihf-fih.org

2011 Corporate Partners

- ARAMARK
- Intermittent
- Philips
- Signum
- HCA
- Johnson Controls
- Johnson Controls
- Veolia

2012 Corporate Partnership Programme

Supporting collaboration, ideas and innovation in global healthcare
Meet IHF corporate partners

Aramark is a leader in professional services, providing award-winning food services, facilities management, and uniform and career apparel to health care institutions, universities and school districts, stadiums and arenas, and businesses around the world. The company is recognized as one of the “World’s Most Ethical Companies” by the Ethisphere Institute, one of the “World’s Most Admired Companies,” by FORTUNE magazine and one of America’s Largest Private Companies by both FORTUNE and Forbes magazines. ARAMARK seeks to responsibly address issues that matter to its clients, customers, employees and communities by focusing on employee advocacy, environmental stewardship, health and wellness, and community involvement. Headquartered in Philadelphia, ARAMARK has approximately 250,000 employees serving clients in 22 countries.

Learn more at www.twitter.com/aramarknews

Bionexo is the center of a community comprised of over 15,000 players of the hospital business. Through our web platform, we integrate hospitals throughout the supply chain sector, focusing on business development and relationships. Established in 2000, in just 10 years, Bionexo was structured in Brazil, becoming the largest marketplace reference to the hospital industry and contributing significantly to the professionalization of the purchasing sector and growth of the healthcare market.

The success of this innovative business model has led to Bionexo for Latin America and Europe, where also attained leadership in addition to export technology and implement a new concept in commercial transactions of organizations.

Everything happened in a short time, just like businesses are made between the companies that integrate our platforms. This makes Bionexo the largest core of the hospital sector in Brazil.

Pioneering and innovation, helping thousands of companies and hospitals.

www.bionexo.com.br

Esri is the world leader in GIS technology. Esri software promotes exploring, analyzing and visualizing massive amounts of information according to spatial relationships. Health surveillance systems are used to gather, integrate and analyze data; interpret disease transmission and spread; and monitor the capabilities of health systems. GIS is a powerful tool for identifying health service needs. Esri software is extensively used by health organizations throughout the world, including the US Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), 127 national health ministries, and over 400 hospitals.

For more information, contact Christina Bivona-Tellez, CBivona-Tellez@esri.com. www.esri.com/health
Ingersoll Rand, the world leader in creating and sustaining safe, comfortable and efficient environments, offers products, services and solutions that allow our customers to create healthcare environments that are an asset to life. We help establish the physical environment as the foundation of all that is done to take better care of patients and staff – optimizing patient outcomes and safety, operational efficiency and patient, physician and staff satisfaction. As a part of Ingersoll Rand, Trane and Ingersoll Rand Security Technologies provide a broad portfolio of energy efficient heating, ventilating and air conditioning systems, mechanical and electronic access control, time and attendance and personnel scheduling systems, architectural hardware, building and contracting services, parts support and advanced controls for healthcare buildings.

For more information, visit ingersollrand.com/healthcare.

At MEDTRONIC, we’re committed to Innovating for life by pushing the boundaries of medical technology and changing the way the world treats chronic disease. Our innovations help physicians diagnose diseases earlier, treat patients with the least amount of disruption possible, and help alleviate symptoms throughout the patient’s life. Each year, we’re improving the lives of millions of people worldwide across numerous conditions - heart disease, diabetes, neurological disorders, spinal conditions, vascular diseases. But it isn’t enough. So we’re innovating beyond products. We’re breaking down barriers and challenging assumptions - to continually find more ways to help people live better, longer.

For further information please visit www.medtronic.com

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## IHF Events calendar

### 2012

#### IHF

**IHF Hospital and Healthcare Association Leadership Summit**  
June 5-6, 2012 – Sun City, South Africa  
(By invitation only)  
For more information, contact sheila.anazonwu@ihf-fih.org/ModisK@health.gov.za

#### MEMBERS

**CANADA**

**National Health Leadership Conference**  
June 4-5, 2012 – Halifax, Nova Scotia  
For more information: http://www.nhlc-cnls.ca/default1.asp

**FRANCE**

**Hôpital Expo**  
May 22-25, 2012 – Porte de Versailles, Paris  
For more information: http://www.hopitalexpo.com

**GERMANY**

**DKG – HOPE**  
**HOSPAGES** Aging health workforce – aging patients: multiple challenges for hospitals in Europe  
June 11-13, 2012, Berlin, Germany 22-25  
Website: www.hospages.eu

**PORTUGAL**

**4th International Hospital Congress**  
November 8-9, 2012, Lisbon, Portugal  
Website: http://www.apdh.pt/

**TURKEY**

**10th International Symposium on Pharmaceutical Sciences**  
June 26-29, 2012, Ankara, Turkey

#### UNITED KINGDOM

**NHS Confederation annual conference and exhibition**  
June 20-22, 2012, Manchester, United Kingdom  
Website: www.nhsconfed.org/2012

#### USA

**Healthcare Financial Management Association’s Healthcare Finance Conference**  
June 24-27, 2012, Mandalay Bay Resort, Las Vegas, NV  
Website: http://www.hfmaconference.org/

**American Hospital Association’s Leadership Summit**  
July 19-21, 2012, San Francisco Marriott, San Francisco, CA  
Website: http://www.healthforum.com/healthforum/html/conferences/12Summit/Summit_home.html

**American Nurses Credentialing Center: ANCC National Magnet Conference**
October 10-12, 2012, Los Angeles Convention Center, CA  
Website: http://www.anccmagnetconference.org/

**Medical Group Management Association Annual Conference**  
October 21-24, 2012, Grand Hyatt, San Antonio, TX  
Website: http://www.mgma.com/mgma12/

**Healthcare Supply Chain Association: 2012 International Expo**  
October 22-24, 2012, JW Marriott Grande Lakes, FL  
Website: www.supplychainassociation.org/?page=Events

**COLLABORATIVE**  
**Hospital Management Asia 2012**  
September 13-14, 2012 – Hanoi, Vietnam (to be confirmed)  
For more information:  http://hospitalmanagementasia.com

**2013**  
**IHF**  
38th World Hospital Congress*  
June 18-20, 2013 – Oslo, Norway  
Theme: Future health care: The Opportunities of new technology  
Email: Sheila@ihf-fih.org / kine.martinez@nh.no  
Website: http://oslo2013.no

**MEMBERS**  
**USA**  
Healthcare Information and Management Systems Society’s Annual Conference and Exhibition  
March 3-7, 2013, Convention Center, New Orleans, LA  
Website: http://www.himssconference.org

American College of Healthcare Executives: Congress on Healthcare Leadership  
March 11-14, 2013, Hilton Chicago, Chicago, IL  
Website: http://ache.org/Congress

American Organization of Nurse Executives’ Annual Meeting and Exposition  
March 19-22, 2013, Convention Center, Denver, Colorado

**American Hospital Association’s Annual Meeting**  
April 28 - May 1, 2013, Hilton Washington, Washington, DC  
For more information: www.aha.org

Events marked * will be in English/host country language only. IHF members will automatically receive brochures and registration forms on all the above events and will be entitled to a discount on IHF Congresses, and Leadership Summits.  
For further details contact the: IHF Partnerships and Project, International Hospital Federation, c/o Hôpital de Loëx, 151 Route de Loëx, 1253 Bernex, Switzerland, E-Mail: sheila.anazonwu@ihf-fih.org Or visit the IHF website: http://www.ihf-fih.org
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<td>Invaluable networking opportunities with peers, healthcare leaders and experts in the field</td>
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