# Better Hospitals, Better Health Systems: The Urgency of a Hospital Agenda

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## Abstract

As the global community shifts to meet the challenge of universal health care (UHC), the new priorities and imperatives facing emerging economies will require attention and investment. Climbing costs, the rapid escalation of chronic diseases, emergence of complex morbidities and poly-morbidities, relentless urbanization, and the expanding expectations of citizens are simultaneously confronting countries as they move towards UHC. Responding effectively to the UHC challenges will entail strengthened health systems to generate better patient services and improved population outcomes. Investing in hospitals and their performance will be key to this success.

Reaching the expectations of universal health coverage requires renewed efforts to upgrade and strengthen hospital investments, and to promote the integration of patient care across levels of care. Whether addressing ebola outbreaks, promoting maternal and infant survival, managing the burgeoning chronic disease epidemic, or simply meeting the ICU and surgery commitments of health care, hospitals remain central. The lack of investment and modernization of hospitals—whether in physical plant infrastructure or management systems—over the past few decades has rendered many expensive inpatient institutions shells of their potential.

This paper outlines the nature of the issues surrounding hospitals in emerging markets and makes the case for early action to bridge the abyss of neglected hospital investments and the path needed to address the shortcomings and gaps in current policies and investments.

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## Contents

As the global community shifts to meet the challenge of universal health care (UHC) the new priorities and imperatives facing emerging economies will require attention and investment. Climbing costs, the rapid escalation of chronic diseases, emergence of complex morbidities and poly-morbidities, relentless urbanization and the expanding expectations of citizens are simultaneously confronting countries as they move towards UHC. As defined in Box 1, responding effectively to the UHC challenges will entail strengthened health systems to generate better patient services and improved population outcomes. Investing in hospitals and their performance will be key to this success.

The role and contribution of hospitals in economic development has been a neglected component of the global health systems agenda over the past few decades (CGD 2014). Despite the importance of surgical interventions as highlighted by the Copenhagen Consensus, the recent priorities of the Commission on Health 2035 (Jamison et al. 2013) or the global commitment on health systems strengthening, policies and funding remain focused on the needs of the shrinking underserved rural populations in emerging markets.

Conclusions of the recent Independent Task Force of the Council of Foreign Relations echo these conclusions and highlight the shifting health priorities in low and middle income countries where non-communicable diseases now dominate (Daniels Jr. and Donilon 2014). The report calls for new and better strategies for health interventions that target some of the major health problems including cardiovascular disease and cancers. To effectively shift the focus health care delivery will have to be strengthened, new technologies harnessed to meet diagnostic and treatment needs and a more effective model of health care delivery adopted. These challenges point to the need to rethink health care systems generally and the role of hospitals in particular.

Hospitals are only marginally included in global health priorities, and donors have effectively ignored them placing continued emphasis on rural primary health care for basic preventive services. Since the 1978 Alma Ata Agreement to focus on providing basic care for low income rural populations the world community has invested heavily in the model, shifting virtually all funding to both basic primary services and increasingly to specific communicable diseases, particularly malaria, TB and HIV/AIDS. The misguided perception of hospitals as sink holes of funding that focus on the diseases of the wealthy has simply fueled investments in public primary care. The health care system has been neglected and with it the role and functions of hospitals. Robbing hospitals to finance primary care revolutionized the focus of publicly funded care in low income countries and no doubt reached outlying populations.

The question is at what cost and with what services. The more immediate questions are how to adapt to changing circumstances, and how to bolster a health care system rather than stand-alone services that narrow the focus of diagnosis and treatment.

Health systems define the delivery of health care and has always played a role, but the decline in predictable communicable diseases has given way to a much broader range of health conditions and traumas that demand better trained providers and availability of multiple treatment options. To make that system work will require new and different arrangements, including a stronger role for hospitals in all aspects of health care from diagnostics to sophisticated treatments to palliative care.

All countries rely on hospitals for medical care training, leadership and referral, and spend considerably on inpatient facilities. At the same time low and middle-income countries often lack the necessary capital to modernize public hospitals or to adapt their infrastructure and services to changing circumstances (IHF).[1] These factors currently limit adaptation and modernization of public hospitals and health care services.

Private hospital investments have taken up some of the slack. In Brazil, Chile, India and Malaysia, among others, private hospitals capture significant segments of the upper income market through self pay either via out of pocket payment or health insurance. While such competition can prove useful in promoting better and more responsive care, resource constraints and rigid financing models that favor public providers limit the ability of government's to take advantage of private options. Whether an Ebola virus outbreak in West Africa, a backlog of basic surgeries in India, persistently high neonatal and maternal mortality, or the worldwide surge in cancer incidence, hospital services remain central to effective responses to existing, new and unexpected health care problems.

By necessity health systems leadership is in hospitals. Hospitals offer the only source of essential specialized services for common conditions such as appendicitis or trauma, afflictions that affect all ages, genders and income groups. The hospital remains the most visible symbol of care for the sick, and is the place to which patients travel, often from great distances and at considerable cost, with an illness episode. In short hospitals occupy a unique leadership position in the health sector that is recognized by citizens and civic leaders alike.

[1] Lewis and Bonfert (forthcoming) discuss the emerging reliance on public private partnerships in financing new public hospitals and the potential of PPPs in constructing and managing public hospitals.

Given their central role in health care systems it is hard to explain the lack of attention and investment in hospitals. If UHC is about timely, appropriate and high quality services at an affordable price, why are hospitals overlooked in the agenda? The lack of investment and modernization of hospitals - whether in physical plant infrastructure or management systems - has rendered many expensive inpatient institutions shells of their potential. Hospitals are falling short of expectations and need. Yet this does not need to be the case.

Reaching the expectations of UHC will require renewed efforts to upgrade and strengthen both inpatient and outpatient services, and promote the integration of patient care across these sources of care. Shortcoming in effectiveness, safety and quality of hospital services pose the biggest challenges to health care systems followed by the need to ensure continuity of care before and after admission to the hospital. Even in those countries that have achieved UHC, like Brazil, Thailand and Turkey, quality and safety remain to be addressed and continuity of care for patients is still uneven. Such lapses jeopardize patient health and waste scarce health resources.

Citizens are expecting more and more sophisticated care from both public and private sources. While hospitals remain the destination of choice for many patients those institutions will need to improve the effectiveness and efficiency of their performance. Adjusting to shifting health care needs of the chronically ill through improved continuity of care across inpatient and outpatient settings, and moving away from episode-specific treatment will be an essential element of reinventing hospitals. If the goal of improved outcomes is to be realized hospitals will need to retool and upgrade their management and clinical services while supporting other upstream providers. Aligning health care needs and effective delivery modes defines the challenge for the health care system, and hospitals represent the nerve center of the effort. In other words, hospitals must be allowed to assert their leadership, but they will need targeted investments to be able to do so effectively. The agenda is a daunting one, but hospitals can be the drivers of change given their credibility, capacity and political support. It is time to harness their potential.

This paper makes the case for the global health agenda to focus more on hospitals because without considering hospitals global health goals cannot be met. It begins by highlighting the importance of hospitals in the health care system of emerging markets. This is followed by a discussion of why now is the right time for the sector to focus on strengthening hospitals. The final section summarizes how the roles and the leadership of hospitals need to change in order to reach the goals of affordable, quality health care. Subsequent papers in this series

will piece together available information on various aspects of hospital and their functioning as a first step in building an information base, a gap that seriously inhibits efforts to place hospitals squarely on the global health system agenda.

## Defining Hospitals

What characterizes hospitals in low- and middle-income countries? The short answer is that we know very little. The availability of hospital services varies dramatically not only from one country to the next but within country health systems as well. Hospital care typically ranges from world class to facilities lacking even the most basic capabilities. Taking stock of the state of hospitals around the world allows us to paint a picture that conveys the experiences of patients and health care professionals in these health care facilities – the types of hospital care that patients can access, the conditions of the hospital facilities, the technology and clinical staff. Such information offers the basis for strategy and action to revitalize and update inpatient facilities, investments that are badly needed.

Two significant constraints limit the ability to characterize hospitals and their performance: first, the lack of an accepted universal definition of what constitutes a hospital, and, second, the uneven evidence base. Little research on hospitals exists outside of the OECD and the Transition Countries. The World Bank reviewed 664 technical reports on health systems (including policy research working papers, discussion papers, books, chapters in books, how-to manuals, guides, briefs, tool kits, policy notes and journal articles) published between January 2000 and September 2010, and found a mere 14 items over more than a decade where hospitals were a main theme. Similar findings emerge from the author's ongoing review of the state of hospitals in emerging markets that has unearthed a strikingly modest literature that focuses largely on clinical assessments.

Whether it is the number of hospitals, how well they are supplied, or relative performance, data remain scarce and lack comparability. Thus conclusions about existing hospitals remain elusive due to the absence of basic information and data. Where periodic or annual surveys record such information, increasingly common in emerging market economies, they simply offer basic data, but little on how the facilities operate or perform.

### What constitutes a hospital?

Hospitals' roles and functions vary across countries depending on their history, governance model and ownership. Existing definitions or classifications of hospitals fail to capture these

differences (de Roodenbeke 2012). For example, a ten-bed building without running water in a Siberian village and a major tertiary facility in Johannesburg, South Africa both qualify as hospitals under most definitions (McKee and Healy 2002). Despite this difficulty, Box 1 attempts to summarize the accepted definitions of hospitals and these definitions are adopted in this paper.

**Box 1: Hospital Definitions**

Given their complex nature, the functions and characteristics that define hospitals differ vastly across countries. A broad definition of the World Health Organization (2014a) describes hospitals as "health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver medical, nursing and related services 24 hours per day, 7 days per week".

A more specific definition adopted by the OECD, characterizes hospitals as "licensed establishments primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing, and other health services to inpatients and the specialised accommodation services required by inpatients. Hospitals provide inpatient health services, many of which can be delivered only by using specialised facilities and professional knowledge as well as advanced medical technology and equipment, which form a significant and integral part of the provision process. Although the principal activity is the provision of inpatient medical care they may also provide day care, outpatient and home health care services as secondary activities" (WHO 2011).

The specific tasks of hospitals may vary by country and are usually defined by legal requirements. In some countries, health care facilities need in addition a minimum size (such as number of beds and medical staff to guarantee 24-hour access) in order to be registered as a hospital" (de Roodenbeke 2012). For example, to register with the American Hospital Association, a hospital must "maintain at least six inpatient beds, which shall be continuously available for the care of patients … who stay on the average in excess of 24 hours per admission." Other requirements include continuous supervision by nurses, pharmacy services, food service, and medical records (American Hospital Association 2014)

Hospitals can be categorized according to their functional level of care (primary, secondary, tertiary), administrative level of ownership (national, regional/city, district and local), size (number of beds), type of ownership (public or private), and range of specialties (general health care or a single specialty). Differences in case mix and technical capacity differentiate hospital categories, but service range and levels of care can vary dramatically as well. Typically, to be categorized as a hospital, facilities need to have at least 10 beds.

In brief, the fundamental factors that distinguish hospitals from other health care facilities are that they provide inpatient health services, have at least 10 beds, and operate and have staffing for continuous supervision of patients and delivery of medical care 24 hours a day, 7 days a week (WHO 2014a; American Hospital Association 2014; de Roodenbeke 2012). Hospital services encompass many different types of patient-oriented activities - from basic inpatient services to all types of specialized care. Hospitals focus on advanced diagnostic and restorative medical services and ideally have linkages to other providers that ensure continuity of care.

Increasingly hospital affiliated outpatient (or "satellite") clinics associated with and overseen by the hospital offer a valuable partnership as they retain the "brand" of the hospital but entail lower costs of operation. Such networks provide a system that meets patient needs and expectations of higher level care while leveraging hospital skills and resources more effectively. While not a hospital, such clinics offer opportunities for the future as services are moved to outpatient settings. It blurs the definition of hospitals but expands their scope and reach. Recent evaluations of such integrated delivery models in the OECD countries show promise in addressing chronic disease management, hospital excellence and continuity of care for patients (see Box 2). Greater efficiency in delivery benefits the providers in using skilled professionals more effectively, satisfying patient needs and reducing costs. The model deserves more attention in emerging markets where similar benefits can be obtained.

**Box 2: Integrated Hospital Care: improving Care and Lowering Costs in the OECD**

Increasingly stand-alone hospital services in OECD countries are being assessed as inefficient and of low quality. From the emergence of accountability care organizations in the US to integrated health and social care initiatives in Canterbury, New Zealand (Timmins and Ham 2013) to the Cochrane Collaboration reviews of specialist primary care and rural hospitals (Gruen et al. 2009) to trend spotting by the American Hospital Association (2014) to smaller efforts in a number of emerging markets where hospitals have established satellite clinics to filter patients and improve pre- and post-hospital care there is an unmistakable trend toward integrating inpatient and outpatient services. Integrating hospital care and patient outreach offers higher quality care and enhanced efficiency that translate into less costly care.

Improved access to outpatient services previously only available in hospitals lowered admissions, reduced in lengths of stay, and a saved roughly $2bn between 2007 and 2010/11 in Canterbury province, New Zealand. Spurred by the US Accountable Care Act a number of *accountable care organizations* have committed to integration of care though bundled payments and rewards to providers for improved patient results. Experiments in Colorado, Chicago, Illinois and Houston, Texas show sharp enhancements in quality of care, shorter patient lengths of stay, fewer readmissions and lower hospital acquired infections, and, in Houston, a 15-33 percent (depending on condition) decrease in the cost of care. Chicago achieved similar results and with outreach chronic care management that resulted in improved diabetes and asthma control (American Hospital Association 2014; Gruen et al. 2009).

Public and private sectors invest in and operate hospitals, expanding options to citizens. Increasingly financing and delivery functions of hospitals are shared or undertaken jointly by the public and private sectors, leading to a mix of alternative delivery and financing arrangements. Providers range from public district level facilities that serve as the "apex of the primary care system" to specialty and university teaching hospitals, and private hospitals that also run the spectrum from basic acute care facilities to highly specialized diagnosis and treatment centers. An important middle ground encompasses non-profit hospitals that again run the gamut of services but become important sources of hospital services for the poor especially in rural areas. In much of Africa these key players offer much needed treatments and trauma care.

Despite hospitals' critical role, a recent review by the International Healthcare Initiative (Mate and Sifrim 2011) focusing on a handful of Sub-Saharan African countries highlighted

the challenges in leadership, management, human resources and quality if district hospitals are to lead and step up to the needs of the community. However, in keeping with the overall findings of this review, the evidence base is thin and in need of data, analysis and intervention to upgrade district hospitals. It is clearly a festering agenda.

While currently experimental in many cases the shape of the hospital networks of the future are likely to encompass lessons from both the decentralization of hospital functions and the gamut of current ownership structures. The future of hospitals will likely encompass both existing ownership arrangements and new options that take advantage of the comparative advantage of both the public and private sectors. That is certainly the lesson from the OECD.

## Why Hospitals?

Hospitals form the backbone of the health care delivery system. Physicians, nurses and other medical staff are trained there, hospital standards set the parameters for quality and performance across the health care system, and hospitals symbolize the health system for citizens. Medical training simply does not exist outside of hospitals. They are the quintessential training grounds for doctors, nurses and other medical practitioners. Without hospitals, or with substandard ones, training suffers and the quality of medical care professionals is compromised. That in turn undermines the quality and resilience of the health care system.

Hospitals make up a large part of government budgets: between 40 and 70 percent of public monies go to finance hospitals. Despite their pivotal role, hospital policy has been consistently overlooked over the past few decades as both the national and global focus has shifted to primary health care in an effort to reach the bulk of the population, particularly in rural areas, and to intervene early to prevent the onset of disease and avoid the high cost of inpatient treatment. While highly laudable, the investment ignored the complementary and leadership role of hospitals, the need for continuity of care across acute and chronic diseases, and the unique lifesaving services that only hospitals can provide.

### Hospitals: The Cornerstone of Successful Health Systems

The emergence of new diseases associated with aging, demands for better diagnoses, and emergence of new pathogens all imply the need for readiness to adapt to the evolving disease landscape. Most low and middle income countries were unprepared for the HIV/AIDS

epidemic and significant global efforts were slowly assembled to staunch the spread and devastation. Countries like Brazil and Thailand harnessed health delivery infrastructure, adapted creative strategies to reach citizens and patients, and successfully stemmed the tide of the epidemic. Hospitals played significant roles in identifying appropriate screening programs, adapting hospital services to permit alternative treatment therapies in hospital outpatient settings, and training cadres of health professionals. Without them the scale up could not have been managed.

The current Ebola outbreak in West Africa highlights the importance of hospitals to fully functioning health care systems. The response to the Ebola outbreak required hospital leadership and management for diagnosis, treatment and quarantine. Yet the health systems of Guinea, Liberia and Sierra Leone were unable to intervene effectively in containing the disease. Ill-equipped hospitals meant that public efforts to identify and manage Ebola cases fell short and many hospitals were shuttered and abandoned, leaving the US military to manage the disease in Liberia where they have effectively built tent hospitals to address the growing epidemic. Guinea and Sierra Leone have not had the same advantages, and hospital care has fallen short in a time of crisis.

A hospital comparison study highlights the extent of hospital inadequacy in Sierra Leone. Using the WHO Tool for Situational Analysis to compare hospitals in Sierra Leone in 2009 and US Civil War era hospitals Crompton el al (2010) showed a shocking discrepancy with the hospitals in Sierra Leone lacking reliable running water, power and anesthesia, in contrast to US hospitals in the 1860s where records show consistent supplies of all three. In addition to poor infrastructure Sierra Leone suffers from underinvestment in key components of their health care system including hospitals, basic standards of care, and the physical and human resources to operate inpatient services. The Ebola outbreak revealed the limited capacity and infrastructure, which have complicated efforts to control the epidemic. If hospitals are dysfunctional the health care system cannot operate -- an important lesson of the West African Ebola epidemic. Investments in health care systems have no substitute if governments choose to provide health care to its citizens.

Médecins Sans Frontières, donors, the International Financial Institutions, NGOs, Cuban doctors and other international players are playing major roles in all three countries. In contrast, Nigeria and Senegal both successfully managed Ebola patients in their hospitals. While the extent of the devastation and rapid spiral of transmission would have challenged many countries fragility of the health care systems in the three countries made it far worse.

The fact remains that the hospital sector was ill-equipped to respond and unable to adapt to changing circumstances.

Donor funds traditionally target primary care and infectious disease, especially TB, malaria and HIV/AIDS. That focus has left all three countries, as well as many of their neighbors, unable to cope with a disease outbreak reliant on the relatively sophisticated patient care that can only be provided by hospitals. Without hospital staff and infrastructure to quarantine and manage patients, the epidemic cannot be contained. The lack of training, inadequate management and insufficient hospital infrastructure have all complicated the effort to control the epidemic and save lives. Emergency and essential surgical care ostensibly make up the basic health care services but these have fallen short in this epidemic.

Because health providers train in hospitals, they represent the clinical, managerial and financial standards in a country's health care system. They serve as the reference point for other health care providers and accept referred patients who cannot be diagnosed and/or treated at lower levels. Hospitals also offer the best means of promoting primary and outpatient care, and are the only source for treating catastrophic health problems and managing illnesses requiring specialization or inpatient care. Surging cancer incidence and prevalence across the globe, for example, demand hospital attention; oncologists require the volume of patients and the range of interventions only available in hospitals. That also applies to trauma care, palliative treatment and sophisticated cardiovascular disease interventions.

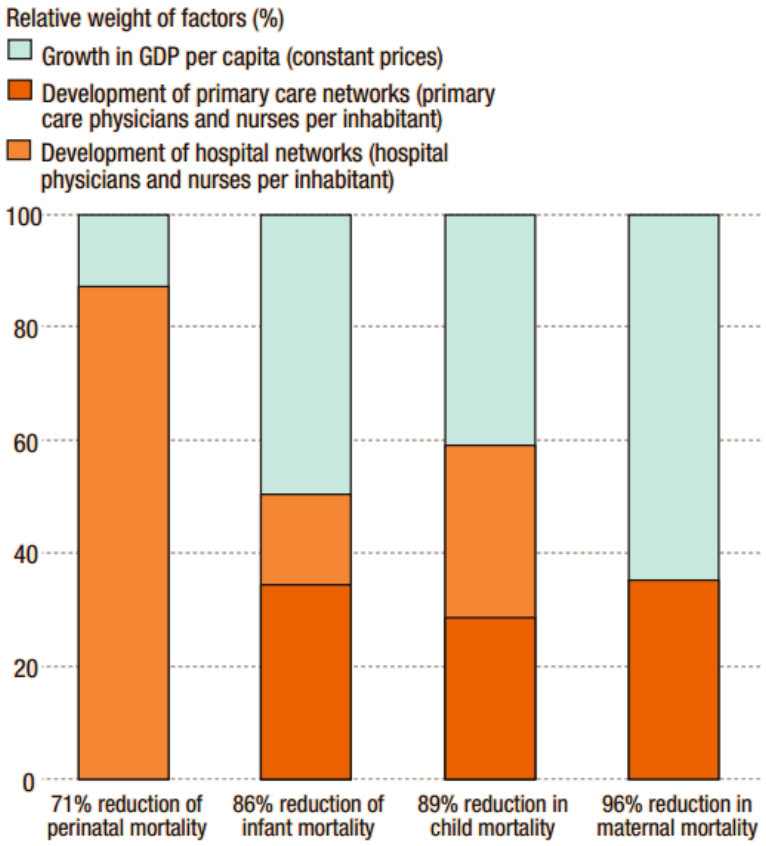
Finally, as the world's health problems change and new technologies emerge, hospitals may well find themselves as the nerve center from which most care is provided. Already telemedicine and e-health are transforming how health care is delivered and how providers and patients interact. Those advances enhance the ideally strong linkages among hospitals, primary care and community services, and facilitates the increasingly important continuity of care for patients. Chronic conditions, high risk patients and those recovering from trauma all require post-hospital care and monitoring. Harnessing e-health via cellphones and other monitoring equipment make the transition to home care easier, more affordable and potentially of higher quality. This represents a frontier area with great promise for the health care system in emerging markets.

## Hospitals Critical to Raising Maternal and Infant Survival

One of the greatest concerns along with much of the funding of donors, philanthropists and the global community focuses on maternal and child health. Targeted programs for expanding pre-natal care and upgrading the skills of traditional birth attendants dominate global priorities. While reducing birth complications and maternal deaths does require investing in pre-natal care, hospital deliveries and the availability of hospital services prove equally important in increasing both infant and maternal survival. The correlation between hospital deliveries and both infant and maternal deaths provide strong support for the role of hospitals in reducing mortality.

The experience of Portugal between 1960 and 2008, a country reclassified as a high-income country only in 2008, makes for an interesting case study. Portugal's perinatal, infant, child and maternal mortality levels have declined dramatically since the 1960s. Figure 1 summarizes the achievements in mortality reduction and the role of GDP, primary care access and supply of hospital services. Together, rising incomes and health care investments have halved maternal deaths; perinatal death declines of over 71% are due largely to improvements in hospital care; and, infant and child mortalities benefited from rising income and all forms of health interventions. This unique analysis provides strong endorsement for the key role of hospitals in reducing mortality of mothers and children.

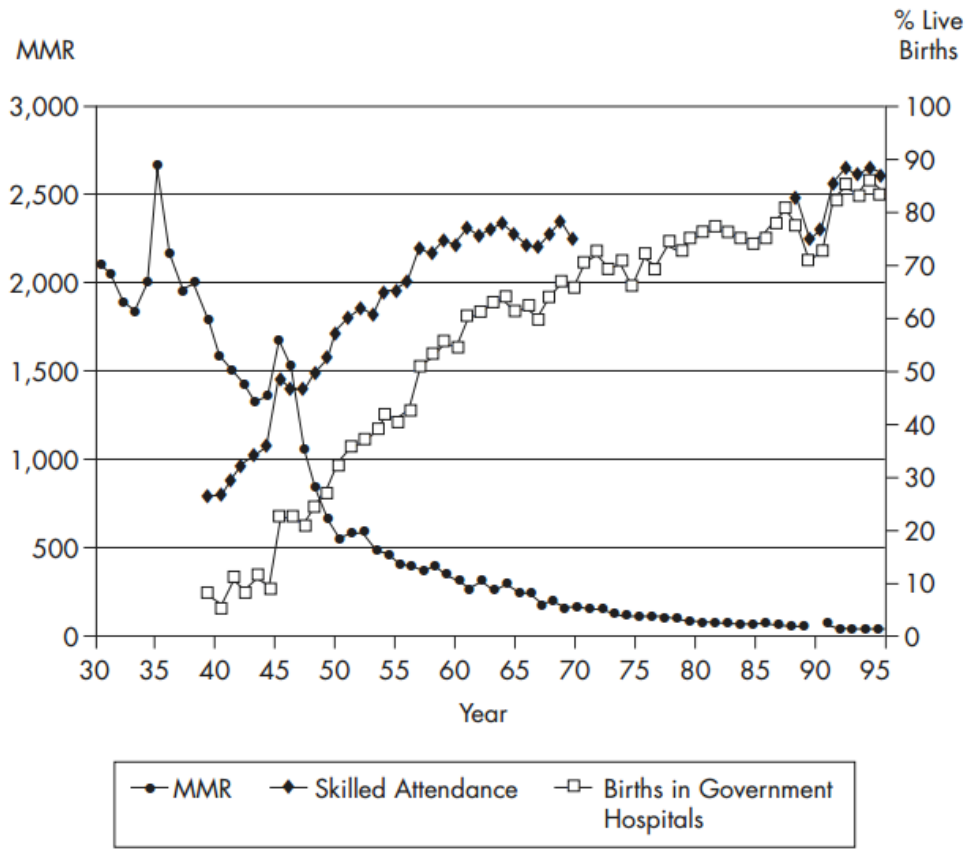
**Figure 1: Factors explaining mortality reduction in Portugal, 1960-2008**




Source: de Roodenbeke (2012) based on Van Lerberghe (2008)

A study in Sri Lanka also highlight the importance of hospital care for reducing maternal and infant mortality (Pathmanathan and Liljestrand 2003). An examination of the returns to Sri Lanka's investment in hospital deliveries between 1930 and 1995 (Figure 2) shows a marked improvement in maternal survival as hospital births rose. The ability of hospitals to provide a sanitary and safe environment, intervene when complications arise, ensure safe deliveries and appropriate care for fragile newborns radically improves the chances of mother and infant survival.

**Figure 2: Maternal Mortality Ratio and Percentage of Live Births with Skilled Attendance and Hospital Births, Sri Lanka, 1930-96**




Source: de Roodenbeke (2012) based on Pathmanaban and Liljestrand (2003)

The Plan Nacer program in Argentina aimed to stem the rising infant mortality that resulted from the 2002 financial crisis. Targeted to the country's poorest provinces it offered physicians and hospitals in the public sector bonuses to ensure access and use of pre-natal care and hospital deliveries for all pregnant women. The results are impressive: a 22 percent decline in overall in-hospital neonatal deaths and a 74 percent decline among Plan Nacer beneficiaries. Hospital care accounted for half of the improvement and pre-natal services for the other half (Gertler, Giovagnoli, and Martinez 2014). Designed a decade ago the program persists and has expanded nationally.

Evidence for the poorest countries suggests the equal importance of hospital deliveries in reducing maternal mortality in those settings. Campbell, Graham et al (2006) carefully assess the evidence on strategies for reducing maternal mortality and conclude that in the lowest income countries maternal mortality can only be seriously addressed through a "health

centre intrapartum-care strategy" that means 24 hour access to maternity care and immediate availability of effective emergency-obstetric care back up. Effectively this implies the need for maternal deliveries at least at district hospitals with back up from higher level inpatient facilities. The authors reject the community health care worker and traditional birth attendant model referring to the "cheap but ineffective technology" as "more of a hope than an effective actuality" in reducing maternal mortality. These insights further bolster the findings from countries that have already achieved dramatic reductions in maternal deaths, and highlight the importance of hospital deliveries for all births.

These examples demonstrate the importance of hospitals and prenatal care, together with the complementary effects of rising incomes, in dramatically improving survival probabilities of mothers and newborns. The evidence shows that both low and high middle income countries directly benefited from interventions that targeted not only prenatal care but hospital births and the post-natal period. Investing in hospital networks and hospital births are the indispensable marginal ingredients that drive infant mortality rates to levels close to those of rich countries.

### Hospital Demand on the Rise

By and large, patients seek hospital care when they need treatment. Although important, prevention efforts can fail to reach at risk families, or require behavior changes that can be difficult to instill. The track record on behavior change for preventive care, even in the OECD countries, is mixed (Harvard University School of Public Health 2011). Seeking treatment incurs costs for patients due to both opportunity cost of lost earnings and direct costs of treatment. The failure of preventative care combined with the costs of treatment help explain why public hospital outpatient departments often receive far more patients than they can handle. Patients find hospitals more attractive than clinics as they offer one stop access reducing the need for repeat visits and therefore incurred costs associated with travel and lost work opportunities. In addition, patients frequently perceive hospitals as having higher end care (Lewis, Eskeland, and Traa-Valerezo 1999). As households earn more they tend to spend more on health care, and when they fall ill seek hospital services perceiving primary care facilities as of lower quality and too limited in scope.

Demonstrations in Brazil in the summer of 2014 demanding "FIFA hospitals" highlighted the frustration of the middle class with inadequate investments in health care in the face of the $62 billion expenditure on soccer stadiums for the World Cup. Both the Brazilian and

Colombian governments are grappling with the demands of citizens for high-end care only available outside their countries. Since both countries have enshrined free public health care in their constitutions citizens obtain care elsewhere and send the bills to the Ministry of Health. Needless to say these costs are high both absolutely and in comparison to national hospital care costs. The courts have sided with citizens on the issue enacting judicial enforcement of claims for health goods and services (Ferraz 2009; Yamin and Parra-Vera 2009). The alternative is locally available services of similar caliber that carry lower costs but entail expanding access to these expensive services. That means improved availability of better-managed hospitals with more sophisticated services.

The expansion of private hospitals across emerging markets reflects a combination of higher incomes, shifting expectations of patients, inadequate public supply and perceptions of higher quality care in private hospitals (IFC 2010). As discussed below, private investment in emerging markets is accelerating in response to patient preferences, and their willingness and ability to pay for modern hospital care. Private hospitals broaden supply options and offer options to citizens, but it also indicates that public hospital investments are falling short of expectations. Both have implications for the future of the sector, but it is unlikely that the private sector will shrink.

Studies on citizen perceptions of government health priorities confirm these findings in even the lowest income countries, reflecting perceived inadequate attention to hospital care. A 2014 Pew Research Center representative survey in six African countries asked citizens to prioritize public health investments. They identified building and improving hospitals and other health care facilities as the most important initiative followed by HIV/AIDS prevention and treatment. A median of 76% of respondents across the six countries surveyed say hospitals should be one of the most important priorities for their national government. The percentage of the public who hold this view ranges from 85% in Ghana to 64% in Nigeria (Wike and Bell May 2014). Relatedly, documentation of patients consistently bypassing primary care clinics to purchase care privately or reach a hospital for care[2] suggests patient preference for better hospitals.

[2] The recent Health Systems Global conference in Cape Town, South Africa October 1-3, 2014 highlighted the bypassing phenomena in various countries.

### Growing Importance of Hospitals in Health Care Systems

The importance of hospitals to strong health care systems has become increasingly clear and the international community has gingerly begun to take a renewed interest in inpatient care. Reaching UHC commitments, achieving the Copenhagen Consensus's surgery objectives, and strengthening health care systems to meet the myriad demands of modern health care all require serious efforts to upgrade and expand hospital networks. Multiple fora sponsored by the World Health Organization (WHO), the Pan African Health Organization (PAHO), the German Federal Enterprise for International Cooperation (GIZ), the Inter-American Development Bank and the World Bank have raised concerns over the lack of knowledge, evidence and advice on hospitals and the dated global perspectives on hospitals. An internal World Bank survey of health staff highlighted the increasing request for assistance with hospital reform in client countries. This renewed interest has yielded little follow up.

Yet requests from governments for advice and loans for hospital services and restructuring to the World Bank and Inter-American Development Bank (IDB) continue to grow. In addition, the International Finance Corporation's expanding portfolio of advisory and investments in hospitals indicate rising private sector interest as well as growth in public private partnerships (PPPs) in construction and management of hospitals. The WHO and GIZ both expressed concern about the lack of attention and spending on hospitals given their importance to country health care systems.

Surging investments in private hospital care, and rising private investment in health care in emerging markets suggest unmet patient demand from traditional public sources as well as competition in the hospital market. Growing foreign direct investment in health care is coming from various sources including other middle-income countries that have established quality products and find a ready market in countries at similar levels of income. For example, the biggest health insurer in China is Discovery Health of South Africa (Broomberg 2014), and India's Fortis and Olympia hospital groups continue to build and operate hospitals across Asia. An important recent global investment was United Health Care's purchase of Brazil's largest health maintenance organization Amil in 2013. Finally the emerging interest in public private partnerships (PPP) in public hospital construction has taken hold across the globe with ongoing or completed projects in Brazil, Chile, Egypt, Lesotho, Mexico and Turkey, among other countries. Currently Netcare South Africa completed construction of Queen Mamohato Memorial Hospital in Maseru and manages the hospital and satellite clinics under a contract with the Lesotho government (Lewis and Bonfert Forthcoming). Hospital PPPs for both construction and management engage

investors from across the globe fueling the growth in foreign direct investment (FDI) in hospitals and health care more generally.

## Why Now?

Pledges to reach universal health coverage and build strong, efficient health care systems mean significant investments to bolster existing arrangements and improve their overall performance. This also implies targeted efforts to bolster access and quality. Years of underinvestment have left hospitals poorly equipped to take on leadership roles, and with little experience in upgrading and modernizing processes and clinical practices.

Over the past 30 years the developing world has experienced profound change. Urban populations are growing rapidly. By 2030, Asia and Africa are expected to join Latin America in crossing the threshold of becoming majority-urban continents (Montgomery 2008). In addition, the disease burden in both low and middle income countries has shifted dramatically and now accounts for eighty percent of the world's mortality from heart disease, stroke, cancer, and other chronic diseases (Jha et al. 2012). This places immense pressures on already weak health care systems.

Simultaneously, despite a renewed interest and a seemingly greater demand for hospital support from low and emerging market economies, donors and philanthropists remain hesitant to step into this field. Chronic disease receives only a fraction of the billions donors spend on global health. At about 1 percent the amount is negligible.

This section will explore these trends and, by doing so, make the case for why it is more urgent than ever for the global health agenda to focus on hospitals.

### The Changing Disease Burden: explosion of chronic and catastrophic conditions

The disease burden in emerging markets has experienced a major shift away from simple treatable infectious diseases like diarrhea or malaria to chronic diseases such as cardiovascular disease, cancers, HIV and diabetes. According to the Institute of Health Metrics and Evaluation (IHME 2014) the number one killer in most emerging markets is heart disease, followed closely by stroke, and traumas from violence and road accidents.

Many individual patients suffer a myriad of complications or are afflicted by multiple conditions simultaneously making diagnosis and treatment complicated and reliant on higher

level medical expertise. Cancers claim more lives in Africa than HIV, malaria and TB combined across all age groups (Moten et al. 2014), and cardiovascular disease kills twice as many people as those same three infectious diseases across all low- and middle-income countries (Jha et al. 2012).

Figures 3.1 and 3.2 show the break down in cause of death in developing countries, which account for 60% of the world's cancer cases and 70% of cancer deaths (Moten et al. 2014). However, cardiovascular disease represents 46% of all non-communicable deaths in low and middle income countries and cancer a mere 19% (2014).

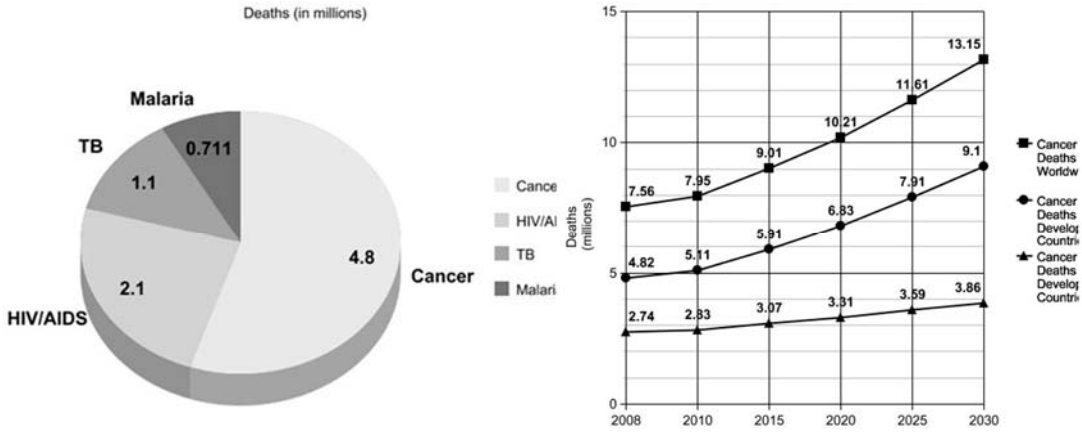



**Figure 3.1: Distribution of major causes of death in Developing Countries, 2008**

**Figure 3.2: Projected Trends in Cancer Deaths in Developed and Developing Countries, 2008-2030**

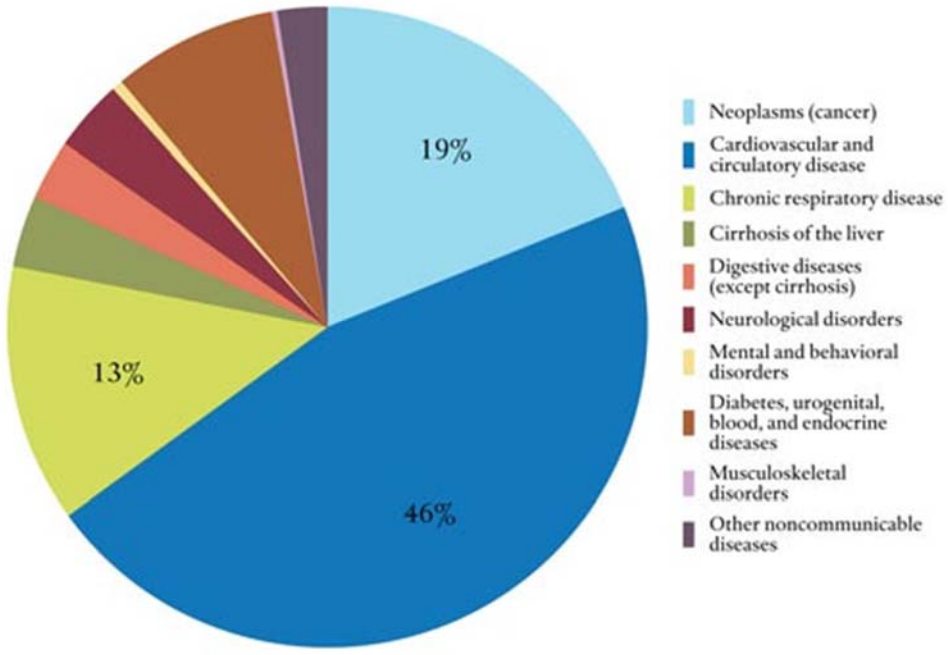
Source: (Moten et al. 2014)

Figure 4 provides the distribution of NCD deaths across low-and middle-income countries, indicating the relative importance of the relevant NCDs.[3] This change has been accompanied by similar shifts toward chronic diseases and patients with multiple morbidities, a particularly serious situation since the rate of increase in chronic disease is accelerating. Population aging accounts for some of the rise in chronic conditions, reflecting

[3] NCDs effectively are the bulk of all health problems. Certain diseases are more prominent than others and will have an influence on the structure of a responsive health care system.

higher income, and successful preventive and treatment investments over the past few decades, but better diagnoses and understanding of disease pathogens has contributed as well.

**Figure 4: Distribution of NCD Deaths in Low and Middle Income Countries, 2012**




Source: Institute of Health Metrics and Evaluation (Anonymous2014)

Latin America's explosion in chronic conditions, cardiovascular disease and diabetes in particular, is forcing a restructuring and reconsideration of country health care systems (Montenegro et al. 2011). Through training, engaging community health providers and providing clinical backup hospitals build capacity and structure clinical management for chronic conditions. That kind of leadership boosts countries' abilities to reinvent health care for the 21st Century and offers a foundation for future changes in response to evolving circumstances. Latin America is not alone in discovering chronic conditions and the need for radical change. In India a re-examination of causes of death reveals higher than expected levels of cancer among young adults in rural areas (Dikshit et al. 2012), a chronic disease requiring very different forms of intervention and treatment. Aging populations further contribute to the rise in chronic conditions and particularly poly-chronic illnesses.

Another rising challenge is trauma, often from road accidents. Road traffic incidents (RTI) represent the leading cause of death of young people ages 15-19 worldwide, and is the 8th

leading cause of death globally. With an average of 20.1 fatalities per 100,000 population, Middle Income Countries exhibit the highest rates of road traffic deaths, with rates reported as high as 38.1 per 100,000 in Thailand and 31.9 in South Africa (WHO 2014b). At the same time traffic deaths are rising exponentially in low income countries and WHO expects an 80% rise in traffic deaths in Sub-Saharan Africa between 2004 and 2020. It is projected to be the number one killer of children aged 5-15 in the region by 2015. Trauma treatment requires the infrastructure, specialization and capacity of hospitals. Outpatient clinics cannot manage the complexity and difficulties of multiple injuries and trauma from road or other serious accidents. Given their already high incidence, traffic accidents will continue to be a major health challenge and they will by necessity rely on hospitals for treatment.

Even in the poorest countries where infectious diseases still play a significant though declining role the lack of investment in hospitals has deleterious effects on morbidity and mortality. For example, in Uganda the lack of capacity to handle basic hospital interventions is a major cause of premature death and a serious shortcoming of health care delivery as it abandons young patients with curable diseases. The young disproportionately are admitted to hospitals and patients under age 30 make up close to 50 percent of surgical admissions. Sepsis, post-operative care, trauma and obstetrical problems constitute the major reasons for admission. Lack of capacity combined with poor education of all medical staff limit Uganda's ability to identify, refer and respond to treatable diseases that require hospital or intensive care units (ICU) attention. As the population of Uganda and other countries ages, the hospital and ICU problems will only be exacerbated. In the meantime, until hospital services become available patients in Uganda and other low-income countries will not be able to access treatments that save lives and reduce morbidities (Firth and Ttendo 2012).

The recent history of sequentially addressing the prevention and treatment of individual diseases, often called the single disease approach, such as AIDS or malaria, through isolated, vertical programs no longer meets the needs (or aspirations) of citizens in developing countries. As Judith Rodin, President of the Rockefeller Foundation highlights, "we know that there is a fundamental need to transform health systems around the world - both the global system and also local systems on the ground. This need should be seen against the backdrop of vertical disease-control programs that have found only mixed success and emerging health spending trends that compel us to change how we design and deliver services in the developed and developing world" (Rodin 2007).

More complicated presenting conditions (often caused by delays in seeking care), the risks of maternal death without hospital deliveries or hospital back up, and the rise of chronic disease together place strains on countries' overall health care systems particularly those still managing infectious diseases. In order to successfully address these new challenges, system reforms that encompass improvements in all aspects of health care delivery are needed. Focusing on hospitals as the cornerstone to these health systems will be key to successful reforms.

## Urbanization accelerating

The world is urbanizing at a rapid rate, leading to important shifts in health care access with implications for patient demand, and for both public and private health care provision. Health care services, and hospitals in particular, become more accessible to households in cities where densities warrant investments in a broader set of interventions. It means that births can be more easily accommodated in hospitals, with the resulting reduction in maternal and infant deaths. The growing disease burden of cardiovascular disease and cancers have a greater chance of being diagnosed and effectively treated while trauma victims have the infrastructure and care required by accidents and other catastrophic events, and chronic conditions can be more easily managed. All of these conditions entail continuity of care either before and/or after hospital care, and linking hospital care to outpatient clinics offers providers and patients the potential for integrating different forms of care that respond to both ongoing and evolving needs of patients. The approach lends itself to effective implementation where population densities are higher as integration proves far more challenging in rural settings.

An increasingly frequent complaint in even the poorest countries is the bypassing of rural clinics for hospital outpatient services in cities. The option makes sense from the perspective of patients who benefit from consulting medical providers who can arrange diagnostic tests or treatments that may be required. Rural primary clinics simply do not have the staff or the services to diagnose and treat anything other than simple complaints. Where they cannot meet the more complicated presenting conditions patients are forced to seek solutions at the next level of care.

Figure 5 shows the patterns of urban growth across the globe. Africa and parts of Asia lead in the rate of growth with expected increases in urban dwellers by 2050 of 53% and 64%, respectively. By contrast the Latin America and the Caribbean region has already reached an

80% urban population, and countries like Syria, Botswana and Albania have some of the highest percentages of city residence in the world. Asia even now comprises 53% of the world's urban population reflecting the concentration of total world population on the continent (UN 2014).

**Figure 5a: City Growth Rates from 1990-2014**

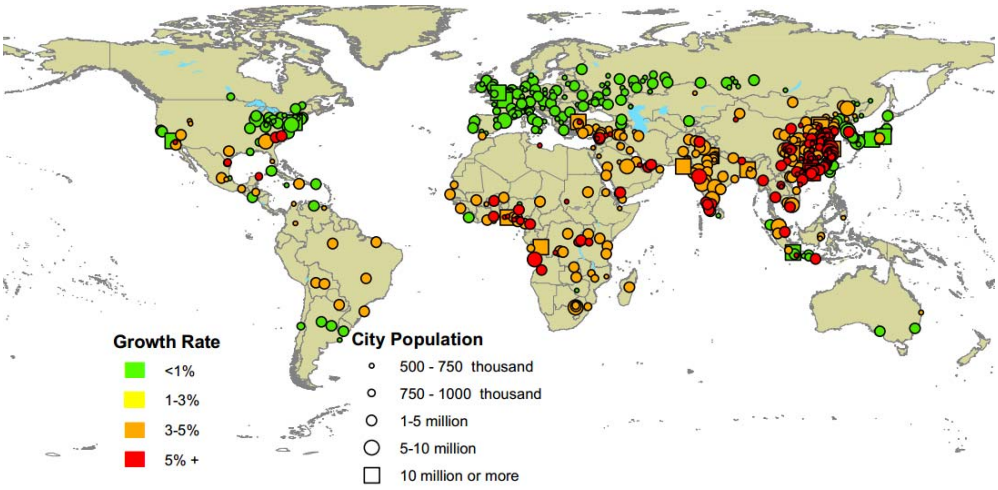
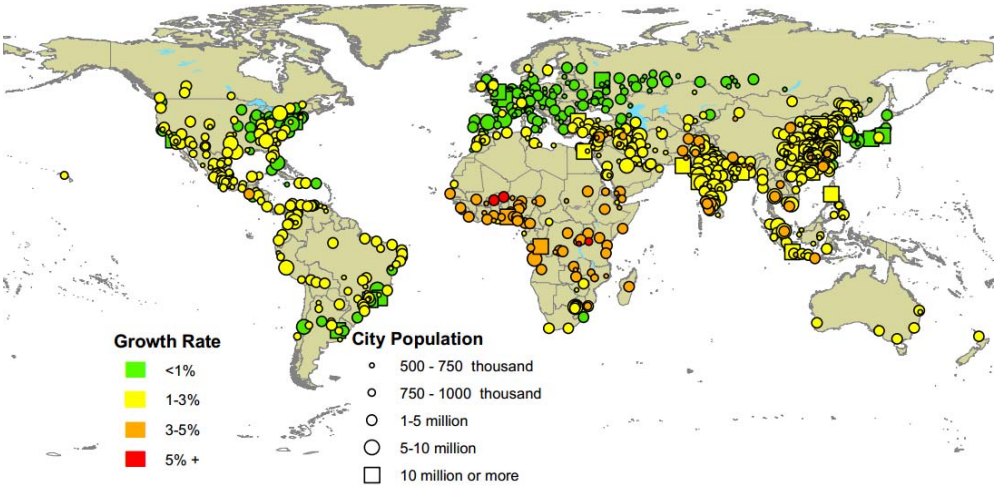



**Figure 5b: City Growth Rates from 2014-2030**

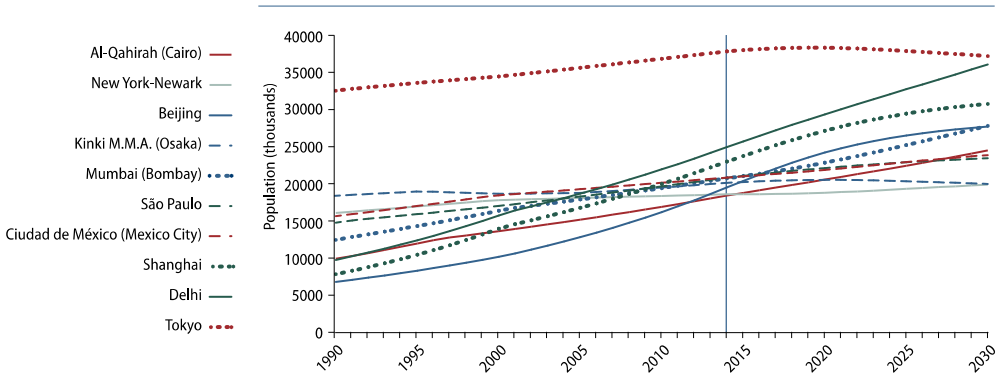



Source: UN (2014)

While the rich countries urbanized during the first half of the last century, pockets of high urban growth occurred in developing countries as well. Figure 6 provides the historical

growth trends for the ten largest metropolitan areas in 2014. Of these 70% are cities in emerging markets, suggesting the importance of considering urban densities in health care and hospital planning and investment. Urban growth occurs across all levels of agglomeration, and small towns often provide the first leg of urbanization. There, as in large metropolitan areas, citizen demands for health care rise but providers can also reach them at lower cost with a broader array of services. For health care the trends offer promise for more and better services.

**Figure 6: Historical patterns of growth in the ten largest metropolises in the world**




Source: UN (2014)

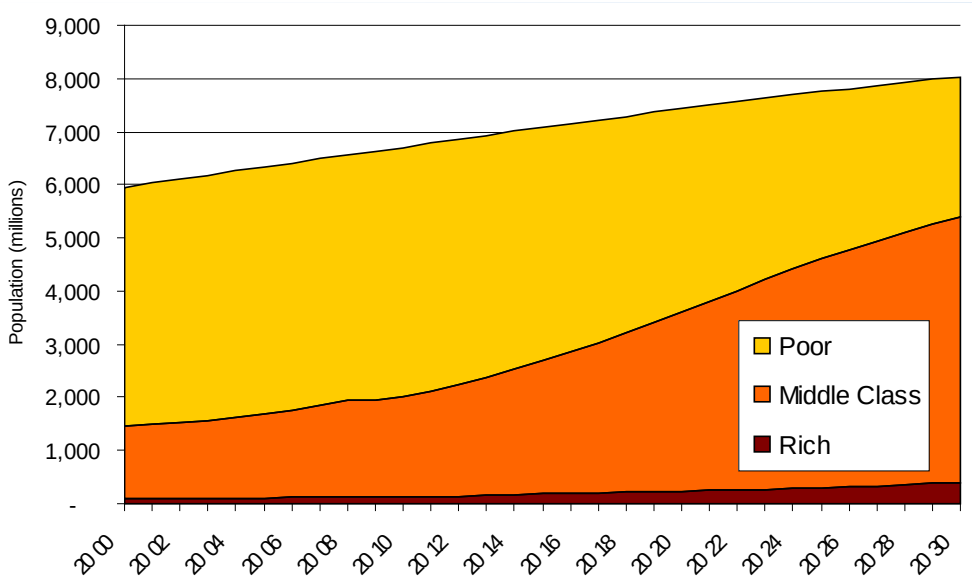
## The rising middle class

Income growth in middle-income countries has overtaken GDP growth in the rich world, and projections predict a continuation of those trends (OECD 2014). That trajectory translates into dramatically lower rates of poverty and expansion of the middle class, and both have implications for health care consumption. While Asia will eventually eclipse the rest of the world in population size it will also be the source of consumption helping to drive the global economy. The sheer size of India and China means they will lead the world in consumption in the near future. Projections suggest that India and China will represent 23% and 18% of global middle class consumption by 2030 (Kharas 2011).

Figure 7 show projections in the growth of the middle class between 2000 and 2030. In 2000 the size of the middle class was dwarfed by the number of poor people, but by 2030 the reverse will be true and the middle class will dominate the distribution of income. The graph shows that the growth in the middle class accelerates from about 2014 suggesting that the

world will experience significant shifts in income over the next decade and a half (Kharas 2011).

**Figure 7: A Surge in the Global Middle Class**

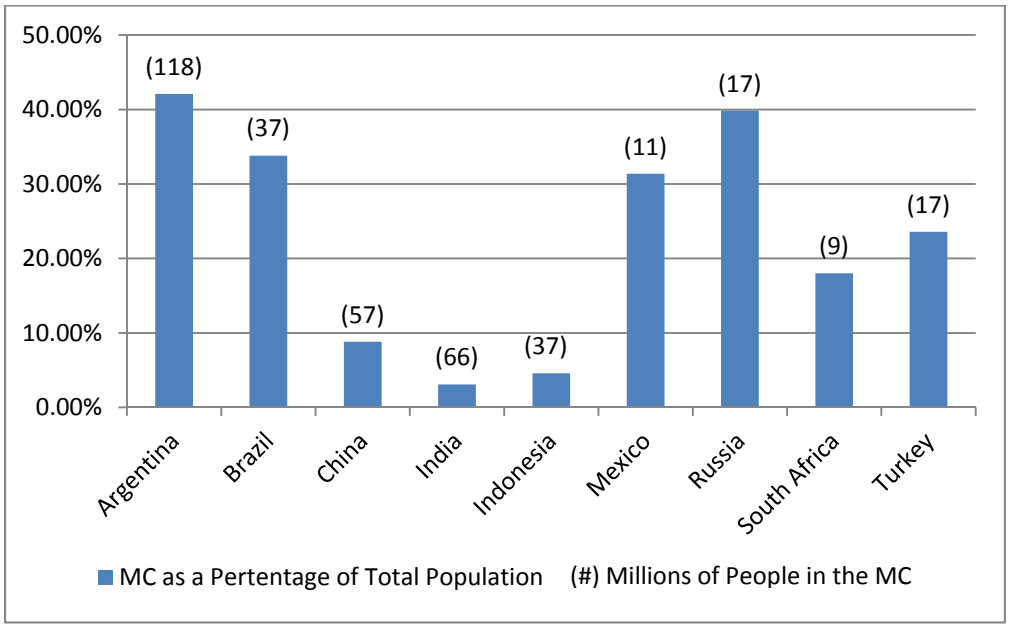



Source: Kharas (2011)

While the future holds promise for higher incomes and wellbeing across the globe, many middle-income countries already have significant middle classes that make up an expanding slice of the population. Using an index of assets, notably car ownership (Dadush and Ali 2012) estimate the percentage of the middle class in selected emerging markets. The proportion of the population that is middle class ranges from 5% in Indonesia to roughly 40% in Argentina and Russia, but Turkey's 22% and Brazil's 33% suggest significant purchasing power and financial clout given their large population size (Figure 8).[4] However, as (Kharas 2011) notes, China dwarfs the other emerging economies. With 157 million middle class consumers China is already the country with the second largest middle class (the US is first) in absolute numbers.

[4] While Birdsall (2000) has pointed out that the purchasing power of the newly middle class is typically modest, health care often claims a disproportionate amount of marginal earnings so tracking middle class entrants may prove particularly useful in projecting health care demand.

**Figure 8: Percent and Number of Middle Class in Selected Emerging Markets**




Source:(Dadush and Ali 2012)

The economic and demographic shifts promise higher consumption of health care, and other goods, as incomes rise and the middle class becomes established. Whereas poverty allows only consumption of essentials, the middle class spends on goods and services that go beyond the basics of life. That spending includes health care. Given government guarantees of citizen access to (free) health care and the activism of the middle class pressures on public health ministries are likely to grow both on spending levels and on improved access to sophisticated care. Hospital services are part of those rising expectations and willingness to spend.

Demand for private insurance to make private options more affordable also correlates with income. For example, 26% of Brazilians, 17% of Chileans and 16% of South Africans purchase private health insurance, which captures the wealthy, the middle class and even some at the bottom rungs of the middle class. Pressure to do more and to improve quality and responsiveness in hospital care should be expected with the shifts in income status, just as occurred in OECD countries.

## Spending and cost containment

Health care costs increases are forcing policy makers and government authorities to examine how resources are spent in health care. Hospitals claim more than half of all health expenditures in most low and middle-income countries but less than half in most high-income countries (WHO 2007). The reality of high costs obliges middle-income countries to explore and embrace cost containment strategies, already a mainstay among industrial countries' health care systems. Recent studies show evidence of major inefficiency in hospitals (La Forgia and Couttolenc 2008; Sahin, Ozcan, and Ozgen 2011) but little evidence on how such shortcomings can be addressed.

A number of studies in Latin America measure health and economic costs of hospital acquired infections (HAI) infections, a major source of unnecessary expenditure and a danger to patient health. While infection rates compromise health they also lead to lost earnings for patients and undermine efforts to contain costs and promote efficiency in hospitals. In a survey of intensive care units (ICUs) in 8 hospitals across five Latin American countries Schmunis et al (2008) concluded that 10 percent of patients suffered at least one adverse event, and 37 percent of these were hospital acquired infections. Half again were preventable with simple strategies revolving around tracking and reporting infection, and following up with targeted remedies. The estimated annual costs of these hospital acquired infections to the hospitals ranged from US$40,000 to US$1.7 million representing 10-35 percent of their annual ICU operating costs.

Acosta-Gnass et al's (2008) seven country study in the Latin American region suggests some of the reasons for the shortcomings. While a third of the 67 sampled hospitals had written, evidence-based standards and regulations only 12 percent retained records of compliance and 6 percent demonstrated supervision of the process, key elements in infection surveillance and control. Furthermore only 19 percent had hand washing facilities in patient care areas, a simple but fundamental component of infection control. These management failures that allow such lapses result in financial and human costs. They highlight the singular lack of attention to basic operational procedures in hospitals, a serious lack of accountability and high levels of wasted expenditure. Effectively HAIs raise spending and drive up costs.

Health reforms increasingly are being structured to not only increase access, but also to improve value, address efficiency and control costs (Barber et al. 2014). The issue of hospital infection levels doesn't appear to be on the reform agenda despite the detrimental effects to all three objectives. The intentions of reform, however, do not always translate into

anticipated results, as seen in China recently. In an effort to improve efficiency, public hospitals have been permitted to distribute surplus revenues to their staff. The perverse incentive for providers to increase revenues has on the one hand led many public hospitals to over-service and provide unnecessary care, and on the other hand limit "free services" to those who pay fees (Allen, Cao, and Wang 2013). Evidence from Eastern Europe suggests that over spending on staff at the expense of other inputs results in neglect of capital investments and maintenance (Lewis and Pettersson 2009). In some cases, it represents limited access to capital, but the lack of a vision for the system and the inability to see beyond the immediate operating demands of hospitals compromises the opportunity to improve efficiency, control costs, and modernize infrastructure.

Few health systems in low and middle income counties have examined the spending or service delivery details of health or hospital services. The lack of experience leaves them ill-equipped to identify and adopt effective means for controlling expenditures, raising quality and improving efficiency of health care delivery in general and hospital services in particular. Since hospitals finance a significant proportion of all health care and are costly to build and operate, greater attention to basic efficiency and quality in services will be critical to long term affordability and effectiveness of hospital investment. Managing threats such as HAI are part of the solution, but enhancing delivery efficiency through integrated care networks is another. Reforms without a grasp of the financial issues in hospital care cannot be expected to translate into improved performance of hospitals or the health care system more generally.

## Shortcomings of hospital reforms and new directions for hospitals

Some countries have recognized the importance of and inadequacy of hospitals in their health care systems. As a result, significant policy reforms have been launched in a handful of countries especially in Eastern Europe. These have, however, only met with limited success. The shortcomings of reforms and policies often result from the absence of a strategic approach. Most emerging economies have failed to modernize public hospitals and typically operate under antiquated models with decaying infrastructure (Couffinhal and Mandeville 2014). Even where countries have sought to cut hospital costs and improve efficiency, dated management, limited autonomy and central control undermine these objectives. New clinical protocols and infrastructure are not enough. A clear vision for the next generation of hospitals, new management structures, better and more appropriate

management information systems remain critical components for reform if reforms are to upgrade quality and transform hospital and health care.

In many cases even when recent health care reform agendas have incorporated attention to public hospitals, success has been modest. The focus has been on increasing access rather than improving quality and performance. Particularly notable examples of incorporating attention to public hospitals into the reform agenda are efforts to offer greater autonomy. In China (World Bank 2011), Vietnam (Wagstaff and Bales 2012; World Bank 2011), and Senegal (Lemière, Turbat, and Puret 2012), experiments with greater hospital autonomy received limited oversight and resulted in higher costs, high out-of-pocket spending, and perverse incentives for overtreatment. The Indian government's initiative to finance neglected surgical procedures in private facilities has spurred private hospital construction. In all cases, autonomy without clinical or managerial standards or performance measures translates into greater supply but not necessarily better care (La Forgia and Nagpal 2012). Ignoring incentives and levers to raise quality and performance undermines reform agendas and limits the benefits of change.

Brazil's experiment with outsourcing hospital management to non-profit organizations in São Paulo state has met with considerable success in quality, efficiency, safety and patient satisfaction (La Forgia and Couttolenc 2008). The model has persisted for over 15 years despite changes in party leadership over the period. A similar PPP concession in Lesotho reduced unit costs, raised volume, improved quality and attracted more patients (Vian et al. 2013). While controversial these innovations have achieved remarkable results in public hospital reform, specifically in raising quality, improving efficiency and more effectively meeting patient needs. They offer alternative models for other countries though they entail a restructuring of current hospital organization and management. Moreover, rethinking hospital financing and accountability arrangements deserve attention and offer the potential for enhanced hospital and health care system performance.

Hospital reform based on benchmarks and better data remains a high priority. The lack of good evidence, inadequate data and poorly evaluated experiences limit the relevance of global experiences, and makes the shaping of reform agendas difficult. Better evidence should drive future reforms, but it entails investments, a reevaluation of objectives and a clear path to a revised model of healthcare delivery that includes hospitals, but harnesses them for change so that they become part of an integrated system for health care delivery.

That concept addresses the shifting circumstances in emerging markets and positions the health care system for the 21st Century.

## Conclusion

Rapid changes in health and health care across emerging markets stemming from higher economic growth, increasing urbanization and an emerging urban middle class have profound implications for the provision and financing of health care. Treating simple health complaints has given way to chronic conditions, catastrophic events from accidents, and diseases of middle age such as cancer and renal disease. Citizens expect governments to respond but the public sector faces difficulties given its neglect of hospital care, the high cost of responding to new morbidities and the associated costs of high-end health care. The private sector has played a role in bridging the gap, and has promise to do more and collaborate with government. These offer encouraging possibilities and new ways to finance and deliver health care.

Varying definitions of hospitals, broad differences in focus, low standards in capacity, quality, patient safety and efficiency, and few tools to measure or improve these components of health care have combined to undermine hospitals and their mission. The emergence of multiple private providers and payers alongside public services has revealed glaring differences between modern private care and traditional public care.[5] The incentives to reach and maintain standards of care and performance in hospitals beyond the few elite institutions are few (Thompson 2014). Part of the difficulty can be attributed to the absence of benchmarks for performance, lack of access to expertise, limited capacity to adapt without knowledge of options, and the inherent conservatism of medical practice. But the romance of primary health care obscures the need for a pragmatic assessment of shifting health care needs, the state of the overall health care systems, and the emerging demand for more and better health care by the rising middle class. Many health systems are unprepared for the next Ebola outbreak, others remain unresponsive to changing health priorities. Effective responses well define the health system for the future. The time for action is now.

Affluent consumers and an aging population combine to make developing countries a value proposition for investors, particularly where public investments have not kept pace with rising demand for quality and technologically sophisticated health care services. The safety

[5] It is noteworthy that Nelson Mandela was treated in private hospitals, as are President Dilma Roussoff and ex-President Lula de Melo da Silva despite the rhetoric in both countries emphasizing the quality and preeminence of public hospitals.

risks of largely unregulated private hospitals combined with the potential for sharp cost increases across the hospital sector as health care services expand and become more sophisticated will place pressure on governments. Strengthened hospital regulation to upgrade quality and safety will fall to governments as private oversight alternatives are rare in emerging markets. At the same time countries will need to reform hospital management and financing arrangements to reduce waste and promote efficiency in both public and private facilities. While difficult to implement, such steps simply follow the experiences of the OECD countries that continue to balance access, affordability and quality in ensuring access to health care.

The shifting circumstances in health conditions, income, location and patient preferences point to the priority for hospital investment and modernization -- and attention is needed now. Part of that agenda entails new approaches to health care delivery that integrate inpatient and outpatient services, but it also implies devising new ways of paying for hospital services, alternatives to public infrastructure investment, hospital management reforms and ways to integrate public and private delivery. Without those reforms the expensive, isolated hospital will persist with minimal impact on patient needs or satisfaction. The articulated global agendas on health care offer a framework for reconsidering hospitals. It is time that that opportunity is seized and hospitals placed on the fast track. There is much ground to recover.

As health systems evolve and patients demand more and better care, hospitals will remain indispensable. Investing in these costly and vital institutions have knock on effects across the health care system. And if health systems are to be transformed to serve more citizens with better and more complex care, hospital leadership will be key, and investments will need to streamline management, integrate health care delivery modes, improve performance incentives and raise the quality of clinical care. The call for better integration between inpatient and outpatient services and the importance of tracking patients to improve their health and wellbeing deserves to be at the core of reforms. It captures the future of health care given patient demand, spacial location, health conditions and technology. Reinventing hospitals and bolstering performance remain the key challenge for health care system reform.

Universal Health Coverage cannot be achieved without bolstering hospital investments. Addressing the hole in surgery and ICU coverage represents a central component of UHC. Investing in improving and supporting hospitals and hospital reform must constitute part of

the health care systems agenda if change is to occur and health care systems are to keep pace with technological advances and citizen demands. Hospitals remain central elements in achieving the agreed UHC goals. Currently, hospitals are barely on the agenda.

Given the current landscape, citizen expectations for higher end care combined with the need for better integrated care place pressure on health care systems in general and hospitals in particular. The challenge is how to best address the gap, how soon and with what resources. But time is running out. Action is needed now.

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