Policy Options for Financing Health Services in Pakistan

VOLUME I

SUMMARY REPORT

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

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Volume I **Summary Report**
by Marty Makinen

Volume II **Hospital Quality Assurance Through Standards and Accreditation**
by Greg Becker

Volume III **Hospital Autonomy**
by Stan Hildebrand and William Newbrander

Volume IV **Development of Private Health Insurance Based on Managed-Care Principles**
by Zohair Ashir, Harris Berman, and Jon Kingsdale

Volume V **Organizing and Financing Rural Health Services**
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VOLUME I - SUMMARY REPORT

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i

ACRONYMS, ABBREVIATIONS, AND GLOSSARY vii

1.0 INTRODUCTION 1

2.0 QUALITY ASSURANCE FOR HOSPITALS 5

3.0 HOSPITAL AUTONOMY 7

4.0 PRIVATE HEALTH INSURANCE 11

5.0 ALTERNATIVE RURAL MODEL 15

6.0 LEGAL ISSUES 21

7.0 ZAKAT AND OTHER CHARITIES 24

8.0 OTHER ISSUES 25

9.0 OVERALL IMPLEMENTATION PLAN 26

BIBLIOGRAPHY 29

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID U.S. Agency for International Development (Washington, D.C.)
AKHS Aga Khan Health Services
AKU Aga Khan University
AKUH Aga Khan University Hospital
AKUHS Aga Khan University Health Services
Amir Head of a Muslim State
ARI Acute Respiratory Infection
Bait-ul-Mal Welfare funds established by the Amir
BHUs Basic Health Units
CCU Cardiac Care Unit
CDA Capital Development Authority
CDD Controlling Diarrheal Diseases
CHW Community Health Worker
CRHP Cost Recovery for Health Project, Cairo, Egypt
chowkidar Watchman
CV Curriculum Vitae
CZA Central Zakat Administration
CZC Central Zakat Council
DHO District Health Officer
DOH Department of Health (provincial level)
EPI Expanded Program of Immunization
ESSI Employee Social Security Insurance
Fatamid Foundation Blood Donor Agency
FGSH Federal Government Services Hospital
FJMC Fatimah Jinnah Medical Center
FMOH Federal Ministry of Health of Pakistan
FP Family planning
GDP Gross Domestic Product
GMO General Medical Officer
GNP Gross National Product
GOP Government of Pakistan
GP General Practitioner
Hakims Traditional health practitioners
HCFA Health Care Financing Administration, U.S. Government
HFS Health Financing and Sustainability Project
HMO Health Maintenance Organization
HPAC Healthcare Provider Accreditation Council
HPN Office of Health Population and Nutrition
HT Health Technician
ICT Islamabad Capital Territory
ICU Intensive Care Unit
IPA Independent Practice Association
ISL Islamabad
JCAHO Joint Commission for the Accreditation of Health Care Organization
JPMC Jinnah Postgraduate Medical Center
Katchi Abadis Squatter Settlements
KEMC King Edward Medical Center
KHI Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

VOLUME I

SUMMARY REPORT

1.0 INTRODUCTION

This is the executive summary report of the work done by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability project (HFS). The task was to design four financing and organizational reform initiatives aimed at improving quality, efficiency, and equity in the Pakistani health system.

This executive summary is made up of sections that correspond to the separate volumes that describe each initiative in detail. The summary outlines the overall study, presents the key elements in each of the four initiatives, and provides supplementary information on religious funds and legal issues. The sections covering the initiatives begin with a statement of what the FMOH wishes to achieve in that program area. This is followed by a brief explanation of the problem the initiative intends to address and a broad outline of the initiative itself. HFS's findings and recommendations for the design and implementation of each initiative follows.

The four initiatives summarized in this volume are addressed in detail in separate volumes of this report. Each volume includes a plan for implementing the initiative as well as a design for monitoring and implementing the reform. The former is to be used as a road map for the carrying out of each initiative. The latter is to be used to determine whether the reforms are achieving the desired ends. An overall implementation plan is found at the end of this summary volume.

The Overall HFS Study

The Federal Ministry of Health's (FMOH) purpose in designing new initiatives for the financing of health services is to:

- Increase the share of Gross Domestic Product (GDP) allocated to health.
- Improve the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban, by targeting the use of limited government resources.

Overall, through the pursuit of the four initiatives, Pakistan's health sector would become more financially sustainable and the growth in the government's resource burden for health would be reduced.

The initiatives are intended to address the current situation in which government and private health delivery systems face a number of problems:

- Low quality of care
- Inadequate allocation of funds
- Inefficient use of available resources
- Inequitable distribution of access to health services among socio-economic groups

The design of the initiatives was guided by the following principles:

- Requiring people who have the resources to pay for a portion of the health care they receive, principally through the payment of user fees, often facilitated through insurance mechanisms.
- Developing methods of organization of service delivery which include incentives for efficiency, cost-effectiveness, and quality.
- Targeting government allocations to make effective services available to lower socio-economic status groups.

In addition, the proposed initiatives contribute to the achievement of several of the objectives of the Government of Pakistan's (GOP's) Social Action Program (SAP). The SAP is designed to improve performance in the social sectors, including health.

The Four Initiatives

In 1990, a broad-scope study of the entire Pakistani health care system was conducted by the FMOH with assistance from the U.S. Health Care Financing Administration (HCFA). This study identified a list of areas where organizational and financing reforms might be of benefit.

In order to design specific initiatives within the areas that have highest priority, the United States Agency for International Development (USAID) made the services of HFS available to the FMOH starting in 1992. Together, the FMOH and HFS gathered up-to-date information about possible areas of intervention, consulting government and private health service providers, provincial and federal health officials, public and private employers, insurers, donor agencies interested in the health sector, and other interested parties.

The information gathered during this period was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were various approaches to financing and organizational reform that could address problems that had been identified. The FMOH listened to commentary from the participants, then selected four areas

to pursue:

- Development of a quality assurance mechanism for hospitals
- Granting autonomy to government hospitals
- Development of private managed-care insurance
- Development of new financing and organizational models for rural health delivery services

These approaches are mutually reinforcing. Autonomy for government hospitals will allow them to more easily meet quality standards. Hospitals also will benefit from the development of private managed-care insurance plans. Managed-care insurance plans, in turn, will use the independent assessment of hospital quality to choose facilities with which to associate. Strengthened rural services will reduce the burden on government hospitals. As government hospitals improve, they will better serve as referral sites for rural care providers.

Following the 1992 workshop, the FMOH proceeded to design initiatives in each of the four selected areas. A decision was made to pursue the development of private insurance in Islamabad and Karachi. The latter appeared to be particularly fertile ground for such development because of the spontaneous growth of interest in managed care by New Jubilee Insurance, the Baqai Foundation, Aga Khan University Hospital, and numerous employers.

It also was decided that the concept of autonomy for hospitals and a new approach to the financing and organization of rural health services could best be pursued in Islamabad Capital Territory (ICT). The former would be done with two hospitals: the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH). The latter would be undertaken with the Islamabad Capital Territory's three Rural Health Centers (RHCs) and thirteen Basic Health Units (BHUs).

The development of a quality assurance mechanism for hospitals was to be taken up on a national basis.

To assist the FMOH, HFS assembled a team of seven national and nine external experts to tackle the four approaches. In addition, one of HFS's experts examined the legal implications of the proposed initiatives. HFS personnel collaborated closely with the FMOH, Capital Development Authority (CDA) personnel, PIMS and FGSH management staff, provincial authorities, government and private hospitals, non-governmental organizations (NGOs), private and government employers, and many others. All were generous in sharing information and opinions. HFS's work from defining problems and identifying possible approaches to finalizing the designs in the four chosen areas took 14 months.

Throughout this time, HFS and the FMOH continued the consultative approach to their work that they had begun with the initial workshop. Three subsequent workshops were held where data was gathered, preliminary proposals for the initiatives were presented, and feedback was sought.

- The second workshop, held in June 1992, assembled national experts and HFS consultants to define options for the quality assurance mechanism.
- A workshop in November 1992 presented interim findings and recommendations for commentary and feedback to the same group that had participated in the initial workshop, plus many who had been consulted in the interim.
- The final designs in all four program areas were presented to this same group at the end of HFS's work in February 1993.

This consultative approach was designed to gain the benefit of the wisdom and experience of all the important actors in the Pakistan health sector. It also was intended to build consensus for the proposed approaches to reform and for the designs chosen for carrying them out.

In addition to the workshops, the FMOH conducted a briefing meeting with donors in November 1992 to seek additional assistance with the testing phase that would follow after the design work was completed. It is now time for the FMOH and/or the Provincial Departments of Health (DOHs) to take the action that is needed to begin to test the implementation of the designs described in this report.

The sections that follow summarize the major findings and recommendations in each of the four program areas chosen by the FMOH. In addition, summaries of the studies done on the role of religious funds and on legal issues are provided. Lastly, an overall implementation plan is presented which integrates the four initiatives, the legal work, and the recommendations concerning consensus and capacity building.

2.0 QUALITY ASSURANCE FOR HOSPITALS

PURPOSE

The FMOH would like the quality of health services to improve throughout the health system in both the public and private sectors. One method that can be used to accomplish this is to establish an independent entity to set standards, monitor compliance, and accredit all providers of health services.

PROBLEM

Low quality of care is pervasive in both the government and private health systems. Means for consumers or entities representing consumers (such as employers) to evaluate the quality of health services are limited by the technical medical knowledge required. Further, if effective health insurance programs are to be developed, mechanisms needs to be put in place that will ensure that minimum standards of quality are being met.

DESCRIPTION OF THE INITIATIVE

To provide an independent assessment of quality of care in hospitals, the FMOH worked with public and private provider representatives to devise an entity that would set standards, assess compliance with them, and offer accreditation. The entity that this study recommends is designed to gain the confidence of provider groups. It is ready to be put into place quickly and to begin to establish standards of quality. Later, this entity could expand its scope to cover non-hospital health service providers.

METHODS

The entity that is proposed was developed through a process which included assessing current standards of quality in the country, examining other countries' experiences, and taking part in a workshop where papers on various approaches to standard setting and accreditation were presented by an external expert and discussed by leading Pakistani specialists. The external expert in hospital standards and accreditation then visited a sample of government and private hospitals to assess the standards that already exist and to consult with leading doctors and hospital administrators. He also examined alternative methods for developing and implementing such standards, drawing lessons from experiences in Latin America, Egypt, and the United States. This information became the basis for a paper that made an initial proposal for a mechanism adapted to Pakistan's particular needs and situation. This paper, along with papers by Pakistani authorities on what standards should accomplish and on the history of accreditation systems, were discussed at the workshop held in June 1992. The Federal Minister and Director General of Health, Provincial Directors General of Health, and 45 leading health care

authorities from the public and private sectors around the nation participated in this workshop. The workshop concluded by making specific recommendations concerning the constitution of a national standards and accreditation mechanism.

FINDINGS AND RECOMMENDATIONS

The analysis of Pakistan's situation concerning the applicability of standards and accreditation for hospitals found:

- The need for standards and accreditation is accentuated when moving towards a system that requires users to make financial contributions to pay for hospital services.
- Mechanisms for ensuring that standards are met may set objectives or require facilities to set their own objectives for quality.
- Accreditation is an effective method for judging compliance with standards.
- To be effective, a standards and accreditation mechanism must be set up to be reward-based and educational, rather than punitive. It also should be set up to realistically show hospitals how to improve the quality of their services.

The consensus conclusions and recommendations from the June 1992 workshop were:

- National minimum standards need to be established to grant official recognition to both government and private hospitals.
- A national council with provincial chapters should be formed to set national standards and grant accreditation.
- This national council should be autonomous and should be composed of proportional representation from the government, the private sector, and professional organizations.
- The Federal Director General of Health should select a nominating committee from workshop participants to choose the national council members.
- The process of standards development should be decided by council members.
- Accreditation should be voluntary.

- Legislation empowering the council should be proposed and enacted.

- Separate from the standards and accreditation process, the FMOH should consider requiring compulsory registration and licensing of hospitals.

These recommendations were summarized in a report to the FMOH. Subsequently, the FMOH wrote to the provinces asking their advice on the matter. FMOH action on the recommendations awaits the provincial replies.

3.0 HOSPITAL AUTONOMY

PURPOSE

The FMOH would like government hospitals to operate as autonomous entities, receiving indexed block annual subsidies from the government. Autonomy would allow these institutions to generate additional revenues through user payments. User payments often would be made through third-party insurers. Efficiency improvement is expected to result from the incentives autonomy would give hospital managers to contain costs, improve cost-effectiveness, and raise quality of care. Because government hospitals would retain their social mission, they would not refuse to provide care to those unable to pay.

PROBLEM

In the current system, government-operated hospitals consume a share of government allocations for health that is disproportionate to the contribution they make to the general health of the population. They are inefficiently operated; many resources are wasted. Quality of care is low. Furthermore, many who would use government hospitals, particularly if the quality of care were better, are able to pay for services. This would be particularly true if these people were able to avail themselves of a financial risk-sharing mechanism such as insurance.

DESCRIPTION OF THE INITIATIVE

The first hospitals to be granted autonomy under the proposed plan would be the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH), both in Islamabad. Other government hospitals, both federal and provincial, would be converted to autonomy on a phased basis (a few at a time). Phased conversion would allow hospital administrators to learn from experience and to revise their conversion plans according to what is learned.

METHODS

A number of steps have been taken to develop the concept of autonomy for government hospitals. HFS studied how hospitals and other enterprises in Pakistan currently operate when granted limited autonomy, how private trust hospitals operate, and how autonomy for government hospitals has been pursued in other countries. HFS also consulted with the management of PIMS and FGSH about how they currently operate and about what powers and incentives would be needed to allow them to achieve the objectives that correspond to the purpose of this approach.

RECOMMENDATIONS

Using the information that was gathered, recommendations are offered in three dimensions: governance, management, and finance. The concepts developed in each of these dimensions are applied to plans for the conversion of FGSH and PIMS.

Governance

In the dimension of governance, the recommendations are:

- The government should retain ownership of the hospitals.
- Financing should be shared between the government and the private sector.
- A board of directors made up of representatives of government, the concerned community, and the medical profession should be granted the power to oversee the operations, management, and financing of the autonomous hospital.
- This board would ensure that:
  - The basic mission of the hospital is accomplished.
  - The current volume and quality of services provided is maintained or improved.
  - Financing is sufficient to provide services of acceptable quality.
  - The social mission of the hospital is achieved.
  - The assets of the hospital are protected.
- The board would hire the hospital's Executive Director who would, in turn, hire staff and operate the hospital.

Management

HFS found that to achieve the purposes designed for autonomous hospitals, the current management of government hospitals will need to take a new approach to the community in which it exists, it will need to learn and use new skills, and it will have to operate within a revised organizational structure. In particular, improved management practices should allow autonomous hospitals to increase efficiency.

Autonomous hospitals have to sell their services to potential paying patients. Because of this, HFS recommends that newly autonomous hospitals clearly define their mission so that it is

understood within the community it serves. It will also need to negotiate referral relationships with other institutions, including pricing policies. Finally, hospital management must develop the capacity to market the institution's services to insurers, employers, and individual patients.

The appropriate management structure for an autonomous hospital may take many different forms depending on the specific needs of the individual institution. However, HFS recommends a certain basic structure for the organization of an autonomous hospital as a starting point for adaptation. This structure takes into account the new or increased needs that come with autonomous status. HFS' recommended basic structure would be made up of:

- A Board of Directors which hires and oversees the Executive Director
- A top management team which is hired and overseen by the Executive Director; this team would be made up of Deputy Directors for:
  - Administration
  - Finance
  - Nursing
  - Medical
  - Support Services
- Middle management overseen by the Deputy Directors

Finally, HFS identified areas in which training for autonomous hospital management will be required. Training is needed to help the Board and the Executive Director understand their respective roles and responsibilities. It also is needed to give management personnel skills in personnel administration, finance, and marketing. The improved management which should result will allow the hospitals to respond to the incentives brought about by autonomy to improve efficiency and quality of patient care while still meeting social objectives.

Finance

HFS's recommendations in the area of finances for autonomous hospitals are based mainly on a study of costs at PIMS and FGSH. Recommendations are made concerning the need to define the respective responsibilities of the board and the top management team in financial areas, compensation for doctors, and funding services for those unable to pay.

A base of the HFS study is the belief that operating and capital funds can largely be made up from user payments on a phased basis over a ten-year period. Hospitals should also be able to obtain funds by increasing utilization of their services, by improving the efficiency of their operations, and by generating more revenues from patients. The ability of patients to pay fees should be enhanced by another of the initiatives explored in the HFS study: the development of insurance systems to share financial risks. For patients unable to pay fees, it is suggested that hospitals seek to develop an enhanced relationship with the Zakat Fund and to grant first call on remaining government subsidies to cover the costs of these patients. It is further recommended that patient welfare committees, currently used to identify those who are unable to pay, be improved.

The HFS study also suggests that the management of autonomous hospitals be held accountable for achieving efficiency and quality of services while still ensuring access to the poor. In return for this accountability, the Board should be given the power to truly direct hospital staff by granting bonuses, making adjustments in pay, and using the power to hire and fire personnel based on how they perform against the achievement of the hospital's objectives.

It is further recommended that management present to the Board for approval annual financial plans, including both operating and capital spending plans and expected revenues from all sources. Performance in meeting this plan also would be a criterion in board evaluation of management.

Finally, it is recommended that to motivate doctors who admit and treat patients, hospitals consider sharing patient fees with the doctors.

4.0 PRIVATE HEALTH INSURANCE

PURPOSE

The FMOH would like an increasing fraction of the population to be covered by health insurance paid for by beneficiary and employer contributions. This insurance system would have mechanisms in place to control cost escalation and to minimize administrative costs. The growth in government financing for health services would be reduced by any growth in health insurance coverage.

PROBLEM

The GOP is pursuing approaches in the reform of its hospitals and rural health services which will result in asking consumers to pay for services used, especially hospital services. User payments would be greatly facilitated if insurance mechanisms existed to facilitate the sharing of financial risks. Current private health insurance programs are plagued by cost escalation, fraud, and abuse. This makes insurance companies reluctant to offer health coverage and makes employers concerned about how to provide health benefits to employees. New approaches to health insurance are needed to allay fears so that expansion of coverage may be attained to complement the planned changes at government hospitals and, to a more limited extent, at rural health facilities.

DESCRIPTION OF THE INITIATIVE

This initiative is intended to stimulate the development of public and private sector insurance mechanisms based on managed-care principles. The focus of the initiative is on designing how to guide and assist the development of insurance in two urban markets, Karachi and Islamabad. Managed-care principles are promoted within this report to address the problems of cost escalation, fraud, and abuse prevalent in current indemnity-style insurance arrangements.

Managed-care principles can be used in many designs for the organization of insurance. Whichever design is used, managed-care principles include using competitive prospective payment mechanisms to help contain costs. Under prospective payment, providers are paid a fixed sum for a set of services to be made available to a given group of people. This system gives no financial motive for providers to over treat patients or to add cost-ineffective technologies. Providers would be motivated to control unnecessary utilization instead of being tempted to join with the insured to defraud the insurer or employer. Finally, under managed care, payments would be made from the insurance organization directly to providers, bypassing the insured and closing off an opportunity for fraud.

METHODS

A multi-dimensional approach was taken in this study to identify the problems inhibiting the development of health insurance and to recommend possible solutions. This approach included having external consultants associated with a managed-care program in United States make technical visits to Pakistan. Working in collaboration with a national consultant, these experts conducted interviews and meetings with representatives of the health sector and members of the health insurance industry to assess the feasibility of using managed-care principles in the design of health insurance plans for the country. An assessment of the current health practices prevalent in Karachi and Islamabad was performed to understand how the health care delivery system operates. To measure their interest in participating in a managed-care plan and to gather baseline data about them, sizable employers in Karachi and Islamabad were surveyed. In addition, some attention was given to analysis of the Employee Social Security Insurance systems in each of the provinces.

RECOMMENDATIONS

The analyses performed found that the share of the population covered by insurance is unlikely to grow and that the performance of existing plans is likely to remain unsatisfactory unless basic changes are made in the approach to health insurance. Under present circumstances, the general business environment is not conducive to encouraging health insurance practices; financial incentives are lacking and a legislative framework needs to be established. Given this, providers currently are wary of using health insurance as a financing mechanism. Stimulation of the development of managed-care approaches to health insurance appears to be a promising way out of this situation.

To facilitate the development of health insurance using these principles in Pakistan, the following recommendations are offered:

- Offer Workshops - Conduct insurance workshops in Karachi and Islamabad for potential insurers, employers, and providers to present this study's findings. The HFS report on insurance development should be made available to workshop participants since the report offers planning and technical information about the current market for a managed-care product. Potential insurers could use the report's implementation chart as a strategic plan for conducting feasibility analyses.

- Demonstrate Managed Care - The GOP or Provincial Governments should consider demonstrating the attractive features of managed care by contracting with private health insurers using managed-care principles to provide services for a selected group of government employees.

- Provide Financial Incentives - The government could provide financial incentives to potential insurers for investing in a managed-care health insurance plan. Private sector employers could be stimulated to purchase insurance by extending to them a temporary tax break in making their first purchase of a managed-care product. Once in the managed-care plan, benefits would be expected to keep them there without the tax incentive. Similarly, state-owned organizations could be induced to purchase managed-care insurance with the funds currently spent on providing these services.

- Revise ESSI Legislation - Implement the pending increase in the income ceiling for participation in ESSI from the current level of Rs. 1,500 per month to Rs. 3,000, and annually adjust this amount to account for inflation. Encourage ESSIs to become more efficient and effective by permitting employers to opt out of ESSI by making equivalent arrangements privately. Foster efficiency by allowing and encouraging the ESSIs to contract with private providers on a capitation basis. Heighten employee interest in ESSI performance by requiring them to contribute toward premiums.

- Study Compulsory Insurance - Conduct a study to assess the advantages and disadvantages of compulsory health insurance coverage of employees by employers. Study the impact of such a policy on employment, production costs, and competitiveness.

- Encourage Providers to Offer Managed Care - Encourage selected health care providers in Karachi and Islamabad to launch their own managed-care plan. The FMOH should consider trying to persuade selected providers in Karachi such as the Aga Khan University Hospital and in Islamabad such as PIMS to start their own managed-care plans. To induce them into taking the initiative, the FMOH could purchase health services from them for a selected group of federal employees, providing them a ready client base until the plan becomes financially self-sustainable.

- Provide Training in Managed Care - Assist potential insurers to acquire technical training in designing and operating managed-care plans. Request donors to provide such training to insurers, employers, and providers as a part of technical assistance programs.

- Target Marketing of Plans - Market managed-care plans to multinational and state-owned organizations. Such organizations provide more liberal and generous health benefits than other employers. They also are prone to accepting concepts like managed care. In the employer survey, they indicated a desire to improve health coverage for all employees. However, the employees belonging to the "management" cadre are better educated and more conscious of the importance of higher quality

of care and of the need for controlling escalating medical care costs, the primary benefits of a managed-care product. Therefore, insurers may wish initially to target this category of employee.

- **Conduct A Feasibility Study** - Conduct a feasibility study for introducing a managed-care product. The employer survey carried out during the HFS study on insurance indicates a strong interest (74 percent asked for follow-up) in learning more about a managed-care plan, especially pricing information on the package of benefits presented in the questionnaire. This suggests that it would be in the interest of potential insurers (insurance companies or providers) to take the next steps to define and price a package of services to test the market.

- **Revise Benefits Package** - Revise the model of managed-care benefits based on feedback obtained in the employer survey. It is recommended that potential insurers price the basic package described in the survey, then price asked-for add ons. These include dental care, health coverage for members' parents, and facilities for treatment abroad in special cases.

5.0 ALTERNATIVE RURAL MODEL

PURPOSE

The FMOH would like its rural health system to effectively address the major sources of morbidity and mortality among vulnerable populations in a cost-effective and affordable way. To achieve this, an alternative to the current system of organizing and financing rural services is presented and plans for its testing are described in the rural HFS report. The alternative that is proposed relies on private delivery of services; on financing primarily coming from government allocations, with an option for some user fees; and on substantial community participation in choosing services to be offered, which provider to engage, and whether or not to charge fees.

PROBLEM

The problems typical of the current government-provided and financed services to rural populations include the general non-availability of "free" health care, absenteeism among health staff, hours that are too short or inconvenient to consumers, an absence of essential drugs and supplies, and insufficient funds to pay for the services that are needed. These problems have contributed to poor health status indicators among rural populations.

DESCRIPTION OF THE INITIATIVE

The rural initiative posits the development, testing, revision, and replication of an alternative model for organizing and financing rural health services. The alternative recommended for testing involves assigning current government operating allocations to rural communities to be used in competitively contracting, on a fixed-price basis, with private providers. The contract would require providers to offer a basic package of services while operating government rural health facilities and equipment in the community. At the option of the community, additional services to the basic package can be asked of the contractor in return for the right to charge limited user fees. When fees are applied, Zakat and other charities would help to pay for services used by the poorest. The government, in addition to supplying the funds, facilities, and equipment, would act as a technical advisor to the community in choosing services to ask for and in monitoring and evaluating provider performance.

This alternative is regarded as highly experimental, since only a few precedents exist worldwide, none in Pakistan. Thus, it is recommended that the first tests of the model be done on a cooperative-agreement basis. A cooperative agreement would build in greater-than-ordinary flexibility to the first contract(s) in order to reduce financial risks to the contractor while permitting government and community access to otherwise proprietary financial and management records. This approach would allow procedures to be fine

tuned before ultimately using competitive bidding as the method for awarding contracts for services.

METHODS

To design this initiative, agreement was first sought among FMOH decision makers about the principles to be used in the design and about the basic elements of the model. This accomplished, specific information was gathered to flesh out the design. Early in the process, the FMOH decided that the test of the alternative model would be conducted in Islamabad Capital Territory (ICT). Although information therefore was gathered about the application of the model to ICT, the structure of this alternative model could be applied elsewhere. Since ICT was designated as the testing site, the current health service delivery system in ICT was examined and evaluated for strengths and weaknesses. Information also was gathered about costs and possible sources of financing for various service packages. The current referral system was analyzed. Similar approaches taken in other countries also were examined for features that could be adapted to Pakistan's needs and replicated in the country. Among the features found to be important elsewhere, is the role of the community. Alternative community roles were explored, specifically the successful involvement of communities by the Aga Khan Health Services (AKHS) in the Northern Areas and Chitral. Finally, the interest of private commercial and voluntary provider organizations in participating in such an initiative was explored.

RECOMMENDATIONS

Recommendations based on the work described above fall into six categories: overall concept, financing, referrals, community role, contractor interest, and implementation.

Overall Concept:

The overall concept of the rural initiative is based on successful experiences in other countries, on analysis of the Pakistani situation, and on discussions with FMOH authorities. Because it is quite different from anything currently operating in Pakistan, it is regarded as experimental. Thus, it must be carefully monitored and evaluated before replication on a grander scale. The basic elements of the concept are:

- Communities should be empowered to hire and oversee performance of providers of rural health services.
- The means for community hiring and oversight would be to contract with a private provider for a specified set of services on a fixed-price basis.

- Current government operating allocations should be made available to communities to fund contracts with private providers for services offered within government facilities using government equipment.

- At the option of the community, the government allocation could be supplemented with user fees to fund the provision of services additional to the basic package.

- The solicitation of providers should be competitive among all organizations interested whether commercial (for-profit) or voluntary (not-for-profit)

- The government should assist communities in evaluating the quality of services that are provided by the private contractor.

- The incentives embodied within the concept are to encourage overall performance and the provision of quality care by using the "carrot" of contract renewal and to encourage emphasis on cost minimization through the promotion of preventive services. (The fixed-price is an incentive to minimize costs, including the avoidance of illness by those covered.)

- Wherever user charges are put in place, Zakat and other charitable funds could be made available to pay for the medically indigent.

Financing:

To illustrate what the concept behind the rural alternative would mean in terms of the body of services communities could purchase, four illustrative packages of services were developed and analyzed for the test site, ICT. These packages were looked at in terms of the services they offer, costs, and user payments. The most basic package of services analyzed is the one currently offered (in principle, although often not in fact) and paid for by government allocations. The three additional service packages each offers the basic package plus supplementary services at additional costs. To obtain more than the basic package would require the community to agree to pay some user charges. The estimated average user charges required per visit vary according to the set of services contained in the optional packages, ranging from Rs. 6 to Rs. 27 for Rural Health Center (RHC) services and from Rs. 4 to Rs. 15 for Basic Health Unit (BHU) services.

It is recommended that the contents of each of the service packages and the associated estimated user charges be explained to the communities involved in the test of the concept. Once the packages and their financial implications are understood, the community can specify which package, packages, or hybrid packages it wishes to include in its request for proposals (RFP) from potential providers.

Referrals:

The work on the referral system is built on the principle that the foundation of an effective referral system is the availability and accessibility of high quality and affordable services at the primary level. The location of facilities in the ICT test area lends itself to a natural referral structure for primary, secondary, and tertiary services. Specific recommendations concerning referrals include:

- Differentiate primary (BHU), secondary (RHC), and tertiary (hospitals) levels of care by providing appropriate and affordable services at each level.

- Institute progressively higher fee schedules at each level.

- Put in place financial disincentives for patients who "jump the queue."

- Provide referred patients with direct access to professional staff at the referral facility.

- Institute a formal communication system with standardized referral forms to enhance coordination and communication among the levels.

Community Role:

Experience with substantial and successful community involvement in oversight and management of health services in Pakistan is limited to that of AKHS in the Northern Areas and Chitral. However, the experience of AKHS, as well as experiences in other countries, demonstrate that such involvement is possible and that it is an important component of many successful health service systems.

The alternative described in this study proposes that rural communities be empowered to choose and oversee the performance of a private provider of basic health services. The operating funds allocated by the government for the health facilities serving the community, the facilities themselves, and their associated equipment will be assigned to the chosen provider for use in offering health care. The services to be provided are those currently offered (theoretically) by the facilities under government management, subject to some negotiation with the community. The community may wish to negotiate the provision of supplemental services in return for the right of the provider to charge specified fees. The government, in addition to providing financial and tangible resources, will act as an advisor to the community in evaluating proposals from providers and in measuring their performance.

To help the communities in test areas (ICT or elsewhere) carry out their role under this initiative, the following steps are recommended:

- Conduct a conference to explain and seek feedback on the concept of the approach from interested providers, communities, and government units.

- Develop a training program for community leaders in the test area to help them understand the concept of the initiative as well as their role in carrying it out:

  - Selection of community representatives
  - Definition of the basic package of services
  - Decision making regarding charging supplementary fees
  - Evaluation of proposals
  - Oversight of providers
  - Evaluation of performance
  - Decision on renewal of contract

- Work with the test communities to enter into cooperative agreements with providers for the test period.

- Assist the test communities in the choice of whether or not to ask for additional services and to permit fees to be charged; if fees are charged, help set up Zakat and other charity assistance to pay for the poorest.

- Assist the test communities in monitoring and evaluating provider performance and in making the decision about whether to renew the contract or open it up for new bids.

- Revise the community training program in light of lessons learned during the test period.

- Assist the test communities with competitive bidding for subsequent contracts.

Interest and Role of Potential Contractors:

Private providers are somewhat interested in participating as contractors to operate government rural health facilities in the proposed arrangement. This interest, however, is tempered by concerns about the government's meeting its obligations to provide the funding. In testing the approach, therefore, the government needs to take measures that will build provider confidence in its seriousness. In light of this, the following recommendations are made:

- Initially use a cooperative agreement-type arrangement in which the provider, community, and government together work

out the specific terms and conditions of the contract, including the option (or mix of options) to be tested, and jointly determine how performance is to be judged.

- Publish a solicitation of "expressions of interest" in major newspapers to identify potential providers.

- Conduct a conference to explain and seek feedback on the concept of the approach from interested providers, communities, and government units involved in test sites.

- Assure providers that they have full authority over personnel policies and procedures, including hiring, discharging, and determining salary levels.

Implementation:

The steps listed below are recommended to implement the initiative that tests the alternative approach to the organizing and financing of rural health services:

- Assign responsibility for oversight of implementation, provision of technical assistance, and monitoring and evaluation of the test to a specific unit of the FMOH.

- Assist communities initially to contract on a cooperative agreement-basis with private providers to manage a set of rural health facilities in rural ICT and, if there is interest, elsewhere.

- Following the initial contract period, formulate a competitively bid contract using lessons learned from the execution of the cooperative agreement.

- Use a fixed-price contract in which the government gives the provider chosen by the community funds that are at least equal to the real (inflation-adjusted) amount currently budgeted for the subject facilities in return for a basic package of services roughly comparable to those now offered (in principle) at government-operated facilities.

- Supplement, at the involved community's option, government funding of the contract with user fees and Zakat funds for the medically indigent in return for services additional to the basic package.

- Contract for management of a related group of facilities, such as an RHC with its associated BHUs, as opposed to a single facility.

- Exclude no party from submitting a bid, although the ideal provider would have sound business skills and a strong sense of being responsive to the "public interest" in health.

- Use more than one provider (if there is sufficient interest and capability) so that different arrangements can be tested and evaluated simultaneously.

- Provide training and technical assistance to communities involved in the tests to help them organize and play the expected role in choice and oversight of the provider.

- Monitor and evaluate the tests to draw lessons for modifications to the concept and, when appropriate, wider replication.

6.0 LEGAL ISSUES

PURPOSE

The four initiatives proposed in this report need to be legally sanctioned. It was therefore necessary to determine whether existing laws would cover the initiatives and, if not, to make recommendations about a new law or laws.

FINDINGS

The analysis of existing laws found that there is no current law under which the initiatives may be implemented. The following recommendations were therefore formulated to provide a legal framework for these initiatives.

RECOMMENDATIONS

Enact A Central Statute

A Central Statute covering all of the initiatives would give them permanence. The statute would:

- Be comprehensive so that there is no need to go back to the legislature for changes in details.
- Reserve for the government the power to implement the initiatives in phases since all initiatives may not be ready for implementation at once.
- Have the Central Statute contain separate chapters on each of the four initiatives.
- Have the statute address issues of zoning, sanctions, and adjudicatory powers.

Include Specific Provisions to Support Each Initiative

The individual chapters on each of the initiatives should contain the following:

Quality Assurance - The section of the Central Statute covering the quality assurance initiative would create an autonomous body with responsibility for devising national standards and awarding accreditation to hospitals.

Hospital Autonomy - The section of the Central Statute covering autonomy for hospitals would include the following provisions:

- The governing boards of the autonomous hospitals would have mixed government, community, and hospital administration representation.

- Rules of governance would be made by the relevant government (i.e., federal or provincial).

- Senior management staff would be nominated to the hospital board by the Executive Director; all other staff would be hired directly by this individual.

- The government would choose either to:

  - Allow current government personnel at hospitals to maintain their jobs and status until retirement or voluntary departure, or

  - Transfer current government servants elsewhere.

- The Management of the autonomous hospitals would have the power to hire, dismiss, discipline, and reward all newly engaged personnel.

- Autonomous hospitals would operate on a no-profit basis, receiving annual block subsidies from government which may be reduced gradually to a set percentage of current annual operating allocations.

- Hospitals would fund operating costs in excess of government allocations from user payments, reimbursements from insurers, contracts with groups, and other mechanisms.

- No one would be denied care because of an inability to pay.

- Capital replacement and acquisition would be funded by the government.

Insurance - The insurance section of the statute would cover the following elements:

- Permit the purchase of insurance coverage for health needs of individuals or groups.

- Allow for the possibility of making purchase compulsory.

- Consider including provisions (e.g., favorable taxation) that encourage managed-care arrangements.

- Allow the ESSI wage ceiling to be indexed to inflation.

- Permit ESSIs to enter into capitation-type contracts with providers.

- Permit employers to opt out of ESSI for improved quality and scope of services.

Rural - The section covering the rural initiative would include the following items:

- Provide for legal recognition of community organizations to enter into contractual relations with providers.

- Specify the use of constant real government operating allocations to fund the community contracts with providers.

- Allow communities to agree to the charging of user fees in order to supplement government allocations.

- Permit the government to specify a minimum package of services to include in such contracts.

- Specify government responsibility for funding capital replacement and acquisition.

- Provide for the government to transfer current government servants working in rural health facilities in order to make it possible for the contract provider to hire, dismiss, discipline, and reward its own employees.

7.0 ZAKAT AND OTHER CHARITIES

PURPOSE

Two of the four initiatives proposed for reform (hospital autonomy and the alternative approach to rural services) may involve requiring users of health services to contribute toward the cost of these services. The Federal Ministry of Health and Provincial Departments of Health wish to ensure that any fees charged do not stop anyone from receiving needed health care. One possibility to fund the use of services by those with limited ability to pay is recourse to Zakat and other charities (e.g., Ushr, Waqf Property, and Bait ul Mal).

FINDINGS

The analysis performed of charities describes each one and how they are administered. Zakat is the charity most likely to be used for the purpose of supporting the initiatives described in this report. About 3.5 percent (Rs. 90 million) of the total annual allocation of Zakat funds goes for health purposes. This is Rs. 0.78 per capita. Zakat Patient Welfare Societies, which function in most government hospitals, help pay for stays by the "mustahaqeen" (needy) who are Muslims. Nearly all of the Zakat allocation for health goes to operating expenses, but there is nothing to restrict it from being used for capital purposes. Bait ul Mal is not restricted to Muslims, but only has recently been set up, so it generates fewer funds and makes few allocations.

RECOMMENDATIONS

The following recommendations are made as a result of the analysis of Zakat and other charities:

- Zakat can serve as a part of the funding for the needy when charges are made for health services.
- Zakat funds likely are inadequate to cover all of the needy's requirements, so other sources must be examined (e.g., cross-subsidization must be sought).
- Procedures for allocating Zakat funds should be streamlined.
- The FMOH should ask the Zakat Council and the Ministry of Finance to increase the share of Zakat allocated to health from 3.5 to 6.0 percent.
- The use of Bait ul Mal for those ineligible for Zakat support should be pursued by the FMOH.

8.0 OTHER ISSUES

Two additional issues are recommended for attention as the FMOH pursues the initiatives described in this report: strengthening analytical capabilities at the FMOH and at DOHs, and the need to build consensus for the reforms that are proposed.

Analytical Capability

Critical to the long-term success of all of the initiatives is the development of analysis, monitoring, and evaluation capabilities within the FMOH and the DOHs. In fact, this capability should be developed to cover all economics and financing-related issues going beyond the four approaches behind the initiatives. The unit within the FMOH assigned responsibility for oversight of the initiatives should be strengthened through hiring people who have experience in (or through providing training in) health economics and related disciplines. This formal training should be supplemented by on-the-job training through the conduct of the analyses of the initiatives, with external consultant help, if necessary. Similar strengthening is recommended for the DOHs.

Consensus Building

The FMOH and the DOHs built consensus around the approaches to be tested through the initiatives. This was done by holding three national workshops that involved all of the major actors in the health sector including providers, health authorities, insurers, and employers. This consensus building should continue and should be broadened with the implementation of the initiatives. Workshops should be conducted to report on and to debate the interpretation of the monitoring and evaluation data from the tests so that modifications can be made in the approaches prior to any replication of the initiatives. Such workshops should include more representation of the public and of health workers. They should begin to prepare all actors in the health field to understand why reform is needed, what improvements can be expected to result from it, and what changes in behavior can be anticipated as a result of implementing each initiative.

9.0 OVERALL IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	DURA-TION (MOS.)	BEGIN - END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
QUALITY ASSURANCE	DEVELOP COUNCIL	1	1-3	FMOH & COUNCIL	FMOH & DONOR	AWAITS FMOH INITIATION
	DEVELOP STANDARDS	3	3-7	COUNCIL & TA	FMOH & DONOR	PROCESS OUTLINED IN HFS REPORT
	ACCREDIT HOSPITALS	2	8-11	COUNCIL & TA	FMOH, DONOR, & COUNCIL FEES	BEGIN SELF-FUNDING
	DEVELOP LICENSING	3	1-9	MOH, DOHs, & TA	FMOH & DONOR	LATER FEES FUND PROGRAM
RURAL INITIATIVE	TEST IN ICT & PROVINCES	12	1-15	FMOH, DOHs, NGOs, & TA	FMOH, DOH, & DONOR	DRAW LESSONS FOR REVISED DESIGN
	TEST IN PROVINCIAL DISTRICTS	12	15-27	DOHs & TA	DOH & DONOR	TEST REVISED DESIGN, REVISE
	PROVINCE-WIDE IMPLEMENTATION	36	28-64	DOHs & TA	DOH & DONOR	IMPLEMENT FINAL DESIGN
HOSPITAL AUTONOMY	TEST AT PIMS & FGSH	15	1-15	FMOH, HOSPITAL MGMT, & TA	FMOH & DONOR	LONG-TERM TA NEEDED; DRAW LESSONS FOR REVISED DESIGN
	REPLICATE AT SELECTED PROVINCIAL HOSPITALS	12	16-27	DOHs, HOSPITAL MGMT, & TA	DOH & DONOR	USE REVISED DESIGN IN DISTRICTS WHERE RURAL CONTRACTS ARE IMPLEMENTED & PRIVATE INSURANCE DEVELOPS
	IMPLEMENT AT ALL REMAINING HOSPITALS	36	28-64	DOHs, HOSPITAL MGMT, & TA	DOH & DONOR	PHASE IN OVER THREE YEARS

OBJECTIVES	ACTIVITIES	DURATION (MOS.)	BEGIN - END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
PRIVATE INSURANCE	WORKSHOP IN KARACHI	1	1-3	TA, DOH, INSURANCE ORGANIZATIONS	DOH, DONORS, & INSURANCE ORGANIZATIONS	DISSEMINATE HFS FINDINGS
	MONITOR DEVELOPMENTS	15	1-15	DOH, FMOH, TA	DOH, FMOH, & DONORS	OBSERVE DEVELOPMENTS IN POPULATION COVERAGE, PREMIUMS, & BENEFITS PACKAGES
	GROUP OF ISLAMABAD GOVT SERVANTS UNDER MANAGED-CARE	12	5-16	FMOH, INSURERS, & TA	FMOH, INSURERS, & DONORS	STIMULATE MANAGED-CARE DEVELOPMENT IN ISLAMABAD
	EVALUATE DEVELOPMENTS	1	15-15	FMOH, DOH, & TA	FMOH, DOH, & DONORS	DETERMINE NEEDS TO EXPAND POPULATION COVERAGE & BENEFITS PACKAGES
ANALYSIS CAPABILITIES	STRENGTHEN HEALTH PLANNING UNITS' ECON CAPABILITIES IN FMOH & DOHs	12	3-15	FMOH, DOHs, & LONG-TERM TA	FMOH, DOHs, & DONORS	BEGIN TO BUILD CAPACITY TO ANALYZE HEALTH ECONOMICS ISSUES
	JOINTLY CONDUCT MONITORING & EVALUATION BETWEEN TA & PLANNING CELLS	12	6-17	PLANNING CELLS & TA	FMOH, DOHs, & DONORS	GAIN EXPERIENCE IN MONITORING & EVALUATING HEALTH FINANCING POLICIES
	BUILD & MAINTAIN DATA BASES ON HEALTH FINANCING	ON-GOING	3+	PLANNING CELLS & TA	FMOH, DOHs, & DONORS	BUILD UNDERLYING DATA FOR HEALTH FINANCING POLICY ANALYSIS & REFORM

OBJECTIVES	ACTIVITIES	DURATION (MOS.)	BEGIN - END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
CONSENSUS BUILDING	CONDUCT PERIODIC WORKSHOPS ON HEALTH FINANCING REFORMS	1	3+	FMOH & DOHs	FMOH, DOHs, & DONORS	DISSEMINATE RESULTS OF ANALYSES, SOLICIT FEEDBACK ON POLICY INITIATIVES & PROPOSALS
LEGAL	PROPOSE COMPREHENSIVE HEALTH FINANCING LAW TO NATIONAL ASSEMBLY	2	3+	FMOH	FMOH	LAW TO ENABLE FMOH & DOHs TO PURSUE INITIATIVES

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Policy Options For Financing Health Services in Pakistan

VOLUME II
HOSPITAL QUALITY ASSURANCE THROUGH STANDARDS AND ACCREDITATION

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

Edited by: Marty Makinen

Volume I	**Summary Report** *by Marty Makinen*
Volume II	**Hospital Quality Assurance Through Standards and Accreditation** *by Greg Becker*
Volume III	**Hospital Autonomy** *by Stan Hildebrand and William Newbrander*
Volume IV	**Development of Private Health Insurance Based on Managed-Care Principles** *by Zohair Ashir, Harris Berman, and Jon Kingsdale*
Volume V	**Organizing and Financing Rural Health Services** *by Richard Yoder, Sikandar Lalani, and Marty Makinen*

Afzal Siddiqui provided the legal analysis for the study and the component initiatives (Volumes 1-5).

Zohair Ashir studied the use of Muslim religious funds for financing health services for the indigent (Volumes 1, 3, and 5).

ABSTRACT

Public and private leaders in the field of health care in Pakistan have agreed that establishing national standards for the delivery of health services would improve the quality of patient care that is delivered in hospitals. This document describes the steps that could be taken to develop a national system that would: (1) create standards to measure the quality of health services offered through medical institutions, (2) develop an accreditation process based on these standards, (3) monitor these standards and the accreditation initiative, and (4) develop, over time, a province-based system of registration and licensing of hospitals, health care personnel, and clinics.

VOLUME II - HOSPITAL QUALITY ASSURANCE THROUGH STANDARDS AND ACCREDITATION

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i

ACRONYMS, ABBREVIATIONS, AND GLOSSARY vii

AN OVERVIEW OF THE STUDY "POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN" ix

EXECUTIVE SUMMARY ➤ QUALITY ASSURANCE FOR HOSPITALS 1

1.0. INTRODUCTION 4
1.1. Background 4
1.2. Methods 6

2.0. ISSUES 7

3.0. RECOMMENDATIONS 9

4.0. A PROPOSAL FOR A HEALTH CARE PROVIDER ACCREDITATION COUNCIL(HPAC) 11
4.1. Statement of Purpose 11
4.2. Organizational Structure and Methodology 11
4.3. Structure of the Health Care Provider Accreditation Council 12
4.4. Health Care Provider Accreditation Funding 13

5.0. HOSPITAL STANDARDS DEVELOPMENT 15
5.1. What Do Standards Accomplish? 15
5.2. What Do Standards Look Like? 15
5.3. Standards Committee Process 18
5.3.1. Standards Manual Sections 19
5.3.2. Standards Committees and Priority Sections 20
5.4. Hospital Compliance With Standards and Accreditation 21
5.4.1. HPAC Inspectors 22
5.4.2. Accreditation With or Without Teeth . . . 22

6.0. PHASES OF DEVELOPMENT OF A QUALITY ASSURANCE SYSTEM . . 24
6.1. Voluntary Accreditation 24
6.2. Licensing 24
6.3. Defining What a Hospital Is 24

7.0. LEGAL FRAMEWORK FOR THE QUALITY ASSURANCE INITIATIVE . 26
7.1. Overview 26
7.2. Sanctions 26
7.2.1. Grievance Structure 26
7.2.2. Ombudsman System 27
7.3. Laws Related to Quality Assurance in Hospitals . . 27

8.0. IMPLEMENTATION PLAN 28

9.0. MONITORING AND EVALUATION PLAN 31

BIBLIOGRAPHY 35

LIST OF EXHIBITS

Exhibit 1 Health Care Provider Accreditation Council Organizational Chart 13
Exhibit 2 Sample Page from Facility Standards Manual (CRHP) 16
Exhibit 3 Sample Page from Facility Standards Manual (JCAHO) 17
Exhibit 4-a Implementation Plan ❯ Hospital Accreditation 29
Exhibit 4-b Implementation Plan ❯ Hospital Licensing . . 30
Exhibit 5 Quality Assurance Monitoring and Evaluation Plan 33

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID	U.S. Agency for International Development (Washington, D.C.)
AKHS	Aga Khan Health Services
AKU	Aga Khan University
AKUH	Aga Khan University Hospital
AKUHS	Aga Khan University Health Services
Amir	Head of a Muslim State
ARI	Acute Respiratory Infection
Bait-ul-Mal	Welfare funds established by the Amir
BHUs	Basic Health Units
CCU	Cardiac Care Unit
CDA	Capital Development Authority
CDD	Controlling Diarrheal Diseases
CHW	Community Health Worker
CRHP	Cost Recovery for Health Project, Cairo, Egypt
chowkidar	Watchman
CV	Curriculum Vitae
CZA	Central Zakat Administration
CZC	Central Zakat Council
DHO	District Health Officer
DOH	Department of Health (provincial level)
EPI	Expanded Program of Immunization
ESSI	Employee Social Security Insurance
Fatamid Foundation	Blood Donor Agency
FGSH	Federal Government Services Hospital
FJMC	Fatimah Jinnah Medical Center
FMOH	Federal Ministry of Health of Pakistan
FP	Family planning
GDP	Gross Domestic Product
GMO	General Medical Officer
GNP	Gross National Product
GOP	Government of Pakistan
GP	General Practitioner
Hakims	Traditional health practitioners
HCFA	Health Care Financing Administration, U.S. Government
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
HPAC	Healthcare Provider Accreditation Council
HPN	Office of Health Population and Nutrition
HT	Health Technician
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IPA	Independent Practice Association
ISL	Islamabad
JCAHO	Joint Commission for the Accreditation of Health Care Organization
JPMC	Jinnah Postgraduate Medical Center
Katchi Abadis	Squatter Settlements
KEMC	King Edward Medical Center
KHI	Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMOH's new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMOH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through

paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan's health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS Project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health, through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of quality assurance for hospitals.

VOLUME II

HOSPITAL QUALITY ASSURANCE
THROUGH STANDARDS AND ACCREDITATION

EXECUTIVE SUMMARY

QUALITY ASSURANCE FOR HOSPITALS

PURPOSE

Pakistan's Federal Ministry of Health (FMOH) would like the quality of health services to improve throughout the country in both the public and private sectors. One method to accomplish this is to establish an independent entity which would set standards, monitor compliance, and accredit all providers of health services.

PROBLEM

Low quality of care is pervasive in both the government and private health systems. Means for consumers or entities representing consumers (such as employers) to evaluate service quality are limited by the technical medical knowledge required. Further, mechanisms to assure minimum standards of quality don't currently exist and are needed if effective health insurance programs are to be developed.

DESCRIPTION OF THE INITIATIVE

To provide an independent assessment of quality of care in hospitals, the FMOH worked with public and private provider representatives to devise an entity to set national standards, assess compliance with them, and offer voluntary accreditation. This entity is designed to gain the confidence of provider groups as to its technical capability and objectivity. It is ready to be put into place quickly and to begin to act to improve quality; later it can expand its scope to cover non-hospital service providers.

METHODS

The proposed entity was developed as a result of a process, including assessment of current quality standards, examination of other countries' experiences, and the holding of a workshop where papers on various aspects of standards and accreditation written by an external expert and leading Pakistani specialists were presented and discussed. The external expert visited a sample of government and private hospital administrators; he also examined alternative methods for developing and implementing standards, drawing lessons from experiences in Latin America, Egypt, and the United States. This information became the basis for a paper setting out an initial proposal for a mechanism adapted to Pakistan's particular needs and situation. This paper, along with papers by Pakistani authorities on what the standards should accomplish, were discussed at the workshop held in June 1992. Participants were the Federal Health Minister and Director General, Provincial Directors General

of Health, and 45 leading health care authorities from the public and private sectors around the nation. This workshop concluded by making specific recommendations for the constitution of a standards and accreditation mechanism.

FINDINGS AND RECOMMENDATIONS

The analysis of Pakistan's situation concerning the applicability of standards and accreditation for hospitals found that:

- The need for standards and accreditation is accentuated when moving toward requiring users to make financial contributions for hospital services.
- Mechanisms for ensuring that standards are met may set objectives or require facilities to set their own objectives for quality.
- Accreditation is an effective method for judging compliance with standards.
- To be effective, a standards and accreditation mechanism must be set up to be reward based, to be educational rather than punitive, and to realistically show how to improve quality.

The consensus conclusions and recommendations of the June 1992 workshop were:

- *National standards for health services provided in hospitals need to be established*. These should be minimum standards that apply to all hospitals, both government and private. The standards should specify the minimum criteria that must be met to be officially considered a hospital. (The participants agreed that a set of 20 to 40 standards encompassing the most critical areas of hospital operations should be developed.)
- *A National Council with provincial chapters should be formed*. This Council should be empowered to set standards and to provide accreditation.
- *The national council should be an autonomous entity composed of proportional representation from the government, the private sector, and professional organizations*.
- *The Federal Director General of Health should select a nominating committee from workshop participants* to select national council members.

- *The process of standards development should be decided by council members*.

- *Federal legislation empowering the council should be proposed and enacted*.

- Separate from setting up a standards-development and accreditation process, *the FMOH should consider instituting a system of compulsory hospital registration and licensing*.

These recommendations were summarized in a report to the FMOH. Subsequently, the FMOH wrote to the provinces asking their advice on the matter. FMOH action on the recommendations awaits the provincial replies.

1.0. INTRODUCTION

1.1. Background

Providing citizens with health care services of the highest possible quality is a moral goal common to all health care systems. In many countries, however, severe resource limitations change the focus of the health care system away from striving for improved quality to merely assuring that services are provided. As Pakistan places greater emphasis on the quality of care received by patients, it has been examining feasible methods of improving health services. Pakistan's Federal Ministry of Health (FMOH), with the technical assistance of USAID's Health Financing and Sustainability Project, has examined the establishment of a national system of hospital standards and accreditation for such purposes.

All hospitals cannot reasonably strive for the same level of care; the differences in available human and material resources are too great. Although successful national accreditation programs have been completely adopted in only four countries (USA, Canada, Australia, Latin America, and New Zealand), recent experience has suggested that hospital standards can be set in developing countries if they reflect the actual conditions found in local hospitals (McMahon & Winters, 1993). The approach taken in Egypt and Latin America has been to make a realistic appraisal of local conditions, especially available resources, and to develop hospital standards for a level of care that can be reasonably achieved, given environmental realities.

Successful management in any type of system can most readily be attained if goals are first established. A set of appropriate hospital standards provides these goals to a nation's health facilities. Hospital managers can focus on attaining levels of care that, although challenging, are achievable. With standards, hospital managers are less likely to be occupied solely by day-to-day problems and are more likely to proactively search for institutional improvement.

In addition to the moral and managerial imperatives that prompt the development of hospital standards, financial factors may also become important. As Pakistan moves in the direction of cost recovery in hospitals and towards the use of more health insurance mechanisms, delivery of higher quality medical care becomes more feasible. If services that were once free are later presented for a fee, patients will expect to "get what they pay for," rather than complacently accepting the level of quality associated with free Ministry of Health hospitals. Market incentives thus become additional reasons for hospitals to deliver the best possible product.

Hospital Accreditation is an effective mechanism for achieving improved quality of care. In this process, a hospital is objectively judged against an accepted level of care and methods of practice, it is informed of weaknesses in its operations, and is given advice on how to correct the detected problems. Once a hospital achieves accreditation, it is given public acknowledgement of its high level of care.

Clear goals and objectives for hospital operations set the direction for the management and staff of the facility and establish criteria for judging success. Hospital standards either directly lay out these goals and objectives or require the facility to develop its own set of operating goals, objectives, and procedures.

With the establishment of standards, an objective method is put into place for judging compliance or progress both to encourage facilities to attain improvements and to inform and assure the public that higher-quality services may be obtained at the institution.

Although the task of developing standards is challenging, gaining acceptance of these standards by the medical community is likely to be the greatest challenge. Members of this medical community may fear that instituting hospital standards and a system of accreditation will pose a burden on the practice of their profession. Some may also fear that standards will be unnecessarily restrictive and may put them at risk of outside scrutiny.

It is therefore critical that the establishment of hospital standards and a system of accreditation be seen as a positive step, one that will support the efforts of qualified and dedicated medical professionals to better serve their patients. Such a system will publicly acknowledge those medical establishments and practitioners that provide the highest level of quality care in Pakistan and will set an achievable goal that all hospitals can strive for.

To be successful, standards and accreditation must be educational in nature, rather than punitive. Standards must show facilities how to improve the quality of care they offer and must be realistic and achievable, given the resources available in Pakistan's hospitals.

This paper presents a model system for the development of hospital standards as well as a framework for a system of hospital accreditation. Based on the results of a Workshop on Hospital Standards and Accreditation held in Islamabad on June 6 and 7, 1992, it also presents implementation, monitoring, and evaluation plans. Participants at this workshop included 45 of the nation's leading health care authorities as well as the Federal Minister of

Health and the Secretaries and Directors General of the federal and provincial health systems.

The workshop was centered on a preliminary concept paper on a standards and accreditation system presented by Gregory C. Becker, Quality Assurance Specialist for the Health Financing and Sustainability Project of USAID. During the workshop, concepts and approaches were discussed, debated, and modified by the participants. They achieved consensus on the need to develop a national system that sets health care standards and accredits hospitals and on the major characteristics of this system.

1.2. Methods

The study on establishing a national system of hospital standards and accreditation for Pakistan involved five major stages:

1. A review of the literature on standards and accreditation systems and interviews with experts.

2. A trip to Pakistan by the Quality Assurance Specialist in February 1992 to meet with a wide range of officials and other leaders in the health field to determine the scope of hospital quality issues and to research appropriate approaches.

3. Preparation of the concept paper.

4. A trip to Pakistan in June 1992 by the Quality Assurance Specialist to lead a two-day workshop during which a consensus was reached on improving quality in Pakistani hospitals through setting standards of quality, establishing an accreditation process, and putting in place systems of registration and licensing for health care providers. The workshop included presentation of the concept paper as well as presentations on the history of accreditation and alternative approaches. These were followed by discussions of alternative approaches during working group meetings, debate, and consensus building during the final plenary sessions.

5. Preparation of this summary report.

2.0. ISSUES

In studying the feasibility of establishing a hospital standards and accreditation system for Pakistan, a number of key questions were asked:

1. Should standards be developed?

2. Should the standards developed cover detailed aspects of hospital operations (should they be specific and comprehensive standards) or should they be limited in number and broad in scope (the Pan American Health Organization approach)?

3. Should standards be applicable both to government and to private hospitals or would they need different sets of standards?

4. What type of organization could best develop standards and monitor compliance?

5. Should accreditation be voluntary or compulsory?

During the February 1992 visit of the Quality Assurance Specialist to Pakistan, a number of issues relating to standards and the accreditation of hospitals became clear:

1. There is a consensus in the health field in Pakistan that both the public and private sectors critically need standards and the regulation of hospitals.

2. With the exception of hospital teaching programs, there are no working control mechanisms to govern the practice of hospitals, clinics, or individual clinicians.

3. There are critical resource deficiencies (particularly in government hospitals) that pose an obstacle to the delivery of quality services.

4. It is reported that those written standards that currently exist are inconsistently adhered to.

5. There is concern that recent medical school graduates are of poor quality.

6. There also is concern that the introduction of standards and/or an accreditation system could lead to greater litigation.

The concept paper developed after the February trip addressed these issues; then they were fully debated and developed at the

June 1992 workshop. Early in that workshop, it became clear that there was a group consensus that standards should be developed. Although there was much discussion about the form standards should take, the idea gradually gained support that a minimum set of 20 to 40 very broad standards should be developed along the lines of the recently published Pan American Health Organization (PAHO) hospital standards (PAHO, 1991). This alternative was chosen over the more in-depth approach taken by Egypt (Becker, 1991) and by the U.S. Joint Commission for the Accreditation of Health Care Organizations (JCAHO). This approach established a much higher number of more specific standards (over 300, in the case of Egypt).

Workshop participants also raised concern over the applicability of standards to both government and private hospitals. They eventually reached the consensus that, by taking a "minimalist" (PAHO) rather than a "comprehensive" (JCAHO or the Egyptian Model) approach, the standards that were established would be usable in all Pakistan hospitals.

During the workshop, participants voiced the most concern over the type of organization necessary to monitor hospital compliance with standards. Support was given by different individuals for developing either an organization made up of combined public and private entities or an organization that was strictly composed of nongovernmental medical groups. Consensus gradually formed that the public/private mix should approximate the proportions of hospital services provided by each sector.

There was further spirited debate on whether the accrediting system should be a national one or whether each province should develop its own. Participants eventually compromised, deciding on a national council with provincial chapters. Although this type of organization will be more complex to develop, the strength of feelings on the subject necessitates the additional effort.

The final point of contention was whether accreditation should be voluntary or compulsory. Those supporting voluntary standards and accreditation argued that hospitals would be more likely to comply if accreditation was based on an incentive system. If accreditation was made compulsory, resistance to the system could render it inoperative. Some voiced the opinion that hospitals would seek accreditation for both the prestige and the publicity that would be gained by publishing the names of accredited facilities in the news media.

Those that supported the pro-compulsory argument believed that marginal or unsafe hospitals would avoid accreditation. According to participants, one of the most urgent problems facing health care in Pakistan is the number of unqualified individuals running unsafe hospitals. The fact that Pakistan has no requirement for any licensure, registration, or minimum qualifications for running a hospital was frequently raised in support of compulsory

accreditation. Reportedly, it is quite common (and legal) for anyone, regardless of qualifications or available resources, to open and run a hospital. The compromise that was finally reached at the end of the workshop was to make accreditation voluntary, but to have the group make a "statement of conscience" indicating that it believed that the Federal Government should "take up" the issue of compulsory hospital registration and licensure.

3.0. RECOMMENDATIONS

After careful debate and deliberation, the participants at the Workshop on Hospital Standards and Accreditation reached consensus on a number of recommendations:

1. National minimum standards for health services are needed to grant official recognition to both government and private hospitals. The standards should specify the minimum criteria that must be met to be officially considered a hospital.

   The participants agreed that a set of 20 to 40 standards encompassing the most critical areas of hospital operations should be developed.

2. A National Council with provincial chapters should be formed. This Council should be empowered to set standards and to provide accreditation.

3. The council should be an autonomous body composed of proportional representation from the government, the private sector, and professional organizations.

4. The Federal Director General of Health should select a nominating committee from among workshop participants. This group would then select the members of the National Council. The nominating group should complete its task and disband within six months.

5. The process of standards development should be decided by the National Council.

6. Accreditation should be voluntary.

   Although there were many calls for compulsory standards which would force an improvement in the level of care provided by poor quality hospitals, the participants finally agreed that voluntary accreditation based on a system of incentives would have a greater chance of success. The incentives would include increased prestige for accredited hospitals and publicity in the news media on the standards of quality achieved by these hospitals.

7. Federal legislation empowering the National Council as an autonomous body responsible for setting standards and granting accreditation should be enacted.

8. Independent of the standards and accreditation process, the Federal Government should look into compulsory registration and licensing for hospitals.

This recommendation was made by the workshop participants as a "statement of conscience." The recommendation was thought to be necessary because participants had concerns about the low quality of care provided at some unregulated hospitals.

Recommendations for the implementation of the accreditation system are presented in Section 8.0 of this volume.

4.0. A PROPOSAL FOR A HEALTH CARE PROVIDER ACCREDITATION COUNCIL (HPAC)

The following is the concept paper presented by Gregory Becker, this project's Quality Assurance Specialist, during the June 1992 workshop as modified to reflect the results of the workshop.

4.1. Statement of Purpose

The improvement and maintenance of the quality of patient care is the main goal of any system to accredit hospitals. In order to achieve this, an organizational structure and methodology is needed for hospital accreditation both in developing standards and in monitoring the compliance of hospitals to these standards.

4.2. Organizational Structure and Methodology

Several alternative organizational structures and methodologies can be used in setting up a system to accredit hospitals. One alternative is for the government to set standards and monitor performance. Although there are good points to this alternative, the critical input of health care practitioners is not assured and the system that evolves may be inflexible and too restrictive of innovation and progress.

Another approach is to establish a "payer-driven system," where standards are enforced by the payers of medical care. Government agencies that pay the costs of health care or insurance companies that reimburse physicians and hospitals may require compliance with certain standards before a provider is able to collect fees. The major drawback of this approach in Pakistan is the present lack of a large insurance system. In the future, when an insurance program is developed, compliance to standards should be required for reimbursement of health care services.

A third alternative is the "peer system" such as is employed in the U.S. This system has the advantage of being run by the health care providers themselves, and, as such, has a high level of technical validity. The weakness of this approach is its heavy reliance on practitioners to police their own ranks. An example of the effectiveness of this method is the U.S. Joint Commission for the Accreditation of Health Care Organizations (JCAHO). The JCAHO is responsible for setting hospital standards in the U.S. and for monitoring the compliance of hospitals to these standards. A hospital that meets these standards is "accredited." Although the JCAHO is a private non-government organization created by medical and hospital associations, its standards are high and the earning of its accreditation carries considerable weight. The U.S.

government's Medicare Program, for example, requires hospitals to obtain JCAHO accreditation in order to receive funding. Medicare can be assured of quality services from accredited hospitals because the JCAHO is strict in adhering to standards.

A shortcoming of the peer system is the control of medical licenses by some state medical societies. Although initially, a physician license is granted according to strict guidelines, in some states the revoking of medical licenses from incompetent practicing physicians is poorly controlled. Physicians are reluctant to complain about their fellow practitioners in cases of incompetence, and medical societies are equally reluctant to take disciplinary action, even when unacceptable behavior has been reported.

The June 1992 workshop participants recommended the alternative of establishing a joint peer/government organization in Pakistan responsible for the development and enforcement of hospital standards. This body would benefit from the technical responsiveness of a private sector/peer organization as well as from the enforcement power of a governmental organization. This entity could be called the Health Care Provider Accreditation Council (HPAC).

The creation of such a body would allow medical professionals to set the standards by which they would be expected to practice; it would also assure that both government and the private sector would share influence over the future directions of health care.

In the near term, this organization would be responsible for: developing and updating hospital standards, monitoring hospital compliance with those standards, and awarding accreditation to those institutions demonstrating compliance. In the more distant future, the role of this organization could expand to cover the practice of physicians and the operation of clinics and other health care providers.

4.3. Structure of the Health Care Provider Accreditation Council

The Health Care Provider Accreditation Council (HPAC) could be made up of representatives from the following organizations:

- The Pakistan Medical Association
- The Private Hospital Association
- The Pakistan Nurses Association
- The Pakistan Nurses Foundation
- The College of Physicians and Surgeons

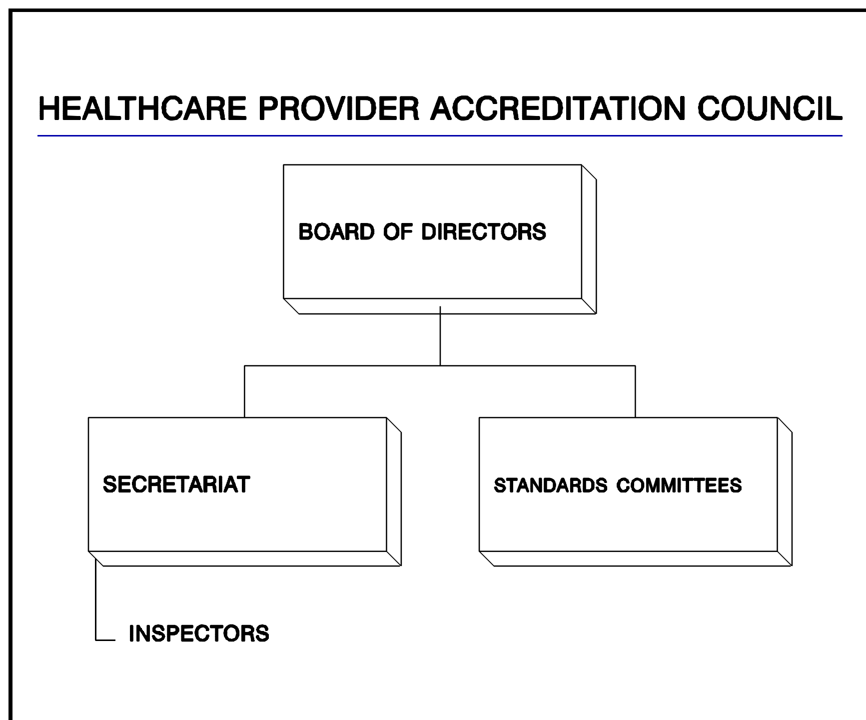
- The Pakistan Medical and Dental Council
- The Provincial Departments of Health
- The Federal Ministry of Health
- Communities

Workshop participants thought that representation from major secular or non-governmental organizations such as the Zakat Councils should also be considered.

The Health Care Provider Accreditation Council could be chartered as an autonomous body with a Board of Directors made up of two members from each of the non-governmental organizations and from the Federal Ministry of Health, and one member from each of the Provincial Departments of Health. Member organizations would each select their representatives to the Board of Directors. Board members would serve for a three-year term (renewable one time for a total of six years).

Exhibit 1 shows an organizational chart for the council. The Secretariat would consist of the permanent HPAC staff who would be responsible for its day-to-day functioning. The Secretariat would also oversee the monitoring and enforcement of hospital compliance with standards. A number of part-time inspectors who would be respected practitioners nominated by member professional organizations would conduct the actual monitoring of hospitals and report their findings to the Secretariat. The Standards Committees would consist of volunteer members selected by the member organizations in each specialty area. For example, the Pakistan Nurses Council and Federation would select committee members to work on nursing standards while the Pakistan

EXHIBIT 1
HPAC ORGANIZATIONAL CHART



Medical Association and the College of Physicians and Surgeons would select committee members to develop surgical services standards. Committee members would serve for a two-year renewable term.

4.4. Health Care Provider Accreditation Funding

The HPAC will require funding in order to carry out its duties. Although the development of hospital standards can be accomplished at minimal cost, the completed standards will need to be reviewed and published. The organization will require a number of full-time and part-time paid staff in order to disseminate the standards and to carry out the inspection, accreditation, and monitoring process. Although these costs can be kept to a minimum, a certain level of start-up and operational funding will be needed. Several possible sources of funding should be considered:

Hospitals might pay for inspections in order to become accredited.

Hospitals might pay an annual fee.

The government could provide start-up funding.

The government could pay operational costs.

A donor agency such as the World Bank could provide start-up funding.

Other sources of funds might become available.

5.0. HOSPITAL STANDARDS DEVELOPMENT

As its first task, the Health Care Provider Accreditation Council would develop hospital standards using Standards Committees composed of experts in each of the relevant fields. The section below describes a process that the committees could follow in writing standards. First, however, it is helpful to review what standards are.

5.1. What Do Standards Accomplish?

- They serve to educate staff, managers, and practitioners about what constitutes minimum acceptable and preferable practice in the delivery of health care.
- They set minimum levels for quality of care, but encourage superior performance.
- They encourage an improvement in medical conditions and practices.
- They provide, where possible, measurable indicators of the quality of care.

5.2. What Do Standards Look Like?

- Standards describe minimal acceptable practice, equipment, facilities, personnel, or personnel qualifications.
- Standards illustrate the "best possible" practices and conditions that can be achieved by Ministry of Health and private hospitals.
- Standards are specific enough to guide actions, but are broad enough to allow adaptation to local circumstances.

Exhibit 2 shows standards developed for the Ministry of Health of the Arab Republic of Egypt. The committee responsible for creating standards began by examining those of the U.S. Joint Commission for the Accreditation of Health Care Organizations (Exhibit 3) as a model. These were then set aside and a single committee member wrote standards based on best practices realistically achievable in Egyptian Ministry of Health Hospitals. The Egyptian committee then reviewed the member's draft, debated its merits, agreed on changes, and submitted the agreed upon text for publication. This procedure has proven to be successful for developing standards, and should therefore be considered for use in Pakistan.

EXHIBIT 2

SECTION 15 - SPECIAL CARE UNITS

Facility Standards
April 30, 1991

15.1 Special care units include general Intensive Care Unit (ICU), burn unit, renal unit, cardiac/cardiovascular surgical unit, neurosurgical unit, coronary care unit, respiratory unit, and neonatal unit.

15.2 The ICU is established for patients requiring extraordinary concentrated care on a continuous basis. The scope of services provided has to be specified. For a general hospital, a general ICU should be available to care for different specialties run by the hospital and should be integrated with other departments of the hospital. For specialized hospitals and institutions, the proper special intensive care units are established according to the specialization of the hospital.

15.3 The ICU shall be properly directed and staffed according to the specialization. The director for the ICU should be a member of the medical staff who has special training, qualifications, experience, and competence in the specialty related to the care provided in the unit.

15.4 Medical staff coverage shall meet the special care needs of the patients. Circumstances should be stated under which consultation by a qualified specialist is required.

15.5 Supervision of nursing care in the unit is provided by a designated registered nurse with relevant education, training, experience, and competence.

15.6 All personnel shall participate in relevant education and training programs (e.g., cardiopulmonary resuscitation [CPR], electrolytes, feeding, emergency medicine, infection control, as well as training related to the psychological and social needs of patients.

Example from Facility Standards Manual Cost Recovery for Health Project (CRHP): EGYPT

EXHIBIT 3

PATHOLOGY AND CLINICAL LABORATORY SERVICES

PA.1
Pathology and clinical laboratory services and consultation are regularly and conveniently available to meet the needs of patients, as determined by the medical staff. *1 2 3 4 5 NA*

PA.1.1 Pathology and hospital clinical laboratory services are directed by an individual(s) who is qualified to do so. 1 2 3 4 5 NA

PA.1.1.1 Clinical laboratory services are under the direction of a physician or a doctoral scientist who is qualified by virtue of documented training, expertise, and experience to assume professional, scientific, consultative, organizational, administrative, and educational responsibilities for the facilities and for the services rendered. In a hospital where the director of clinical laboratory services provides clinical consultation and/or medical opinions, the director is a physician, and preferably a pathologist. 1 2 3 4 5 NA

PA.1.1.2 Anatomic pathology services are under the direction of a pathologist. 1 2 3 4 5 NA

PA.1.1.3 Blood transfusion services are under the direction of a pathologist or other physician who is qualified in immunohematology and is knowledgeable about the principles of hemotherapy and blood banking. 1 2 3 4 5 NA

PA.1.2 There are sufficient qualified personnel with documented training and experience to supervise and conduct the work of the laboratory(s). 1 2 3 4 5 NA

PA.1.2.1 The director(s) is knowledgeable about the laboratory services offered and is available to render administrative decisions and to assist in obtaining other required professional consultation. 1 2 3 4 5 NA

PA.1.2.1.1 An individual determined to be competent to do so effectively communicates with the practitioner, when appropriate to clinical circumstances, in order to discuss, relate correlations, or interpret the clinical significance of laboratory results. 1 2 3 4 5 NA

PA.1.2.2 When a pathologist is not the director of clinical laboratory services, the services of a pathologist are retained where the functions of the laboratory(s) so require. 1 2 3 4 5 NA

PA.1.2.3 When the director(s) is a physician who serves in a clinical supervisory capacity but is unable to supervise the technical aspects of laboratory procedures, appropriate technical supervision is provided. 1 2 3 4 5 NA

PA.1.2.4 When the director(s) is a physician, he/she is appointed or elected by the process outlined in the medical staff bylaws. 1 2 3 4 5 NA

PA.1.2.4.1 When the director(s) is a physician, he/she participates in medical staff functions as required. 1 2 3 4 5 NA

Standards must keep pace with changes in technology and with changes in the health care system. It is only by continually updating standards that Pakistan's accreditation program will continue to have a positive effect on the quality of patient care. It is recommended that the Standards Committees be reconvened every two years to review standards in the light of changes in the health system and to make whatever modifications are needed to bring the standards up to date. These changes would then be published by the HPAC and disseminated to all hospitals covered by the accreditation system.

5.3. Standards Committee Process

The committee process is a relatively simple one that can be completed in a reasonable period of time. For example, while the Egyptian Standards have 30 sections covering all aspects of hospital operations, not all of these standards were developed at the same time. Early in the development process, areas of highest priority were selected for immediate attention while other, less critical sections were left for future development. Later in this document, proposed standards sections are outlined, and those of a critical nature are highlighted. Once the areas most critical to patient care are developed, standards should be published and the process of hospital compliance and inspections begun. Those areas considered less urgent may be developed at a more casual pace, published, and disseminated as periodic updates to the standards manual.

In brief, the committee process is as follows:

- Committee members are selected by HPAC member organizations.
- Educational materials such as copies of the JCAHO and Egyptian Standards are forwarded to committee members along with instructions on the development of standards, the members' assignment to specific committees, and specifications on areas to be studied and drafted.
- Each member reviews the materials and develops a draft of key issues, procedures, and technology elements that, in the member's opinion, should be included in the standards.
- A committee meeting is held to:

    1. Discuss and review the goals of standards and their development process, particularly in the technical area being considered by the committee.

2. Discuss the key issues, procedures, and technological elements contained in the members' drafts.

3. Select a lead writer for each standards section, specify reviewers, and work out details of the review process.

4. Distribute copies of drafts to lead writers with a timetable for completion of section drafts and for draft review.

- Lead writers produce drafts of standards sections and forward to reviewers.

- Reviewers propose changes and/or write alternatives.

- The committee reconvenes to:

1. Formally review the draft sections and propose changes and alternatives.

2. Agree on and write the final draft of the standards section.

3. Forward the completed draft to HPAC's Secretariat.

- HPAC reviews, word processes, edits, publishes, and disseminates the Standards Manual

This process, if diligently followed, should result in the publication of the first version of the Standards Manual within six months. Again, this would not be the complete manual, but would cover those sections most critical to beginning the accreditation process.

5.3.1. Standards Manual Sections

This section reviews areas that could be covered by standards, priority areas for initial development, and proposed areas of committee responsibility.

Participants at the workshop decided that an approach of developing fewer, wider-reaching standards would be preferable to developing more comprehensive ones such as those of the JCAHO or Egypt. The hospital standards developed by PAHO provide a good example of the desired approach. The sections and titles of specific PAHO Compulsory Minimum Standards are:

Organization of Medical Care ❩ Continuity of medical care, transfers, outpatient clinics, emergency services, clinical/laboratory services, diagnostic imaging, chemotherapy, care at birth, surgical services, anesthesiology, and control of infections that originate in hospitals.

Technical Support Areas ❩ Food service, laundry, cleaning, sterilization, drug dispensing, nursing, clinical records, statistics, hospital government, administration, occupational safety and health, general safety, and quality assurance.

Building Documentation ❩ Plans.

Functional Physical Structure ❩ Entrances and access.

Installations ❩ Electrical system; control of excreta and wastes, including radioactive ones; water potability; and inpatient comfort.

There is much room for discussion about what constitutes the most critical set of standards; this issue should be one of the first taken up by Pakistan's Health Care Provider Accreditation Council. If a PAHO-type approach is used, standards should be developed that cover the minimum critical areas, and also serve as a guide/measure for the achievement of superior performance.

5.3.2. Standards Committees and Priority Sections

In order to achieve an effective accreditation system in the most efficient manner, areas for priority development must be selected and committee resources marshalled accordingly. As an alternative to directly following the PAHO list of standards, it is proposed that four standards committees be established to cover priority areas. A list of proposed committees follows, along with their areas of responsibility in suggested order of completion:

Management Committee:

- Governing body and chief executive officer/director
- Financial management
- Management and administrative services
- Personnel policies and procedures

Patient Care Committee:

- Medical staff
- Nursing
- Medical records
- Quality assurance
- Infection control
- Ambulatory services
- Surgical and anesthesiological services
- Special care units – Intensive care unit (ICU), cardiac care unit (CCU), and burn unit.

Technical Services Committee:

- Laboratory
- Radiology
- Pharmacy

Hotel Services Committee:

- Housekeeping, physical plant maintenance and operation, safety, and sanitation
- Biomedical equipment maintenance
- Purchasing, central supply, and sterile supply

5.4. Hospital Compliance With Standards and Accreditation

Once standards are completed, published, and disseminated, hospitals will need to study the standards and to develop and implement programs that bring their facility into compliance.

The HPAC will begin inspecting hospitals on a voluntary basis during this period as part of the learning process. The results of these initial inspections should be non-binding in the case of failure to meet standards, but should award accreditation for those facilities that pass inspection. It is suggested that accreditation be awarded for a period of three years with renewal based on reinspection.

Hospital inspections should occur for the following reasons:

- To gain accreditation.
- To renew accreditation.

  In the case of a hospital already accredited, inspection could come as a response to substantiated complaints from patients, staff, or regional health authorities of unsafe practices that endanger the lives of patients or hospital staff. Such an inspection could help the hospital determine the root of the problem and find a workable solution.

Under a voluntary accreditation system, inspections would be initiated at the request of the hospital seeking accreditation. If the HPAC should choose to follow a voluntary model of accreditation such as Australia's (Lloyd, 1987), the HPAC would forward a questionnaire to the hospital for completion prior to the actual inspection. The purpose of this questionnaire would be to solicit baseline information to be used by the inspectors in completing their analysis and as an indicator of possible problem areas that would need scrutiny during the inspection.

A team of inspectors would visit the facility for a one-to-four-day period, depending on the size of the hospital, and review medical and hospital records, operations and procedures manuals, and other written plans. They would also inspect equipment and buildings and interview certain staff.

The results of the inspection would be forwarded to the HPAC Secretariat which would review the report, and, based on the inspectors' recommendations, make a determination on accreditation. A copy of the report would be sent to the Federal Ministry of Health and to the hospital director. If the hospital passes, a certificate of accreditation would accompany the report to the hospital director.

5.4.1. HPAC Inspectors

The HPAC needs to decide who the inspectors will be, what skills are required, and how many will be sent to inspect a hospital. It is vital that inspectors be qualified to judge the technical status of a hospital, but which specialties should be represented on the inspection team is open to debate. It is suggested that, at a minimum, four technical areas be represented on each team:

- **Administration/management** to review financial, general, and logistical management of the hospital;

- **Medical/surgical** to review medical and surgical services;
- **Nursing** to review nursing services and patient care; and,
- **Technical** to review diagnostic (such as x-ray and lab) services.

Either volunteer or professional inspectors would be acceptable, although if the accreditation system is voluntary, it would be strengthened by having part-time inspectors. Part-time inspectors might be less susceptible to corruption as they would not be dependent on performing inspections for their livelihood.

5.4.2. Accreditation With or Without Teeth

Finally, the team should carry out the inspection as an educational process. The inspection should be conducted in the presence of responsible parties at the hospital and problem areas should be identified and discussed. The aim of the inspection process should be to uncover problem areas and to work out corrections to the problems. Above all, the inspectors should offer solutions and alternatives to problems found, as opposed to solely criticizing.

The workshop consensus to make accreditation voluntary leaves open the question of how to address the number of poor-quality hospitals currently being opened and operated. Although there is solid justification for having an accreditation system based on incentives, such a system does not directly address the problem of unregulated hospitals. It is therefore recommended that a two-pronged approach be taken to improve the quality of hospitals.

6.0. PHASES OF DEVELOPMENT OF A QUALITY ASSURANCE SYSTEM

6.1. Voluntary Accreditation

The first prong of this approach is to develop the voluntary accreditation system recommended by the June 1992 workshop. This system would be aimed at improving the quality of care at the higher end of the spectrum of hospitals. Although accreditation would be voluntary, it is recommended that when any insurance or Health Maintenance Organization program is developed in Pakistan, it would require a hospital to be accredited before it can be reimbursed for patient care. Reimbursement could also be tied to a multi-level system of accreditation, where a hospital with more complete and higher quality services could be reimbursed at a higher rate. Further, both the Health Care Provider Accreditation Council and hospitals achieving accreditation could actively publicize to consumers the difference between accredited and non-accredited hospitals. This would tend to discourage consumers from using non-accredited hospitals, giving the latter the financial incentive needed to become accredited.

6.2. Licensing

The second step in this approach would be to develop a national compulsory hospital licensing system. As the Pakistan Constitution recognizes health as a provincial responsibility, it is recommended that the Provincial Departments of Health carry out the licensing program.

6.3. Defining What a Hospital Is

The HPAC needs to develop a definition of a hospital and absolute minimum requirements in terms of personnel, operations, and facilities. A preliminary draft of this definition could be:

> Hospitals are locations where persons suffering physical or mental ailments are provided medicine, surgery, or other forms of therapy while being housed in a location other than their own home for a continuous period of 24 hours or longer. Defined this way, a hospital must provide:
>
> 1. A licensed physician who is responsible for assuring that every patient is diagnosed as to the nature of his or her ailment and receives either effective therapy to alleviate the malady or palliative care in cases where effective therapy is not available.

2. Nursing care any time there are patients at the facility.

3. A bed that is occupied by a single individual except in extreme situations of need where beds may be shared by more than one person. At no time may more than one person occupy a bed when such sharing would result in an adverse medical outcome for any of the persons (such as the transfer of communicable disease). Beds may not be shared by persons of the opposite sex except in the case of children under the age of five years.

4. Sufficient sanitary facilities to prevent the spread of fecal-borne disease.

5. Potable drinking water.

6. Food service with meals that are appropriate to the needs of the patients, adequate cooking facilities, or arrangements where food is provided to patients by an outside source such as family members.

This definition is incomplete and will require elaboration and refinement, but could be used as a basis for the licensing and registration of hospitals. It is recommended that a province be selected as a pilot site for the development of a hospital-licensing system. In addition to establishing the definition and minimum requirements of a hospital, an accreditation system would need to work out mechanisms for enforcing standards.

Although this two-pronged approach would not guarantee the delivery of high-quality care in all hospitals, it would be a major step towards achieving this goal. The accreditation system, if adequately publicized, would encourage patients to use the better quality hospitals, thus encouraging facilities to seek accreditation as a means of increasing bed occupancy and outpatient visits. Simultaneously, the licensing system, while setting minimal standards rather than ideal ones, would give health officials the authority they need to close the worst-offending facilities in terms of poor-quality patient care.

7.0. LEGAL FRAMEWORK FOR THE QUALITY ASSURANCE INITIATIVE

7.1. Overview

The team carrying out the overall Health Financing and Sustainability study found that no law currently exists in Pakistan under which the initiatives in the four program areas can be implemented. It is therefore recommended that a single Health Policy Law be enacted as a comprehensive Central Statute to provide a permanent legal framework for these initiatives. Within this statute, the details of each initiative would be worked out. These details would include specific regulatory provisions, sanctions, administrative structures, and financing.

Having a comprehensive statute would remove the need for going back to the legislature on a regular basis. The proposed law would encompass all four of the health financing initiatives and would be applicable to the whole of Pakistan.

7.2. Sanctions

The Health Policy Law should identify reasonable sanctions that could be invoked to ensure that the various initiatives are implemented. The HFS team believes that these sanctions should be corrective and remedial rather than punitive.

This law also should mandate the creation of mechanisms that provide ways for grievances and complaints to be addressed. This would help the consumers of health services provided through the four initiatives not to feel helpless and in need of resorting to litigation.

Possible mechanisms could be a local-to-federal grievance structure and a system of ombudsmen to serve as advocates and adjudicators of issues.

7.2.1. Grievance Structure

A self-contained adjudicatory system could be established to handle grievances. One possible way of designing it would be to:

(1) Have grievances against an individual brought to the notice of an authority at the divisional level.

(2) Have grievances against a hospital also be brought before this divisional-level authority.

(3) Create an appellate authority at the provincial level.

(4) Establish a final adjudicatory authority at the central level.

7.2.2. Ombudsman System

An ombudsman system could be established to serve as an advocate for consumers and an arbiter of issues. Within this system, all except trivial matters would be dealt with at the local level by a tribunal made up of at least two members, one of whom would be a medical specialist. More serious matters would be dealt with through the ombudsman structure: Deputy Medical Ombudsmen would serve at local and regional levels, Provincial Medical Ombudsmen would serve at the provincial level, and a Central Medical Ombudsman would serve as a final arbitrator at the federal level.

7.3. Laws Related to Quality Assurance in Hospitals

The Central Statues of the overall Health Policy Law would establish a National Council with provincial chapters (the Health Care Provider Accreditation Council) which would be empowered to set standards and provide accreditation. This council would be an autonomous entity composed of proportional representation from the government, the private sector, and professional organizations.

The law also would also have provisions which specify how the standards that are set by HPAC are implemented and enforced.

In the longer run, the Central Statute would have provisions added that institute a provincial system of compulsory hospital registration and licensing.

8.0. IMPLEMENTATION PLAN

Workshop participants gave the government a clear mandate to proceed immediately with the process of establishing an accreditation system for the country. They recommended that the Federal Director General of Health appoint a nominating group from workshop participants to select the members of this Health Care Provider Accreditation Council. Later, in the interest of expediting the selection process, Health Financing and Sustainability staff recommended that the Director General of Health directly name the first members of the HPAC. It is recommended that this process be carried out as soon as possible in order to benefit from the support evident in Pakistan's health care community.

Once the composition of the HPAC is decided, it becomes the responsibility of the Government of Pakistan to find donor support or to provide start-up and initial operating funds. This support should also include resources to provide technical assistance to guide the formation of the council and to develop the standards.

The next step in the process is the actual writing, publication, and dissemination of the hospital standards. The HPAC would select from among its member organizations highly qualified individuals to form HPAC's Standards Development Committees. The initial set of standards could be produced and published over a five-to-six-month period after member nomination.

The HPAC would then develop and implement the inspection/accreditation process. It is suggested that outside technical assistance be retained to assist in developing this inspection process, including the initial questionnaire. Once initial inspections are carried out and a number of hospitals are accredited, efforts should begin to publicize the names and qualities of the accredited institutions.

In order to implement the hospital licensing program, the HPAC should choose a province as a pilot site. The Federal Ministry of Health, the provincial Departments of Health, and, as needed, outside providers of technical assistance would work together to further develop the definition of a hospital, and to create the inspection, monitoring, and enforcement mechanisms. A pilot program then would be carried out, modifications and refinements made, and the resulting system made available to the remaining provinces.

Exhibit 4 charts implementation plans for the proposed hospital accreditation and licensing systems.

EXHIBIT 4-a
IMPLEMENTATION PLAN — HOSPITAL ACCREDITATION

OBJECTIVE	ACTIVITIES	DURATION* (MONTHS)	END DATE/END OF MONTH #	WHO/WHAT	BUDGET RESOURCES	COMMENTS
DEVELOP ACCREDITATION COUNCIL	1) SELECT MEMBERS OF NOMINATING GROUP	1	1	FEDERAL D.G. HEALTH	FMOH	SHOULD BE CHOSEN FROM JUNE 1992 WORKSHOP PARTICIPANTS
	2) STAGE MEETING OF NOMINATING GROUP	1	1	FMOH & TA	FMOH & DONOR ORGANIZATIO N	START-UP & INITIAL FUNDING FROM OUTSIDE DONOR
	3) HOLD MEETING OF HPAC BOARD OF DIRECTORS	1	2	HPAC & TA	FMOH & DONOR	
	4) SELECT STANDARDS COMMITTEE MEMBERS	1	3	HPAC	FMOH & DONOR	
DEVELOP STANDARDS	1) STAGE MEETING OF STANDARDS COMMITTEES	1	3	HPAC & TA	FMOH & DONOR	FOLLOW COMMITTEE PROCESS OUTLINED IN THIS PAPER
	2) WRITE STANDARDS	2	3-4	STANDARDS COMMITTEES	FMOH & DONOR	
	3) EDIT & DISTRIBUTE STANDARDS	2	5-7	HPAC & TA	FMOH & DONOR	

OBJECTIVE	ACTIVITIES	DURATION* (MONTHS)	END DATE/END OF MONTH #	WHO/WHAT	BUDGET RESOURCES	COMMENTS
ACCREDIT HOSPITALS	1) SELECT INSPECTORS	1	7	HPAC	FMOH	
	2) DEVELOP AND DISTRIBUTE QUESTIONNAIRE	2	3	HPAC	FMOH	
	3) PERFORM INITIAL INSPECTIONS	2	8-9	HPAC & TA	FMOH & DONOR	
	4) ACCREDIT HOSPITALS	2	10-11	HPAC	HPAC FEES	HPAC SELF-FINANCING

TA = Technical Assistance

*Measured from the time the process begins.

EXHIBIT 4-b
IMPLEMENTATION PLAN — HOSPITAL LICENSING

OBJECTIVE	ACTIVITIES	DURATION* (MONTHS)	END DATE/ END OF MONTH #	WHO/ WHAT	BUDGET RESOURCES	COMMENTS
DEVELOP HOSPITAL LICENSING PLAN	1) SELECT PROVINCE FOR PILOT OF LICENSING PROGRAM	1	1	FMOH & DOHs	FMOH	INITIAL FUNDING OF PILOT BY FMOH & DONOR -- THEN LICENSING SYSTEM WOULD BECOME SELF-FUNDING THROUGH LICENSE FEES
	2) DEVELOP HOSPITAL DEFINITION	1	2	FMOH, DOHs, & TA	FMOH & DONOR	
	3) ESTABLISH PLAN FOR INSPECTION, MONITORING, & ENFORCEMENT	2	2-3	FMOH, DOHS, & TA	FMOH & DONOR	
	4) DEVELOP PROVINCIAL LICENSING AGENCY	3	3-5	FMOH, DOHs, & TA	FMOH & DONOR	
	5) TEST MODEL	4	6-9	FMOH, DOH, & TA	FMOH & DONOR	

TA = Technical Assistance

*Measured from the time the process begins.

9.0. MONITORING AND EVALUATION PLAN

The hospital accreditation system will be successful if the standards it develops improve the quality of care delivered in a substantial number of Pakistan's hospitals. This success will be a function of two major variables: (1) the usefulness of the standards, and (2) the willingness of hospitals to participate in the accreditation system.

The usefulness of standards may best be ascertained through a survey/questionnaire of participating hospitals. The Health Care Provider Accreditation Council should ask hospitals to evaluate the proposed standards according to these criteria:

- Are the proposed standards attainable, given present resources?
- Do the standards provide a useful guide to improving patient care and hospital operation?
- Do the standards force the hospital to improve its level of care or to maintain currently acceptable levels of care?

Next, the standards may be reviewed for usefulness during the actual inspection process to gain accreditation. When inspectors visit the facilities, they will gain firsthand knowledge of the effect of standards on those organizations. Obtaining inspector feedback on the utility of standards should be a constant process and should be used to update them.

The HPAC should set goals for the number of hospitals it wants to see accredited in a specific time frame. It should monitor the progress of hospitals towards accreditation and should also monitor on-going compliance of those that are accredited. If there is a shortfall in numbers attaining accreditation or if any institution stops participation in the system, the problem should be diagnosed and corrective measures taken.

It is recommended that the HPAC produce an annual report documenting the results of hospital inspections; the feedback by inspectors on the effectiveness of standards; and the numbers of hospitals presently accredited, those accredited during the year, and those failing to achieve accreditation. This report would be sent to the Federal Ministry of Health, to the provincial Departments of Health, to member organizations of the HPAC, and to any other professional association involved in health care.

The hospital licensing program will be judged successful when it reduces the number of non-licensed facilities to near zero. Numbers of existing hospitals are presently unknown, so monitoring success will be very difficult. Developing the licensing program

should include creating a mechanism for identifying unlicensed facilities. As a by-product, the process of licensing will create a data base on existing facilities. This data base will make future monitoring easier, but will not eliminate the need for detecting newly created, non-licensed facilities.

Exhibit 5 presents a monitoring and evaluation plan for improving the quality of health care in Pakistan by setting standards for health services and by accrediting and licensing hospitals.

EXHIBIT 5
QUALITY ASSURANCE MONITORING AND EVALUATION PLAN

OBJECTIVES	MONITORING INDICATORS	EVALUATIONS
QUALITY OF CARE IMPROVED THROUGH STANDARDS	STANDARDS ARE ESTABLISHED	ANNUAL REVIEW OF STANDARDS
	STANDARDS' ATTAINABILITY, AND USEFULNESS IN GUIDING PATIENT CARE AND HOSPITAL OPERATIONS	ANNUAL SURVEY OF HOSPITALS
	STANDARDS LEAD TO INCREASE IN SELF-PERCEIVED QUALITY	ANNUAL SURVEY OF HOSPITALS
	STANDARDS IMPROVE PATIENT SATISFACTION	BASELINE AND EVERY-TWO- YEAR PATIENT SURVEYS
QUALITY IMPROVED THROUGH ACCREDITATION	ACCREDITATION MECHANISM ESTABLISHED	ANNUAL REVIEW OF ACCREDITATION SYSTEM
	NUMBER OF GOVERNMENT AND PRIVATE HOSPITALS SEEKING AND ACHIEVING ACCREDITATION	ANNUAL REVIEW
LICENSING IMPROVES QUALITY	PROPORTION OF HOSPITALS LICENSED	ANNUAL REVIEW
QUALITY MECHANISM ASSISTS INSURANCE DEVELOPMENT	INSURANCE COMPANIES AND EMPLOYERS USE ACCREDITATION TO SELECT HOSPITALS FOR CONTRACTS	ANNUAL SURVEY OF INSURERS AND EMPLOYERS

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Policy Options for Financing Health Services in Pakistan

VOLUME III
HOSPITAL AUTONOMY

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

Edited by: Marty Makinen

Volume I — **Summary Report**
by Marty Makinen

Volume II — **Hospital Quality Assurance Through Standards and Accreditation**
by Greg Becker

Volume III — **Hospital Autonomy**
by Stan Hildebrand and William Newbrander

Volume IV — **Development of Private Health Insurance Based on Managed-Care Principles**
by Zohair Ashir, Harris Berman, and Jon Kingsdale

Volume V — **Organizing and Financing Rural Health Services**
by Richard Yoder, Sikandar Lalani, and Marty Makinen

Afzal Siddiqui provided the legal analysis for the study and the component initiatives (Volumes 1-5).

Zohair Ashir studied the use of Muslim religious funds for financing health services for the indigent (Volumes 1, 3, and 5).

ABSTRACT

This report is based on the assumption that concrete benefits would result from allowing hospitals currently owned and run by the Government of Pakistan to begin to operate as autonomous entities. These benefits would include reducing the amount of government funds needed to run these institutions by replacing much of the public subsidy with user fees. Autonomous hospitals would operate using private-sector management principles which are expected to improve efficiency in operations, contain costs, and raise the quality of health services. This would be done while still retaining the hospital's social mission of providing free care to those who are unable to pay.

This document presents principles in the areas of governance, management, and finance that would guide the running of an autonomous hospital. It recommends a phased approach to conversion starting with the Pakistan Institute of Medical Services and the Federal Government Services Hospital.

VOLUME III - HOSPITAL AUTONOMY

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i

ACRONYMS, ABBREVIATIONS, AND GLOSSARY vii

AN OVERVIEW OF THE STUDY "POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN" ix

EXECUTIVE SUMMARY ➤ HOSPITAL AUTONOMY 1

1.0. INTRODUCTION 5

2.0. BACKGROUND 7

3.0. FRAMEWORK, METHODOLOGY, AND ORGANIZATION OF THIS STUDY 8
- 3.1. Conceptual Framework for Understanding Autonomy . . 8
- 3.2. Methodology Used in This Study 11
- 3.3. Organization of Findings 11

4.0. GOVERNANCE 12
- 4.1. Structuring of Governance 12
- 4.2. Considerations in Operating Autonomous Hospitals . 13
- 4.3. Mandate of the Board of Directors 13
  - 4.3.1. Clarification of the Hospital's Mission . 14
  - 4.3.2. Oversight of the Hospital Administrator . 15
  - 4.3.3. Development of Referral Protocols 15
- 4.4. Recommendations in the Area of Governance 16

5.0. MANAGEMENT 17
- 5.1. Structuring Management 18
- 5.2. Role of Management 19
- 5.3. Clarification and Delegation of Management Authority 22
- 5.4. Organizational Structure 23
  - 5.4.1. The Concept of Delegation 23
  - 5.4.2. The Concept of a Management Team 23
  - 5.4.3. Management Team Structure 27
  - 5.4.4. Using a Management Team 31
- 5.5. Personnel 32
  - 5.5.1. Key Personnel Issues 33
- 5.6. Recommendations in the Area of Management 35

6.0. FINANCE 36
- 6.1. Financial Authority 37
- 6.2. Financial Functions 39
- 6.3. Self-Financing Possibilities 40
- 6.4. Unit Costs 41
- 6.5. Cost Recovery 43

6.5.1. Assuring Quality of Services for Sustainable Cost Recovery 44
6.5.2. Objectives and Principles of Cost Recovery Policies 44
6.5.3. Gradual Cost Recovery Approach 46
6.5.4. Some Considerations for Establishing User Fees 47
6.5.5. Non-Medical Expenses Incurred by Patients 48
6.5.6. Equity and Access: Effects of User Fees on Utilization 49
6.6. Recommendations in the Area of Finance 49

7.0. LEGAL AND REGULATORY ISSUES 52
7.1. Legal Issues 52
7.1.1. National Legislation Needed to Enact Hospital Autonomy and Other Reform Initiatives 52
7.1.2. Legal Issues Related to Hospitals Keeping User Fees 55
8.0. USING ZAKAT AND OTHER MUSLIM RELIGIOUS FUNDS FOR THE INDIGENT 56
8.1. Administration of Zakat Funds 57
8.2. Zakat Health Funds 57
8.3. Recommendations 58

9.0. IMPLEMENTATION PLAN 60

10.0. MONITORING AND EVALUATION PLAN 64

APPENDIX A: PROPOSED ORGANIZATIONAL STRUCTURE FOR AN AUTONOMOUS HOSPITAL 65

APPENDIX B: SAMPLE MID-LEVEL MANAGEMENT FUNCTIONS IN AUTONOMOUS HOSPITALS 75

APPENDIX C: CALCULATIONS RELATED TO EXHIBIT 7 - Finance Section 83

BIBLIOGRAPHY 87

LIST OF EXHIBITS

Exhibit 1 Different Forms of Hospital Autonomy by Operational Area 10
Exhibit 2 Levels of Management 18
Exhibit 3 Management Range of Hospital Autonomy Options from Fully Public to Fully Private 21
Exhibit 4 Proposed Organizational Structure for an Autonomous Hospital 24
Exhibit 5 Key Management Personnel 30
Exhibit 6 Financing Range of Hospital Autonomy Options from Fully Public to Fully Private 38
Exhibit 7 Expenditure, Workload, and Unit Costs for PIMS and FGSH 42
Exhibit 8 An Example of a Phased-Cost Recovery Schedule . . 46
Exhibit 9 Examples of Fees Under Phased-Cost Recovery . . . 48
Exhibit 10 Hospital Autonomy Implementation Plan 61
Exhibit 11 Hospital Autonomy Monitoring and Evaluation Plan . 64

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID	U.S. Agency for International Development (Washington, D.C.)
AKHS	Aga Khan Health Services
AKU	Aga Khan University
AKUH	Aga Khan University Hospital
AKUHS	Aga Khan University Health Services
Amir	Head of a Muslim State
ARI	Acute Respiratory Infection
Bait-ul-Mal	Welfare funds established by the Amir
BHUs	Basic Health Units
CCU	Cardiac Care Unit
CDA	Capital Development Authority
CDD	Controlling Diarrheal Diseases
CHW	Community Health Worker
CRHP	Cost Recovery for Health Project, Cairo, Egypt
chowkidar	Watchman
CV	Curriculum Vitae
CZA	Central Zakat Administration
CZC	Central Zakat Council
DHO	District Health Officer
DOH	Department of Health (provincial level)
EPI	Expanded Program of Immunization
ESSI	Employee Social Security Insurance
Fatamid Foundation	Blood Donor Agency
FGSH	Federal Government Services Hospital
FJMC	Fatimah Jinnah Medical Center
FMOH	Federal Ministry of Health of Pakistan
FP	Family planning
GDP	Gross Domestic Product
GMO	General Medical Officer
GNP	Gross National Product
GOP	Government of Pakistan
GP	General Practitioner
Hakims	Traditional health practitioners
HCFA	Health Care Financing Administration, U.S. Government
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
HPAC	Healthcare Provider Accreditation Council
HPN	Office of Health Population and Nutrition
HT	Health Technician
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IPA	Independent Practice Association
ISL	Islamabad
JCAHO	Joint Commission for the Accreditation of Health Care Organization
JPMC	Jinnah Postgraduate Medical Center
Katchi Abadis	Squatter Settlements
KEMC	King Edward Medical Center
KHI	Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMOH's new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMOH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan's health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS Project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health, through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more

workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of hospital autonomy.

VOLUME III

HOSPITAL AUTONOMY

EXECUTIVE SUMMARY

HOSPITAL AUTONOMY

PURPOSE

Pakistan's Federal Ministry of Health (FMOH) would like government hospitals to begin to operate as autonomous entities. They would receive indexed block annual subsidies from government which would diminish over a period of years, with substitute revenues being generated through user payments. With control over their budget, personnel, and service policies, autonomous hospitals' Boards of Directors and senior administrators would have the incentive — and the authority — to increase efficiency in hospital operations, contain costs, and raise the quality of care. Government hospitals would retain their social mission and would continue to provide free care to those unable to pay.

PROBLEM

In the current system, government-operated hospitals consume a share of government allocations for health that is disproportionate to the contribution they make to the health of the population. They are inefficiently operated; many resources are wasted. Quality of care is low.

Many Pakistanis already pay for health services in the private sector, so the concept of user fees is a familiar one in the country. If the quality of health services provided at government facilities were better, these people might well be willing to pay for such services, especially if they were able to avail themselves of a financial risk-sharing mechanism such as insurance.

DESCRIPTION OF THE INITIATIVE

The FMOH anticipates a phased conversion of government hospitals to autonomous status. This would allow hospitals to learn from experience and to revise their plans along the way. The first hospitals to be converted would be the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH), both in Islamabad.

METHODS

To develop a set of recommendations concerning what steps would be involved in moving government hospitals towards autonomy, a study team of Pakistani and outside experts reviewed how hospitals and other enterprises in Pakistan currently operate when granted limited autonomy, how private trust hospitals (non-profit organizations established by endowments from donors and/or private businesses) work, and how autonomy for government hospitals has been pursued in other countries. Consultations also were held with the management of PIMS and FGSH to assess their current operations and to determine what powers and incentives would be needed to achieve FMOH cost-efficiency and service-provision objectives.

RECOMMENDATIONS

Recommendations on hospital autonomy are offered in three categories: governance, management, and finance. The concepts developed in each of these areas are applied to plans for the conversion of FGSH and PIMS.

Governance

In the dimension of governance, this study recommends that:

- The government retain ownership of its hospitals.
- Financing be shared between government and private payments.
- A Board of Directors made up of representatives of government, the concerned community, and the medical profession be granted the power to oversee the operations, management, and financing of the hospital. The mandate of this board is to ensure that:
  - The basic mission of the hospital is defined and accomplished.
  - The current volume and quality of services provided is maintained or improved.
  - The assets of the hospital are protected.
  - Financing is sufficient to provide services of acceptable quality.
  - Efficiency and cost-effectiveness are operational goals.
  - The social mission of the hospital is achieved.
- The board hire a Hospital Administrator who would, in turn, hire staff and operate the hospital.

Management

The team carrying out this study found that, for an autonomous hospital to achieve its desired ends, a new management approach will have to be used, a revised organizational structure put in place, and improved management practices adopted.

Furthermore, autonomous hospitals will have to sell their services to potential paying patients. Thus, hospital management will need to develop the capacity to market services to insurers, employers, and individual patients.

Also, as user fees become increasingly important to the operation of an autonomous hospital, the relationship between it and other medical institutions from which it receives and to which it sends patients on referral will become more critical. It must, therefore, negotiate referral relations with other institutions, including pricing policies.

To stake out an external identity and to guide staff, the autonomous hospital should first define its mission clearly and simply.

The management structure of an autonomous hospital may take many different forms, depending on the specific needs of the individual institution. The following basic structure is proposed as a starting point for adaptation:

- A Board of Directors which hires and oversees the Hospital Administrator.

- A Management Team, hired and supported by the Hospital Administrator. This team would primarily be made up of Deputy Directors for: Administration, Finance, Medical Services, Nursing Services, and Support Services.

- Middle-management personnel overseen by the Deputy Directors.

This study also identifies areas in which training for autonomous hospital personnel will be required. Notable within this realm would be training to help define the roles and responsibilities of the board, the Hospital Administrator, and the Management Team. Training also is recommended in overall management techniques, in personnel and financial management, and in marketing.

Finance

The study team's recommendations in the area of finance are mainly based on a study of costs at PIMS and FGSH. Using this information, recommendations are made regarding the transfer of operating and capital expenses from the government to user payments on a phased basis over a ten-year period.

Additional issues addressed are:

- The management of hospital finances.

- Compensation and incentives for doctors.

- The effects of user fees on the use of urban and rural health services.

- The need to assure quality services in order to sustain cost recovery.

- Ways to fund services for those who are unable to pay.

Concerning the latter issue, it is suggested that:

  - Hospitals seek to develop an enhanced relationship with the Zakat Fund;

  - Patient welfare committees responsible for identifying those who are unable to pay be improved;

  - Poor patients be given first call on remaining government subsidies.

This study also suggests that the management of autonomous hospitals be held responsible for achieving efficiency goals and for improving the quality of services. This could be encouraged by giving the board the power to grant bonuses, to make adjustments in pay to reward high performance, and to hire and fire management personnel in relation to their achievement of the hospital's objectives.

Furthermore, it is recommended that management prepare and present annual financial plans for the board's approval, including both operating and capital spending plans which identify expected revenues from all sources. Performance in meeting these plans would be another criterion used by the board to evaluate management's performance.

Legal

Possible legal constraints involved in moving toward hospital autonomy were examined as part of a larger review of health legislation. That review found that new legislation will be needed to facilitate the movement to autonomy. Nevertheless, the FMOH appears to have sufficient authority at the present time to move ahead in making PIMS and FGSH autonomous hospitals. Doing this would be the first step in moving all federal and some provincial government hospitals toward autonomy.

1.0. INTRODUCTION

At question in Pakistan today is the form which cost recovery for Federal Government-provided hospital services should take and the way this recovery should be implemented while safeguarding the poor from potential adverse effects.

In light of the country's general economic situation, cost recovery for health services is doubly important, first to expand services to rural areas and to address the major preventive and communicable disease problems facing the country. Second, recovering such costs is critical to the sustainability of existing services. A UNICEF report stated that there currently appears to be a general recognition that it will become progressively less feasible for the government to maintain its current subsidy level for publicly provided goods and services (WP, 1992). The result is that practical, achievable ways must be found to supplement and partially to supplant the government's investment in the health care of its people.

The Government of Pakistan (GOP) is committed to having high-quality health services for its people, however, only a small percentage of the Gross National Product (GNP) was spent on health care in 1991/92. This is a low figure compared to other countries in the region and to nations at a similar level of economic development. Public expenditure for health during this period in comparable countries was 3.5 percent of GNP (World Bank Report No. 11127, 1992).

With this small expenditure, the Government of Pakistan manages to provide a large portion of the medical services offered in the country, especially to people of lower socio-economic status. The public sector employs 26,000 government physicians, most of whom also have their own private practices, and it runs 733 government-financed federal, provincial, and special hospitals including facilities for certain groups such as the police, water and power authority personnel, and staff of the forest department (Report to the GOP, 1988). Because the government is responsible for this many health facilities, its actions strongly affect how health care is provided throughout the country.

The private sector accounted for nearly 60 percent of the 22.4 billion rupees spent on health services in 1991/92. At that time, there were 12,000 private practitioners and over 500 private hospitals (including maternity and nursing homes) in the country (Report to the GOP, 1988). Total per capita health expenditure for 1991/92 was approximately 191 rupees, with 115 rupees of this amount being private payments (Tibouti, 1991).

This high level of private expenditure for health shows that the payment of fees for medical care is a commonly accepted

practice in Pakistan. Under these circumstances there is room for the government to experiment in giving greater financial autonomy to government hospitals and to expect that these institutions may increase their level of cost recovery through user fees, insurance, and employer-contracted health plans. A United Nations' report indicated, "There is evidence in the Household Survey of a willingness to pay more for Government services if there were improvements in the quality of these services" (Tibouti, 1991, p.15). Moving more health costs to the private sector, however, must be done with caution to not create financial barriers to hospital services for the poor.

Pakistan's Federal Ministry of Health has supported the idea of providing more autonomy to government hospitals and has proposed that initial activities in pursuit of hospital autonomy be centered in the Islamabad Capital Territory (ICT). Two FMOH institutions in the ICT, the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH) have been selected as the first sites for carrying out this idea.

This report focuses on the conversion of these two facilities from fully government-run institutions to government-owned but autonomously run entities. The FMOH expects that the lessons learned in this conversion will enable it to gradually move other federal and provincial hospitals toward autonomy.

2.0. BACKGROUND

The Government of Pakistan has provided free health care to its population since it became an independent country in August 1947. Unfortunately, as a result of ever-increasing economic pressures, the government has been unable to provide adequate resources to maintain the level of services required by a growing population. As in many countries, under-investment is particularly acute in public health, in prevention programs, and in primary health care services.

The 8 federal and 725 provincial hospitals run by the government are experiencing severe financial strains. Hospital budgets are so inadequate that facilities are unable to provide a reasonable standard of care. As a result, the reputation of these facilities is extremely poor, often making them the provider of last resort. Families with either sufficient personal income or access to government or private employee benefits or to insurance programs generally seek care at non-Ministry of Health facilities. This may have some beneficial effect as those who can afford to pay for services are using private providers. However, another consequence is that it lowers utilization rates at government facilities and may reduce already low rates of efficiency.

The number of alternative service providers from which Pakistani households can choose varies considerably, depending on geographic location, on the type of illness, and on the financial resources available to the patient. In addition to government facilities, there are large numbers of health facilities in urban areas such as Aga Khan University Hospital, Trust Hospitals such as the National Cardiovascular Disease Hospital (NCVD), and other private hospitals as well as thousands of multiple- and single-specialty clinics. The capacity of these facilities ranges from a few beds to hundreds. Only in the rural sectors of Pakistan is there a limited selection.

Although there are currently no legally autonomous public sector hospitals in Pakistan, the country has had some recent experience with the concept. In the 1980s, a number of government hospitals were granted limited autonomy by executive order through Resolutions of Autonomy. Institutions affected were the Pakistan Institute of Medical Sciences (PIMS, October 22, 1986), the Sheikh Zayed Postgraduate Medical Institute (May 29, 1986), and the NCVD (January 7, 1979). These Resolutions did not allow the facilities to establish user fees nor to have much authority to operate in an autonomous manner and in 1990 the Houses of Parliament invalidated all autonomy resolutions.

3.0. FRAMEWORK, METHODOLOGY, AND ORGANIZATION OF THIS STUDY

This section discusses the way the study on hospital autonomy was organized and its findings are presented. The approach used by the specialists on the team reflects other health management studies undertaken in the Philippines and in Egypt (Stover, Almario, & Mendoza, 1991; and Hildebrand & Becker, 1992).

3.1. Conceptual Framework for Understanding Autonomy

Many developing countries have come to the realization that it has not proven to be economically feasible for the state to provide a full range of health services to all citizens. Most are now experimenting with alternative methods of organizing and financing those services. In some, increasing the autonomy of state-owned hospitals has increased the quality of services, reduced the financial burden on the country's government, and redistributed the money that is saved to primary and other health services.

Hospital autonomy generally means that hospitals are at least partially self-governing, self-directing, and self-financing through the generation of revenues from user fees. Hospital autonomy can take a variety of forms. On one end are government-owned, centrally financed and directed hospitals. On the other end are private, fully independent medical institutions. In between is an array of forms which autonomous institutions can take.

Discussions of autonomy often deteriorate into heated debates over whether the government intends to privatize health care. Critics of privatization in health can become uninformed critics of autonomy and often feel that steps toward autonomy mean that government is "abdicating its social responsibility to protect the health of the nation's citizens." It is essential to note that total ownership by non-government is only one of the forms which autonomy can take.

Moving state-owned and operated, centrally directed and financed hospitals toward autonomy does not indicate how far along the spectrum they should or will move. To become fully autonomous, government hospitals would, indeed, have to be more privatized. Indeed, it should be clearly understood that a policy of moving toward greater autonomy does <u>not</u> mean that hospitals need to be fully privatized.

In Pakistan, the FMOH's intention is that government hospitals will continue to be state owned. Giving them some autonomy is a way to empower the hospitals' management and to allow these institutions to become largely self-financing and self-governing.

This report examines how the Government of Pakistan might achieve its health care and financial objectives by providing

considerable autonomy to state-owned hospitals. Three areas of hospital operation are addressed in this study:

> *Governance* refers to the act of setting the goals and objectives of the organization, overseeing its operational policies, and being responsible for the overall management of its assets.
>
> *Management* refers to the senior group that makes day-to-day decisions about the operations of the hospital in its various functional areas: medical services, nursing care, administration, training, and research.
>
> *Finance* refers to the methods by which the funds for the hospital's operation are generated, the ways recurrent and capital budgets are established and controlled, and the mechanisms by which costs are projected and contained.

Exhibit 1 illustrates the alternative levels of autonomy possible in each category. Options for governance, for example, range from fully public facilities directed by the Ministry of Health (MOH) to a for-profit institution controlled by a single owner, partnership, or corporation.

The plan proposed by this study recommends initially moving toward hospital autonomy for two hospitals in the Islamabad Capital Territory: the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH).

The Pakistan Institute of Medical Sciences is composed of two acute-care, referral hospitals, the Islamabad Hospital and Children's Hospital. It has an affiliation with the College of Nursing and the College of Medical Technology. In 1992, the number of operational beds were 543 in Islamabad Hospital and 213 in Children's Hospital (although the number of sanctioned beds for the hospitals are 573 and 230, respectively). Most PIMS patients are from Islamabad and Rawalpindi. Based on 1992 admissions and an average length of stay of 8.9 days, the Islamabad Hospital had an occupancy rate of 77 percent while Children's Hospital had 81 percent occupancy. Compared to other government hospitals, PIMS is perceived as offering a higher standard of care.

The Federal Government Services Hospital in Islamabad tends to have a greater proportion of patients from the lower-income classes. The perception of the medical establishment is that the quality of care is greater at PIMS, but that FGSH is more "culturally comfortable" for the poor and non-elite who frequent it.

This study recommends that other government hospitals, both federal and provincial, would be converted to autonomy on a phased basis, learning from the experiences gained by PIMS and FGSH. Because of this phased move towards autonomy, PIMS and FGSH are the primary focus of the analysis that follows.

EXHIBIT 1
DIFFERENT RANGES OR DEGREES OF HOSPITAL AUTONOMY
BY OPERATIONAL AREA

	FULLY PUBLIC < PRIVATE			
GOVERNANCE	MOH HOSPITAL WITH MOH HOSPITAL ADMINISTRATOR	NON-PROFIT CORPORATION; GOVERNMENT OFFICIALS AND COMMUNITY BOARD OF DIRECTORS	FOR-PROFIT CORPORATION; PRIVATE BOARD	PRIVATELY OWNED AND MANAGED
MANAGEMENT	MOH PERSONNEL	BLEND OF MOH AND PRIVATE SECTOR PERSONNEL	HOSPITAL CORPORATION PERSONNEL	PRIVATE SECTOR PERSONNEL AND OWNERS
FINANCING	100 PERCENT GOVERNMENT ALLOTMENT	MODEST INCOME FROM USER FEES AND INSURANCE; MOST INCOME FROM GOVERNMENT ALLOTMENT	MOST INCOME FROM USER FEES AND INSURANCE; SOME GOVERNMENT SUBSIDY	100 PERCENT INCOME FROM USER FEES AND INSURANCE

3.2. Methodology Used in This Study

Field work on this study of granting autonomy to government hospitals began in January 1992 and ended in February 1993. The Pakistani and American HFS team began by gathering information on Pakistan's current systems of hospital organization and finance from sources in both the public and private sectors. An initial workshop was then organized by the FMOH in February 1992 for participants from the groups initially consulted by the study team. These participants were able to reach agreement on the principle issues to be addressed in granting autonomy and on the approaches that most likely would be successful in the Pakistani context.

In workshop discussions, participants concluded that government hospitals should be granted managerial and financial autonomy and should receive indexed block annual subsidies from the government. These hospitals would generate additional revenues through user payments, utilizing a portion of these revenues to improve quality of care and efficiency. It was agreed that the government would gradually reduce its subsidization of these hospitals, permitting the freed-up public resources to shift to primary health care and prevention efforts.

Following the workshop, the study team examined the ways various health-related and non-health-related enterprises in Pakistan have operated when granted limited autonomy. Specifically, team members studied the NICVD's and PIMS' recent, limited experience with autonomy. They also looked at private trust hospitals such as Liaquat Hospital, Shalamar Hospital, and Sheikh Zayed Medical Institute (which had different experiences from NICVD and PIMS). Finally, they consulted with autonomous organizations in sectors other than health such as Pakistan Telecommunications and the Muslim Commercial Bank.

3.3. Organization of Findings

Issues of governance, management, and finance, including recommendations for action, are addressed in Sections 4.0, 5.0, and 6.0 of this document. Section 7.0 presents additional issues associated with autonomy, including the national legislation which needs to be enacted to provide autonomy for government hospitals. Section 8.0 addresses the possible uses of Zakat and other Muslim religious funds to pay for health care for the indigent. Section 9.0 summarizes the implementation plan, and Section 10.0 provides recommendations for monitoring and evaluating progress in establishing autonomy in government hospitals in Pakistan. Appendices A and B support this overall study by providing concrete descriptions of the roles and responsibilities involved in managing autonomous medical institutions.

4.0. GOVERNANCE

In January 1991, the FMOH announced that the administration of hospitals and health facilities in Pakistan would be decentralized by establishing district and *Tehsil* (zones within districts) health committees. This was a key starting point for decentralizing management of public sector health facilities.

4.1. Structuring of Governance

Governance — the control, ownership, and authoritative direction of a hospital — can be structured in many ways as seen earlier in Exhibit 1. There is a range of options concerning where power and responsibility for managing hospitals can reside. At one end of the governance range is a fully public facility of the Ministry of Health. Under this option, the hospital is governed by officials within the Ministry. The Hospital Administrator receives policy direction from and reports to these officials. Since policies are set at high levels of the Ministry, there is no need for a Board of Directors. At the opposite end is a fully private facility whose owners may be individuals, partners, or a corporation. The goals and policies of this institution are set by the owners, subject to government regulations. Such an institution may or may not have social and equity objectives promoted by the government.

The hospitals under consideration for autonomy in this study are fully public facilities of the FMOH. Most have governing Boards of Directors comprised of government officials from various ministries. These boards were established to help move the hospitals gradually toward autonomy, perhaps becoming a quasi-public corporation or a para-statal one. As community participation on the board increases, control over the hospital would be gradually transferred to the community, which is in the best position to assess its needs, make trade-offs between service options, and determine the ability of clients to pay for services.

Under the autonomy scheme proposed in this study, each Board of Directors will assume responsibility for policy making, albeit with the active participation of the Hospital Administrator and key medical staff. To do this, the board must understand the environment in which it operates, particularly the limits on its decision-making powers as determined by the federal and provincial Ministry of Health.

For the governance of hospitals to be successful, hospital leaders will need to make sure that the institution plays an active and positive role in its community. Relationships with community groups and local businesses can provide direct, tangible benefits to the hospital such as contracts to provide health services to

employees and individuals. Indirect benefits could take the form of drawing on local financial management expertise, using community members to help plan and carry out marketing activities, and seeking honest feedback regarding the facility's strengths, weaknesses, and programs. Involvement with the community also strengthens the facility's image with community leaders and should encourage local use of the hospital's programs and services. One of the avenues for community participation is community representation on the hospital's Board of Directors which can also be an active voice for the hospital to the citizens in the catchment area, in addition to guiding the direction of the institution.

4.2. Considerations in Operating Autonomous Hospitals

As hospitals become more autonomous, they will need to become increasingly market and community oriented. Low utilization rates and high unit costs will be unacceptable as they would force changes in the services that are offered. Factors that must be considered in charting a positive direction for the institution include:

- *Mission* ➧ The institution's mission must define the scope and purpose of the hospital, guide its future direction, and establish the boundaries and framework for decision making.

- *Government Regulations and Policies* ➧ Government actions determine such things as the amount of funds received and their allocation. Regulations also affect the extent of mandated access to care, labor policies, and methods of providing care.

- *Financial Limitations* ➧ The amount of money available, the relative cost of providing various services, the availability of capital, and government restrictions on uses of funds affect how hospitals carry out their mandate.

- *Competition* ➧ Hospitals need to determine which services are provided by competitors and decide whether or not to compete in providing these services.

- *Quality of Care* ➧ Institutions must decide if their services meet medical and regulatory norms. Is a certain service provided in sufficient volume to maintain a high level of staff expertise?

- *Community Needs* ➧ Everyone involved in governing a hospital must realize that needs and priorities are likely to be viewed differently by the marketing staff, medical personnel, politicians, and community groups;

efforts must be made to constructively use these various perspectives.

4.3. Mandate of the Board of Directors

Boards of Directors are important vehicles for introducing and considering new ideas. They work best when there is a commonly held vision and a substantial level of understanding among the board members. Boards can lead hospitals as they progress through the conversion to autonomy. The Board of Directors of an autonomous hospital should ensure that:

- The hospital's basic mission is clearly identified and accomplished
- The quality of services provided pre-autonomy is maintained or improved.
- Financing is adequate to meet service requirements.
- The hospital's assets are protected.
- The Hospital Administrator manages the hospital according to board policies.
- The Federal Ministry of Health's social mission is achieved.

In return, the hospital must use the board to further its goals. The board can obtain the additional expertise it needs in areas such as finance, insurance, and marketing by carefully selecting business and community representatives. These members can also be valuable as they provide perceptions of service needs and expectations for quality.

4.3.1. Clarification of the Hospital's Mission

The Boards of Directors of PIMS and FGSH will need to review the services their facilities provide. This can be accomplished by collecting quantitative and qualitative information from hospital records and by interviewing management and selected other people both inside and outside the hospital.

One of the roles of the board is to establish and clarify the hospital's mission. To understand its mission, the board needs to ask:

- How does the care provided at the hospital compare with the mission as specified in the Autonomous Entity Act proposed in this study.

- How does the medical training provided at the hospital fit with its mission?

- What issues faced by the community it serves affect the hospital?

Various interpretations can be made of any hospital's mission. Boards should select the interpretation that best serves the broad needs of the community. (Appendix A.1 provides guidelines for reviewing the mission of the hospital.) One of the purposes of carrying out this clarification task is to more specifically define hospitals as being primary, secondary, or tertiary care facilities and to assure that patients are then appropriately referred to the hospital most capable of treating them.

4.3.2. Oversight of the Hospital Administrator

Another role of a Board of Directors is to hire and oversee the Hospital Administrator. Before it can monitor the administrator's performance, it must first carefully define the role by developing a concise job description. Just as it does for other employees, the job description should explain the duties, responsibilities, and educational requirements of the position as well as the board's expectations in areas such as finance, results reporting, and planning. The job description should also outline responsibilities which the board believes the Hospital Administrator should delegate to deputies or to area managers. The management section of this report provides further discussions on the administrator's role and functions.

4.3.3. Development of Referral Protocols

Referral means the transfer of care from one provider (doctor, clinic, or hospital) to another, either for consultation or to make available clinical or technical expertise not found at the point of origin. This practice is most often used for unusual cases and conditions infrequently, if ever, seen by the referring entity, but treated often by a few select providers. Once the referred patient has been treated, he or she is returned to the referring source for follow-up and ongoing care.

The board's interpretation and clarification of the hospital's mission will provide guidance in determining how each hospital is to receive patients on referral from other hospitals or institutions within Pakistan for specialized or other care. For example, tertiary and specialized-care facilities such as PIMS may not be required to accept the admission referral of primary or secondary care patients.

Whether the autonomous hospital is a primary, secondary, or tertiary care hospital, it must control admissions and monitor referral processes. This can be achieved through developing and communicating to all concerned clear information about referral practices between the autonomous hospital and other institutions. The development or reconsideration of referral protocols and procedures should be a priority task of autonomous hospitals. (Appendix A.2 provides guidelines for the development and enforcement of referral protocols.)

4.4. Recommendations in the Area of Governance

No matter what form the management and financial component of an autonomous hospital takes, the recognition of community, business, and consumer needs will allow the hospital to provide services that are essential to the people of that area.

The following ingredients are necessary for an autonomous hospital to provide appropriate, high-quality care:

- A clearly defined mission which is responsive to the community needs;
- The power to make policy and financial decisions such as increasing salaries for select specialties or rewarding superior performance (these institutions need to be free from government regulations that hamper their ability to achieve their mission);
- A referral system which uses primary, secondary, and tertiary resources appropriately; and
- The capacity and willingness to provide high-quality services that fit the community's needs. A hospital's capital development and service planning process needs to be based on genuine community needs rather than dictated by government budget considerations.

The study team recommends that:

- Ownership of public hospitals remain with the federal and provincial governments.
- These governments delegate policy and management authority to the hospitals.
- Policy making should become the responsibility of the hospital Board of Directors.
- The Board of Directors establish and interpret the hospital's mission and oversee its operations.

Given additional freedom, the board should be able to improve efficiency and deliver appropriate, high-quality health care services.

5.0. MANAGEMENT

The Boards of Directors and management staff of the Pakistan Institute of Medical Sciences and the Federal Government Services Hospital must decide how they want to organize the work of their hospitals to meet the demands of their markets and consumers.

It may help to look at how the management of a hospital compares to that of other organizations. Compared to business executives, Hospital Administrators typically have less authority over the professionals who work in their facility (i.e., physicians and consultants). Also, the goals of hospitals are often more complex than those of manufacturers of finished products; those of public organizations such as water, sanitation, utilities, and telecommunications; or even those of service providers such as banks and insurance companies. Hospital goals include patient care, research, teaching, and community service. In business, the goal is primarily profit, regardless of the function or services of the organization. Greater complexity of goals implies increased problems in directing and managing an organization.

Katz and Kahn (1966), organizational specialists, include within the managerial function the general task of optimizing relations between the organization and its environment. Translated to PIMS and FGSH, this means that the hospital administrator and the managers of departments need to decide issues on the basis of what is good for the hospital as a whole as well as for the community it serves, not on the basis of what serves an immediate departmental or emergency need. They also need this larger view as they make decisions about how to use the resources at hand to improve the quality of services of the entire institution.

Autonomy should be implemented using sound management principles. These principles may challenge traditional management approaches. An environment that encourages creativity must be established, accountability and responsibility must be given to line managers, and employee morale must be considered.

This would be an opportune time to take advantage of current management approaches such as "re-engineering." This idea capitalizes on the characteristics that have traditionally made great business innovations: individualism, self-reliance, a willingness to accept risk, and a propensity for change. It is the notion of "discontinuous thinking" — identifying and abandoning outdated rules and fundamental assumptions that underlie current business operations.

Financial management (accounting/budgeting) will be critical to the operation of the autonomous institution. Hospitals will be accountable for the public and private funds (user fees) received and responsible for keeping track of income and expenses. Personnel management will increase in importance as hospitals will

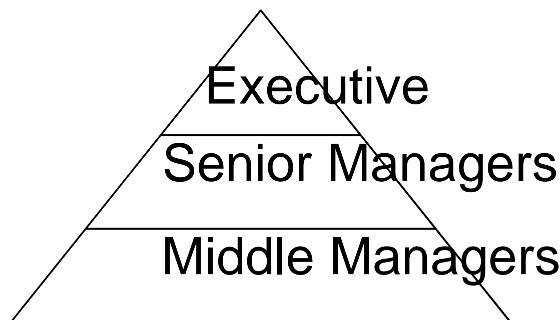
be able to recruit their own staff and will therefore have to develop job descriptions and a performance-based compensation system.

To change from traditional management practices to those needed to reap the benefits of autonomy may require technical assistance. The amount of technical assistance that will be needed depends on existing management skills and the system of governance already in place. PIMS and FGSH have management staff with demonstrated skills, however, training in management principles and practices as well as in technical skill areas such as nursing, laboratory procedures, and maintenance functions could be helpful to all levels of management. Hence, one of the tasks during the first year of conversion to autonomy will be to train upper management, then to define the requirements for training the remaining staff.

5.1. Structuring Management

An organizational structure delineates authority, responsibility, and accountability. Although each organization has different goals and emphasizes different internal functions, there are some aspects of organization that are true for most hospitals. They have one person at the top, a layer of senior managers next, and, below that, middle managers. Organizations must strike a balance between having a structure that has many layers with small spans of control or fewer layers with larger spans of control. Appendix A.3 provides guidelines for the development of a decentralized management organization.

EXHIBIT 2
LEVELS OF MANAGEM



The standard pyramid-shaped organizational structure of most hospitals is well suited for PIMS, FGSH, and other autonomous hospitals because it can be adjusted, depending on the desired

scale of operations. When management requires workers, it simply adds positions at the level required and establishes management-reporting requirements. This structure is also ideally suited for planning and control. It allows the administrator and department managers to ensure consistent and accurate work performance by delegating responsibility and authority throughout the pyramid's structure and establishing monitoring and reporting requirements.

Still, management of PIMS, FGSH and other autonomous hospitals will require certain new ways of thinking such as:

- Clarification of (and sustaining) the mission statement
- Oversight by a Board of Directors
- Use of a management team
- Delegation of responsibilities
- An upgraded role for the financial manager
- Increased skills in personnel management
- A proactive marketing of services

Exhibit 3 describes various management structures for the autonomous hospital, ranging from a fully government operation to a fully private one.

5.2. Role of Management

To better understand the management aspects of a hospital, three dimensions of a manager's role were examined at PIMS, FGSH, and Shalamar Businessmen Trust Hospital, a non-profit. The first dimension studied was the amount of discretion – or autonomy – managers were given within the organization. The second was the amount of authority managers had to determine how actual services were provided in their unit. The last was the amount of responsibility and accountability managers had in their overall service area.

Shalamar differs from the other two hospitals as it is a non-profit institution governed by a Board of Directors comprised of local businessmen and government officials. It was built with private donations and funds on government land. Its mission is to provide quality health care to the community. Those patients that have the financial capability, pay a reasonable fee for services. In exchange for the government land and a small allotment, the hospital provides services to those who are not financially capable. The Hospital Administrator (Superintendent) of Shalamar

is empowered to operate the hospital and provides the Board of Directors with operating statistics and financial information. He receives guidance from them on community services, capital expenditures, resource utilization, staff (i.e., professional, technical, and lay personnel) compensation, and clinical services. The hospital is "customer-service oriented" with the understanding that resources available must equal or exceed the cost of those services.

- Discretion

  On the issue of discretion or autonomy, the team studied how a manager sets and acts on priorities. Did managers initiate work programs and schedules for their area or did they merely react to the initiatives of the hospital administrator or others? At both PIMS and FGSH, managers were given little freedom in setting priorities. On the other hand, at Shalamar, managers were given flexibility and discretion in determining the direction of their departments. Most managers maintained service logs and understood the relationship of time management and service response. The Shalamar Hospital Superintendent received weekly and monthly reports on area operations. This information was then presented to the Board of Directors which provides guidance on service delivery and resource utilization.

- Authority

  The team also studied the amount of authority managers had in determining how services are actually provided. Were they involved in the finite operations of their area, or were they merely supervisors of the service outcome? Involvement could include the review of day-to-day operating needs, understanding the budgets and financing of their area, and/or comprehending the requirements of those to whom they provided support (i.e., physicians, patients, and community.) At Shalamar, managers were responsible for the budget and services provided in their departments. They established departmental operating procedures, scheduled personnel, and exercised control over their department. At both PIMS and FGSH, managers did not oversee budgets for their areas, financial reporting was minimal and only provided in the accounting department. Yet, the managers were cognizant of their day-to-day operating needs because they had a practical working knowledge of their areas.

- Accountability

  Finally, the team studied the amount of accountability managers had. At PIMS and FGSH, true responsibility and authority were not delegated to managers. They were more custodians of their areas. As a result, discipline and morale

were problems, schedules were not adhered to, and resources such as supplies, equipment, and raw materials were not always available. At Shalamar, on the other hand, managers were accountable for the services and resources of their areas and were responsible both for providing quality services and for maintaining harmony within the staff.

EXHIBIT 3

MANAGEMENT
RANGE OF HOSPITAL AUTONOMY OPTIONS
from
FULLY PUBLIC TO FULLY PRIVATE

FULLY PUBLIC <——————————————————> FULLY PRIVATE					
Fully government operation with government employees providing all administration, research, and training functions.	Mostly government operation with primarily government employees who contract out for certain services such as medical services, management, and housekeeping.	Quasi-government operation with a mix of government and private employees connected through wage contracts or service and management contracts.	Quasi-government operation with primarily private or contract employees. Services provided by hospital employees on contracts.	Private operation with employees hired from private sector. Some services contracted out. Others provided directly by private hospital staff.	Fully private operation with all employees hired from private sector.

Under autonomy, the Hospital Administrators and managers at PIMS and FGSH must change their thinking from a traditional "hold expenses down" approach to one more appropriately described as "a customer-service orientation combined with financial flexibility." This is not to suggest that there will be freedom to spend as they wish, but the new orientation should allow for more freedom in deciding how resources should be used to provide quality services.

Management responsibility and accountability, supplemented by a quality- service orientation, should make PIMS and FGSH improved hospitals. To do this, the Hospital Administrators and managers will have to be able to promote and reward this new way of thinking and behavior within their staff.

5.3. Clarification and Delegation of Management Authority

In the areas of management, patient services, and medical services, the underlying assumption is that: changes in theory and practice are required. Management restructuring must take place at two levels: in the relations between the MOH and the individual facilities, and within facilities themselves.

- Personnel Management

  In the first category, more authority needs to be delegated by the FMOH to the administrators of autonomous hospitals. In personnel management, for example, autonomous hospitals will employ salaried staff (physicians, nurses, technicians, and laborers) and will abide by the general government rules for personnel deployment, base salary, and benefits. However, autonomous hospitals should be empowered to accept or refuse an employee assigned from the ministries; hire personnel as needed; reward employees for superior performance with incentives (overtime and merit pay); and reprimand, transfer, or dismiss an employee whose work is unsatisfactory.

  Within autonomous facilities, clear lines of authority and responsibility will be needed. In a typical Pakistan hospital, these lines are blurred below the position of Hospital Administrator. This lack of clarity places too much emphasis for the success of the hospital on the abilities of the administrator. Despite the abilities of some administrators, this burden is ultimately detrimental to the efficient operation of the hospital. Suggestions made in this report about clarifying roles, specifying lines of authority, creating job descriptions, and delegating authority can be ways to improve management practices in autonomous hospitals.

- Quality of Services

  A key task of management is to improve the quality of services provided. Facilities must improve all aspects of medical care (including physician and nursing care), they must increase the responsiveness of support departments such as the laboratory and pharmacy, and they must improve the physical condition and regular up-keep of the building.

Furthermore, the autonomous hospital and its administrator will need to aggressively adopt the attitude that patient service is a key goal and priority. Patients who feel cared for will become committed consumers. Equally importantly, they will refer others to the hospital. Viewing service as a priority and implementing systems and programs which further this goal may – in the overall cost recovery effort – be one of the most important elements in making the difference between success and failure.

5.4. Organizational Structure

5.4.1. The Concept of Delegation

The management structure proposed in this report is a mix of the classic American structure and the traditional Pakistani one. In both systems, ultimate authority and responsibility for the functioning of a hospital rests with the Hospital Administrator. As an important change from the traditional system, this report recommends that the Hospital Administrator delegate operational authority of the hospital to Deputy Directors in key program areas. In turn, these Deputies will then delegate day-to-day operational authority to departmental managers. (See Exhibit 4)

The effects of this decentralized approach are twofold:

- The number of persons having a direct reporting relationship with the Hospital Administrator will be reduced. This will limit the number of daily problems that often distract the Hospital Administrator from major issues; and

- The delegation of authority and responsibility effectively institutionalizes managerial responsibility at the hospital, rather than having it rest solely with the Hospital Administrator.

5.4.2. The Concept of a Management Team

The design of an appropriate, workable organizational structure with its policies and procedures for managing operations, finance, personnel, medical, and other departmental operations can best be accomplished by establishing a hospital Management Team. This team would be made up of the administrator and the deputy

directors of the hospital's key departments. This report proposes that consideration be given to having these departments be:

- Administration
- Finance
- Medical Services
- Nursing
- Support Services

Insert Exhibit 4 here

Insert Page 2 of Exhibit 4 here

Insert Page 3 of Exhibit 4 here

At the discretion of the Hospital Administrator or through a consensus decision, the Management Team could expand its membership to include the heads of other key departments such as radiology, pharmacy, or laboratory services. Additional members might be added on a rotating basis. Exhibit 5 describes the qualifications of the management team. The responsibilities of the directors of the five departments are described below.

5.4.3. Management Team Structure

Hospital Administrator

The Hospital Administrator is responsible for assuring that patients receive high quality health services. Working with the Board of Directors, this person is responsible for clarifying the mission of the hospital, for planning policy, and/or developing programs that further this mission, for overseeing the hospital's management, and for delegating appropriate authority to managers at other levels in the organization.

The principal duty of the Hospital Administrator is to oversee the overall operation of the hospital and to supervise the management team. Individual team members should possess skills to manage the diverse technical areas of the hospital and still maintain a larger view of the hospital's overall mission. They also need a willingness to support cost recovery principles and to learn new operating methods for meeting the goals of the autonomous institution.

(The person in this position is called the "Joint Executive Director" at PIMS Children Hospital and the "Medical Superintendent" at FGSH.)

Deputy Director, Administration

It is most critical that the Deputy Director, Administration be well versed in the implementation and operation of management and cost recovery principles. This person will be responsible for overseeing the development, implementation, and operation of management systems for all hospital departments in the areas of: patient records and registration/admissions, information systems (statistics and reporting requirements of various ministries), personnel, and marketing.

Deputy Director, Finance

The Deputy Director, Finance will oversee all of the autonomous hospital's financial operations, including general and

grant accounting, budget and reimbursement, patient accounts, and financial reporting. This person will be responsible for developing utilization and growth measures that will allow services-area managers to evaluate the financial efficiency and effectiveness of their departments as well as to plan for the future. These measures will be based on historical patient services utilization information as well as on the projected growth of clinical services.

Providing financial management and direction for the hospital will ensure that the board and the Hospital Administrator can obtain the management expertise they need to operate within the financial constraints of the institution. Financial stability will ensure the needed resources are available to maintain quality patient care and to support the expansion of medical services.

Deputy Director, Nursing

The Deputy Director, Nursing will be responsible for the operation of the nursing department and for assuring that all patients receive high-quality, courteous, considerate care given by skillful, understanding personnel. This person will oversee the quality of nursing care, control supplies, and schedule nurses. Senior general nurses who report to this deputy will act as the Head Nurses for each nursing service.

Deputy Director, Medical Services

The Deputy Director, Medical Services will be responsible for overseeing the operation of all Medical Departments and for managing the development of short- and long-term plans for patient service. This person will chair regular meetings of Heads of Medical Services Departments and staff physicians to discuss operations and problems, maintain continuous communication to lead staff to perform their tasks in a satisfactory manner, and establish formal guidelines to assure quality services.

The Heads of Medical Departments will report to the Deputy Director, Medical Services. The physicians who manage the various Medical Departments will need both leadership and managerial skills. They will be responsible for developing programs for their departments, for overseeing the management of these departments, and for understanding their financial operations.

Deputy Director, Support Services

Support Services include those services that are largely "invisible" to the patients, but which are essential to the medical care of the hospital. The areas of responsibility for the Deputy

Director, Support Services are:

> *Technical Services* – Diagnostic services such as Radiology, Laboratory, and Pharmacy. Obviously, these services must be of highest quality for good care to be provided within a hospital.

> *Hotel Services* – The operations that ensure the physical functioning of the hospital: the housing and feeding of patients, the repair and maintenance of buildings and equipment, laundry and linen services, and cleaning of all areas of the hospital.

Under autonomy, hotel services will be particularly important. A basic belief of the self-sufficient health system process is that patients will be willing to pay for good-quality health services. Although the cleanliness and state of repair of hospital buildings and patient rooms are vital to a hospital for health reasons, they gain importance under autonomy because of their impact on patients' perceptions of quality. The same is true of hospital meals. Again, although good nutrition is a critical element in the healing process, patients who are now paying for their meals will demand good taste and presentation as well as nutritional quality.

EXHIBIT 5
KEY MANAGEMENT PERSONNEL

TITLE	QUALIFICATIONS
HOSPITAL ADMINISTRATOR	▲ Qualified as an administrative manager and experienced in managing a hospital in the FMOH system (may or may not be a physician). ▲ Must have a firm commitment to the principals of hospital management and be able to assure that management and quality care principles are followed by the hospital's staff. ▲ Must be able to delegate responsibility and authority to other members of the Management Team.
DEPUTY, ADMINISTRATION	▲ Qualified as an administrative manager of a medium-size hospital. ▲ Must have a working knowledge of Pakistan MOH Administrative System, be able to learn, adapt, and implement the new management, finance, personnel, marketing, information, and medical records systems that will be introduced under the autonomy program. ▲ Must be skilled in managing, motivating, and guiding staff and be able to delegate authority and responsibility to department managers.
DEPUTY, FINANCE	▲ Qualified as a financial manager. ▲ Must have accounting and budgeting skills. ▲ Must have experience in the development, implementation, and operations of a transactional-based accounting system, financial reporting system, and budgetary system, and must provide financial management and direction to the Hospital Administrator.
DEPUTY, NURSING	▲ Degree Nurse experienced in the operation of a nursing department of a medium-size hospital. ▲ Must have administrative and management skills, understand organization structures, and be familiar with advanced nursing techniques. ▲ Must be able to develop and operate a quality- and patient-satisfaction-oriented nursing service, able to manage the Nursing department, and teach other supervisor nurses in management techniques.
DEPUTY, MEDICAL SERVICES	▲ Physician skilled in the management of medical departments. ▲ Must have administrative and management skills to ensure that quality medical care will be provided. Must have experience in the development, implementation, and operation of quality assurance programs; must be skilled in managing physicians and able to assure equitable treatment of all medical services despite internal political pressures.
DEPUTY, SUPPORT SERVICES	▲ Qualified administrator or physician skilled in the administration of diverse hospital services. ▲ Must have administrative and management experience in the development, implementation, and management of hospital diagnostic and hotel services. ▲ Responsible for the operation and quality aspects of diagnostic and hotel services. ▲ Excellent organizational and personnel management skills to assure the quality and smooth functioning of the various hospital departments.

(Adapted from Hildebrand, Lee, & Becker, 1992)

5.4.4. Using a Management Team

The Hospital Administrators of PIMS and FGSH will need to develop a Management Team structure. This team will be responsible for overseeing the tasks delegated by the Hospital Administrator and will also be valuable contributors to decision-making about the management of the hospital as a holistic institution with integrated parts.

This team's success depends on good communication among members and a practical synergy of talents which can be used to move the organization ahead in productive ways. The Management Team should meet regularly and should focus both on planning for and on maintaining the overall direction of the hospital. Working together, they should also address and resolve issues which most directly affect the departmental managers.

The exact composition of the Management Team may vary for each hospital, depending on the strengths of the key staff, but it should generally consist of the Hospital Administrator and Deputy Directors plus any of the managers of the stronger technical departments such as laboratory, radiology, pharmacy, operating theater, or engineering. The group should be selective, based on the particular situation at the hospital. A rotation system is an approach to department-head involvement, allowing one or two department managers to join the management team for three months or so, and then rotating others into team meetings for subsequent three-month periods. Again, the composition is not the key element, the important one is the team approach to planning, decision making, and the completion of tasks.

The Management Team must understand that the staff of their hospital will need clear guidance as the facility moves towards autonomy. To do this, job descriptions and task assignments must be developed that are clear, accurate, consistent, and of high quality.

The role of the Management Team is to review and streamline the hospital's processes. Departments would be arranged to provide patient services or services to other departments based on a cooperative process. The team members would also be advocates of the concept of working for the patient and this would then be reflected in the satisfaction of the hospital's customers with the services they receive.

The Management Team would have the following responsibilities:

- Review present positions and job descriptions with the understanding that this process may lead to the integration and compression of several jobs into one.

- Create new job descriptions with the understanding that most jobs in an autonomous hospital will carry more authority and responsibility than before, very possibly including certain tasks that managers previously performed.

- Review work processes and determine their optimal sequence. Reviewing and daring to change the sequence can speed the process in two ways: First, many jobs can get done simultaneously; second, the amount of time that elapses between each step in the process may be reduced as well as the number of steps in the process itself (Hildebrand, 1992).

- Develop optional functions for processing patients through the hospital. Determine the controls that are necessary to ensure appropriate and efficient treatment. The team will need to find a way to check that appropriate processes are being followed without encumbering the system with excessive authorizations and controls. While the objectives of a system of control may be laudable, the costs associated with strict controls can be exorbitant. An approach that examines aggregate patterns instead of individual instances tolerates modest and limited abuse, and provides adequate checks to accomplish control, reduce abuse, and dramatically lower the costs and encumbrances associated with the control itself.

The Hospital Administrator must acknowledge and promote the key management positions of the hospital and job descriptions must specify both the authority and the responsibility of the employees and identify the key tasks of the departments. The Hospital Administrator must delegate authority so that the Management Team can carry out their responsibilities.

Appendix B provides descriptions of other middle-level management positions below that of the Management Team such as personnel, medical records, information systems, and marketing.

5.5. Personnel

The personnel function within autonomous hospitals will be placed under the Deputy Director, Administration. A personnel system that specifically supports the needs of an autonomous hospital will have to be established.

The management of personnel at Ministry of Health hospitals has always been handled entirely at the MOH. Autonomy would be accompanied by a transfer of certain responsibility and authority to individual hospitals. These include handling performance

review, manpower planning, budgeting for staff, job descriptions, pay and incentives, benefits planning, and employee hiring and firing. Each facility will need to create and support a Human Resources/Personnel Department. This department will be responsible for developing and implementing these activities and other programs and for protecting the rights of all employees of the organization. (Appendix A.4 provides guidelines for the development of a personnel system to employ, retain, and evaluate all levels of salaried staff.)

5.5.1. Key Personnel Issues

The study team recommends that PIMS and FGSH be given considerable autonomy in the management of medical personnel and other hospital staff than currently exists within the FMOH system. The current system presents significant problems, including a lack of local control over the quantity and quality of staff members, an inability to ensure that trained employees will not be transferred by the FMOH, and no way of rewarding employees for good performance (or disciplining them for poor performance).

The following personnel issues must be considered as hospitals move towards autonomy and could result in a memorandum of understanding, a governmental decree, or legislation establishing guidelines in these areas.

Control Over the Selection and Retention of Personnel

In order to improve the quality of medical care, autonomous hospitals may have to retrain many employees and hire new employees to fill un-met personnel needs. This is true for physician, technical, and support staff. However, improvements in quality cannot be maintained if employees are routinely reassigned to other facilities, as is the current practice. Quality improvements are critical, and retaining quality employees is critical to achieving and sustaining these changes.

Control Over Discipline and Firing

In the current system, there is no useable mechanism for "encouraging" an employee to do the job well. Disciplinary measures are rigid and ineffective: employees can perform at totally unacceptable levels (fairly routine absenteeism, for example) and still be within acceptable limits of the current government system. The present system also makes it difficult to fire an employee; even when firing occurs, the government can overrule a Hospital Administrator's decision. In order to maintain quality personnel, the facility must gain control over these activities.

Authority to Evaluate and Reward Performance

Management needs to have a system which relates performance to specific job duties and expectations and which allows rewards for above-average performance. Incentive pay and bonuses can provide substantive reasons for employees to do what is expected in a quality manner or to reach beyond a "normal" level of performance. A performance-based evaluation program can greatly increase the output of a facility's employees, as long as it is fair and provides incentives valuable enough to be interesting to these employees.

In regard to Hospital Administrators, there are provisions in the current FMOH system for bonuses, but there is little relationship between these bonuses and actual performance. The Board of Directors of PIMS and FGSH must directly manage the incentive pay of the Hospital Administrator and tie it to successful performance of the tasks and duties identified in the job description.

Clarity of Job Responsibilities

Many current employees don't know exactly what is expected of them. Historically, communication regarding expectations has been incomplete and job performance may not have been tied to specific tasks or duties. Job descriptions which are clear, concise, and communicated to employees will allow for better employee performance. They will also provide a mechanism for evaluating employees.

Establishment of Higher Pay Levels

Employee morale at MOH hospitals is generally quite poor; much of this can be attributed to low pay. Salary will continue to be a morale and equity issue until pay levels can be improved. Without a financial incentive to come to work and to perform, doctors and staff may not have a commitment to make meaningful contributions to the conversion to autonomy.

Control of Staffing

There is a significant shortage of trained, experienced nursing and technical personnel. Because of the ability of the private hospitals to pay better salaries, this shortage is particularly dramatic within FMOH facilities. A key goal within autonomous hospitals will be to establish staffing levels that assure appropriate patient care and high-quality service. Streamlining personnel operations may result in an actual reduction

of the number of personnel on the payroll. This reduction in staff could result in savings that, in turn, might be applied to other expenses, including increases in salaries and/or an incentive program which relates pay to performance. Clearly, this will require the full and generous cooperation of the FMOH, as they must provide any "released" personnel with other positions.

Nursing and technical staff may be somewhat difficult to find and, in some instances, will be expensive in comparison to the "average" employee. In these circumstances, the facility will need to retrain or upgrade current employees.

Management Training for Middle- and Upper-Level Staff

Management skills are weak at all levels of the hospitals. Little effort has been made to develop top managers besides the Hospital Administrators. Management training for department managers and chief technicians will be important so that they can take on more responsibility and be more active in carrying out the various managerial and financial tasks of the hospital.

5.6. Recommendations in the Area of Management

The team carrying out this study found that, for an autonomous hospital to achieve its desired ends, a new, more decentralized management approach will have to be used, a revised organizational structure put in place, and improved management practices adopted.

Furthermore, autonomous hospitals will have to sell their services to potential paying patients. Thus, hospital management will need to develop the capacity to market services to insurers, employers, and individual patients.

Also, as user fees become increasingly important to the operation of an autonomous hospital, the relationship between it and other medical institutions from which it receives and to which it sends patients on referral will become more critical. It must, therefore, negotiate referral relations with other institutions, including pricing policies.

To achieve the objectives of the FMOH, the current management of government hospitals will need to:

- Work with the Board of Directors to develop and define clearly and simply the mission of each autonomous hospital.

- Adopt a management structure that both reflects the unique needs of that individual institution and espouses a multi-layered management system. In this system, the Hospital Administrator delegates authority and

responsibility to Deputy Directors responsible for various program areas. The basic organizational structure would be:

- △ A Board of Directors which hires and oversees the Hospital Administrator.

- △ A Management Team, hired and overseen by the Hospital Administrator, made up of Deputy Directors for Administration, Finance, Nursing, Medical Services, and Support Services.

- △ A middle-management structure overseen by the Deputy Directors.

- ▲ Develop a new personnel system and staffing structure that will define and support the needs of the autonomous hospital.

- ▲ Train upper- and middle-management personnel both in management techniques and in the technical skills needed to operate an institution which provides high-quality health services. Also provide training in personnel management, financial systems, and marketing.

- ▲ Sell the services of autonomous hospitals to potential paying patients including insurers, employers, and individuals.

6.0. FINANCE

Government of Pakistan expenditures in the field of health were 0.73 percent of GNP in 1991/92, having declined from a peak of 1.08 percent in 1987/88. This is low compared to other countries in the region and to countries at a similar level of economic development where public expenditure for health has been about 3.5 percent of GNP. By contrast, the Government of Pakistan's expenditure on education as a percentage of GNP has been rising and stood at 3.55 percent in 1989/90 (World Bank Report No. 10391, 1992).

Government expenditure for health (development and recurrent expenditure only) for 1991/92 was 8.9 billion rupees which represents only 2.4 percent of total government expenditure (World Bank Report No. 11127, 1992). A report prepared for the GOP's Ministry of Planning and Development in April 1988 showed the public sector as having 26,000 government physicians, most of whom also had their own private practices, and 733 government-financed federal, provincial, and special hospitals such as those run for certain categories of civil servants such as the police.

A large private sector accounted for nearly 60 percent of the 22.4 billion rupees paid out for health services in Pakistan in 1991/92. There were 12,000 private practitioners and over 500 private hospitals (including maternity and nursing homes) at that time, most of which were in urban areas and had fewer than 50 beds. The unregulated pharmaceutical manufacturing and dispensing industry is large. It was estimated in 1985 that 2.2 percent of disposable household income was spent on pharmaceuticals. One reason given for this high level of expenditure for care from the private sector is the perception that the quality of care and the availability of physicians for treatment in private facilities is much higher than in public hospitals. "In terms of use of health facilities, visits to private practitioners are far more frequent than attendance at public health facilities, especially in urban areas" (World Bank Report No. 7522, 1988, p.18).

These figures indicate that there already are significant out-of-pocket payments for health services. The total per capita health expenditure for 1991/92 was approximately 191 rupees, 115 of these rupees were the per capita private expenditure. This level of private expenditure for health indicates that the payment of fees for medical care is a commonly accepted practice in Pakistan. These figures suggest that there is room for the government to experiment in giving greater financial autonomy to hospitals, including increasing the level of cost recovery through user charges, insurance, and employer-contracted health plans for employees. A United Nations' report indicated that "There is evidence in the Household Survey of a willingness to pay more for Government services if there were improvements in the quality of

services" (Tibouti, 1991, p.15). The wide variations in income levels of those needing services, however, requires that any cost recovery efforts must be undertaken with caution so that financial barriers are not created for access to hospital services for the poor.

6.1. Financial Authority

If PIMS, FGSH, and other institutions are to succeed as autonomous hospitals, they must cease to be almost totally dependent on government subsidies. In fact, even if hospitals are to remain as directly administrated government facilities, cost recovery will be necessary. The Pakistan Federal Ministry of Health issued a statement in January 1991 indicating, "Completely free health services are almost impossible to finance by government. It is therefore proposed that user fees be levied in order to recover some of the cost of operating the hospital. Simultaneously, the performance of public health sector facilities will be improved" (p.60). Exhibit 6 describes the range of possible financing structures for autonomous operations.

Guidelines will have to be established to determine equitable and realistic user charges. Regardless of how money is generated, it is critical that the administrator of an autonomous hospital have the authority and flexibility to use the income from user fees to defray operating expenses and notably to promote superior staff performance through rewards and incentives. Beyond this, the Hospital Administrator needs funds to cover unexpected day-to-day emergencies such as the breakdown of important equipment, the unanticipated replacement of essential supplies and temporary replacements for staff.

One of the key responsibilities the Board of Directors of an autonomous hospital should grant to the Hospital Administrator is that of financial management of the institution. Financial management is the life blood of an organization. Without proper financial controls and monitoring, a hospital can lose its assets and its patients, it can develop credit problems and get "cut off" by suppliers and equipment vendors, and it can suffer major payment difficulties. The board and Hospital Administrator are jointly responsible for the financial status of the organization. Clearly, one of the most significant acts of the Hospital Administrator is to obtain the services of a qualified financial manager.

EXHIBIT 6
FINANCING RANGE OF HOSPITAL AUTONOMY OPTIONS
from
FULLY PUBLIC TO FULLY PRIVATE

FULLY PUBLIC <)))))))))))))))))))))))))))))))> FULLY PRIVATE						
RECURRENT/ OPERATING COSTS	Fully subsidized by government -- direct or indirect (100% of operating costs paid from government budget or through payment for services)	Government subsidy of less than 100% of costs	Government revolving funds for operations	User charges of less than full costs with remainder paid from government subsidy combined with health insurance	User charges of full costs with small subsidy from government for things such as teaching or research	User charges of cost plus pricing combined with health insurance
CAPITAL COSTS	Fully purchased by government	Government subsidy for more than 50% but less than 100% of purchase costs (through supplying money, providing import licenses, providing incentives or use of hard currency, or lending money)	Government subsidy for less than 50% of purchase costs	Lending of government buildings and equipment to quasi-government body to operate	Leasing of government buildings and equipment to quasi-public or private corporation or entity	Selling of government buildings and equipment to private corporation or entity

6.2. Financial Functions

The administrator of an autonomous hospital will have more responsibility for finances than the current directors of government hospitals do since overall hospital budgets should increase and more money should flow through the organization. The control of funds will become increasingly complex whether in the cashiering function at discharge, in the outpatient areas, in handling payments for significantly larger pharmacy and medical supply inventories, or in other areas.

Also, more control over the payment system for personnel should lead to the creation of a new, more equitable, incentive program related to employee pay. Having this responsibility, however, will also increase accounting requirements. New or expanded facility departments such as maintenance, engineering, food and catering services, and social services may also require additional procedures, financial attention, and clear lines of managerial authority.

The board and the Hospital Administrator will need to work together to clarify the responsibilities of new or expanded departments and to find appropriate managers for the supervision of service and support units. These clarifications will take time and energy; the traditional way will not be sufficient to move the organization forward with a workable management structure or a financial control system which is responsive and adequate to the new organization.

The hospital has two major financial functions: (1) to identify the sources and amounts of money the hospital receives in revenue; (2) to analyze how the hospital structures its financial operations, handles its cash flow, and works with its capital budget.

The Deputy Director, Finance serves as the overseer of the financial tasks, including the accounting discipline, the accounts receivable function, accounts payable, cash management, inventory management, capital assets management, budgeting, and internal controls. (Appendix A.5 provides guidelines for creating this post.) The importance of this role and function cannot be understated. The Hospital Administrator must have a person in this position who is knowledgeable about finance and dedicated strictly to the financial matters of the organization. It is not a part-time job, and it is not a part of the Hospital Administrator's job description. (Appendix A.6 provides guidelines for the development of financial planning, budgeting, and user-fees accounting controls. Appendix A.7 addresses the establishment of procurement procedures.)

Accounting records describe the financial status of the hospital. Through establishing and maintaining these records from

which the hospital's financial statement can be prepared, the hospital can determine how financially sound it is. The hospital accountant is the principal person assigned the responsibility for the hospital accounting system. The accountant must be familiar with current accounting procedures and statistical financial analyses used in the hospital field.

6.3. Self-Financing Possibilities

It is clear that the majority of Pakistan's population has limited financial resources. The critical factor which determines whether people will spend their resources on health care may depend on their perception of the quality of medical care, its management, and the nature and availability of patient services. Satisfied patients talk to relatives and friends; over time, these conversations create a perception of the facility in the community and develop its "reputation." Having a reputation for quality, service, and commitment will be critical to any long-term success for an autonomous hospital.

There are a number of examples in Pakistan where self-financing of hospitals is working: private-sector hospitals, the Aga Khan Hospital, the Shalamar Businessmen Trust Hospital, health facilities of Islamic charitable organizations, and others. These institutions have developed user fees for utilization of patient beds as well as for patient procedures and services.

At present in Pakistan, there are virtually no indemnity health insurance plans in the pure sense; almost all are services reimbursed on charges or on a negotiated fee schedule. The insurance industry emphasizes property and casualty programs. There are almost no Health Maintenance Organizations or Preferred Provider Organizations (PPOs) like those in the United States, yet private sector hospitals have many of the attributes of a prepaid health plan: periodic prepayment, comprehensive medical care, and incentives to physicians. Health insurance and other financing arrangements for medical care (e.g., direct contracting) vary among companies according to their resources, the type of work force they have, and their history with health insurance programs.

In the long run, the development of a system of largely self-financing hospitals will require a more predictable insurance system funded through per-capita monthly premiums. The conversion to self-financing is a process that will require expanded contracts with insurance companies, individuals, and business. These contracts should lead to arrangements for third-party payment of fees-for-service, to comprehensive per diem arrangements, and to contracts for capitation of services. Each alternative accepts increasing risk and requires more sophisticated management tools, but yields greater stability of revenues for the hospital and greater continuity of care for the patients/enrollers.

Volume V of this compendium discusses the potential for the development of private health insurance programs in Pakistan based on managed care principles.

The number of private businesses in the country is growing; the majority of these companies currently have no arrangements to take care of the health care needs of their employees. Business health service contracts are a large potential market, one that is particularly valuable to hospitals because of the relative predictability of monthly cash payments that would be made. The leadership of PIMS and FGSH will have to develop products and service packages that respond to the needs of these businesses and to present these packages in a way that is attractive to local entrepreneurs and agencies. (Appendix A.8 provides guidelines for the development of service contracts to individuals, businesses, and organizations that include arrangements for third-party payments.) Developing consumer-oriented coverage packages will necessitate the hiring of a marketing staff who will become acquainted with decision makers in companies and unions. Model contracts, strategies for marketing, and analysis of fees and benefits will be important components of a marketing and contracting effort. A hospital's medical staff and specialists also may need to lend their prestige to this outreach program.

Patient satisfaction will be extremely important if the hospital is to sell its services and, thereby, to increase its revenue. Therefore, all complaints from patients must be promptly investigated. The spirit of solidarity should be established among all staff with emphasis on the fact that the success of the hospital and, therefore, of every professional on the staff depends on a team effort. Suggestions for improvements in services and in perceptions of services should be actively solicited and considered.

6.4. Unit Costs

Information on patient utilization and facility expenses were obtained from two PIMS hospitals (Islamabad and Children's) and from FGSH (see Exhibit 7) in order to estimate the actual cost of treatment of patients per day during the 1992 calendar year.

Approximately 30 percent of all admissions during the period for which data was available were paying patients. Forty percent were government employees for whom no fees were collected. Ten percent were patients with Zakat (religious fund) certificates whose costs were paid by Zakat. Twenty percent were considered by the hospital as being too poor to pay. Only approximately 7 percent of operating expenses were recovered from patient fees.

Expenditure information was available for recurrent costs only. The combined recurrent cost for the two PIMS hospitals for 1992 was 175 million rupees. The capital costs of buildings and major equipment were not available. Since the capital investment had already been made in these facilities, there is a need to know the capital replacement costs over the life of the capital investment (i.e., the annualized value of capital). Assuming that buildings have a 20-year useful life, major equipment has ten years, and minor equipment five, it has been found in some developing countries that, using a straight-line depreciation method, annual capital replacement costs are 30 percent of recurrent costs. Based on this, the combined total operating costs and workload of both PIMS hospitals was determined. Assuming annual capital costs represent 30 percent of operating costs, 1992 capital costs were 53 million rupees for a total of 228 million rupees for recurrent and capital costs.

Cost estimates portrayed in Exhibit 7 (see Appendix C for method of calculation) are consistent with user fees charged at the better urban private hospitals in Pakistan and by private physicians for their consultations. They are also within the range of current hospital charge levels by PIMS: private wards: 600 rupees per day; special room: 400 rupees per day: and general ward: 100 rupees per day. Current outpatient consultations fees at PIMS are much lower than in the private sector, at 3 rupees per visit.

EXHIBIT 7
Expenditure, Workload, and Unit Costs for PIMS and FGSH

	PIMS TOTAL (1992)	Islamabad Hospital (1992)	Children's Hospital (1992)	FGSH Hospital (1991)
EXPENDITURE				
				(ESTIMATED)
Personnel	91.642*	67.586	24.056	N.A.
Minor equipment	0.932	0.902	0.030	N.A.
Maintenance	8.190	8.064	0.126	N.A.
Food Service	3.982	3.230	0.752	N.A.
Pharmaceuticals	27.928	23.054	4.874	N.A.
Supplies	1.132	0.830	0.302	N.A.
Utilities	19.104	19.104	0.000	N.A.
Miscellaneous	22.532	16.652	5.880	N.A.
TOTAL RECURRENT	175.4	139.4	36.0	86.6
ESTIMATED CAPITAL COSTS	52.6	41.8	10.8	26.3
TOTAL COSTS	**228.0**	**181.2**	**46.8**	112.9
WORKLOAD				
Inpatient (IP) Admissions	24,105	15,098	9,007	
Outpatient (OP) Visits	381,690	300,901	80,789	
Total beds available	753	540	213	
Days in a year	365	365	365	
Total bed days possible	274,845	197,100	77,745	
Total bed days	214,029	150,980	63,049	
Occupancy	77.9%	76.6%	81.1%	63.0%
ALOS (Average Length of Stay)	8.9	10.0	7.0	
Total Workload	309,452	226,205	83,246	
IP Days	214,029	150,980	63,049	
OP Equivalent days	95,423	75,225	20,197	
ESTIMATED UNIT COSTS				
TOTALS				
Unit Costs per IP Day	737	801	562	505
Recurrent IP Unit Costs	567	616	432	388
Capital IP Unit Costs	170	185	130	117
Unit Costs per OP Visit	184	200	141	126
Recurrent OP Unit Costs	142	154	108	97
Capital OP Unit Costs	42	46	33	29

(*Rupees = 25 to $1.00 U.S. in 1992)

See Appendix C for Method of Calculation.

Specific, detailed financial and workload information for 1992 was not available for FGSH at the time of this review. The bed occupancy rate at FGSH, approximately 63 percent as of 1991, was lower than at PIMS, although FGSH's daily outpatient load was close to 50 percent greater than that of PIMS. Aggregate expenditure estimates indicated that FGSH's recurrent costs were nearly 37 percent less than PIMS' (World Bank Mission, 1992). FGSH user fee collections represented less than 1 percent of total expenditures. For private wards, the charges were 22 rupees per day. However, fewer than 1 percent of the patients pay any fees at all.

Unit costs were estimated based on global cost data from FGSH and inpatient-outpatient service and cost ratios from PIMS' Islamabad Hospital. The Islamabad Hospital costs will be used as the basis for the estimates because these costs were higher and it will prevent underestimation. This estimate was also considered more accurate since the total costs of FGSH were nearly one third less than PIMS' total expenditures. In addition, the Islamabad Hospital encompasses a full-service acute care hospital which more closely matches the mission of FGSH.

Based on these figures, it is estimated that costs for an inpatient day at FGSH are: 505 rupees (388 rupees for recurrent costs and 117 for capital costs) and 126 rupees for outpatient visits (97 rupees for recurrent and 29 rupees for capital costs). This is considered a reasonable figure since the FGSH administration, with sparse expenditure data, estimated that the expenditures per patient day were 458 rupees. The outpatient visit costs may be overestimated in that FGSH has a much higher outpatient volume and may have lower unit costs due to economies of scale.

From these calculations, it is estimated that the range of full costs at large government hospitals in an urban area stretches from 505 to 801 rupees per inpatient day and from 126 to 200 rupees for outpatient consultations. These estimates include capital and recurrent costs.

6.5. Cost Recovery

Actual user fees which patients are charged for services at PIMS and FGSH are substantially lower than the above-estimated unit costs. The private sector charges high user fees for private hospitals; private physician consultations (which are considered to be of a higher standard) are within this range. Thus, for some segment of the population, full-cost charges might be acceptable if the quality of care were considered equal at government hospitals. However, as charges at most government hospitals are currently substantially lower or nonexistent, institution of high charges for all patients would be unacceptable.

So, what would a reasonable charge for services be and how high and how fast should these charges rise? In designing a cost-recovery scheme to further hospital financial autonomy at PIMS and FGSH, several factors must be kept in mind.

6.5.1. Assuring Quality of Services for Sustainable Cost Recovery

For fee levels to increase until there is full recovery of costs, services will have to be improved to the point that patients value what they are getting for their money. Autonomous hospitals must make sure that some of the funds generated through fees are devoted to improving the quality of care offered. The biggest challenge will occur later when provincial hospitals (which may not have as high a standard of care as urban hospitals) begin to move towards financial autonomy. They will have to make a concerted effort to improve the quality of their services prior to introducing or increasing patient fees.

The government also must closely examine the appropriate regulatory actions needed to establish standards of performance, to monitor these standards, and to enforce compliance in both public and private health facilities. This may lead to regulation not only of public and private hospitals, but also of pharmaceutical services and of medical care provided by private practitioners.

The volume of this compendium (See Volume II — Assuring Quality Health Services Through Hospital Standards and Accreditation) will help PIMS and FGSH during the transition from being FMOH institutions to being autonomous hospitals with quasi-private status. In order to upgrade the quality of their services and programs, PIMS and FGSH will need to set standards for operating and managing their finances. These standards should ensure a quality environment and should clarify for patients the nature and level of services they can expect.

6.5.2. Objectives and Principles of Cost Recovery Policies

First, cost recovery by itself is not the ultimate objective. If it were, hospitals would charge full costs and not be concerned about whether or not that prevents patients from receiving needed care. Rather, cost recovery must take into account people's ability to pay while also ensuring that access and equity concerns are not ignored.

Second, increased levels of cost recovery will come from two sources:

- *User Fees* – Increasing charges so that they more closely reflect the actual costs of delivering services.

- *Quantity of Patients* – Increasing the number of patients who pay user fees since many who can afford to pay and are willing to do so either are in the private system or are not currently being charged for the public services they receive.

Several principles should guide the autonomous hospital's introduction of cost recovery:

- *Ascertain capacity to pay* – The system must design a way to find out which patients are not able to pay. Several hospital administrators have mentioned using patient welfare committees to do this. This study was not able to determine the effectiveness of such committees in the few places where they exist. PIMS, FGSH, and other hospitals need to be aware of the administrative burden the establishment of a welfare committee places on the hospital. Unless the personnel assigned the task of assessing a patient's ability to pay have incentives, they may quickly revert to the old ways of granting near-blanket exemptions for all patients receiving care. One means of addressing this issue would be to insist that all patients, even the poor, pay some nominal amount for their care. Since even the poor are making out-of-pocket payments for care and drugs from the private sector, perhaps a minimum of 25 rupees per day should be collected from all patients.

  Shalamar Hospital and the Aga Khan Hospital have found ways to obtain revenues from those who are able to pay and they have sliding fee scales for others according to the hospital's assessment of their ability to pay. Mechanisms such as these will have to be designed and implemented if cost recovery is to succeed.

- *Improve patients' perception of the quality and value of services provided* – Since most patients using the public sector are not now paying for services, cost-recovery schemes should segment the market by charging higher fees for private wards than for public-ward patients. Patients' perception of quality must also be considered in determining how high charges can be. Thus, fees at PIMS might be higher than at FGSH due to quality-of-care issues as well as to the greater ability of PIMS' clientele to pay.

- *Use a gradual approach* – Hospitals must undertake cost recovery according to a gradual schedule such as the one shown in Exhibit 8. Within this gradual approach, a positive pace must be maintained or the momentum will not be kept to bring about fundamental changes in the Pakistani health system. In light of the current amount

of private expenditure, the plan that appears below may appear shocking, but should not be considered totally unrealistic.

6.5.3. Gradual Cost Recovery Approach

EXHIBIT 8
AN EXAMPLE OF A PHASED-COST RECOVERY SCHEDULE

Year 1	90% Government subsidy for recurrent costs – remainder of operating costs recovered thorough user fees Government fully funds capital expenses (through Year 6)
Year 2	90% subsidy – 10% recovery of recurrent costs
Year 3	80% subsidy – 20% recovery of recurrent costs
Year 4	70% subsidy – 30% recovery of recurrent costs
Year 5	60% subsidy – 40% recovery of recurrent costs
Year 6	50% subsidy – 50% recovery of recurrent costs
Year 7	50% subsidy – 50% recovery of recurrent costs <u>and</u> capital costs (capital costs folded into cost recovery, cutting capital cost subsidy to 50%)
Year 8	No change: 50% subsidy – 50% recovery of recurrent and capital costs
Year 9	40% subsidy – 60% recovery of recurrent and capital costs
Year 10	30% subsidy – 70% recovery of recurrent and capital costs

The basic principles underlying this phased-cost recovery approach are:

- The government's subsidy for hospital care should decline. Money freed from providing hospital services could then be used for other areas of need such as preventive care.
- Initially, cost recovery should be for a proportion of only recurrent costs.
- After five-to-six years, capital costs should be folded into user fees.
- The government subsidies which remain should be used to pay for the care of the indigent and to subsidize those patients who can pay some amount toward their care, even if not the full charges.

- Each hospital's plan should establish overall revenue goals as a percentage of costs, but should give the hospitals flexibility in figuring out ways to achieve their goals. For example, since total revenues are determined by quantity (number of paying patients) multiplied by the price (the established user fees), a hospital should periodically review and adjust the mix of user fees it sets with the number of patients who pay all, some, and none of the costs related to their care.

- The leadership of autonomous hospitals should be "at risk" in the sense that if they fail to meet revenue targets, they will have to find ways to handle the cash-flow problem. No supplemental government allocations should bail out hospitals with financial difficulties. If management is monitoring the fiscal situation throughout the year, it should not be "surprised" by large deficits at the end of the year.

The implications of this cost-recovery schedule in terms of fees for PIMS and FGSH are shown in Exhibit 9. These estimates assume that patient volume will remain constant and that there will be no improvements in operating efficiencies (improvements would reduce user fees since they are based on actual costs). In addition, these estimates do not account for any cost increases due to quality improvements, although these are necessary to continue to attract patients to the public hospitals and away from private facilities. The projections in Exhibit 9 are in constant rupees and are used simply for illustrative purposes.

6.5.4. Some Considerations for Establishing User Fees

Several cautions must be noted in examining the fee-schedule chart in Exhibit 9. First it is only one example of how to phase in cost-recovery levels. The fee schedules are illustrative, rather than definitive. Hospitals could determine other means of dividing the source of revenues. These examples are meant to help decision makers "count the costs" rather than talk of cost recovery in abstract terms. They also try to show the implications of seeking a high degree of financial autonomy for hospitals.

EXHIBIT 9
EXAMPLES OF FEES UNDER PHASED-COST RECOVERY

		PIMS		FGSH	
		Inpatient Fees	Outpatient Fees	Inpatient Fees	Outpatient Fees
Year 1	10% Recurrent Cost Recovery	Rs 57*	Rs 14	Rs 39	Rs 10
Year 2	10% Recurrent Cost Recovery	Rs 57	Rs 14	Rs 39	Rs 10
Year 3	20% Recurrent Cost Recovery	Rs 113	Rs 29	Rs 78	Rs 20
Year 4	30% Recurrent Cost Recovery	Rs 170	Rs 43	Rs 116	Rs 29
Year 5	40% Recurrent Cost Recovery	Rs 227	Rs 57	Rs 155	Rs 39
Year 6	50% Recurrent Cost Recovery	Rs 284	Rs 71	Rs 194	Rs 49
Year 7	50% Recurrent & Capital Cost Recovery	Rs 369	Rs 92	Rs 253	Rs 63
Year 8	50% Recurrent & Capital Cost Recovery	Rs 369	Rs 92	Rs 253	Rs 63
Year 9	60% Recurrent & Capital Cost Recovery	Rs 442	Rs 110	Rs 303	Rs 76
Year 10	70% Recurrent & Capital Cost Recovery	Rs 516	Rs 129	Rs 354	Rs 88

*($1.00 U.S. = 25 rupees in 1992)

6.5.5. Non-Medical Expenses Incurred by Patients

Hospitals should be aware of and sensitive to costs patients have to pay other than user fees. These costs, which include transportation and time, have an effect on people's willingness — and ability — to pay as well as on the choices patients make in choosing where they seek care.

A 1986 survey of households in low-income urban areas of Pakistan reported that the travel time to a government clinic was 60 percent greater than to a private doctor: 0.35 hours travel time to a government clinic compared to 0.22 hours to a private doctor (Alderman and Gertler, 1989). If these travel time costs are also true for private hospitals compared to government hospitals, the costs to patients of government care would be higher than those in private hospitals. As hospitals determine user fees, these comparative cost issues must be considered.

6.5.6. Equity and Access: Effects of User Fees on Utilization

As government subsidies to hospitals are reduced, efforts must be made to determine the effects on access to care and on distribution of services. For example, there are concerns that, due to FGSH's clientele of lower-income patients, user fees would place a greater burden on their patients than such fees would place on people who go to PIMS. Patient Welfare Committees, such as the Love Children Society at PIMS' Children's Hospital, need to be established at each facility to determine the ability of patients to pay for services. Beneficiaries of free or subsidized care must then be monitored to ensure that they are not displaced from receiving hospital care due to an inability to pay.

Further, the introduction of fees for medical services implies that consumers have the resources they need to seek substitute goods. Will increases in fees for services at government hospitals result in patients seeking care from private hospitals, private physicians, or chemists, or will they result in needy people either self-treating or not receiving care at all? These questions need to be answered.

The results of the Living Standards Measurement Study done in Pakistan by Alderman & Gertler in 1989 indicate that raising user fees at government health facilities will result in some reduced utilization of those facilities due to pricing, but that most people will shift to the private sector rather than forego care. This study shows, as expected, that the poor were more price-sensitive than the general population, but it projects that their utilization rates were not expected to drop significantly due to price increases in the public sector. (This assumes that the prices of private providers remains unchanged despite increased demand.) Thus, the private sector and public sector seem to be close substitutes for each other in meeting outpatient care needs. This study, while informative, was not conclusive because it dealt with only clinic visits for treatment of children in urban areas. It will be important for PIMS and FGSH to monitor the effects of user fees on various income groups.

6.6. Recommendations in the Area of Finance

At the present time, only 7 percent of PIMS' recurrent costs are recovered from user fees. FGSH recovers less than 1 percent of total recurrent expenditure from fees. PIMS has set the goal of moving toward 30 percent cost recovery and FGSH has stated the need to increase fees and to recover a greater portion of costs. PIMS and FGSH goals can be initial targets to move towards 30 percent recovery of recurrent costs within four years, as proposed in the phased schedule in Exhibit 9. Within seven years, the expenses of annual capital costs should begin to be folded into user charges which are based on total costs.

Activities which need to be undertaken in the area of finance are:

- *Improve hospital financial management systems so that hospitals can better determine the actual costs of providing various services.* They can control expenditures better, and they can increase efficiency using limited financial resources. (See Appendix A.6)

- *Increase fees for the paying patients and ensure that appropriate charges are billed for Zakat patients.* (See Section 8.0.)

- *Study the effects of user fees on the use of urban and rural health services.* When setting user fees, autonomous hospitals need to be aware of the effect fee rates may have on the rural health system. For example, if fees for outpatient consultations at urban hospitals are set at only marginally higher levels than fees at rural facilities, patients may by-pass the rural facilities and go to urban hospitals. In order to promote appropriate utilization and referral patterns throughout the entire health system, hospital fees must be levied for outpatient visits as well as for inpatient hospitalization services.

- *Weigh incentives to physicians.* The benefits of hospital autonomy for various professional groups will have to be examined closely. The most perplexing group is physicians. Although many staff physicians at government hospitals receive salaries, many also have private clinics and/or associate with other private hospitals where they can refer patients. A way must be found to encourage government physicians to admit patients to autonomous hospitals rather than sending them to private health facilities or to their own clinics. Earlier studies have recommended the establishment of total patient charges at hospitals, with a portion of these fees to be paid to physicians as a way of encouraging them to remain within the government system. This idea deserves to be looked into further.

- *Examine ways to improve efficiency in hospital operations.* The cost of providing the current level of services will be lower and, thus, fees will not have to be as great.

- *Study the operations of the not-for-profit institutions of the private sector* (such as Shalamar Hospital, Aga Khan Hospital, and other mission and foundation hospitals). These can provide models and lessons for the

government in how to provide quality care while charging fees that cover a substantial portion of recurrent costs.

- *Increase usage of the expertise of the private sector.* Private- sector businesses can be a source of and a training ground for hospital managers. Businesses can provide experts to advise hospitals through informal arrangements or by serving on their boards. Business leaders could provide guidance on topics such as financial management and costing, marketing, dealing with governing boards, competing with the private sector, labor relations, and human resource development.

- *Hold the leadership of autonomous hospitals responsible for achieving efficiency goals and for improving the quality of services.* This could be encouraged by giving the board the power to grant bonuses, to make adjustments in pay to reward high performance, and to hire and fire management personnel in relation to their achievement of the hospital's objectives.

- *Have management prepare and present annual financial plans for the board's approval*, including both operating and capital spending plans which identify expected revenues from all sources. Performance in meeting these plans would be another criterion used by the board to evaluate management's performance.

These activities, plus ones undertaken in the areas of quality assurance, governance, and management would be first steps in a long-term plan to move all federal and some provincial government hospitals toward autonomy. This would result in a "cascading" effect for hospital autonomy. As experience is gained, the lessons that are learned can be used to better plan the autonomy of additional hospitals as well as to improve the practices of those already having some degree of autonomy. Funds released from each successive group of hospitals that become financially autonomous may be used to: (1) improve quality at other government hospitals so that the introduction of or the increase in user fees in those hospitals at a later date becomes more palatable to the public, and (2) increase government resources devoted to preventive and primary health services, especially in rural areas.

7.0. LEGAL AND REGULATORY ISSUES

In addition to the issues which fall into the categories of governance, management, and finance, there are legal matters that must be addressed if the Government of Pakistan gives autonomy to Federal Ministry of Health hospitals. The purpose of this section of the report is to identify and begin to address some of these issues.

7.1. Legal Issues

7.1.1. National Legislation Needed to Enact Hospital Autonomy and Other Reform Initiatives

An analysis of existing laws in Pakistan found that there is no current law under which the recommendations on hospital autonomy proposed in this report (as well as the recommendations made in the other volumes of this study) can be implemented. The study team, therefore, suggests that a single Health Policy law be enacted to provide a permanent legal infrastructure for the various initiatives. With such a comprehensive statute, it would not be necessary to repeatedly return to the legislature to enact different aspects of the proposed reforms. This umbrella legislation would encompass all four of the initiatives addressed in this study, and would be applicable to the whole of Pakistan. Since it may not be possible for the government to enforce all four initiatives immediately upon passage of the law, the government may reserve the power to take a phased approach, applying different provisions of the law over time.

The section of this law that would cover autonomy of management and financing for hospitals might be called the Autonomous Entity Act. It would need to include provisions related to governance; the hiring, evaluation, and rights of personnel; and the management of hospital finances. Suggestions related to each of these areas follow.

Governance

Legislation concerning governance would address the role of the Board of Directors, the Hospital Administrator, and community representatives. It would also outline Rules of Governance that would guide hospital operations.

Basically, this legislation would propose that responsibility and authority for managing hospitals be conferred to a Board of Directors made up of government servants (nominated by the Federal Ministry of Health or by the relevant Provincial Department of Health), representatives of the administration of the hospital, and

members of the community it serves. The number of board members in each category would be specified by the ministry. The board would function as an autonomous body. It would be permanent, but its members would retire after a specific time period to be replaced by others from the same category.

The Board of Directors would select and hire a Hospital Administrator who would sit on the board in an ex officio capacity. This administrator would be a person of proven administrative abilities, but not necessarily a member of the medical profession.

Local government would determine the way of selecting community representatives. Representatives of the Ministry of Health would be named by the MOH's Director General. Representatives of the Provincial Department of Health would be named by the Provincial Secretary. The Hospital Administrator would represent its administration.

Model Rules of Governance of autonomous hospitals should be developed by the federal government. Boards also may develop their own rules within the framework of the parent law.

Management

Legislation related to management would specify the responsibilities of the hospital's Management Team and would identify personnel policies, including ones that would move hospital staff from being government to being private-sector employees.

Specifically, this legislation would empower the Hospital Administrator to nominate individuals to the board for appointments to senior management positions. The administrator will have the authority and responsibility to engage, reward, discipline, and discharge personnel as well as to delegate this responsibility to other staff. The administrator's authority would be similar to the power of leaders of private-sector enterprises. At the same time, hospital employees would benefit from all the rights and protections of private-sector employees. Since the current personnel of government hospitals are public servants, plans must be made for making the transition from public to private employee status. Possible ways to make this change-over include:

- Allowing current employees to maintain their jobs and government servant status until they retire, are transferred, quit, or are removed from their job for cause under government servant rules. All newly engaged personnel would be hired under private-sector terms. Under this option, a long time would be needed to reach full private-sector status.

- Offering current employees the choice of being transferred to other government jobs where they would maintain their government servant status or of retaining their jobs at the hospital while changing their status to become private-sector employees . This option would allow hospital management to reach the optimal situation more quickly, but would require that other jobs be found within government for personnel unwilling to convert their status.

Finance

In the area of finance, national legislation would address the issues of decreasing government subsidization, provide guidance in setting user fees, propose ways to cover payments for the indigent, and establish regulations related to the financial management of autonomous hospitals.

This legislation would propose that autonomous hospitals be operated on a non-profit basis. Annual operating expenses would be planned in a budget developed by the Hospital Administrator and approved by the board.

The government would provide a subsidy to the hospital for use in meeting its operating expenditures. In the first few years, this subsidy would be at least the average of the real (adjusted for inflation) allocations of operating funds the hospital incurred during the last five years. The real (adjusted for inflation) value of this subsidy would gradually be reduced to a fraction (e.g., 50 percent) of the real value of the average of the operating allocations of the last five years.

The hospital will have to make up the remaining operating expenses from fees charged to consumers, reimbursements from insurers, contracts with groups of consumers or employers acting on behalf of their members or employees, and from other funds raised in ways prescribed by law, including donations and subsidies from charitable organizations such as the Zakat fund.

Fees to be charged to consumers would be proposed by the Hospital Administrator to the board for approval. The hospital will need to institute a system that judges a patient's ability to pay. No one should be turned away because of inability to pay at the time of treatment. However, efforts should be made to collect fees from those who cannot pay at the time services are delivered, but who have the means to do so later on.

The board will be responsible for ensuring that shortfalls or excesses in earnings should never be greater than 5 percent of operating expenditures. Changes in fees or reductions in costs should be made during the course of a fiscal year to ensure that the foregoing is achieved. Annual excesses or shortfalls should be

adjusted in the following year's operation by changing costs and fees.

Capital is defined as durable equipment and structures with a lifetime of three years or longer. The government should provide funds for all capital replacement and new capital acquisitions by hospitals. In an annual capital budget, the Hospital Administrator should recommend to the board what the capital replacement and acquisition requests to the government should be. The board-approved capital budget would then be submitted to the government and the hospital would be responsible for acquiring capital items against whatever budget is approved by the government.

7.1.2. Legal Issues Related to Hospitals Keeping User Fees

In general, government hospitals in Pakistan are required to remit revenues generated from user fees to the Ministry of Finance. However, PIMS has received an exemption from this requirement and does not appear to have any legal problems in charging and increasing its user fees. Thus, while legal steps are developed to bring a Health Policy law through the legislative process, PIMS can proceed to make changes in its fee schedules and to use the money that is collected. For other hospitals, retention of fees may well be a major barrier to experimentation prior to the passage of the Hospital Autonomous Entity Act.

8.0. USING ZAKAT AND OTHER MUSLIM RELIGIOUS FUNDS FOR THE INDIGENT

Many in Pakistan are concerned that when people are charged for the health care they receive, the poor will suffer the most because they may not have access to free care and their ability to pay is limited. In fact, the government is not willing to grant autonomy if it means reduced access to health care for this section of the population.

When looking for non-government funds to pay the health costs of the poor, many have suggested the option of utilizing religious funds such as Zakat, Ushr, Waqf Property, and Bait ul Mal.

> *Zakat* is an obligatory transfer of funds to poor Muslims by a Muslim who owns or possesses more wealth than the limit prescribed by Shariah (Islamic laws). By doing so, a Muslim purifies his wealth and assets in accordance with the commands of Allah, and also cleanses his heart from greed and lust. Zakat is required to be paid at 2.5 percent per annum on savings, gold, silver and other items of wealth covered under Shariah. Zakat is one of the five basic pillars of Islam.
>
> *Ushr*, an aspect of Zakat, literally means "one tenth" of something. It is levied on the production of agricultural land (i.e., crops, garden produce). It is paid annually in the ratio of 1:10.
>
> Both the 2.5 percent levy on wealth and the Ushr are part of Zakat, one of the five pillars of Islam. Zakat is obligatory to a true Muslim.
>
> *Waqf Property* refers to property of any kind which is permanently dedicated by a person professing Islam for any purpose recognized by Islam as religious or charitable. Unlike Zakat, it is not obligatory for all Muslims.
>
> *Bait ul Mal* refers to welfare funds established by the Amir (head of a Muslim state) for the purpose of providing help to the poor and the needy. It is not obligatory, nor is any fixed rate set for the collection of these funds. The source of these funds is through the state treasury. Bait ul Mal funds have no religious significance and are considered means of helping the poor and needy population, regardless of their religious beliefs.
>
> The Bait ul Mal in Pakistan was only introduced in 1991 and its structure and objectives are still being defined. It is recommended that Bait ul Mal's purpose and initial "teething problems" be solved before any concrete conclusions or recommendations be made on its availability and utilization as an alternative for funding health services for the poor and needy population of Pakistan.

8.1. Administration of Zakat Funds

All of these funds have defined eligibility criteria. Generally, utilization of Zakat funds (the largest fund) is restricted to those Muslims called "mustaqueen" (needy). Non-muslims are not eligible. However, this view is subject to different interpretations by religious scholars and, in some cases, these funds are being dispensed to the needy without any discrimination based on their religious affiliation.

Zakat funds are collected through local banks. On the first day of each Ramdhan month, the banks in Pakistan make a 2-1/2 percent deduction from the bank account of all individual account holders except those who are exempt from paying Zakat (non-Muslims). Also, all other investments made through the government such as bonds and securities have deductions taken from them at the time they are cashed in.

The overall responsibility for the administration, collection, and custody of Zakat funds rests with the Central Zakat Council (CZC), an independent body headed by a judge of the Supreme Court of Pakistan. The CZC is a nine-member council with representation from various federal ministries and agencies. Other Zakat bodies involved in the disbursement and implementation of the funds are:

The Zakat Councils are responsible for policy making with regard to Zakat funds. The Central Zakat Council, through its Central Zakat Administration (CZA), disburses funds through the Provincial Zakat Councils (PZC). The membership of the PZCs is similar to that of the CZC, though at the provincial level. The PZC in each province forwards the Zakat funds to District Zakat Councils which then forward them to the Tehsil Zakat Committees (Tehsils are zones within each district). The Tehsil Zakat Committee relies on the Local Zakat Committee (LZC) to identify people eligible for Zakat funds. The LZC is at the grassroots community level and its members are elected by each "*mohalla*" (neighborhood) in the LZC. There are 39,000 LZCs in existence in Pakistan. Their main objective is to issue eligibility certificates to residents of their neighborhood who are eligible to receive Zakat funds. The LZC mainly relies on the reputation of each applicant regarding his economic status and general condition.

The State Bank of Pakistan retains custody of all the Zakat funds collected by nationalized banks.

8.2. Zakat Health Funds

Zakat funds can and are being utilized for providing both health and educational services to the poor, if they qualify as "mustaqueen" or needy. In the 1991-92 fiscal year, 2.6 billion

rupees in Zakat funds were collected. Approximately 90 million rupees (4 percent) were designated and spent on health-related projects. The Central Zakat Administration indicated that health-related Zakat spending could perhaps be increased to 6 percent, if the Federal Ministry of Health made such a request to the Central Zakat Council.

Zakat funds for health are distributed through two mechanisms: the Patient Welfare Society; and direct disbursements to facilities. The Patient Welfare Society functions in most government hospitals. Patients requiring hospital services who cannot afford to pay for their hospital stay are referred to the Patient Welfare Society. The Society verifies their eligibility (possession of "needy" certificate issued by the Local Zakat Committee). It then may approve using Zakat funds to pay for the patient's hospital expenses. No maximum ceiling on the amount of money available through the Zakat for each hospitalization has been established. Under the current practice, eligible patients are being covered for up to 100 percent of their total hospital expenses.

Direct disbursements of Zakat funds also are made to a number of health facilities on a regular basis. These include the Fatamid Foundation (Blood Donor Agency), the Federal Government Services Hospital, and the Pakistan Institute of Medical Sciences.

Generally speaking, the use of Zakat funds is limited to the provision of services, although there is no such religious requirement. According to Islamic International University, the Zakat funds can also be used for capital and development purposes, including construction and purchase of equipment. They believed that a general consensus is building in the Pakistani religious community that a more liberal interpretation for the use of Zakat funds should be implemented. They also indicated that the amount of Zakat money collected is rather small, and that is why its utilization in the health sector has been limited to providing curative services.

Zakat funds are not adequate to cover the health costs of the indigent in Pakistan since they amount to less than 1/2 of 1 percent of the country's health expenditures. It may be appropriate to recommend that the FMOH develop a system for handling Zakat funds that identifies maximum ceilings to ensure that the benefits of these funds are maximized. Since religious funds and their utilization are sensitive matters in Pakistan, caution should be exercised in making any recommendations regarding the Zakat funds which can be termed "interference" by the Zakat administrative and policy-making bodies.

8.3. Recommendations

Zakat funds can serve as one source for financing hospital and rural health services for poor and needy patients, but they cover only a small percentage of the health care costs of the indigent. Nevertheless, this study recommends to the FMOH that Zakat funds be made available for use both in rural and urban areas, when the recipients of Zakat funds meet the strict requirements laid out for the "mustaqueen." Also, the procedures for dispensing Zakat funds through the Patient Welfare Society at each government hospital should be streamlined and strengthened to ensure that Zakat funds are used optimally and the benefits are enjoyed by a larger segment of the eligible population.

As stated above, the current allocation for health services of 4 percent of total Zakat funds might be increased to 6 percent by making a request to the Ministry of Finance and the Zakat Council. The Federal Ministry of Health should take the initiative and meet with the relevant officials of the Central Zakat Council to initiate this process. However, it is very important to realize that not all Pakistanis are eligible to receive Zakat funds. The funds are restricted to certain classes of Muslims. To ensure availability of funds for the remaining population, close monitoring of Bait ul Mal funds should be maintained and the FMOH should use its influence to make the Bait ul Mal funds available for those people not eligible for Zakat funds.

9.0. IMPLEMENTATION PLAN

Planning provides a structure for the future, taking into consideration specific goals, time frames for achieving these goals, and the activities needed to carry them out. The following pages revisit the issues discussed during the study of hospital autonomy, identify the objectives that have been set, and show the steps that need to be taken to achieve these outcomes.

This plan should be administered by an agency within the government or by an independent organization charged by the FMOH with responsibility for directing and implementing autonomy. The parent body should be a legal entity which will have independent control over policy making, program management, budgeting, finances, personnel, and the internal functioning of autonomous hospitals.

With the exception of the recommendation for the composition of the Board of Directors, it is assumed that implementation of this program can begin prior to the passing of a comprehensive Health Policy law that makes autonomy for government hospitals possible.

EXHIBIT 10

HOSPITAL AUTONOMY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	REPORT SECTION REFERENCE	LENGTH OF TIME IN MONTHS*	WHO/WHAT	BUDGET RESOURCES	COMMENTS
APPOINT BOARD OF DIRECTORS	COMPOSITION OF THE BOARD OF DIRECTORS DEFINED AND RESPONSIBILITIES DEVELOPED	4.3.	1-12	FMOH; PIMS' & FGSH's Boards of Directors	FMOH, PIMS, & FGSH	THE AUTONOMOUS ENTITY ACT WILL DEFINE THE RESPONSIBILITIES AND PROCESS FOR DECENTRALIZING BOARD CONTROL.
ESTABLISH AND CLARIFY MISSION OF AUTONOMOUS HOSPITAL	REVIEW MISSION STATEMENT AND DEFINE THE PURPOSE AND SCOPE OF THE HOSPITAL (APPENDIX A.1)	4.3.	3-9	PIMS & FGSH Boards of Directors and Management	PIMS, FGSH, & DONOR	THE MISSION STATEMENT SHOULD BE A FORMAL DOCUMENT THAT EXPRESSES THE IDENTITY, FUNCTION, AND COMMUNITY/PUBLIC SERVICE GOALS OF THE HOSPITAL.
COORDINATE PRIMARY, SECONDARY, AND TERTIARY CARE	ESTABLISH REFERRAL PROTOCOLS AND PROCEDURES AND DEVELOP IMPLEMENTATION PLAN (APPENDIX A.2)	4.3.	9-21	PIMS & FGSH Management, Private Sector	PIMS, FGSH, & DONOR	ESTABLISH CLEAR AND FIRM PROTOCOLS (CRITERIA) AND PROCEDURES FOR REFERRALS TO THE HOSPITAL.
ESTABLISH MANAGEMENT TEAM	DEFINE ORGANIZATION STRUCTURE AND MANAGEMENT TEAM (APPENDIX A.3)	5.4	9-33	PIMS & FGSH Boards of Directors, Management, & TA	PIMS, FGSH, & DONOR	DETERMINE THE NEED FOR PHASED IMPLEMENTATION OF THE ORGANIZATIONAL STRUCTURE AND DETERMINE THE ACTION STRATEGIES AND STEPS.
ESTABLISH PERSONNEL FUNCTION	ESTABLISH PERSONNEL ADMINISTRATION FUNCTIONS AND DEPARTMENT (APPENDIX A.4)	5.5	24	PIMS & FGSH Board of Directors, Management, & TA	PIMS, FGSH, & DONOR	PREPARE PLAN FOR THE DEVELOPMENT OF THE PERSONNEL FUNCTIONS.

* Time measured from start of the move to autonomy.

EXHIBIT 10 (Continued)

HOSPITAL AUTONOMY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	REPORT SECTION REFERENCE	LENGTH OF TIME IN MONTHS*	WHO/WHAT	BUDGET RESOURCES	COMMENTS
ESTABLISH MANAGEMENT TRAINING PROGRAMS	DEVELOP AND CONDUCT MANAGEMENT TRAINING PROGRAMS INVOLVING PRIVATE SECTOR	5.5	24	PIMS & FGSH Top Management, Private Sector, & TA	PIMS, FGSH, & DONOR	USE PRIVATE SECTOR AS TRAINERS & MENTORS IN FINANCIAL MANAGEMENT, MARKETING, ETC.
IMPROVE FINANCIAL MANAGEMENT	DEVELOP PROCEDURES AND GUIDELINES FOR FINANCIAL OPERATIONS - BUDGETING AND ACCOUNTING (APPENDIX A.5)	6.1 & 6.2	12	PIMS & FGSH Deputy Directors for Finance & TA	PIMS, FGSH, & DONOR	DEVELOP ACCOUNTING, BUDGETING, & PLANNING CAPABILITIES; MONITOR & MANAGE COSTS
IMPROVE FINANCIAL MANAGEMENT CONTROL AND MONITORING	DEFINE FINANCIAL CONTROLS AND MONITORING REQUIREMENTS (APPENDIX A.5 and A.6)	6.2	12	PIMS & FGSH Top Management & TA	PIMS, FGSH, & DONOR	DEFINE STATEMENT OF FINANCIAL PURPOSE AND CHOOSE A STRATEGY THAT ESTABLISHES THE BASIC FINANCIAL DIRECTION OF THE HOSPITAL. RELATE PERFORMANCE CRITERIA TO AUTONOMOUS HOSPITALS' MANDATES
IMPROVE INVENTORY CONTROL	DEVELOP PROCUREMENT SYSTEM (APPENDIX A.7)	6.2	36	FMOH; PIMS & FGSH Boards of Directors, Management & TA	PIMS, FGSH, & DONOR	DEVELOP GUIDELINES TO EXPEDITE THE TENDER PROCESS FROM NOTIFICATION OF AWARD TO SIGNING OF CONTRACT
EVALUATE HEALTH SYSTEM DELIVERY	STUDY PRIVATE TRUST HOSPITALS FOR LESSONS FOR AUTONOMOUS HOSPITALS	6.3	12	PIMS & FGSH Top Management, Trusts Management, & TA	PIMS, FGSH, & DONOR	CONCENTRATE ON USER PAYMENTS, IDENTIFYING WHO CANNOT PAY, & ASSURING QUALITY AND ACCESS

* Time measured from start of the move to autonomy.

EXHIBIT 10 (Continued)

HOSPITAL AUTONOMY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	REPORT SECTION REFERENCE	LENGTH OF TIME IN MONTHS*	WHO/WHAT	BUDGET RESOURCES	COMMENTS
MARKET CLIENTS AND SET USER FEES	INCREASE FINANCIAL AUTONOMY THROUGH COST RECOVERY	6.4 & 6.5	24	FMOH; PIMS & FGSH Boards and Management; & TA	FMOH & DONOR	LONG- & SHORT-TERM TA NEEDED
MONITOR & EVALUATE PERFORMANCE AT PIMS & FGSH	GATHER DATA ON PERFORMANCE INDICATORS, EVALUATE, THEN REVISE APPROACHES	10	24	FMOH, PIMS & FGSH Management; & TA	FMOH, PIMS, FGSH, & DONOR	LEARN LESSONS FROM PIMS & FGSH TO MODIFY APPROACHES BEFORE UNDERTAKING ADDITIONAL IMPLEMENTATION
REPLICATE AT SELECTED PROVINCIAL HOSPITALS	SELECT TWO OR MORE HOSPITALS IN EACH PROVINCE FOR CONVERSION TO AUTONOMY, THEN ASSIST TO IMPLEMENT	1 THROUGH 10	36	FMOH, PMOHs, & TA	FMOH, PMOHs, & DONOR	BEGIN PROVINCIAL IMPLEMENTATION AFTER ONE YEAR OF LEARNING FROM PIMS & FGSH
MONITOR & EVALUATE PERFORMANCE AT PROVINCIAL AUTONOMOUS HOSPITALS	GATHER DATA ON PERFORMANCE INDICATORS, EVALUATE, THEN REVISE APPROACHES	10	36	FMOH, Autonomous Provincial Hospital Management, PMOHs, & TA	FMOH, PMOHs, & DONOR	LEARN LESSONS FROM HOSPITALS MADE AUTONOMOUS TO MODIFY APPROACHES BEFORE ADDITIONAL IMPLEMENTATION
IMPLEMENT AT ALL REMAINING HOSPITALS	OVER TEN-YEAR PERIOD IMPLEMENT IN ALL REMAINING HOSPITALS	1 THROUGH 10	--	FMOH, PMOHs, Hospital Management, & TA	FMOH, PMOHs, & DONOR	COMPLETE NATIONWIDE AUTONOMY ON A PHASED BASIS

* Time measured from start of the move to autonomy.

10.0. MONITORING AND EVALUATION PLAN

The following plan can be used for monitoring and evaluating progress in granting autonomy to government hospitals. It indicates what kind of data to collect in order to judge whether the intended consequences of the reform are realized.

The following table spells out the objectives for autonomy, it recommends indicator data that should be gathered for each objective, and it shows how often the data should be evaluated.

EXHIBIT 11

HOSPITAL AUTONOMY MONITORING AND EVALUATION PLAN

OBJECTIVES	MONITORING INDICATORS	EVALUATIONS
REDUCE GOVERNMENT SUBSIDY TO HOSPITALS	REAL (ADJUSTED FOR INFLATION) AMOUNT OF SUBSIDY DECLINING	ANNUAL
	PERCENT OF TOTAL FUNDING OF HOSPITALS FROM SUBSIDIES DECLINING	ANNUAL
BILL THOSE ABLE TO PAY FOR CARE	REAL HOSPITAL REVENUES FROM USER PAYMENTS INCREASING	ANNUAL
IMPROVE EFFICIENCY	UNIT COSTS OF A SET OF COMMON INPATIENT AND OUTPATIENT PROCEDURES ARE DECLINING	EVERY 6 MONTHS
RAISE QUALITY	COMPLY WITH HOSPITAL ACCREDITATION STANDARDS	ACHIEVE ACCREDITATION WITHIN 2 YEARS OF BECOMING AUTONOMOUS, THEN MAINTAIN ACCREDITATION
	PATIENTS SATISFIED WITH CARE	CONDUCT QUARTERLY PATIENT SURVEYS
ENSURE ACCESS TO THE POOR	10 PERCENT OF PATIENTS ARE TOTALLY EXEMPTED FROM PAYMENT, 20 PERCENT MORE ARE PARTIALLY EXEMPTED	ANNUAL
	SIGNIFICANT DIFFERENCES IN SOCIO-ECONOMIC STATUS OF EXEMPTED, PARTIALLY-EXEMPTED, AND PAYING PATIENTS	SURVEY ONCE EVERY 2 YEARS

APPENDIX A

PROPOSED ORGANIZATIONAL STRUCTURE FOR AN AUTONOMOUS HOSPITAL

A.1. MISSION CLARITY

Interpretation of the hospital's mission will help the hospital to efficiently target services to patients and focus on a specific level of care (primary, secondary, or tertiary).

Timeframe

Duration of Initial Steps: Six months for the board to hold meetings to discuss issues related to the care and services provided by the hospital. Within the first six months, the Board should also notify the staff and the public of the "Autonomous Status" of the hospital.

Resources

Personnel: No staff will be needed to review the care and services provided by the hospital. The Hospital Administrator and Deputy Directors will participate in the discussions.

Financial: No financial requirements for implementing the mission statement.

Dependence

Interrelationship: The discussion of the mission statement is preceded by the decentralization of board control to the District and Tehsil health committees. All administrative, medical, and support staff should be aware of the discussions on the care and services provided by the hospital. The Public Relations and Marketing Departments should be well informed, so that they can incorporate the agreed-upon mission into all public relation and planning activities.

External: There may be minimal involvement from the Federal and Provincial Ministries of Health.

Impact

Short-term: Low—
The planning process and preparations for informing the community will have little impact on the current operations of the hospital.

Medium-term: High—
Although careful planning will help minimize disruptions, there will be a period of adjustment as hospital staff get used to the ``new'' role of the hospital and patients become accustomed to not going to the hospital for inappropriate services.

Long-term: High—
The hospital will become strictly a primary, secondary, or tertiary care hospital. This will make more effective use of the hospital facilities. Elimination of [primary, secondary, or tertiary] care from the hospital will ease congestion and increase quality of care for patients.

Responsibility

The board will have primary oversight responsibility for the discussions on Mission Clarity.

Implementation Steps

- The board should review and revise the present Mission Statement of the hospital. It should be a formal document that expresses the identity, function, and community/public service goals of the hospital.
- The board should assess the care and services provided by the hospital.
  - Review the category of services, primary, secondary, and tertiary.
  - Review the service needs of the community.
- The board should assess how the care provided compares with the mission as specified in the hospitals Act/Ordinance.
- For teaching facilities - The board should assess how the medical training provided compares with the mission as specified in the hospitals Act/Ordinance.
- The board should make sure that the Mission Statement defines the scope and purpose of the hospital.
- The board should make sure that the Mission Statement serves as a means for adding unique direction and shape to the hospital's strategic goals by setting out guidelines for determining what generic activities the hospital should (as well as should not) pursue.
- The board should keep the Public Relations and Planning Departments informed of all activities.

A.2. REFERRAL PROTOCOLS AND PROCEDURES

Develop, communicate, and enforce referral protocols between the hospital and other government and non-government organizations, and private physicians.

Timeframe

Start: The Hospital Administrator should appoint a committee consisting of the top clinicians from the major clinical areas and several key department managers of the hospital.

Duration of Initial Steps: The committee should take approximately three months to carry out the duties described below in the Implementation Steps. The board will take an additional two months to communicate the admissions procedures and criteria to the hospitals in the catchment area.

Resources

Personnel: Physicians, nurses, technicians, and medical records personnel will devote some of their time to reviewing the protocols. Additional staff may be required to monitor the process to assure compliance.

Dependence

Interrelationships: Audits to assure compliance will be required by the Medical Records Department; the Hospital Administrator will monitor the process.

External: A good working relationship with other hospitals in the catchment area; a key element of success will be whether the private physicians, private clinics, and other hospitals adhere to the protocols.

Impact

Short-term: Low—
It will take some time to develop the protocols. Once they are established it, will take a while before everyone becomes familiar with and follows them.

Medium-term: Medium—
The hospital staff should follow the procedures as soon as they are established, but it will take several months of enforcement to get other health care providers to do the same.

Long-term: High—
Once the procedures are running smoothly at all hospitals and physicians' offices, the hospital will begin to achieve its stated mission. Congestion and queues in the hospital will decrease, and the hospital will be more effectively using the skills and expertise of its professionals.

Responsibility

The committee appointed by the Hospital Administrator will be responsible for establishing the protocols. All hospital staff connected with the admissions and medical record process are responsible for following them. The board and the Public Relations department are responsible for communicating the protocols to concerned outside entities. Responsibility for enforcement rests with the Hospital Administrator and board.

Implementation Steps

- The board will authorize the Hospital Administrator to appoint a Committee consisting of top physicians from the major clinical departments and selected department managers.
- The committee's terms of reference will be to:
  - Establish clear and firm protocols (criteria) and procedures for referrals to the hospital.
  - Develop an implementation plan which will include various deadlines for which categories of "unreferred" patients will no longer be seen at the hospital.
  - Develop necessary mechanisms and procedures to enforce the protocols. The mechanisms should allow access to critical groups of patients who require the skill, expertise, and equipment that is available at the hospital.
- The committee should establish guidelines, time tables, and milestones for both the short- and long-term steps and actions in the implementation plan.
- The committee's report on the above issues should be presented to the board for approval within three months after the commencement of its work.
- The board will develop a plan to communicate the criteria and procedures for referral to the hospital and submit copies to all hospitals, private physicians, physician clinics, and other medical groups that refer patients to the hospital.

A.3. ORGANIZATION STRUCTURE

Development of a decentralized management organization structure that delineates authority, responsibility, and accountability.

Timeframe

Start: The board and Hospital Administrator should meet to review the proposed Multiple-Layer Organization Structure against existing personnel resources to determine the extent of promotions and additional personnel required. They should determine the need for phased implementation of this structure and strategies and steps to be taken. The board should communicate the proposed changes to the hospital management.

Duration of Initial Steps: Three months to develop position descriptions and promotion criteria. Three months after this to recruit and employ the senior and line management positions. Six months to recruit and employ the department manager positions.

Iterative Review: Through regular Management Team meetings, the board, Hospital Administrator, and senior management will be able to assess the appropriateness of the implemented organizational structure. Problems that the Management Team identifies should be presented to the board for discussion. The board will then formulate modifications.

Resources

Personnel: Management Team, including senior management and one or several department managers, depending on the judgements made by the board.

Financial: There may be substantial salary costs resulting from hiring new personnel or promoting internally. This, however, could be incurred incrementally over time.

Dependence

Interrelationship: It is important that those on the department- manager level and below completely understand the changes and not be adversely affected by them.

External: To some extent, the elements of all external working relationships that the hospital has with other organizations will be determined by the hospital's new internal structure.

Impact

Short-term: Low—
It will take some time to hire new personnel and write job descriptions.

Medium-term: Medium—
It will take time for new and promoted personnel to feel comfortable in their jobs and for obsolete working relationships to be replaced.

*Long-term:*High—
Hospital management will be strengthened as spans of control are worked out; decision-making will be expedited as decisions will be made by those closest to the situation; the Hospital Administrator's time will be freed- up for activities that only he or she can perform.

Responsibility

The Hospital Administrator will be primarily responsible for organizing Deputy Directors' and department managers' positions, and the Board will have oversight responsibility for the organizational structure changes.

Implementation Steps

- Assess skill of those who will be given additional management responsibilities; determine extent of new hires and promotions.
- Develop position descriptions and promotion criteria for all senior and middle management positions.
- Determine the need for phased implementation of the organizational structure and the associated strategies and iterative steps.
- Implement the new structure, communicating changes to all hospital staff and doctors.

A.4. PERSONNEL ADMINISTRATION

The Board of Directors of autonomous hospitals will be empowered to employ, retain, evaluate, and dismiss all levels of salaried staff. It will be able to accept or refuse an employee assigned from any Ministry, to hire personnel as needed, to adjust salaries, reward employees for superior performance, to impose fines, and to request the transfer or dismissal of an employee whose work is unsatisfactory.

Timeframe

Start: The development of a Personnel Department should begin within three months of the passing of the Autonomous Entity Act. The development of the personnel function should begin immediately thereafter.

Duration: Recruitment of a Personnel Manager should be accomplished within four months. The development of the personnel function, including the writing of job descriptions, designing of a system for maintaining personnel files, the development of a staff appraisal and performance review process, and the development of staff training programs should take one year from the date the Personnel Manager is hired.

Resources

Personnel: The Deputy Director, Administration will write the job description of the Personnel Manager for approval by the Hospital Administrator. The Hospital Administrator and Deputy Director, Administration will interview candidates and employ the most qualified. The Personnel Manager will hire staff for the new Personnel Office from existing staff and from external hires.

Financial: Annual salary for a Personnel Manager.

Dependence

Interrelationship: The writing of hospital personnel job descriptions is preceded by the development of the Personnel Department.

Impact

Short-term: Low—
Will show hospital staff that management is taking control over personnel, but will have little direct effect on day-to-day operations in the short term.

Medium-term: Medium—
Management will begin to gain control over quality of hiring, training, performance, compensation, promotion, and discipline of staff.

Long-term: High—
Management will have maximum control over quality and performance of staff.

Responsibility

The Deputy Director, Administration is responsible for recruiting and employing the Personnel Manager. The Personnel Manager is responsible for developing the Personnel Department.

Implementation Steps

- Develop job description for Personnel Manager position (Deputy Director, Administration)
- Approve job description (Hospital Administrator)
- Interview candidates for Personnel Manager
- Select and employ Personnel Manager
- Assist in writing job descriptions of Management Team (Hospital Administrator, Personnel Manager, and Personnel Department staff)
- Prepare plan for the development of the personnel functions: writing of staff job descriptions; designing a system for maintaining personnel files; developing staff appraisal and performance reviews; and structuring a process for hiring, disciplining, and dismissing employees; developing staff training programs; and developing a system of incentives and rewards for outstanding performance. (Personnel Manager).
- Implement the plan for the personnel function (Hospital Administrator and Personnel Manager).

A.5. FINANCIAL CONTROLS AND MONITORING

Create the post of Deputy Director, Finance to be responsible for the financial operations and management of the hospital

Timeframe

Start: The Hospital Administrator should define the job. The candidates should be screened by the Administrator and select board members.

Duration: The development of a job description should take no longer than 60 days. The goal of the screening and interviewing process should be to select, hire, and employ the successful candidate within 120 days.

Resources

Personnel: The Hospital Administrator will be required to develop the job description and to interview the candidates.

Financial: Additional funds will be required for the annual salaries for one full-time Deputy Director, Finance, one full-time Accountant, and one full-time secretary.

Dependence

Interrelationship: Improvement in the financial operations of the hospital depends on establishing and maintaining appropriate and accurate accounting and fiscal controls.

Impact

Short-term: Medium—
The improvements in financial controls will be helpful in maintaining funds for operations.

Medium-term: High—
Financial controls will lead to fiscal strength.

Long-term: High—
Fiscal strength will provide sound budget and financial operations.

Responsibility

The board will ensure that financial operations are performed appropriately. The responsibility for implementing the financial policies of the board relative to the control and effective utilization of the physical and financial resources of the hospital will reside with the Hospital Administrator. The responsibilities for safeguarding the assets of the hospital, supervising the receipt and disbursement of cash, and ensuring that the operation is adequately financed should be given to the Deputy Director, Finance.

Implementation Steps

- Define a statement of financial purpose and strategy that establishes the basic financial direction of the hospital. (board and Hospital Administrator)
- Create the position of Deputy Director, Finance (board)
- Write job description for Deputy Director, Finance (Hospital Administrator) with the following functions:
  - Establish, coordinate, and maintain, through authorized management, an integrated plan for the control of financial operations.
  - Measure performance against approved operating plans and standards, and report and interpret the results of operations to all levels of management.
  - Interpret and report on the effects of external issues on the attainment of the financial objectives of the hospital.
  - Provide controls to safeguard the assets of the hospital.

A.6. FINANCIAL OPERATIONS ❯ ACCOUNTING AND REPORTING

Autonomy-related financial planning and budgeting, as well as the projected increased dependence on user-fees, requires strengthening hospitals' accounting and reporting programs.

Timeframe

Start: Within 30 days of the employment of the Deputy Director, Finance.

Duration: The duration will continue through the submission of the budget and financial plan to the board for review and approval.

Resources

Personnel: Annually one full-time accountant to support the financial planning and budget function.

Financial: Annual salary for one full-time accountant.

Dependence

Interrelationship: Support and cooperation of senior management and department managers. Planning department should assist in the development of operating statistics, forecasted utilization, rates, estimated work loads, and resource requirements.

Impact

Short-term: Low—
Development and implementation of financial planning and budgeting programs will require several months.

Medium-term: High—
Financial planning and budgeting programs will monitor each department's actual results related to standard requirements.

Long-term: High—
Implementation of financial planning and budgeting guidelines for all departments will result in savings. Having the accounting and budgeting programs should allow hospital management to monitor the fiscal operations of the hospital and to adjust operations to assure financial soundness.

Responsibility

The Deputy Director, Finance serves as the overseer of the financial tasks including the accounting discipline, the accounts payable and receivable function, cash management, inventory management, capital assets management, budgeting, and maintaining internal controls. This person must be knowledgeable and dedicated strictly to overseeing the financial matters of the hospital.

Implementation Steps

- Financial Planning - General estimates of future volume will be refined to provide specific workload estimates necessary to develop the details of the financial plan and to calculate resource requirements.
  - ❯ Accounting system—implementation of a transactional- based, double-entry accounting system.
- Budget Planning ❯ Development of hospital objectives and priorities, identification of factors and trends which affect operations and costs, and preparation of the preliminary budget.
  - ❯ Budget system—implementation of budget guidelines and system.
- Revenue and Expense guidelines — conversion of department managers' detailed resource specifications into actual rupees required.
- Review, modify, and publish - generation of the final revenue, expense, and capital requirements for each department.

A.7. FINANCIAL OPERATIONS ❩ PROCUREMENT

In order to provide an efficient procurement system, tendering and procurement procedures should be reviewed and streamlined.

Timeframe

Start: Hospital Administrator, Deputy Director, Administration, and the manager of the hospital's store of supplies will draft procedures that will provide improved access to tender by major reputable suppliers and improve evaluation and contractual arrangements.

Duration: Process will be constantly upgraded and revised.

Resources

Personnel: Stores manager and one full-time staff will prepare procedures and guidelines. The Hospital Administrator and Deputy Director, Administration will review the procedures and guidelines.

Dependence

Interrelationship: Cooperation between administration, finance, and stores to effectively implement, monitor, and enforce procedures and guidelines.

External: Coordination with major suppliers and other vendors to ensure impartiality of procurement system and to enhance price competitiveness.

Impact

Short-term: Low—
Will require several month to prepare procedures and guidelines and to inform vendors.

Medium-term: High—
Once the procedures are in place the procurement process will be shortened and vendors that can supply the product will be out under contract.

Long-term: High—
Procedures will enhance the hospital's opportunities for volume discounts from vendors.

Responsibility

Deputy Director, Administration, and Stores Manager.

Implementation Steps

- Revise and enforce guidelines for confidentiality of contracting information and vendor sources.
- Estimate utilization of major supply items and plan to order sufficient quantity to obtain volume discounts and to avoid inconveniencing suppliers.
- Develop guidelines for all major suppliers of goods/services to receive notification of proposed hospital contracts.
- Develop evaluation criteria to help deal with price variations.
- Develop guidelines to expedite the contracting-for-supplies process from notification of award to signing of contract to be completed within one month.

A.8. CONVERSION OF AUTONOMOUS HOSPITALS TO SELF-FINANCING OPERATIONS

Develop, communicate, and market health service contracts to individuals, businesses, and organizations that include arrangements for third-party payments.

Timeframe

Start: When the Autonomous Entity Act has passed, the Hospital Administrator should prepare a plan for future contracts with employers and should make arrangements with insurers or other prepaid insurance providers. The Deputy Directors', Administration and Finance and the Marketing Manager should design benefits packages and prepare an estimate of costs for these packages. The Marketing Department should begin marketing contracts to employers and pursue arrangements with Muslim charitable organizations and other insurers. The Finance department should study the feasibility of charging fees to doctors with private practices who utilize hospital services.

Duration of Initial Steps: Three months to design benefits packages and prepare cost analyses. The marketing of contracts and other arrangements will take six months.

Iterative Review: It will be essential to conduct regular cost and utilization analyses for employer contracts and other prepaid arrangements.

Resources

Personnel: One full-time employee from the Marketing Department to work on benefit design and marketing. One full-time employee to perform monthly cost and utilization analyses and do feasibility studies.

Dependence

Interrelationships: The ability to generate revenue from these programs will be dependent on the existence of an accounting and financial information system.

Impact

Short-term: Low—
Some additional revenue will be generated through contracts and other arrangements, but it will be difficult to estimate costs and utilization correctly in the early stages.

Medium-term: Medium—
Services will have to be carefully monitored and contracts recalculated on the basis of past consumption.

Long-term: Medium—
The hospital will be only one of many providing benefit packages. As employers become more experienced with contracting for health care benefits for their employees, they will try to obtain better deals from other hospitals.

Responsibility

Deputy Director, Administration and Marketing Manager will be responsible for development of policies and procedures. The Deputy Director, Finance will be responsible for monitoring costs and utilization of contracts, and for billing and producing financial data.

Implementation Steps

- Develop prototype benefits packages with different price ranges for different size companies.
- Evaluate cost of providing these benefit packages given historical and predicted morbidity and utilization data, and estimated costs of services.
- Prepare marketing strategy and plan.
- Pursue arrangements with insurers and with other Muslim charitable organizations.

APPENDIX B

SAMPLE MID-LEVEL MANAGEMENT FUNCTIONS IN AUTONOMOUS HOSPITALS

APPENDIX B

SAMPLE MID-LEVEL MANAGEMENT FUNCTIONS IN AUTONOMOUS HOSPITALS

ADMINISTRATION DEPARTMENT

Following are the functions of the department managers who report directly to the Deputy Director, Administration. Each will be responsible for the successful operation of that department and will have staff to carry out departmental duties.

Personnel Manager

Under autonomy, the hospital will need complete authority over personnel working at the facility. The Personnel Manager will develop a written set of personnel policies and procedures covering areas such as employee benefits; recruitment and contracting; training and development; promotions; disciplinary system; wages, hours, and salary; administrative rules of conduct; and performance appraisals. These are the basic functions of the employment process. The Personnel Department will also function in an advisory capacity in training and orienting personnel, keeping personnel files, and coordinating personnel assigned throughout the hospital. The Personnel Manager will work with department managers throughout the hospital to develop job descriptions for each of the key positions in the organization. This should allow the efficient hiring of employees whose skills and qualifications match those required by the hospital. It will also give employees an understanding of what their duties and responsibilities are and give administrators ways of measuring employee performance.

Medical Records Manager

Up-to-date and complete patient medical records are vital to control the quality of medical and nursing care. The Medical Records Manager should work with the Deputy Directors of Medical Services and Nursing Services to establish procedures for medical records to be completed by physicians, technicians, and nurses. The Medical Records Manager will be responsible for training medical and nursing staff in the use of the medical records system.

The Medical Records Department is responsible for handling: (1) storage and retrieval of medical information; (2) admission and discharge analyses; (3) coding and abstracting of diagnoses and procedures; (4) information on disease patterns, patient morbidity, and mortality statistics; and (5) patient social services.

The Medical Records Manager will be responsible for the Social Services Department, a major contributor to the mission of the hospital. Specifically, the Social Services Department:

- Aids the health team in understanding the social, economic, and emotional factors that affect the patient's illness, treatment, and recovery.

- Aids the patient and the patient's family to understand these factors and to make constructive use of the resources in the medical care system

- Promotes the well-being of the patient and improves morale of the patient's family by working with both the family and the patient.

- Provides education about social issues to hospital staff and members of the community.

- Offers better patient care by identifying various services, including external aftercare services available to the patient.

- Improves the utilization of the community's resources in order to support patient and family needs when the patient leaves the hospital.

The Social Services Department, possibly working with welfare committees, will be asked to study those who cannot pay for health services and classify them as "free" patients. The social workers in this department must be highly trained individuals and must have an advanced degree of education.

Information Systems Manager

Management information will enable the Hospital Administrator, Deputies, and Departmental Managers to monitor the performance of the various aspects of the hospital and to respond appropriately and in a timely manner to problem situations. The hospital needs an efficient flow of information in order to enable it to function as an autonomous institution and to deliver effective services. The hospital deputies will assist in developing and implementing this system in order to assure that all information required by the management of the hospital is gathered, disseminated to the particular departments that require it, and used effectively to gain greater control over hospital operations.

Marketing Manager

The marketing of hospital services will become a critical function for autonomous hospitals. Marketing is one of the most important managerial roles in health services. Patients are the primary, sometimes the only, source of revenue, and the hospital must promote its services in order to attract paying patients. An immediate task for the Marketing Manager will be the establishment of contracts between local businesses and the hospital to provide medical care to employees.

FINANCE DEPARTMENT

The Finance Manager, who reports directly to the Deputy Director, Finance, will be responsible for ensuring the successful operation of the department. This person will oversee all phases of financial management of the hospital, including general accounting and bookkeeping, patient financial accounts, and financial reporting. Responsibilities will include handling a capital replacement fund for the repair of equipment, the purchase of new equipment, and the maintenance of the physical plant of the facility.

MEDICAL SERVICES DEPARTMENT

The hospital's medical staff has the greatest impact on the quality of care and utilization of services given at the institution. Under this function are: internal medicine, surgery, anesthesia, pediatrics, urology, orthopedics, ophthalmology, obstetrics/gynecology, dentistry, dermatology, emergency services; and other medical specialties offered by the hospital. Each of these departments will be headed by a physician specialist who reports to the Deputy Director, Medical Services. Each of these physicians will be responsible for both inpatient services and outpatient clinics (where applicable) under each medical specialty.

NURSING SERVICES DEPARTMENT

All nursing care will be the responsibility of the Deputy Director, Nursing. This person will be assisted by a Degree Nurse responsible for the management of the Nursing Department. Each specialty department such as pediatrics, intensive care, and surgery will require nurses trained in these areas. In addition, each inpatient wing needs a Head Nurse Supervisor.

It is vital that Nursing Services develop a written plan that assures coverage on a 24-hour-basis for all patients, with appropriately trained nurses on all shifts.

SUPPORT SERVICES DEPARTMENT

The following describes the functions of the department managers who report directly to the Deputy Director, Support Services. Under these functions are: (1) Technical/Diagnostic Services (radiology, laboratory, and pharmacy) and (2) Hotel Services (housekeeping, maintenance, kitchen, laundry, and hospital store). Each of these areas will be headed by a manager responsible for the successful operation of the department. It should be noted that if a skilled administrator cannot be found to fill the position of Deputy Director, Support Services, this

position may be combined with that of Deputy Director, Administration.

(1) TECHNICAL/DIAGNOSTIC SERVICES:

Senior Radiology Technician

The Senior Radiology Technician will be responsible for operating the Radiology Department and establishing radiology administrative procedures. This person will also work with the Medical Records Manager, Finance Manager, and the Deputies of Medical Services and Support Services to develop a method of ordering radiology services that will be medically appropriate, will record the results of tests on the patient's medical record, and will capture this information on the patient's bill for services.

Senior Laboratory Technician

The Senior Laboratory Technician will be responsible for operating the Laboratory Department and establishing laboratory administrative procedures.

Pharmacist

The pharmacist will be responsible for the operation of the hospital's Pharmacy and for establishing pharmacy administrative procedures. The Pharmacist will determine what drugs will be stocked and will develop an inventory management system to assure the supply and security of the pharmacy's inventory. An important factor in assuring patient satisfaction is the uninterrupted supply of appropriate drugs.

Another responsibility of the pharmacist will be to work with the Medical Records Manager, the Finance Manager, and the Deputy Directors of Medical and Support Services to develop a method of ordering drugs for inpatients that will be medically appropriate, will record the nature and quantity of these drugs in the patient's medical record, and will capture them on the patient's bill for services. For outpatients, the Pharmacist will work with the Finance Manager to develop a system where outpatients will pay for drugs at the time of delivery.

(2) HOTEL SERVICES:

Housekeeping Manager

The cleanliness of the hospital is vital for both the health of the patients and for their perception of quality service. Housekeeping staff have the primary function of keeping the hospital clean – not an easy task. Part of the problem is that a hospital is an active place, open 24 hours a day, every day of the year. Frequently, the high traffic areas need special attention; if they are not cleaned properly, they can give a negative image to the entire hospital. A clean hospital is perceived to be a well-organized and well-managed hospital.

Under autonomy, the Housekeeping Department will develop and implement plans and schedules to clean the hospital. The Housekeeping Manager will be responsible for developing a schedule for daily cleaning of the hospital. The Housekeeping Manager will train staff to follow the cleaning plan and will arrange additional training in techniques to clean such specialty areas as operating theaters, intensive care units, isolation rooms, and delivery rooms. Also, housekeeping personnel are needed to work in the laundry, kitchen, and dry waste disposal areas. Housekeeping personnel should be sufficient in number to clean the hospital twice daily.

Maintenance Manager

A department in the hospital that often is overlooked by patients and visitors is the Maintenance Department. There are essentially two aspects of the maintenance function of the hospital: (1) traditional maintenance, and (2) biomedical maintenance.

Traditional maintenance involves maintaining the building and machinery of the hospital. These functions may be improved if the Maintenance Department and the hospital have preventive maintenance programs to ensure that work will be done on a regular basis to keep the hospital's machinery and equipment from breaking down. The preventive programs include periodic inspections of the equipment, at which time inspectors should make minor adjustments to the apparatus. Record keeping is critical to adequate preventive maintenance programs; the purchase date of the item, major repair of the equipment, and inspection reports all must be recorded.

Biomedical maintenance involves the repair and scheduled testing, calibration, and upkeep of diagnostic and therapeutic devices used in patient care.

Kitchen Chief

The Dietary Department has a role in the therapeutic care of the patients, as well as in providing quality food menus for the patients and the staff. No department in the hospital reaches more patients and hospital staff than this department. If the food service is good and adequate, it receives only faint praise from patients and personnel. If the food service is inadequate, criticisms abound.

The Kitchen Chief will be responsible for the department and will have two supervisors, one for each shift. The Kitchen Chief will develop a reliable source for procuring food stuff, oversee the operation of the kitchen, develop a schedule for preparation of patient meals, and determine how meals will be served to patients. A qualified professional dietician will plan and direct the patient menus.

Laundry Manager

Without clean linen and staff uniforms, the hospital cannot operate properly. The Laundry Manager is responsible for developing a plan for the operation of the Laundry Department and the distribution of clean and the collection of soiled linens. The Laundry Manager will also develop a method for the control of linen inventories and determine the specialty services which are required, such as linen repair.

Stores Manager

A wide variety of materials are required for the operation of any hospital. These range from bandages to medical gasses to sterile supplies. The Hospital Stores department is usually under the direction of a Stores Manager. This manager has to determine what, when, and how much should be purchased for hospital inventories. The receipt of goods is the responsibility of the manager and the personnel in purchasing. These goods must then be maintained in the storeroom. The Stores Manager determines which supplies will be stocked, the quantities required, and how they will be procured, stored, and distributed.

In developing this inventory, the Stores Manager will also develop an inventory control system that accounts for the quantity, location, and condition of storeroom items. This system will include an efficient method for the ordering of supplies by the various departments of the hospital, the rapid delivery of the supplies to the department, and any accounting of all items consumed. The Stores Manager will also develop a plan for the operation of the Sterilization Department, determine what quality

control methods will be used, and how sterile items will be stored, cared for, and supplied to the areas where they are needed.

APPENDIX C

CALCULATIONS RELATED TO EXHIBIT 7 - Finance Section

APPENDIX C

Calculations Related to Exhibit 7 - Finance Section

Unit Costs

The following calculations were used to arrive at estimates of unit costs per inpatient day and outpatient visit in 1992 at the two institutions targeted in this study.

The total workload was 24,105 admissions and 381,690 outpatient visits. To determine the total workload for a facility whose output includes both inpatients and outpatients, four outpatient visits were assumed to equal one inpatient day of care with regard to resource consumption. This is consistent with the methodology used by Shepard and Carrin in Rwanda and cost studies in Papua New Guinea. Using the 4:1 ratio of outpatient visits to one inpatient day with regard to resource intensiveness, there were a total of 309,452 patient days of which 214,029 (this implies an average length of stay of 8.9 days) were attributed to inpatients and 95,423 to outpatient visits.

Dividing total costs by total patient days yields the average cost per patient day. On the basis of these assumptions, the average cost per patient day at PIMS, including both recurrent and capital costs, was estimated at 737 rupees. This breaks down to an estimated 567 rupees per day for recurrent costs and 170 rupees per day for capital costs. With four outpatient visits equaling one inpatient day in resource consumption, the average cost of an outpatient consultation at the two PIMS hospitals is 184 rupees (142 rupees are the recurrent costs and 42 rupees the associated capital costs.)

There are cost differences between the two hospitals, with Children's Hospital having a lower unit cost. Breaking down the costs, the unit costs of an inpatient day and an outpatient visit are 801 rupees and 200 rupees, respectively, at Islamabad Hospital and 562 rupees and 141 rupees at Children's Hospital. However, the higher costs estimated for Islamabad Hospital are due, in part, to the fact that certain costs, such as utilities and maintaining the site on which both hospitals are located, are attributed solely to the Islamabad Hospital. Thus, its total recurrent costs are overstated and those of Children's Hospital are understated.

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Policy Options for Financing Health Services in Pakistan

VOLUME IV
DEVELOPMENT OF PRIVATE HEALTH INSURANCE BASED ON MANAGED-CARE PRINCIPLES

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

Edited by: Marty Makinen

Volume I **Summary Report**
by Marty Makinen

Volume II **Hospital Quality Assurance Through Standards and Accreditation**
by Greg Becker

Volume III **Hospital Autonomy**
by Stan Hildebrand and William Newbrander

Volume IV **Development of Private Health Insurance Based on Managed-Care Principles**
by Zohair Ashir, Harris Berman, and Jon Kingsdale

Volume V **Organizing and Financing Rural Health Services**
by Richard Yoder, Sikandar Lalani, and Marty Makinen

Afzal Siddiqui provided the legal analysis for the study and the component initiatives (Volumes 1-5).

Zohair Ashir studied the use of Muslim religious funds for financing health services for the indigent (Volumes 1, 3, and 5).

ABSTRACT

This report focuses on the potential for developing in Pakistan private health insurance programs based on managed-care principles. Fostering such programs would benefit the Government of Pakistan because encouraging private coverage of health care costs would reduce the burden that the government currently bears in financing health services. At the same time, promoting the development of a private-sector insurance industry with the managed-care approach would contain the costs of health services while improving the quality of care provided. This study surveys employees in Karachi and Islamabad to ascertain the market potential for private insurance programs and makes recommendations about developing these markets. It also presents the basic elements of a model managed-care health insurance program for Pakistan.

VOLUME IV - DEVELOPMENT OF PRIVATE HEALTH INSURANCE BASED ON MANAGED-CARE PRINCIPLES

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i

ACRONYMS, ABBREVIATIONS, AND GLOSSARY vii

AN OVERVIEW OF THE STUDY "POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN" ix

EXECUTIVE SUMMARY ❩ PRIVATE HEALTH INSURANCE 1

1.0. INTRODUCTION 5
- 1.1. Background of Health Insurance in Pakistan 5
- 1.2. Objectives of the Study 6

2.0. METHODS 7
- 2.1. Issues that Need to be Addressed in Order to Develop Private Health Insurance 8

3.0. FINDINGS 10
- 3.1. The Employee Social Security Insurance Systems . . 10
- 3.2. The Condition of the Health Care Delivery System in Karachi and Islamabad 11
- 3.3. The Current Private Health Insurance Market and its Planned Products 12
  - 3.3.1. New Jubilee Insurance Company 13
  - 3.3.2. Adamjee Insurance Company 13
  - 3.3.3. Other Insurance Companies 14

4.0. THE POTENTIAL FOR MANAGED-CARE INSURANCE IN PAKISTAN . 15
- 4.1. Assessing the Potential for Managed Care 15
- 4.2 Description of Managed Care 15
- 4.3. Issues and Suggestions for Managed Care 17
- 4.4. The Potential for Managed Care 17
  - 4.4.1. Potential Managed-Care Providers 18
  - 4.4.2. Resources Required for the Development of Managed Care 18
  - 4.4.3. Major Obstacles to Developing Managed Care 19
- 4.5. A Managed-Care Insurance Model for Pakistan 19

5.0. A MARKET SURVEY OF EMPLOYERS 21
- 5.1. Methodology of the Survey 22
- 5.2. Findings and Analysis of the Employer Survey . . . 22
  - 5.2.1. Employers' Profile and Review of Current Health Benefits 22
    - 5.2.1.1. Responding Organizations by Type of Ownership 23
    - 5.2.1.2. Management and Unionized (Non-management) Personnel 23
    - 5.2.1.3. Eligible Populations 24

5.2.1.4. Current Benefits 25
5.2.1.5. Contracts with Health Care Providers 26
5.2.1.6. Hospital Rankings 27
5.2.1.7. Medical Care Expenditures 28
5.2.2. Employer Response to Managed-Care Plan and Benefits 29
5.2.2.1. Employers' Expression of Interest in a Managed-Care Health Insurance Product 29
5.2.2.2. Organizations Interested in Considering the Purchase of this Plan for Their Employees 30
5.2.2.3. Willingness to Pay More for Managed-Care Health Insurance 31
5.2.3. Features of the Model Managed-Care Plan That Were Liked and Disliked by the Respondents 31
5.2.4. Additional Services Recommended by Employers 31

6.0. LEGAL ISSUES RELATED TO PRIVATE HEALTH INSURANCE . . . 33
6.1. Creating a Legal Framework for Private Insurance . 33
6.2. Improving the Employee Social Security Insurance (ESSI) System 33
6.3. Establishing a Government Entity to Monitor Performance of Insurance Programs 34

7.0. RECOMMENDATIONS 35

8.0. IMPLEMENTATION PLAN 38

9.0. MONITORING AND EVALUATION PLAN 41

APPENDIX: CONCEPT PAPER: FEATURES, BENEFITS, AND PROCESSES FOR MANAGED-CARE HEALTH INSURANCE IN PAKISTAN . . . 43

BIBLIOGRAPHY 57

LIST OF EXHIBITS

Exhibit 1 A Brief Description of Managed Care for Survey Participants 15
Exhibit 2 Organizations Surveyed by Type of Ownership 23
Exhibit 3 Division of Personnel in Organizations Surveyed . . 23
Exhibit 4 Populations Eligible to Receive Health Benefits . . 24
Exhibit 5 Medical Benefits by Type of Services Provided by Employers 25
Exhibit 6 Number of Organizations Which Contract With Providers for Medical Services 26
Exhibit 7 Ranking of Hospitals by Employers 27
Exhibit 8 Total Annual Expenditure for Medical Care by Organizations Surveyed 28
Exhibit 9 Employers' Expression of Interest in a Managed-Care Health Insurance Product 29
Exhibit 10Organizations Interested in Considering Purchase of This Plan for Their Employees 30
Exhibit 11Willingness to Pay More for Managed Care 31
Exhibit 12Private Managed-Care Health Insurance Implementation Plan 39
Exhibit 13Private Health Insurance Monitoring and Evaluation Plan 42

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID	U.S. Agency for International Development (Washington, D.C.)
AKHS	Aga Khan Health Services
AKU	Aga Khan University
AKUH	Aga Khan University Hospital
AKUHS	Aga Khan University Health Services
Amir	Head of a Muslim State
ARI	Acute Respiratory Infection
Bait-ul-Mal	Welfare funds established by the Amir
BHUs	Basic Health Units
CCU	Cardiac Care Unit
CDA	Capital Development Authority
CDD	Controlling Diarrheal Diseases
CHW	Community Health Worker
CRHP	Cost Recovery for Health Project, Cairo, Egypt
chowkidar	Watchman
CV	Curriculum Vitae
CZA	Central Zakat Administration
CZC	Central Zakat Council
DHO	District Health Officer
DOH	Department of Health (provincial level)
EPI	Expanded Program of Immunization
ESSI	Employee Social Security Insurance
Fatamid Foundation	Blood Donor Agency
FGSH	Federal Government Services Hospital
FJMC	Fatimah Jinnah Medical Center
FMOH	Federal Ministry of Health of Pakistan
FP	Family planning
GDP	Gross Domestic Product
GMO	General Medical Officer
GNP	Gross National Product
GOP	Government of Pakistan
GP	General Practitioner
Hakims	Traditional health practitioners
HCFA	Health Care Financing Administration, U.S. Government
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
HPAC	Healthcare Provider Accreditation Council
HPN	Office of Health Population and Nutrition
HT	Health Technician
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IPA	Independent Practice Association
ISL	Islamabad
JCAHO	Joint Commission for the Accreditation of Health Care Organization
JPMC	Jinnah Postgraduate Medical Center
Katchi Abadis	Squatter Settlements
KEMC	King Edward Medical Center
KHI	Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMOH's new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMOH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan's health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health, through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative

approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of health insurance.

VOLUME IV

DEVELOPMENT OF PRIVATE HEALTH INSURANCE BASED ON MANAGED-CARE PRINCIPLES

EXECUTIVE SUMMARY

PRIVATE HEALTH INSURANCE

PURPOSE

The Federal Ministry of Health would like more Pakistanis to be covered by health insurance paid for by beneficiary and employer contributions. A private insurance system would include mechanisms that limit increases in health care and administrative costs. The current growth in the government's responsibility for financing health services would be reduced by any growth in private health insurance coverage.

PROBLEM

The Government of Pakistan is pursuing approaches in the reform of its hospitals and its rural health services which will result in consumers being asked to pay for the services they use. User payments, particularly for hospitalization, would be greatly facilitated if insurance mechanisms existed that shared the financial risks. Presently, the few private health insurance programs in Pakistan are plagued by escalating costs, fraud, and abuse. Thus, insurance companies are reluctant to offer health coverage, and employers worry about how to provide health benefits to their employees. New approaches to health insurance are needed to allay fears so that expansion of coverage may be attained to complement the changes being planned at government hospitals and, to a limited extent, in rural health facilities.

DESCRIPTION OF THE INITIATIVE

This initiative is designed to stimulate the development of private-sector insurance mechanisms based on managed-care principles. The focus is on designing ways to guide and support the development of insurance programs in two urban markets, Karachi and Islamabad. Managed-care principles are espoused to address the problems of cost escalation, fraud, and abuse prevalent in current indemnity-style insurance arrangements. Managed-care principles can be used in many designs. Whichever form is used, managed-care principles include having competitive prospective payment mechanisms to help contain costs. Under prospective payment, providers are given a fixed sum to have a set of services made available to a given group of people. This leaves providers with no financial motive to over-treat patients or to add ineffective, costly technologies. Further, providers are motivated to control unnecessary utilization rather than being tempted to join with the insured to defraud the insurer or the employer. Lastly, payments are made from the insurance organization directly to providers, bypassing the insured and closing off an opportunity for fraud.

METHODS

A multidimensional approach was taken to identify the problems inhibiting the development of health insurance in Pakistan and to recommend possible solutions. This approach included having technical visits made by external consultants associated with managed-care programs in the United States. Along with a Pakistani consultant, they conducted interviews and meetings in 1992 with representatives of the health sector and with members of the health insurance industry to assess the feasibility of using managed-care principles in the design of health insurance plans. An assessment of the health practices currently being used in Karachi and Islamabad also was done in order to understand how the health care delivery systems operate. To determine their interest in participating in a managed-care plan and to gather baseline data about them, employers of mid-size companies in Karachi and Islamabad were surveyed. In addition, an analysis was done of the Employee Social Security Insurance systems in each of the provinces.

These analyses found that, unless changes are made in the overall approach to health insurance, the share of the population covered by insurance is unlikely to grow and the performance of existing providers is likely to remain unsatisfactory. Under current circumstances, the general business environment is not conducive to encouraging good health insurance practices; both financial incentives and legislative measures are lacking. The result is that providers are wary of health insurance. A promising way out of this situation is to find methods of stimulating the development of private health insurance in the country.

RECOMMENDATIONS

To facilitate the development of health insurance using managed-care principles in Pakistan, the following recommendations are offered:

Near-Term Government Actions:

Conduct insurance workshops in Karachi and Islamabad for potential insurers, employers, and providers to present this study's findings. The Health Financing and Sustainability (HFS) report on insurance development should be made available to workshop participants since it offers planning and technical information about the current market for a managed-care product. The report's implementation plan could serve as the strategic plan for potential insurers to conduct feasibility analyses.

Help potential insurers acquire technical training in designing and operating managed-care plans. Request donor organizations to provide such training to insurers, employees, and providers as a part of technical assistance programs.

Encourage selected health care providers in Karachi and Islamabad to launch their own managed-care plan. The FMOH should consider trying to persuade selected providers in Karachi (such as the Aga Khan University Hospital) and in Islamabad (such as the Pakistan Institute of Medical Sciences) to start their own managed-care plans. To induce them into taking the initiative, the FMOH could purchase health services from them for a selected group of federal employees, providing them a ready client base until the plan becomes financially self-sustainable.

Give potential insurers financial incentives for inventing a managed-care health insurance plan. Private sector employers could be stimulated to purchase insurance by extending to them a temporary tax break when making their first purchase of a managed-care product. Once in the health care plan, benefits would be expected to keep them there without their tax incentive. State-owned organizations also could be induced to purchase managed-care insurance using funds currently spent on providing medical services.

Arrange for a government-backed demonstration of a managed-care plan. The GOP or Provincial Governments should consider showing off the attractive feature of managed care by contracting with private health insurers that use managed-care principles to provide services for a selected group of government employees.

Near-Term Insurer Actions:

Revise the HFS model of managed-care benefits based on employer survey feedback. It is recommended that potential insurers price the basic package described in this survey, then price asked-for "add ons." These include dental care, health coverage for members' parents, and the possibility of arranging for treatment abroad in special cases.

Conduct a feasibility study for introducing a managed-care product.
The employer survey conducted during the HFS study on insurance indicated a strong interest in learning more about a managed-care plan. Seventy-four percent of those surveyed asked for follow-up information. This suggests that it would be in the interest of potential insurers (insurance companies or providers) to take the next steps in defining and pricing a package of services to test the market.

Market managed-care plans to multinational and state-owned organizations. Multinational and state-owned organizations provide more liberal and generous health benefits than other employers in Pakistan These organizations are open to accepting concepts like managed care. In the employer survey, they indicated a desire to improve health coverage for all employees. Employees at management levels are better educated and more conscious of the importance of providing high quality care and of controlling escalating medical costs, the primary benefits of a managed- care product. Therefore, insurers may wish initially to target this category of employer.

Long-Term Government Actions:

Enact national legislation to provide the framework for managed-care insurance programs. Such legislation could allow for the revision of Employment Social Security Insurance, and to establish a national body to oversee insurance issues in Pakistan.

Revise the policy on Employee Social Security Insurance (ESSI). There are a number of areas that government can intervene in the ESSI program to improve its effectiveness. These include:

- Raising the income ceiling of ESSI-eligible employees and indexing it to inflation (i.e., have it increase annually by the rate of inflation). Also, employees who pierce this ceiling should be allowed to stay in the program, if they so desire.
- Making all non-supervisory employees eligible for enrollment in the ESSI program.
- Encouraging employee contributions on a monthly basis to further improve ESSI-provided services.
- Contracting with private providers on a capitation basis.
- Permitting employers to opt out of ESSI by selecting alternative insurance programs.

Conduct a study to assess the advantages and disadvantages of compulsory health insurance of employees by employers. Study the impact of such a policy on employment and competitiveness.

The HFS study concludes that employers in Pakistan are interested in exploring further the potential benefits of private health insurance and that, if the above recommendations are pursued, insurers could be attracted to offer private health care insurance plans based on managed-care principles.

1.0. INTRODUCTION

The development of private insurance based on managed-care principles in Pakistan is seen by the Federal Ministry of Health (FMOH) as an important way to address several of the major problems currently faced in the health sector. Expansion of private health insurance would help mobilize more resources for health, it would contribute to greater efficiency and would improve the quality of services offered. It would result in private payment for costly services such as hospitalizations. Using managed-care principles would put incentives in place for containment of costs and for increased health prevention efforts. Competing insurers would require participating providers to reach and maintain standards of quality. Furthermore, as private health insurance develops, the government would be able to reduce its subsidies to those able to pay, concentrating the freed-up resources on assisting those who are poorer.

The development of private health insurance also would complement and be complemented by the initiatives on hospital autonomy and quality assurance proposed in the overall Health Financing and Sustainability (HFS) study. Autonomous hospitals would be able to increase their revenues by competing for contracts with insurance organizations. Furthermore, the hospital standards and accreditation system that is expected to be developed through the quality initiative would provide insurers with information about which hospitals offer the best value for money.

The FMOH is eager to explore the prospects of developing Pakistan's private health insurance market. The approach chosen would include programs along the lines of managed-care efforts which have proven successful in the United States. The initial target groups would be large employers in urban centers. It is expected that after gaining experience and confidence during this period, insurers would expand coverage and market size to include larger portions of the population.

To help the FMOH address issues related to fostering the growth of private health insurance in Pakistan, a team of local and U.S.-based consultants was formed in February 1992. The FMOH requested that the work on the insurance initiative focus on two cities, Islamabad and Karachi.

1.1. Background of Health Insurance in Pakistan

Only a limited amount of health insurance now exists in Pakistan. The government is interested in the potential of the insurance market in the country. The seventh national five-year plan declares this interest.

Provincial Employee Social Security Insurance (ESSI) programs mandated (but not run) by the government provide insurance to industrial workers. Employers of these workers are required to pay into a fund 7 percent of the wages of workers earning up to Rs. 1,500 per month. As the Rs. 1,500 limit has not been raised since 1986 (although it is currently being revised upward to Rs. 3,000), there has been a reduction in the number of workers eligible for insurance since their pay level, raised by inflation and other factors, exceeds the current Rs. 1,500 ceiling.

The ESSI program provides medical services to non-government workers and their dependents through its own dispensaries and hospitals, and by paying for some inpatient services. The program does not enjoy good support from employers who frequently fund it for less than their full complement of employees, or fail to fund it at all.

The private health insurance market in Pakistan is just beginning to develop. It appears to be centered in Karachi and is largely limited to corporate executives and non-residents, particularly employees of multinational organizations and foreign governments. Insurers seem to be reluctant to enter this market for fear of losing money due to irregularities in the system, false claims by providers and chemists, expectations of full recovery of the medical allowance by beneficiaries, and fear of outright fraud or abuse. Only the New Jubilee Insurance (NJI) Company of Karachi has entered this market with enthusiasm. It now has over 25,000 people covered (Berman, 1992). Life insurance was denationalized in the last few years, and private insurance companies appear to use health insurance primarily to complement the commercial, life, and fire insurance portfolios of their preferred customers.

While government health services are "free," a number of factors suggest that a potential market for private health insurance exists in Pakistan:

- There is widespread dissatisfaction with existing government health services.
- Consumers are accustomed to paying for medical services in the private sector which accounts for the majority of the health expenditures in Pakistan (Berman, 1992).

1.2. Objectives of the Study

The specific objectives of the HFS study on private health insurance were developed after the February 1992 workshop, and were refined through subsequent consultation with FMOH officials. The objectives for this study were:

1. To review the existing health insurance market and the products currently available and to assess the potential for a managed-care service in the Karachi and Islamabad areas.

2. To define the incentives needed to encourage the establishment of a private sector health insurance market.

3. To conduct a survey of employers to help potential insurers ascertain the market for a managed-care product in Karachi and Islamabad. Also, to determine the level of interest among medium-to-large employers for a private managed-care health insurance product.

2.0. METHODS

This study on the development of private health insurance in Pakistan involved a broad array of policymakers and health professionals. The study relied heavily on an interactive process of data collection. Components of the study methodology were:

- **Development of the Terms of Reference**

  The terms of reference for this study of insurance were developed over a period of time beginning with the 1990 Phase I study, moving to the January 1992 research and the February 1992 framework workshops, and continuing during Marty Makinen's visit to Pakistan in July 1992 and a special team planning meeting held in September of that year. During this time, many discussions were held with USAID/Islamabad and with the FMOH to refine the scope of work of this project.

- **Visits to Pakistan by External Consultants**

  The visits of Harris Berman and Jon Kingsdale, executives of the Tufts Associated Health Plans of Boston, in February and April 1992, respectively, assessed the potential for the development of a private health insurance market, particularly for managed care, in this country. These visits culminated in a report that outlined what a managed-care health insurance plan for Pakistan might look like. This report was used to present information on managed care to Pakistani officials and to health care and insurance industry personnel. It was also given to those who were asked to fill out the insurance market survey developed for this study as a way of helping them understand and respond to survey questions.

- **Interviews with Health Sector Representatives**

  Over the course of the insurance study, interviews and meetings were held with health care providers, insurance companies, employers, and officials of the FMOH. These interviews are an important part of the findings presented later in this volume.

- **Team Planning Meeting**

  A special planning meeting of the HFS team of technical experts for the insurance component was held in Boston, Massachusetts in September 1992. During this planning session, work plans and details relating to the employer survey were developed.

- **Survey of Employers in Karachi and Islamabad**

  To assess the interest of employers in a managed-care health insurance plan, a survey was conducted in November and December 1992 of 52 selected businesses based in Karachi and Islamabad. This survey is the basis of the findings and analysis described in this report. The employers in medium- to large-size firms were drawn from a "reasoned sample" of companies in the two cities.

- **Health Financing and Sustainability Workshops**

  During the course of the HFS study, three workshops were held in Pakistan to give Pakistani health policy planners and administrators a chance to express their views about insurance and the health sector and to learn more about the work being performed under this study. In the February and November 1992 workshops, issues relating to the development of private health insurance along managed care lines were discussed. This enabled the technical experts to build a work plan that included the opinions and views of workshop participants.

- **Final Report on the Development of Private Health Insurance Based on Managed-Care Principles**

  This report is the final step in carrying out the methodology of the insurance study. A draft copy was submitted for comment to the FMOH and to USAID/Pakistan. A summary was presented to the participants in the February 1993 workshop, and their feedback has been incorporated. This report also was commented on by external reviewers.

2.1. Issues that Need to be Addressed in Order to Develop Private Health Insurance

Questions addressed in this private health insurance study are:

1. What can be done to improve the efficiency and quality of care provided in the provincial Employee Social Security Insurance (ESSI) systems?

2. Are the current health care systems in Karachi and Islamabad open to the development of private and managed-care health insurance?

3. What is the nature of the private health insurance market in Islamabad and Karachi and what products could be planned that would be attractive to this market?

4. Looking beyond Karachi and Islamabad, what is the potential for managed-care health insurance in Pakistan?

5. What would a benefits package and a managed-care health insurance program for Pakistan look like?

6. What do major employers in the country think about the prospects for private managed-care health insurance in Pakistan?

7. What are the legal issues related to managed-care health insurance in Pakistan?

8. What has to be done to encourage the development of a private insurance market?

3.0. FINDINGS

The findings of this study are presented in reference to the questions listed in Section 2.0. As mentioned earlier, the FMOH requested that the investigative efforts related to insurance be focused on the cities of Karachi and Islamabad since these cities seem to have the most immediate potential users of managed-care insurance programs.

3.1. The Employee Social Security Insurance Systems

Pakistan's provincial ESSI program was among the long list of items that HFS proposed to the FMOH for study. HFS gathered information about the ESSI in preparation for the February 1993 workshop at which the long list also was discussed. Following the workshop, the FMOH decided that, although the ESSIs should not be a major focus of this study, it wanted the study team to make a summary assessment of the program.

Employee Social Security Insurance is a non-governmental, self-financing insurance scheme which has been operating in most of the provinces since 1967. Mandated by the participating provincial governments, this program provides direct outpatient and pharmacy services to its members and reimburses them for inpatient services. It was initiated to extend health coverage to private-sector, non-supervisory employees and their dependents. Employers are required to pay 7 percent of an eligible employee's salary to ESSI. For many years, only employees earning less than Rs. 1,500 per month were eligible. Recently, the government has decided to raise this ceiling to Rs. 3000 per month, and should implement this decision soon. Currently, the program is under-subscribed, under-funded, and has trouble meeting its objectives.

In some cases, however, such as in the province of Sindh, the program enjoys considerable support from both employers and employees. In Karachi, the Sindh Employee Social Security Insurance (SESSI) program owns and operates some outpatient and hospital facilities. These facilities suffer from shortage of funds and capital availability, but the services they provide are extensively used by the eligible population. Strengthening such facilities by improving the infrastructure and by providing additional capital would enable SESSI to offer quality medical care at a reasonable price.

The ESSI concept has two major flaws. First, it operates as a bureaucratic organization. Since funding is assured regardless of performance, efficiency is poor and quality of care is low. Second, the maximum wage allowable for inclusion in ESSI is adjusted only rarely; as a result, many who need it are excluded from using the program. Also, given inflation, ESSI revenue

declines in purchasing power every year. For example, at a rate of inflation of 5 percent, the purchasing power of ESSI funds over a ten-year period would fall by about 40 percent. With these two fundamental flaws, it is little wonder that ESSIs have poor reputations. They often have declining resources to work with in an institutional set-up where there is no incentive for responsiveness to consumers.

The following suggestions are offered to address these flaws:

- Index to inflation the maximum wage for eligibility for ESSI. This would permit workers in the same wage group always to be covered. It also would protect the purchasing power of ESSI revenues.

- Allow all non-supervisory employees to enroll in ESSI.

- Permit employers to opt out of ESSI by making contracts with other providers for the same amount of money (7 percent of wages up to the maximum) in order to obtain the same basic package of health care benefits. This would force the ESSIs to compete on the basis of quality of service or to lose members and their contributions to non-ESSI providers.

- Permit and encourage ESSIs to contract with providers on a capitation (fixed annual payment per individual or family covered) basis. This would permit ESSIs to use competition among providers to control costs and improve quality.

3.2. The Condition of the Health Care Delivery System in Karachi and Islamabad

Islamabad is the capital of Pakistan. It is a new city; construction began in 1960. Its population is approximately 500,000. Although the center of government, it has limited commercial or industrial activities at this time. Karachi, on the other hand, has a population of over ten million and is the largest commercial and industrial city as well as the largest port in the country.

Based on interviews conducted with a variety of consultants, insurance company executives, and health care providers in Karachi and Islamabad, the following picture of the Karachi and Islamabad health care delivery systems emerged. The conditions and characteristics highlighted below are those related to the feasibility of private managed-care programs.

The major characteristics of these cities' health care delivery system are:

- Most medical care settings, both public and private, lack important, even rudimentary, technology. Few health care delivery institutions meet the minimal standards of service now available in moderately developed Asian countries.

- The quality of training and of care delivered is highly variable.

- Few physicians specifically trained in general practice are available. Most of the general practitioners begin practice right after finishing medical school and their residency program; few have post-graduate experience.

- Most general practitioners are expected by patients to prescribe in order to justify charging for a visit.

- Poly-pharmacy (prescribing an excessive number of medications) is rife and patients demand it (chemists are free to prescribe medicines without the approval of a physician).

- Most patients skip the general practitioner and go directly to specialists who enjoy higher prestige.

- The quality of care varies according to the patient's socioeconomic status.

- There is an abundance of hospital capacity in Karachi. (In 1989, 123 hospitals and approximately 12,000 beds of highly variable quality were listed as available — 1 bed for every 420 people). This compares with an estimated need of approximately 9,000 beds (Aga Kahn University Hospital Report, 1989).

- Many large employers provide medical care to their employees (and, in some cases, to their dependents) from a panel of selected providers (doctors, hospitals, and diagnostic facilities), some employ general practitioners who can refer patients to panel-approved hospitals and specialists.

- Employee health benefits, which are shallow, typically include a cash allowance, a capped allowance per hospitalization or per year, or some combination of the two. There is no tradition of co-payment as distinct from a ceiling on the monetary value of insurance.

- Employee health benefits often distinguish between inpatient and outpatient care. The more generous health benefit plans not only select providers, but set fees, manage referrals, and review utilization.

- Employers, providers, and insurers recognize the rising cost of medical benefits and admit the presence of abuse and corruption in the administration of these benefits.

- In general, employers support the need for raising the standards of medical care and are willing to consider health insurance products which can contain costs and provide better-quality health services.

3.3. The Current Private Health Insurance Market and its Planned Products

The private health insurance market is just starting to develop in Pakistan. Most private and state-owned insurance companies do not offer health care insurance products, instead concentrating on the commercial and life insurance business. The few that offer health insurance products, do so mainly to retain the commercial and life insurance portfolio of their preferred clients.

Still, two companies in the private sector have made health insurance available to their clients: the New Jubilee Insurance Company and the Adamjee Insurance Company, both based in Karachi.

3.3.1. New Jubilee Insurance Company

Of the two companies, New Jubilee Insurance (NJI) seemed most interested in promoting health insurance products. It also is the only private, large insurance company which has a separate division to handle the health insurance market. NJI sells health insurance products to interested companies which may or may not have commercial and other insurance business with NJI.

A review of current health insurance services provided by NJI reveals a membership base of 15,000 to 18,000 people. At this time, NJI provides a limited range of services, basically extending indemnity-based health insurance coverage. However, NJI has made arrangements with most of the leading hospitals in the city for NJI-covered patients; in this way, it follows some managed-care principles.

In discussions with HFS, NJI offered some suggestions about ways to develop the private health insurance industry. They included:

1. Introduce legislation requiring employers to provide health insurance benefits for all employees (the current legislation only applies to employees in the Rs. 3000 per-month-or-less income bracket).

2. As part of the same legislation, allow employers to opt out of ESSI and buy health coverage from insurance companies on the open market.

3. Provide tax breaks that would encourage employees and employers to purchase health insurance. For example, allow employers and employees to write off their health insurance premiums against their tax burden.

Currently, NJI is concentrating on employers in the Karachi area and is selective about its clients. Only recently has NJI chosen to actively promote its health insurance product on a larger scale by, among other things, placing front-page advertisements in a leading newspaper.

In seeking to help develop the private health insurance industry, the FMOH may wish to keep in touch with NJI since it seems to be the most likely company to promote health insurance products in an aggressive manner. It may also have the greatest potential for providing private health insurance on a national scale.

3.3.2. Adamjee Insurance Company

Adamjee is the largest private insurance company in Pakistan. It offers a limited number of health insurance products to individuals and businesses. Its health insurance portfolio, however, only extends coverage to clients who depend on Adamjee for commercial and other general insurance. In its meetings with HFS, Adamjee Insurance expressed reluctance to expand beyond this client base.

3.3.3. Other Insurance Companies

Similar views were expressed by the State Life Insurance Company and by Alpha Insurance, other Karachi-based companies. A change in these companies' strategic position on health insurance is not expected any time soon.

It should be noted that these insurers' assessment of the viability of private health insurance products is a function of the current environment. If the government were to introduce legislation requiring employers to provide health insurance benefits to their employees, the private health insurance market would broaden and the interest of other insurance companies might increase dramatically.

4.0. THE POTENTIAL FOR MANAGED-CARE INSURANCE IN PAKISTAN

4.1. Assessing the Potential for Managed Care

In order to assess the potential for a managed-care health insurance program in Karachi and Islamabad, preliminary discussions and interviews were conducted by HFS insurance specialists with a cross section of employers, providers, and potential insurers in both the cities. These interviews were the base for exploring the feasibility of developing private health insurance in Pakistan and for testing some of the concepts which have made managed-care successful in other environments. Interviewees were asked a series of questions about the current health benefits provided by their employers and about their reactions to a model managed-care health insurance program. They were given the brief description shown in Exhibit 1 of a proposed managed-care product under consideration for Pakistan.

4.2 Description of Managed Care

EXHIBIT 1

A BRIEF DESCRIPTION OF MANAGED CARE FOR SURVEY PARTICIPANTS

<u>Principles of Managed Care</u>

1. Prepayment (premium) for a specified package of medical care services (benefits).
2. Delivery of services, primarily through a network of providers (hospitals, clinics, and physicians) selected by the health plan (health insurance company).
3. Provider and health plan share financial incentives for the plan's successful operation (risk sharing).
4. Systematic medical management by the health plan to assure delivery of high quality, cost-effective services to plan members.

EXHIBIT 1
A BRIEF DESCRIPTION OF MANAGED CARE FOR SURVEY PARTICIPANTS (CONTINUED)

Organization

In practice, managed care in the United States takes several distinct organizational forms:

- Pre-Paid Group Practice (PPGP) under which a multispecialty group (or groups) agrees to deliver a package of services to members enrolled in the health plan. Typically, a separate organization is set up to market the plan, enroll members, price and collect premiums, and generally manage financing of the health care services. Members are entitled to obtain specified types of medical care (e.g., obstetrical care, pediatric, hospital, drugs) directly from the multispecialty group(s) at the direction of the physician group, or from other providers (hospital, chemist, specialist) with which the group normally works. Because a large share of the multispecialty physician group's income depends on attracting members and keeping total costs below total expenses, the group tries to tightly manage the cost and quality of services.

- Another form of managed care is an Independent Practice Association (IPA). It is somewhat more complex than the Pre-Paid Group Practice and requires sophisticated data gathering and measurement. Typically, the IPA health plan contracts with a network of independent practitioners to arrange for the delivery of medical care to the plan's members. These physicians are then listed as plan providers from whom members may select their doctors. The quality, geographic accessibility, and quantity of such participating physicians influences how attractive the plan is compared to its competitors.

Operations

Often the management of services for individual patients is done by their primary care physicians who are on contract not only to deliver care to patients, but also to monitor and coordinate any services they refer patients to. Typically, the physicians are paid fees for service, but part of their fees are held back and returned at year-end only if the plan meets the budget. This form of risk sharing motivates the physicians to deliver and manage services at low cost.

Through its payment terms, risk-sharing arrangements, selection of providers, and measurement of the costs and quality of services delivered, the health plan plays a critical role in ensuring that most providers actively manage services in the best long-term interests of the plan's membership.

There are numerous variations on these two general types of managed-care health plans.

4.3. Issues and Suggestions for Managed Care

Managed care is a tool for influencing the cost, quality, and accessibility of medical care services for an enrolled population. Insurers and some employers who were interviewed by HFS health insurance experts acknowledged their inability to control yearly escalation of costs. However, most of the employers interviewed did not see cost reduction as one of their most urgent concerns. Given the business environment in Pakistan, particularly in Karachi, satisfying labor unions' concerns about the quality of medical care was a higher priority than controlling health care costs. In the initial interviews conducted by the HFS technical experts, virtually all of the interviewees expressed their preference for obtaining greater value for health care expenditures by improving the quality of care delivered and reducing "abuse." Abuse, in this case, refers to such issues as beneficiaries fraudulently arranging benefits for their uninsured friends.

The following responses from interviewees might be helpful in developing a model for a managed-care health insurance product for Pakistan.

- More emphasis needs to be put on training and retaining general practitioners.
- Referral systems from generalists to specialists need to be established for particular conditions and interventions.
- Poly-pharmacy practices need to be discouraged and a control system established for prescribing and dispensing drugs.
- Ways need to be found to reduce "abuse" by beneficiaries and/or providers. In particular, padding of hospital bills by providers, admitting patients without justifiable cause, or reimbursing the medical expenses of ineligible people needs to be stopped.

4.4. The Potential for Managed Care

It appears that there is greater potential for managed care in Karachi than in Islamabad because of the more competitive nature of Karachi's labor market and provider economy. In addition, the prevalence in Karachi of large, progressive private sector employers (especially multinational and semi-autonomous companies) is an asset. At the same time, Islamabad is growing rapidly and, as it adds health care resources and private employers, it may become more hospitable to managed care. Nonetheless, initiating managed-care plans in either city would not be easy, and success is far from assured.

Karachi also looks like a good place to market managed-care insurance because it has decent hospitals and specialists who provide quality services. These institutions and individuals compete vigorously for paying patients. If promised a steady flow of such patients through a managed-care plan, providers might well be interested. In particular, there are more private and semi-private hospital rooms in Karachi than there are patients, so hospitals would be very responsive to a scheme that fills them.

In terms of the target market, managed-care health insurance plans should initially focus on multinational and state-owned organizations. These organizations have more generous benefits and are more conducive to introducing change.

4.4.1. Potential Managed-Care Providers

Baqai Foundation

Among potential sponsors other than insurance companies, only the Baqai Foundation has indicated a determination to start its own Health Maintenance Organization (HMO)-type health insurance program in the near future (Kingsdale, 1992). The Baqai Foundation is headed by Dr. Farid Baqai. Besides operating Baqai hospital, the Foundation also owns and operates Baqai Medical College. Dr. Baqai has made at least one presentation to the officials of FMOH in which he has indicated the Foundation's intention to purchase and/or build four additional hospitals in Karachi and to use them as part of an HMO-style health insurance effort. He expects this health insurance plan and the five hospitals to become operational in the near future. The Baqai Foundation's managed-care program seems still to be in the planning stages, however, Dr. Baqai has offered to host a workshop in Karachi focusing on private managed-care health insurance in Pakistan to follow up on HFS's work.

The Aga Khan University Hospital (AKUH)

The AKUH in Karachi seems to be the most qualified and capable organization to start a HMO-type insurance plan, but it currently is focusing its resources on developing its provider capacity. Based on its excellent reputation and its strong position in the marketplace, AKUH in the future may plan to launch a health insurance scheme on its own or in association with other providers.

Shifa International Hospital

A multispecialty group in Islamabad sponsored by Pakistani physicians in North America is currently building a 200-bed hospital. The group has also expressed an interest in developing its own HMO health insurance plan to serve Islamabad, Rawalpindi, and the surrounding areas. It is too early to evaluate the group's capacity to do this.

4.4.2. Resources Required for the Development of Managed Care

To successfully introduce a private managed-care health insurance plan, some of the resources required will be:

- Credible sponsorship by prestigious, progressive organizations such as the Aga Khan University Hospital (provider) and/or the Habib Bank (employer).
- Expertise in medical management in the Pakistani context.
- Good primary care physicians.
- Interested employers and employees who are conscious of benefits derived from high-quality health services (such as lower absenteeism due to the emphasis placed by managed-care providers on preventive care and on high-quality curative care).
- Substantial start-up capital to create the managed-care organization, provider arrangements, and administrative systems. Initially, a reserve fund will also be needed to cover medical expenses that may exceed the collected premiums as a result of underpricing due to insufficient data.

4.4.3. Major Obstacles to Developing Managed Care

Based on its research and its knowledge of managed care, HFS found the following obstacles to developing private managed-care health insurance in Pakistan:

- The lack of good generalist physicians to coordinate care for plan members and the consequent absence of a referral system built upon generalists.
- The tradition of employees' expecting a relatively small cash allowance for medical care.
- The informal method by which some large domestic employers manage employee health benefits. The current system would have to be replaced by delegating management functions to a managed-care health insurance plan. Such delegation would erode the paternalistic "credit" and control that employers enjoy on a case-by-case basis as they determine the benefits for serious illness.
- The relative dearth of sophisticated, capable, non-profit organizations interested in sponsoring managed-care health insurance plans.

- Illiteracy and infrastructure problems that inhibit ready communication about medical issues, as well as problems related to patients finding transportation to preferred providers.

- An abundance of labor, reducing the need for generous, well-managed health care benefits that attract employees.

4.5. A Managed-Care Insurance Model for Pakistan

Synthesizing these findings, the potential for managed care in Pakistan is limited by the constraints of the current health care system environment and the responses of employers, employees, and providers to managed-care incentives. Consequently, the initial managed-care insurance efforts cannot fulfill all aspects of the standard managed care definition. They can, however, reflect managed-care principles that, if successful, will evolve into a full-scale managed-care organization that delivers cost effective health care at a reasonable price. The Appendix to this volume describes in more detail a conceptual model for private health insurance with managed-care principles that could operate in Pakistan. Further development would be based on actual experience. The system would have the following features:

- The system would operate simply and rely more on the selection of competent physicians than on any sophisticated monitoring of physician behavior through data systems, due to Pakistan's current unfamiliarity with managed care.

- Managed-care benefits would be introduced in two phases. The first phase would cover only inpatient and specialty services with the establishment of co-payments to discourage the use of specialists and to encourage the use of primary care physicians. In the second phase, primary care physician referrals would be required for coverage of inpatient and specialist care.

- The provider network would be limited in Phase 1 in order to ensure the selection of committed providers and to test administrative and financial systems.

- Due to the lack of adequate data to predict reliable capitation figures and due to the unfamiliarity of the concept to providers, care givers would first be reimbursed on a fee schedule. To encourage risk sharing, a certain amount of the fees charged would be held back by the managed-care organization and paid to providers after a year-end reconciliation.

- Successful implementation of managed-care principles will require skilled managers. Significant training may be necessary if management resources are not presently available in the country.

There seems to be a market for expanding private health insurance. This can be encouraged by addressing some of the concerns related to current private health insurance products by:

- Improving eligibility systems to eliminate coverage for false claimants.

- Improving quality assurance systems to eliminate poly-pharmacy practices.

- Improving systems to monitor provider fraud and abuse.

There may also be an opportunity to increase private managed-care health insurance by working within the context of current medical benefits plans. For large employers that are already using provider panels, co-payments, and utilization reviews, the inclusion of managed-care principles into their plans may be feasible. This possibility should be investigated.

5.0. A MARKET SURVEY OF EMPLOYERS

The FMOH and HFS agreed that a systematic survey of employers' interest in managed care would provide important data to this study. A market survey of selected employers in Karachi and Islamabad could indicate their interest in a managed-care product; this interest might stimulate interested insurers to develop plans. A survey would also demonstrate the commitment and support the FMOH is willing to provide in introducing a managed-care product in Pakistan. The details and findings of the survey that was conducted are presented in this section.

Specific objectives developed for the survey of employers were:

- To obtain information on current health benefits provided by employers in the two cities surveyed.
- To ascertain the most recent year's expenditures of these organizations on employee medical care.
- To assess employers' reactions to and views about a managed-care health insurance product, and their interest in acquiring this type of insurance were it available in their local market.
- To provide potentially interested insurers with a model of a managed-care health insurance plan which could be marketed in Pakistan.

This study was a market survey and did not seek to be representative of all businesses in Karachi and Islamabad.

To help surveyed employers understand what was meant by a managed-care health insurance product, HFS gave them a concept paper on such a product prior to the survey interviews. This paper can be found in the Appendix. Briefly, the services and benefits described to employers were:

- Ambulatory services including primary care, specialist care, diagnostic services, and drugs.
- Inpatient professional services including surgery, obstetrics, anesthesia, and psychiatry.
- Health promotion services including family planning and health education.
- Exclusions: dental, eye wear, non-prescription drugs.

In order to price this product, an interested insurer would have an actuarial projection performed based on reasonably comparable experiences in using medical services.

5.1. Methodology of the Survey

A list of organizations to involve in this survey was prepared based on "reasoned selection." They included organizations already visited by HFS technical experts as well as others selected randomly. A total of 52 organizations were short-listed; 32 based in Karachi and 20 in Islamabad. Out of the 52 organizations, 38 responded to the questionnaire. The response rate was best for international organizations and was lowest for Pakistani state-owned enterprises. This could be an indication that international organizations may be more interested in managed-care health insurance plans than are state-owned enterprises. The survey information presented in this section is based on the responses received from these 38 organizations.

The survey was conducted by having HFS technical experts schedule an interview with a responsible official of the company, normally a Human Resources Director or an Administrative Manager. Each respondent was given a specially prepared information and survey package which contained:

- An introduction to the HFS project.
- A basic description of managed care.
- A proposed summary of benefits (model care plan).
- The survey questionnaire.

5.2. Findings and Analysis of the Employer Survey

The findings and the analysis are presented in two parts. The first part is a profile of the employers surveyed and their current health benefits programs. The second part is employers' opinions about the hypothetical managed-care health insurance program described in the Appendix. A commentary after each table describes the survey findings.

5.2.1. Employers' Profile and Review of Current Health Benefits

This section briefly describes the employers who participated in the survey, indicating the type of ownership, the number of management and non-management (unionized) personnel, and information about their eligible populations, current benefits, contracts with providers, rankings of hospitals, and recent medical expenditures.

5.2.1.1. Responding Organizations by Type of Ownership

Exhibit 2 provides information on the ownership of the responding organizations.

EXHIBIT 2
Organizations Surveyed
By Type of Ownership
(N = 38 of 38)

Ownership	Karachi	Islamabad	Total
Multinational or Foreign	10	4	14
State Owned	6	5	11
Private (Pakistani)	7	6	13
Total	23	15	38

Commentary:

Four state-owned organizations (Habib Bank Ltd., the National Bank of Pakistan, the Pakistan National Shipping Corporation, and the State Bank of Pakistan) initially agreed to be interviewed for the survey, but were not willing to provide information without a specific request in writing by the Director General, Health. Even after getting this approval, however, these organizations failed to provide the information requested. This is an indication of the difficulties and obstacles facing potential insurers in dealing with organizations. The above-named organizations are still included as part of the 38 respondents.

5.2.1.2. Management and Unionized (Non-management) Personnel

EXHIBIT 3
Division of Personnel
in Organizations Surveyed
(N = 17 of 38)

	Karachi	Islamabad	Total # of Employees
Management	4,423	2,852	7,275
Unionized	6,411	7,656	14,067
Total	10,834	10,508	21,342

Commentary:

Staff classification information was made available for only 45 percent (17 out of 38) of the organizations surveyed. Personnel classified as management represented 34 percent (7,275 out of 21,342) of the employees.

5.2.1.3. Eligible Populations

Exhibit 4 shows who within the respondent organizations is eligible to receive health benefits provided by or paid for by the organization.

EXHIBIT 4
Populations Eligible to Receive Health Benefits
(N = 34 of 38)

Eligible Population	Number of Organizations
1. Employee only	4
2. Employees and Dependents (spouse and children)	17
3. Employee and Dependents (spouse, children, parents)	12
4. No Health Coverage Provided	1
Total	34

Commentary:

The majority of the organizations responding to this question (85 percent: 29 of 34) provide medical care to employees and their dependents; in some cases, this includes the parents of the employees.

5.2.1.4. Current Benefits

Exhibit 5 shows the nature of the health services provided by or paid for by responding organizations.

EXHIBIT 5
Medical Benefits
By Type of Services Provided by Employers
(N = 28 of 38)

Type of Services	Number of Organizations	
	Management Personnel	Unionized Personnel
Hospitalization (including specialty care)	27	27
Outpatient (including spec. care, diagnostic services, and pharmacy)	27	27
Max. ceiling in Rs./ Hospitalization	15*	15
No maximum ceiling	12	12
No health benefits provided	1	1

** In thousands. ($1.00 U.S. = 25 rupees in 1992).*

Commentary:

These data could be helpful in designing a managed-care benefits package. The organizations surveyed pursue an even-handed policy in providing medical care benefits to their employees. While all organizations responding to this question provide some form of both inpatient and outpatient services, there are differences in the level of services provided to the staff based on their classification and grades. It is noteworthy that 54 percent (15 out of 28) of the organizations have stipulated some form of capping system to limit their risk. The ceilings ranged between Rs. 25,000 to Rs. 35,000 per year per employee. This could offer a distinctive marketing advantage to a prospective insurer

since, under a managed-care health insurance plan, the maximum ceiling would probably be much higher. However, this is countered by the No Maximum Ceiling policy pursued by 43 percent of surveyed employers (12 of 28), mostly belonging to the state-owned category. Since state-owned organizations provide liberal health benefits, they are not able to control cost escalation; the major advantage for these organizations under a managed-care health insurance plan would be the incentives given to providers to control costs.

5.2.1.5. Contracts with Health Care Providers

Exhibit 6 shows the number of responding organizations that maintain contracts with either hospitals, specialists/consultants, and/or general practitioners.

EXHIBIT 6
Number of Organizations Which
Contract With Providers for
Medical Services
(N = 34 of 38)

	Yes	No	Did Not Respond	Total
Maintain Panel of Hospitals	17	9	8	34
Maintain Panel of Specialists/Consultants	8	8	18	34
Maintain Panel of GPs*	9	7	18	34

** General Practitioners*

Commentary:

These data indicate that many of the employers surveyed already use some form of managed-care principles by directing employees and their dependents to contracted providers. The majority of respondents (17 of 26) contract with hospitals to provide inpatient care to their employees and dependents. Half (8 of 16) of those responding said that they maintain panels of specialists and general practitioners. It may be possible to improve these provider arrangements by introducing additional managed-care principles such as risk sharing, quality assurance, and utilization reviews while also addressing benefits. Employers who have contractual arrangements already in force may be candidates for initiating private managed-care health insurance.

5.2.1.6. Hospital Rankings

Exhibit 7 indicates, in descending order, the quality of hospitals in the view of the respondents.

EXHIBIT 7
Ranking of Hospitals
by Employers

Rank	Karachi	Islamabad
1	Aga Khan University Hospital	PIMS*
2	Liaquat National Hospital	FGSH**
3	Ziauddin Memorial Hospital	Capital Hospital
4 (tie)	Baqai Hospital Orthopedic Medical Institute	
6	Medicare Hospital	

** PIMS = Pakistan Institute of Medical Sciences*
*** FGSH = Federal Government Services Hospital*

Commentary:

The rankings given to the hospitals listed are based on the perceptions of the employers surveyed. From a managed-care viewpoint, this information is helpful in developing a short list of hospitals which could be considered by a potential insurer as having considerable support and following among users. These rankings only serve as a guideline for identifying the perceived leading hospital in a city. A prospective insurer should select providers also based on quality of care standards, cost of treatment, and geographical location. For example, in a city like Karachi, managed-care health insurance contracts could exist with 5 to 7 hospitals as a way of providing accessibility to a majority of plan members. Other hospitals mentioned positively by respondents were the National Institute of Cardiovascular Diseases, Mideast Hospital, and some other smaller hospitals in Karachi.

5.2.1.7. Medical Care Expenditures

Exhibit 8 shows data on expenditures by responding organizations, by type of organization, and by city.

EXHIBIT 8
Total Annual Expenditure for Medical Care
by Organizations Surveyed
(N = 27 of 38)

Type of Organization	# of Orgs. Responding	# of Employees	Total Annual Cost (Rs. in Millions)	Avg. Exp. Per Employee (Rs.)
a. Multinational/ Foreign Agency	12	8,100	44.3	5,469
b. State Owned	7	28,584	182.4	6,381
c. Private	8	9,075	124.3	13,697*
Total:	27	45,759	351.0	7,670
Karachi	15	35,258	287.2	8,146
Islamabad	12	10,501	63.8	6,076

** Muslim Commercial Bank (MCB) accounts for Rs. 100 million of Rs. 124.3 million total expenditures for private organizations. Without MCB expenditures, the average cost per employee for private organizations comes to Rs.4,119.*

Commentary:

Caution should be used in interpreting the data presented in Exhibit 8. This information is based on a company's best estimate for the most recent year. In most cases, the total expenditure data included both hospitalization and outpatient costs. Total expenditures also include cash benefits provided by some companies for medical care. Information relating to the state-owned organizations is lopsided because of the presence of some very large companies such as Pakistan International Airways with 19,319 employees and Rs. 120 million in annual expenditures.

From a potential insurer viewpoint, however, these data are helpful in assessing the level of financial commitment made by the organizations surveyed to their medical care programs. This information can be used as a guideline in determining the premium-paying capacity of employers. Based on the data given in Exhibits 5 and 8, it is possible to extract information to use in designing a managed-care product which reflects employers' preference in level of coverage desired and inability to pay. The total health expenditure of this sample of employers of Rs. 351 million offers an attractive potential market for a prospective insurer. It is broken down as Rs. 287 million for Karachi-based employers and Rs. 64 million for Islamabad employees. Prospective insurers are advised to use the information given in these exhibits as baseline data to be built upon.

5.2.2. Employer Response to Managed-Care Plan and Benefits

In the second part of the survey, the questions were based on how a proposed managed-care health insurance plan might work in Pakistan using the model described in the Appendix. The intent in preparing this model was to test the concept of such a plan on the employers and to assess their interest in purchasing this service if it were available in the market. Employers were told that the plan could be modified by the prospective insurer to include amendments and additions requested by the employers. The findings and analysis of this model-based survey are summarized on the following pages.

5.2.2.1. Employers' Expression of Interest in a Managed-Care Health Insurance Product

The first survey question asked employers to express their interest in offering a managed-care health insurance plan such as the model in place of their existing medical benefits. Their responses were:

EXHIBIT 9
Employers' Expression of Interest
in a Managed-Care Health Insurance Product
(N = 33 of 38)

Interest	Number of Organizations
Responses received	33
Organizations that wished to provide the model managed-care plan to both management and unionized staff	23
Organizations that wished to restrict the plan to management staff only	7
Organizations not interested in managed care (satisfied with their existing arrangement)	3

Commentary:

The model managed-care health insurance plan found a strongly favorable response with 91 percent (30 of 33) organizations interested. Of these employers, 77 percent (23 of 30) expressed their desire to offer such a plan to both their management and unionized staff. Only 23 percent (7 of 30) stated that they would restrict the availability of this plan to their management cadre.

5.2.2.2. Organizations Interested in Considering the Purchase of this Plan for Their Employees

Employers were asked to rank on a scale of 1 to 5 their interest in receiving pricing information as a way of considering purchase of this plan for their employees. Their responses are shown in Exhibit 10.

EXHIBIT 10
Organizations Interested in Considering
Purchase of This Plan for Their Employees
(N = 34 of 38)

Ranking	# of Organizations
1 Not Interested	3
2	-
3	4
4	2
5 Very Interested	25

Commentary:

The employers surveyed were very interested in receiving pricing information about this plan; 74 percent (25 of 34 organizations) expressed deep interest in the product. A prospective insurer may want to initiate the process of pricing such a product since the employer market may be receptive to considering purchase of a managed-care health insurance plan, provided the price is right.

5.2.2.3. Willingness to Pay More for Managed-Care Health Insurance

Respondents were asked to indicate if the prospective managed-care health insurance plan needed to cost less than their existing health benefit program in order to interest them further. They were also asked if they would be willing to pay more for managed care.

EXHIBIT 11
Willingness to Pay More for Managed Care
(N = 31 of 38)

	Yes	No	Total
Plan must cost less than existing costs	13	18	31
Willing to pay more	18	13	31

Commentary:

While only 42 percent (13 of 31) of the respondents felt that the managed-care plan must cost less than their current health coverage, 58 percent (18 of 31) were willing to consider this plan even if it costs more than their existing health care.

5.2.3. Features of the Model Managed-Care Plan That Were Liked and Disliked by the Respondents

Fourteen percent of the employers surveyed felt that the co-payment feature of the managed-care health insurance plan would be helpful in controlling costs and reducing the abuse of medical benefits. Other features which employers felt were helpful were the availability of preventive and outpatient services.

Fourteen percent of the employers also indicated their dislike for the concept of co-payment, feeling that it might be difficult to implement in their environment. There also was some resistance to the idea of not funding inpatient private rooms as well as to the idea that managed care restricts the freedom to choose health care providers.

The mixed response on co-payments, private room availability and physician choice indicates that insurers may need to tailor products to employers' individual needs. Managed-care health insurance products including no co-payments, private rooms, and greater choice (preferred providers) would have to be priced higher.

5.2.4. Additional Services Recommended by Employers

Dental coverage was cited by most employers as a service which should be included as a standard feature of managed-care health insurance plans, with 30 percent of the respondents requesting addition of this service. Other services that could be considered for inclusion were treatment abroad for selected medical conditions, prescriptions for eyeglasses, inclusion of parents as part of dependent coverage, and enlisting *hakims* (traditional practitioners) and homeopaths as part of the managed-care health insurance plan.

One of the major pharmaceutical companies interviewed in the course of this study replied that it is required by law to pay 2 percent of its pre-tax profit to the government every year for a Workers' Welfare Fund and 5 percent towards a Workers' Participation Fund. The general idea is to use these funds to give workers and their families better education, health care, and other social services. The company felt that these monies were not being used for the purpose for which they were collected. A review of these funds and their use could be undertaken as a way of assuming that more of them get applied to improving health and other services for employees.

6.0. LEGAL ISSUES RELATED TO PRIVATE HEALTH INSURANCE

The HFS study team examined the legal framework that currently exists in Pakistan related to private health insurance. The study found that health insurance programs can be developed by private individuals and organizations in Pakistan under existing laws, including the Companies Ordinance, the Partnership Act, and the Insurance Laws. Although the latter legislation gives permission to sell health insurance policies, most of its provisions deal with life and general insurance. At this time, there is no formal statutory private health insurance law and no machinery is available to enable a consumer to go to a designated authority and seek redress on insurance issues.

For discussion of the overall legal issues relevant to health sector reform and the other initiatives in this study, see summary Volume I. The study team decided that three things need to be done in the area of insurance: (1) laws must be written that would foster the development of private insurance along the lines of managed care, and (2) the Employee Social Security Insurance system needs to be improved, and (3) an oversight organization needs to be created to monitor the development and performance of private insurance programs. Recommendations are made below in each of these areas.

6.1. Creating a Legal Framework for Private Insurance

Laws need to be created that make it possible for individuals or their agents (such as employers, cooperatives, or other group representatives) to purchase managed-care-style medical coverage for themselves and their dependents. Eventually, insurance coverage could be made compulsory for some groups such as for employees of enterprises employing a certain number of employees.

These laws should also provide that insurance companies be subject to financial regulation. Among other things, they should be required to have minimum reserves or re-insurance coverage in relation to potential actuarial obligations.

Further, the new laws may wish to favor insurance which features managed-care types of organizations (groups which have prospective payments for services on a capitation basis). This approach is expected to help control costs of care, promote the use of preventive services, encourage healthy lifestyles, and reduce fraud and abuse. Methods for favoring such approaches could include offering favorable tax treatment of premiums paid for such coverage or of profits earned by insurers.

6.2. Improving the Employee Social Security Insurance (ESSI) System

Any new insurance laws should allow provincial governments to index the wage ceiling for eligibility for ESSIs to an official measure of the inflation rate. They also should provide that ESSIs be permitted to enter into capitation-type contracts with provider organizations for the provision of services to members. Finally, these laws should permit provincial governments eventually to allow employers to opt out of ESSI if they provide their employees with alternative services of equal or better quality and scope.

6.3. Establishing a Government Entity to Monitor Performance of Insurance Programs

Consideration should be given to creating a government entity to monitor the financial and quality-of-care performance of managed-care health insurance plans. This idea seems to have value, but needs to be explored further.

7.0. RECOMMENDATIONS

Private health insurance has become a mechanism for financing health services in many countries. This could also be true in Pakistan. To facilitate the development of health insurance and managed-care health insurance in Pakistan, the HFS study offers the following recommendations:

Near-Term Government Actions:

- *Conduct workshops for potential insurance organizations, employers, and health care providers in Karachi and Islamabad to present the findings of this study*. The HFS study report would be made available to the participants. The report's implementation plan could serve as a strategic plan for potential insurers.

- *Help potential insurers acquire technical training in designing and operating managed-care plans.* The FMOH could ask donors to provide technical training to interested insurers as part of their programs in health care for Pakistan. This would both stimulate private insurers and also demonstrate the government's commitment to helping introduce private health insurance along managed-care lines in this country.

- *Encourage selected health care providers in Karachi and Islamabad to initiate their own managed-care health insurance plans.* The Pakistan Institute of Medical Sciences (PIMS) is already used by government employees. If the government agrees to refer its employees to PIMS on a capitation basis, this would enable the hospital to amplify its revenue source while also gaining experience in managing its own health insurance plan. Depending on the success of such a plan, this approach could be expanded to other cities.

- *Provide financial incentives to potential insurers for investing in a managed-care health insurance plan.*

  Private sector employers could be stimulated to purchase health insurance by extending to them a temporary tax break to offset a part of the expenditure incurred in making the first purchase of one of these new products. This tax break could be a temporary way to "break the ice" to induce employers to try out the concept. Once employers enroll in a managed-care plan, the benefits could be expected to keep them there without the tax incentive.

- *Arrange for a government-backed demonstration of a managed-care plan.* The GOP or Provincial Governments should consider showing off the attractive feature of managed care

by contracting with private health insurers that use managed-care principles to provide services for a selected group of government employees.

Near-Term Insurer Actions:

- *Revise the HFS managed-care model to incorporate employer feedback*. The views of the employers surveyed in Karachi and Islamabad regarding the strengths and weaknesses of the model would be helpful in structuring a benefits package that would be attractive to them and their counterparts. Some of the features they suggested are dental care, benefits for parents of plan members, and access to treatment abroad, when appropriate. HFS recommends that, first, a basic package be priced. Then, each of the desired add-ons could be individually priced. Adding together the cost of the basic package and the prices of chosen add-ons would give employers the total price of the specific package they desire.

- *Conduct a feasibility study for introducing a managed-care health insurance product.* The survey conducted during this study shows that employers are very interested in considering managed-care health insurance options as an alternative to their current system of health benefits. Ninety-one percent of the respondents wanted to know more about the model managed-care health insurance plan. Seventy-four percent asked to receive pricing information on the model.

  The size of the potential market (Rs. 351 million: Rs. 287 million for Karachi and Rs. 64 million for Islamabad) in annual expenditures for 45,759 employees for the 27 respondents alone should make this market an attractive proposition for any interested insurer.

- *Market managed-care plans to multinational/foreign and state-owned organizations.* Based on the survey findings, interest among employers for a managed-care product is quite high. The findings also indicate that while organizations provide medical coverage for most of their employees, multinational/foreign and state-owned organizations tend to furnish more liberal and extensive health benefits. Therefore, these organizations may be more inclined to participate in a managed-care health insurance plan; this should be part of the initial marketing strategy of a prospective insurer.

Long-Term Government Actions:

- *Enact national legislation to provide the framework for managed-care insurance programs.* Such legislation could allow for the revision of Employment Social Security Insurance, and the establishment of a national body to oversee insurance issues in Pakistan.

- *Revise the policy on Employee Social Security Insurance (ESSI).* There are a number of areas that government can intervene in the ESSI program to improve its effectiveness. These include:

  - Raising the income ceiling of ESSI-eligible employees and indexing it to inflation (i.e., have it increase annually by the rate of inflation). Also, employees who pierce this ceiling should be allowed to stay in the program if they so desire.

  - Making all non-supervisory employees eligible for enrollment in the ESSI program.

  - Encouraging employee contributions on a monthly basis to further improve ESSI-provided services.

  - Contracting with private providers on a capitation basis.

  - Permitting employers to opt out of ESSI by selecting alternative insurance programs.

- *Conduct a study to assess the advantages and disadvantages of compulsory health insurance coverage for employers.* Study the impact of such a policy on employment and competitiveness. New legislation could cause a reduction in employment and a loss of competitiveness in export markets. Before enacting any such legislation, the impact of these consequences should be estimated and alternatives considered.

8.0. IMPLEMENTATION PLAN

The details of an implementation plan to introduce managed-care health insurance in Pakistan are laid out in Exhibit 12. This plan begins with introducing managed-care health insurance to insurers, employers, providers, and the Department of Health in Karachi and Islamabad. This could be done in workshops that would present and discuss the findings contained in the HFS report. The plan also includes offering financial incentives, initiating a study of the effects of compulsory insurance, beginning a dialogue with providers about starting their own managed-care health insurance plans, conducting a feasibility study, and submitting the ESSI recommendations to provincial governments.

The second stage of this plan would be to implement model managed-care health insurance plans in Karachi and/or Islamabad and would be followed by monitoring and evaluating those efforts. Assuming that pilot programs go well, managed-care health insurance could then be introduced, first, in other selected cities and, then, nationwide.

EXHIBIT 12
PRIVATE MANAGED-CARE HEALTH INSURANCE
IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	DURATION IN MOS.*	START/ END MO.	WHO/WHAT	BUDGET RESOURCES	COMMENTS
INTRODUCE MANAGED-CARE HEALTH INSURANCE IN KARACHI AND ISLAMABAD	CONDUCT WORKSHOP IN KARACHI AND ISLAMABAD TO PRESENT HFS STUDY FINDINGS TO INSURERS, EMPLOYERS, PROVIDERS & DOH	1	1-1	FMOH, DOH, INS, EMP, PROVIDERS & TA	FMOH, DONOR & INSURER	FMOH MAY REQUEST PROSPECTIVE INSURER TO SPONSOR WORKSHOP
	DEVELOP FINANCIAL INCENTIVES FOR POTENTIAL SPONSORS & PARTICIPANTS INCLUDING LEGAL FRAMEWORK	18	1-18	FMOH, DOH, INS, EMP & TA	FMOH & DONOR	CONSIDER FORMING A WORKING GROUP AND REVIEW INCENTIVES GIVEN TO OTHER INDUSTRIES
	BEGIN STUDY OF COMPULSORY HEALTH INSURANCE	18	1-18	FMOH, DOH, INS, EMP & TA	FMOH & DONOR	LEGISLATION SHOULD CONSIDER DISADVANTAGES OF COMPULSORY INS. LAW, FORM WORKING GROUP
	BEGIN DIALOGUE WITH PROVIDER(S) TO START THEIR OWN MANAGED-CARE HEALTH INSURANCE PLAN	6	3-9	FMOH, DOH, PROVIDERS, TA	FMOH & DONOR	IDENTIFY ONE PROVIDER EACH IN KARACHI & ISLAMABAD
	SUBMIT ESSI RECOMMENDATIONS TO PROVINCIAL GOVERNMENTS	12	3-15	FMOH, DOH	FMOH	FINALIZE HFS RECOMMENDATIONS
IMPLEMENT MANAGED-CARE HEALTH INSURANCE PLAN(S) IN KARACHI AND/OR ISLAMABAD	HELP INTERESTED/CAPABLE PARTIES TO START A MANAGED-CARE HEALTH INSURANCE PLAN INCLUDING A FEASIBILITY STUDY	18	6-24	FMOH, INS, PROVIDERS, EMP, TA	FMOH, INSURER, PROVIDERS, EMP, DONORS	BEGIN IMPLEMENTATION, STEP BY STEP
MONITOR & EVALUATE PERFORMANCE AT KARACHI & ISLAMABAD	GATHER INFORMATION ON EXPERIENCES IN KARACHI & ISLAMABAD, EVALUATE, THEN MODIFY APPROACHES	MONITOR: 24 EVALUATE: 2	MONITOR: 24-48 EVALUATE: 36; 48	FMOH, DOH, INS, EMP, PROVIDERS & TA	FMOH & DONOR	DRAW LESSONS, MODIFY AND CONSIDER FOR ADDITIONAL IMPLEMENTATION

**From start of process.*

FMOH: FEDERAL MINISTRY OF HEALTH DOH: DEPARTMENT OF HEALTH (PROVINCE)
TA: TECHNICAL ASSISTANCE
INS: INSURER EMP: EMPLOYER

EXHIBIT 12
PRIVATE MANAGED-CARE HEALTH INSURANCE
IMPLEMENTATION PLAN
(CONTINUED)

OBJECTIVES	ACTIVITIES	DURATION IN MOS.*	START/ END MO.	WHO/WHAT	BUDGET RESOURCES	COMMENTS
CONSIDER IMPLEMENTATION OF MANAGED-CARE HEALTH INSURANCE TO OTHER SELECTED CITIES	DEVISE PLANS BY CITY/PROVINCE FOR INTRODUCING MANAGED-CARE HEALTH INSURANCE BASED ON EXPERIENCES OF OTHER CITIES	24	48-72	FMOH, DOH & TA	FMOH, DOH & DONOR	IN CONSULTATION WITH PROVINCES, IDENTIFY OTHER CITIES FOR IMPLEMENTATION
MONITOR & EVALUATE PERFORMANCE AT OTHER LOCATIONS	GATHER DATA ON PERFORMANCE INDICATORS, EVALUATE, THEN REVISE APPROACHES	MONITOR: 24 EVALUATE: 2	MONITOR: 72-96 EVALUATE: 84, 96	FMOH, DOH & TA	FMOH, DOH & DONOR	LEARN LESSONS FOR MODIFYING INSURANCE MODEL BEFORE FURTHER IMPLEMENTATION
INTRODUCE MANAGED-CARE HEALTH INSURANCE ON A NATIONWIDE BASIS	DEVISE/IMPLEMENT A LONG-TERM PLAN (10 YEARS) FOR NATIONWIDE IMPLEMENTATION	120	84-204	FMOH, DOH, INS/EMP/TA	FMOH, DOH & DONOR	COMPLETE MAXIMUM POPULATION COVERAGE

**From start of process*

FMOH: FEDERAL MINISTRY OF HEALTH DOH: DEPARTMENT OF HEALTH (PROVINCE)
TA: TECHNICAL ASSISTANCE
INS: INSURER EMP: EMPLOYER

9.0. MONITORING AND EVALUATION PLAN

Ongoing monitoring and evaluation activities are included within the implementation plan described in the preceding section. Once managed-care initiatives are developed and implemented by providers, an evaluation will have to be done of the impact of these programs on all parties: employers, employees, providers, insurers themselves, and the Government of Pakistan. Monitoring and evaluation activities that are additional to the ones mentioned in the implementation section are:

- Observing insurers' responses to government actions aimed at fostering managed care.
- Obtaining feedback from employers using the new insurance services.
- Evaluating the experiences and level of satisfaction with managed-care services of employees of participating government departments compared with previous practices.
- Reviewing insurers' plans for expanding health insurance coverage to the uncovered population of the country.
- Conducting recurrent reviews with providers regarding the performance of health insurers.
- Considering the formation of a "watchdog committee" in each of the provinces to oversee the conduct of both insurers and providers and to protect the interests of users.

These activities would be carried out in addition to any regulatory activities the government might undertake as a result of establishing a legal framework for managed care within the country.

EXHIBIT 13
PRIVATE HEALTH INSURANCE
MONITORING AND EVALUATION PLAN

OBJECTIVES	MONITORING INDICATORS	EVALUATIONS
INTRODUCE MANAGED-CARE HEALTH INSURANCE IN KARACHI & ISLAMABAD	OBSERVE POTENTIAL INSURERS RESPONSE TO FMOH INITIATIVES	ONGOING
MEASURE CONSUMER SATISFACTION	EMPLOYER/USER SURVEY GOVT. EMPL/USER SURVEY	ANNUAL ANNUAL
DEVELOP AN EXPANDING PRIVATE HEALTH INSURANCE MARKET	INSURERS MEMBERSHIP ENROLLMENT	ANNUAL
INSURANCE AS AN ALTERNATE SOURCE OF HEALTH FINANCING	PARTICIPATING PUBLIC & PRIVATE SECTOR REVENUE INCREASE	ANNUAL
NATIONWIDE HEALTH INSURANCE COVERAGE	INCREASING INSURANCE MEMBERSHIP TO ADDITIONAL CITIES & RURAL AREAS	ONCE EVERY TWO YEARS

APPENDIX

CONCEPT PAPER:
FEATURES, BENEFITS, AND PROCESSES
FOR MANAGED-CARE HEALTH INSURANCE IN PAKISTAN

APPENDIX

CONCEPT PAPER: FEATURES, BENEFITS, AND PROCESSES FOR MANAGED-CARE HEALTH INSURANCE IN PAKISTAN

INTRODUCTION

The following concept paper is intended to be a preliminary design for a Pakistani managed-care health insurance plan. Using as a base a plan organized and operated in the United States, this paper proposes modifications for the Pakistani context. Due to the newness of managed-care concepts in Pakistan and to the radical changes such plans bring about in provider relationships, it is clear that a Pakistani managed-care plan will need to be altered significantly from the American model.

Managed care must be developed in phases. Progress can be determined and efforts redirected based on initial experiences. Additional analysis would need to precede the development of an implementation plan.

This paper presents the key features of a model plan. Consideration is given to the composition of the provider network, operation of referrals among physicians, reimbursement of providers to encourage cost effectiveness, and benefits coverage. Information also is included on a dozen key administrative processes that are essential to the operation of a successful plan.

FEATURES

Simplicity

In light of Pakistan's current unfamiliarity with managed-care concepts and programs, its partial literacy rate (16-18 percent nationally, higher in urban areas), other social and economic support system deficiencies, and the relatively low price of medical services, it is critical that any managed-care program operate relatively simply. Any such programs should have minimal administrative overhead and relatively elemental requirements for communication among health care personnel, employers, employees (and their dependents), participating physicians, and other providers. Therefore, plan designs must rely more on the selection of competent, motivated providers and on clear financial incentives to reinforce cost-effective service delivery than on sophisticated monitoring and regulation of provider behavior based on claims or other data analyses. Perhaps the claims payment mechanism (whereby the insurance system pays the patient or provider for the service rendered), subject as it is to abuse, delay, and confusion, should be kept as uncomplicated as possible.

Minimizing claims payments without reverting to a simple cash allowance is a challenge. Because transferring payments is complicated for a widespread Independent Practice Association (IPA) network, a pre-paid group practice (PPGP) model may be more practical in the Pakistani context. Alternatively, if a patient's freedom to choose practitioners is not crucial to market appeal, then an IPA with relatively few hospitals and physicians participating, or one hospital with specialists on salary and a small network of highly qualified primary care physicians (called "generalists" in the Pakistani context) may be both administratively feasible and attractive to the market.

In order to simplify the flow of money, primary care physicians might eventually be paid by "capitation" (i.e., so many rupees per covered member per month). A single, sophisticated hospital and affiliated specialists in each city could provide all other services. In a large market such as Karachi, however, multiple hospitals would be needed in order to ensure access of many people to care and to give individuals a choice of care providers. Each member and PCP could be linked either by geography or by choice to one hospital with its associated specialists.

To keep the system manageable as it begins (Phase I), the program could initially be largely limited to inpatient and specialty services. Later, in Phase II, such services as outpatient care and pharmaceuticals could be offered.

Fee Schedule

A managed-care health plan would need to develop a fee schedule that would pay specialists and primary care providers fees-for-service with some portion withheld as a way of sharing risks. Employer fee schedules are common and very simple (e.g., one fee for a visit to the generalist, one or two fees for specialist visits, and surgical procedure fees). Any plan would need to call for pre-authorization of all non-emergency hospital admissions and of continued visits to specialists (e.g., more than five on a single referral or during an episode of care). Pre-authorization and concurrent review for inpatient and outpatient specialty care are familiar practices in Pakistan, but the withholding and capitation concepts are foreign. The acceptance of the latter ideas on the part of providers must be tested. (The British National Health Service's "honorarium" is known to some of the more sophisticated Pakistani physicians.)

Primary Care Providers

Generalist practitioners are central to a managed-care insurance plan and must be carefully selected. This is the weakest professional link in Pakistani medicine, yet the most important management device (the "gatekeeper") in managed care where the generalist is expected to restrict unnecessary utilization of

services. In Phase I, a managed hospital care plan would cover inpatient and specialist services only, allowing time to establish and train a network of general practitioners to centerpiece the system in Phase II.

Selection of generalist physicians should involve site visits and substantial input from qualified specialists. Selection should also be reinforced on a continuing basis by intensive training and education. Consideration may have to be given to using a non-gatekeeper managed-care plan design if Pakistan's primary care physicians prove simply to be too weak to manage referrals effectively.

In Phase II, plan members would be free to select a general practitioner from the participating panel and would then be required to use that physician for all generalist services as well as for referrals to specialists. Specialists would not be reimbursed by the plan unless services were rendered as a result of a proper referral from the patient's core physician.

Co-Payments

In order to keep patients interested in obtaining services at the primary care level and to keep the primary care physician interested in providing this care, patients should pay a small but not a token amount (a co-payment of perhaps Rs. 10) for visits to their own primary care physicians. A more sizeable co-payment would be required to see specialists. This co-payment should be a fixed amount per visit (possibly Rs. 50 so that the fee works as a real disincentive to overuse specialists for trivial visits). Co-payment is a foreign concept, so market acceptance may dictate that the plan phase this in, starting with only the co-payment on specialty care in Phase I and adding co-payment on primary care physician services in Phase II.

Pharmaceuticals

Because pharmaceutical services might well be the single largest cost (perhaps 25 to 50 percent) of a comprehensive plan, this aspect of a care plan must be tightly managed to keep down costs and to reduce poly-pharmacy (excessive prescribing). Outpatient drugs should require a co-payment and should be dispensed only from carefully selected and professionally run pharmacies. This may mean that the health plan has to start its own central pharmacy and formulary.

Management of a pharmacy, reduced use of specialists for minor complaints, and decreases in unnecessary hospitalizations for relatively minor complaints may prove to be the most fruitful forms of cost containment in Phase II.

Benefits

Any plan for the administration of managed-care health programs is affected by the menu of medical services being proposed. A first cut at a package of benefits is shown below. Following the menu are some preliminary ideas on the administration of managed-care insurance plans. These ideas take into consideration the different administrative demands of Phase I and Phase II.

Covered Services

In Phase I, the package would not cover any physician, hospital, or ancillary service (other than eye exams) not performed at the hospital with which the member of a plan is associated. Repeat visits, admissions, and same-day surgery would have to be pre-authorized by the health plan. (Emergency services would have to be authorized within 24 hours of their being incurred.)

In Phase II, the package would not cover any physician, hospital, or ancillary service (other than eye exams and Ob/Gyn services) not performed by the member's primary care physician, by a specialist to whom the primary care provider referred the patient, or pre-authorized by the health plan. (Again, emergency services would have to be authorized within 24 hours of receiving the care.)

OUTPATIENT SERVICES		
SERVICE	COVERAGE	CO-PAY/QUALIFICATION
PCP** Office Visits	Unlimited*	Rs. 10/visit
Specialist Consults in Med/Surg/Peds/ Ob-Gyn	Unlimited*	Rs. 50/visit, W/PCP referral, up to 5 visits
Psychiatry	10 Visits/yr*	50% co-pay
Laboratory tests	Unlimited	No co-pay
Diagnostics Radiology	Unlimited	No co-pay
Other Diagnostics	Unlimited	No co-pay
Outpatient Hospital	Covered on same basis as individual PCPs and specialists	
Prescription Drugs	Unlimited at Plan Pharmacy*	Rs. 10/prescription
Eye Exam	One per year	No co-pay
INPATIENT SERVICES		
Surgeon	Unlimited	No co-pay (pre-auth.)
Obstetrician	Unlimited	No co-pay
Anesthesia	Unlimited	No co-pay
Psychiatry	30 Days	50% co-pay
Other Specialist	Unlimited	No co-pay

** These items would be covered only in Phase II, and then, perhaps, as a rider.*
*** Primary Care Physician*

HOSPITAL FACILITY		
SERVICE	COVERAGE	CO-PAY/QUALIFICATION
Obstetrics	1 Day/normal del. Add'l Days for C-section	No co-payment if pre-authorized
Medical/Surgical	Unlimited	No Co-pay (pre-auth.)
Psychiatric	30 Days/year	No Co-pay (pre-auth.)

HEALTH PROMOTION
Family Planning Services, including IUD insertion, pill, and contraceptives (but co-payment may be required to avoid abuse)
Patient self-care and plan procedures guidebook
Quarterly newsletter on health promotion and preventive techniques, including precautions during epidemics (meningitis, flu, etc.)

EXCLUSIONS *(unless added as a rider with additional premium)*
Routine dental, other than trauma
Eye wear
Non-prescription drugs

KEY PROCESSES

The following processes are considered critical in delivering value to managed-care health insurance consumers, especially in Phase II.

1. Underwriting
2. Pricing and Budgeting of Premiums
3. Marketing
4. Enrollment and Collection of Premiums

5. Membership Identification

6. Customer Service

7. Processing and Payment of Claims

8. Management of Financial Risks

9. Selecting, Credentialing, and Contracting With Providers

10. Provider Relations, Medical Management, and Quality Assurance

11. Determination and Interpretation of Benefits

12. Data Collection and Analysis of Prices and of Utilization of Services

1. Underwriting Guidelines. Initially, underwriting guidelines should target sizeable firms (ones that have over 50 subscribers) in order to reduce marketing costs. Subscribers should be full-time employees not otherwise eligible for ESSI (i.e., they should have wages at least in excess of Rs. 3,000 per month). When legal changes allow conversion of ESSI contributions to private plans, it may become feasible to extend eligibility to lower-paid employees.

If employees are asked to contribute to their premiums (not unreasonable if, as seems likely, the managed-care health insurance plan will be more expensive than current plans), under no circumstances should premium contribution from employees exceed 50 percent. In Phase II, employers should give their eligible employees a choice between traditional benefits (such as cash or indemnity) and the managed-care health insurance plan. Plan pricing should reflect the preference for replacement rather than option coverage. Some minimum participation level (e.g., 50 percent of eligible employees) would be required, even in an option situation. In Phase II, how the employer structures the choice of health plan or the rider for medicine (the relative benefits and costs to the employee) will be critical to the plan's market appeal and to its cost performance.

2. Pricing and Budgeting Premiums. This will be inexact at first. Provider capitation arrangements for payment would fix the payor's risk, but the initial paucity of credible utilization data will make determining such capitation amounts fairly problematic. At first, perhaps all physician and hospital payment arrangements should be fee-for-service with a withholding of 15 to 25 percent with settlement on a plan-wide basis. This would provide a large retention fund (reserves). With experience over time, each hospital and specialist grouping should be budgeted

separately for its own members, and primary care physicians should be capitated for their own members.

Specifically, each hospital and its associated specialists would be budgeted for expected expenses per member month. Hospitals could be paid discounted charges at first and, eventually, a comprehensive per diem plus operating theater rate. General practitioners could be paid by claim with an amount withheld until such time as their panel reaches 100 plan members. This would allow the plan to gain some experience before setting global payment rates; it would also protect providers from getting too many sick people under a capitation payment scheme.

3. Marketing. Developing a marketing plan will be a learning experience. It would be smart to start with some form of "sponsorship" from a foreign partner and with backing from opinion leaders in the local business community. If the product were to target managers and junior managers (sometimes as many as half the employees in a firm), it could cater to their status ambitions. For example, having a prestige name for the plan, offering a special membership identification card, and providing access to special benefits such as semi-private accommodations would play to this image and market niche.

The "sale" of a managed-care health plan will have to be made at the highest level of a business in order to have the support needed to institute radical innovations. As the concept is so new to Pakistan, intensive sales force training will be required and enrollment must be preceded by extensive education of the potential membership.

Reliance must be placed largely on local expertise to get the marketing on track. Preliminary meetings, including ones with the general managers of target companies and with prestigious medical personnel could help smooth the way for follow-up sales calls. Getting a few opinion leaders in the business community to take this project under their wing or to try it on a low-risk pilot basis may also be helpful.

4. Enrollment, Billing, and Collection of Premiums. These activities will require careful controls. Advance billing would be safer for the plan. Apparently, this is common practice by insurers in Pakistan. However, for employers who are sensitive to the time-value of money, billing could be made quarterly. At a minimum, the plan must have strict policies for terminating services for non-payment of premiums.

Enrollment, disenrollment, and reconciliation of premiums would be complicated by high turnover rates. In a work force with very low turnover, this should not be a problem. Nevertheless, enrollment and disenrollment should be possible only at time of hiring or at an annual offering date. All additions and

terminations of members must be done prior to the start of the eligibility period in order to allow time for activities such as producing identification cards and updating providers' membership lists.

5. <u>Membership Identification</u> A system of member identification must be "tight" to avoid abuse. Some employees currently carry work-related identification (I.D.) cards, with their pictures and the names and ages of their dependents. Most Pakistani adults also carry a pictured I.D. card with a unique national I.D. number. At a minimum, the managed-care health plan should give each adult member an insurance card which lists his or her national identification number and all enrolled dependents (with age, sex and other identifiers). Members would have to present their health plan and that national I.D. cards to get service. Production and distribution of these cards will require careful planning and management to minimize costs and abuse. For example, employers must agree to return an employee's card upon termination of employment. In Phase II, on a monthly basis the plan should provide each primary care physician with a list of plan members (subscribers and dependents) on his/her panel. As long as a way is found to discourage abuse, the referral system and card combination should eliminate the problem of covering non-members.

6. <u>Customer Service</u>. Providing high quality customer service will be an extremely complex task, depending on the plan's ability and the employer's willingness to educate and train members and providers about the plan's processes and procedures. On-site training of employers and employees by plan sales personnel must be extensive and comprehensive. Since in-house medical officers currently provide annual check-ups and other clinical services, an attractive feature might be to offer, as a benefit, having the plan's medical officer routinely visit work sites in order to educate employees, do physicals, and handle customer service issues.

Assuming that the higher-paid employees in Pakistan are generally literate, each subscriber could receive a health-plan handbook as a benefit of joining the plan and as a training device. If read and consulted, such a handbook could become a critical tool in customer relations, a vehicle for health education, and a very attractive marketing device. This handbook could counsel members on self-limiting symptoms, on a few simple and effective home remedies, on when and how to access plan providers and on simple preventive measures such as smoking cessation.

7. <u>Processing and Payment of Claims.</u> This may be done on a relatively simple basis compared to the U.S. because: (1) payers now use relatively few fees (as stated before, one for generalists and two for specialists, plus procedures, tests, and hospital charges), and (2) primary care and pharmacy services could be delayed until Phase II and then paid on something other than

fee-for-service. Comprehensive hospital per diems appear to be practical, with a standard per diem set for all secondary-care facilities in a city and another for tertiary-care referrals.

Hospital accommodations and charges almost always vary by the patient's socio-economic status, and some accommodation to this norm will be required. The plan may have to process hospital and related-specialty claims on a two-tiered or three-tiered schedule of payments and be able to check a member's eligibility file and the account's plan type in order to pay at the appropriate accommodation level.

Pre-authorization for hospitalization can be performed by telephone or fax and concurrent review of extended hospital stays and repeat specialty visits can be done by medical officers. In Phase II, management of specialty referrals could be the trickiest piece from a claims-processing and communication perspective. To monitor for abuse in referrals, the plan would audit the primary care provider's records of referrals against referral slips submitted by specialists during the plan's annual inspection and review of primary care physicians prior to contract renewal (see #9 below).

In Phase II, the plan could supply duplicate referral slips and ask the primary care physician to retain one copy for the patient's medical record. The other copy would go with the patient to the specialist who, in turn, would send it with the claim to the plan. It would need to specify member data, date, the condition for which the primary care physician referred the patient, diagnostic information, and recommended treatment. Each referral form would need to be numbered for auditing purposes.

The plan should own/manage its own pharmacy(s) in Phase II and should fill only official prescriptions containing the following information: physician's name, member's name and health plan I.D. number, condition/diagnosis, name and quantity of drug, renewal information, and the day's date. Special prescribing pads (duplicate) will generate a copy for the member to give to the pharmacy and a copy for the prescribing physician to keep as part of the patient's medical record. It will be critical for the plan to collect these prescriptions from any participating private pharmacy as a pre-condition for payment, both because of the threat of abuse and because of the need for data on drug use.

Special emphasis must be placed on guarding against such abuses as buying medicines under the plan for non-members, "lending" the ID number to friends, and fee-splitting between the primary care physician and the specialist. A separate fraud/audit team may be needed to send a strong signal that such practices are being monitored and will be punished. To discourage fraud and abuse, criminal action against providers or members may be required.

8. Management of Financial Risks. This may be eased by the apparent lack of concern that most payers have about catastrophic claims. The style of medicine and patient expectations in Pakistan do not indicate the need for high-impact case management or individual stop-loss protection. (Of course, these conditions may change, especially if private insurance becomes more viable.)

Nevertheless, pricing and budgeting will be hit-or-miss at first. Because of this, it is probably prudent to initially collect a withholding, wherever possible, from specialists, primary care physicians, and hospitals, and to return this whole or in part at year-end settlement uniformly across the relatively small network in each market. This practice will obviate the need for having a fixed budget per member month and will allow for benefit variations without generating a new budget for each benefit level. Acceptance of financial risk by providers is key and must be tested.

After gaining experience and membership, the plan would evolve into a system of separate budgeting, retention funds, and settlement for each provider unit (i.e., each hospital and associated specialist as a single provider unit). Specialists can be in more than one provider unit, in which case they will be subject to multiple settlements, but members must be allocated to only one such unit. Hospitals without full secondary-care services would have to be grouped with other hospitals offering complementary services. Specialty hospitals, such as eye hospitals, could serve all members and be settled on a plan-wide basis.

9. Selecting, Credentialing, and Contracting With Providers. These activities may be the most important managements tool for the plan. The key to provider selection may be to start with a well-organized, prestigious, committed group of specialists. As multispecialty groups do not currently exist in Pakistan, finding such a group becomes a critical challenge. Large hospitals are the other option, such as the Aga Khan and Baqai Hospitals in Karachi or PIMS and Shifa International hospitals in Islamabad. Specialists enjoy prestige in Pakistan and will be the fulcrum for market appeal. Their willingness to participate in managed-care plans must be tested.

In smaller cities, a single, good hospital and associated specialists may suffice and would simplify administration and control of any plan. Discussions with providers and employers in Karachi indicate that a minimum of five geographically dispersed secondary-care hospitals and one tertiary-care facility would be required. If confirmed, then the plan should design its network so that each hospital has its own service area, specialists, and associated network of primary care providers.

In Phase II, the network of practitioners must be carefully selected, with substantial input from specialists. This selection should be based on interviews, on site visits, and on objective minimum standards. Examples of the standards could be that the primary care physician has an examining table, uses lab tests and x-ray in diagnosis, keeps medical records, has a minimum of one-year house officership and three years of subsequent experience or has actually done some additional residency in general medicine or primary care specialties, and arranges for coverage when he or she is not available. Primary care provider capitation or fees could be increased for generalists who meet these procedural standards and have post-graduate training in a primary-care specialty. The plan could provide training and aides (such as medical record folders on its members) to encourage such practices. Ideally, other providers in a service region would form one or more coverage groups for plan members. Continuing medical education and support by the plan, matched by requirements that the providers achieve these standards within a specified number of years after joining, will be critical to quality improvement.

10. <u>Provider Relations, Medical Management, and Quality Assurance.</u> In order to monitor practice, audit records, and stay in close contact with providers, a rotating committee comprised of specialists, providers, and the plan's managing physician should visit each provider's office annually prior to contract renewal in order to observe practice, review records, and get the provider's thoughts.

Although the primary care providers initially need to be paid fees-for-service with a withholding as soon as actuarial experience and membership is built up, they could be switched to capitation. Any adjustment to capitation would have to be proven by medical records indicating frequency of visits. The annual review should capture such data, which is also useful for actuarial projections and budgeting.

Each managed-care plan will need a full-time medical director. Fortunately, many large employers have such personnel to manage their own in-house clinics or to provide gatekeeper services, referral management, utilization review, and quality assurance functions for their in-house plan of benefits. These Senior Medical Officers, as they are called, would make perfect candidates for the managed-care plan's post. They are accustomed to performing telephone review of a sort, to interviewing and selecting generalists and specialists for their panels, and to negotiating fee levels and referral patterns.

Monitoring for under-use will be required for the primary care providers on capitation payment. In addition to auditing their records annually, the plan should develop protocols for encouraging and following-up on member grievances, especially regarding under-service by providers. The threat of termination

ought to prove a powerful incentive to good service once the practitioner has acquired 100 or more plan members on his/her panel.

Many generalists practice in pairs (often, both a female and a male physician) and there is a growing prevalence of family practices (i.e., a family of physicians in practice together who must be treated as a single provider unit for plan purposes). Problems may arise if the family includes specialists or if solo practitioners share an office with specialists, as some of the better ones do. Measures will be needed to guard against abuse of the referral system in such contexts. It may be that provider capitation will present too strong a temptation to many primary care providers to make too many referrals, in which case a fee-for-service with withholding approach would be preferable. Again, the key lies in choosing reputable, honest, and competent primary care physicians and specialists.

In addition to monitoring over-referral to specialists, medical management should focus on physicians' prescribing patterns, on the need for secondary-care hospitalizations, and on inpatient lengths of stay. These are all areas frequently identified as subject to waste. Follow-up specialty visits are another area of concern, although this may be a tough one to monitor.

Quality improvement should focus on continuing medical education and on training to a standard of practice management such as keeping elementary medical records, the norm for ambulatory care in the West.

11. Determination and Interpretation of Benefits. This determination must, of course, reflect local expectations and practices. Beneficiaries are accustomed to employers making relatively informal, paternalistic decisions about extending limited cash benefits in special circumstances. As a result, there may be a substantial problem of members and/or providers trying to stretch the interpretation of covered benefits or trying to upgrade patient accommodations with the active concurrence and support of client employers. Clearly, hospitals will want to fill their private and semi-private rooms at higher rates, so guidelines in this area must be both socially acceptable and firm.

Other issues may include access to tertiary out-of-country care facilities, interpretation of eligibility for certain dependents, and resort to homeopaths and other non-panel practitioners in special circumstances.

12. Data Collection and Analysis of Prices and of Utilization of Services. This may be somewhat simpler than in the U.S. because units of service are more global in Pakistan. Moreover, the problem of over-reliance on high-tech or even on

rudimentary diagnostic procedures is not yet relevant in Pakistan. For purposes of assuring quality in diagnoses, counts of lab tests and x-rays would be helpful. As most practitioners must refer out for such services, the plan should be able to track their utilization of claims data.

The relevant units of analysis for Phase II are:

- Drug Prescriptions
- Generalist Office Visits
- Specialists Office Visits
- Hospital Admissions and Days
- Surgical Procedures

For purposes of quality assurance and utilization review, claims-based data should be aggregated by member, by provider unit, and by primary care physician. (For capitated providers, claims data should be supplemented by annually collected medical records data.) Some data should be analyzed by specialists. This would be easy to do in non-tertiary care specialties where each participating hospital has one participating specialist with an assigned membership base. Physicians and hospitals should be profiled annually and compared with their peers in order to identify those providers who refer their members to specialists more than twice as often as the average provider, those members who use more than five times the average number of prescriptions per year, and those hospitals with high average lengths of stay.

For purposes of budgeting and premium projection, both utilization and fee data will be required, mainly on a per-member, per-month basis. Also, administrative overhead must be kept within bounds. (Employers and insurers need to be queried in greater detail on how much they currently spend to administer their own health benefits.)

Although more complex and administratively rigorous than current benefit plans, a managed-care health insurance plan would enjoy substantial economies over in-house employer benefit programs in terms of provider selection, contracting, claims payment, and other aspects of medical management. If administrative costs prove overly burdensome, there may be little choice but to contract with single, comprehensive provider entities such as the Aga Khan Hospital and Community Health Center, and simply pay them a capitation fee for all services rendered to enrolled members. Such a plan would have to be offered as an option to a reasonably comprehensive indemnity benefit package.

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Policy Options For Financing Health Services in Pakistan

VOLUME V
ORGANIZING AND FINANCING RURAL HEALTH SERVICES

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POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

Edited by: Marty Makinen

Volume I	**Summary Report** *by Marty Makinen*
Volume II	**Hospital Quality Assurance Through Standards and Accreditation** *by Greg Becker*
Volume III	**Hospital Autonomy** *by Stan Hildebrand and William Newbrander*
Volume IV	**Development of Private Health Insurance Based on Managed-Care Principles** *by Zohair Ashir, Harris Berman, and Jon Kingsdale*
Volume V	**Organizing and Financing Rural Health Services** *by Richard Yoder, Sikandar Lalani, and Marty Makinen*

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ABSTRACT

The purpose of this report is to explore an alternative approach to organizing and financing rural health services in Pakistan. The proposed model calls for the government to assign directly to rural communities the financial resources currently allocated to their local health facilities. The communities would then take responsibility for managing a contracting process whereby providers would compete to offer them a basic package of health services using existing government facilities and equipment. At the option of the community, additional services could be asked of the contractor in return for giving the provider the right to charge limited user fees. This report addresses the financing of different packages of services, including the provision of financial support for the needy; the development of a medical referral system; defining the contractual and oversight roles of the community; attracting providers to bid; and implementing, monitoring, and evaluating the proposed approach. Also included are a sample Request for Proposal and contract form that could be used in carrying out this alternative approach to the management of rural health services.

VOLUME V - ORGANIZING AND FINANCING RURAL HEALTH SERVICES

TABLE OF CONTENTS

ACKNOWLEDGEMENTS i

ACRONYMS, ABBREVIATIONS, AND GLOSSARY vii

AN OVERVIEW OF THE STUDY "POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN" ix

EXECUTIVE SUMMARY ➤ ORGANIZING AND FINANCING RURAL HEALTH SERVICES 1

1.0. INTRODUCTION 7
- 1.1. Background 7
- 1.2. Rural Health and Primary Health Care in Pakistan . 7
- 1.3. The Rural Health Care Study 8

2.0. PURPOSE AND OBJECTIVES 10

3.0. METHODS 12
- 3.1. Frameworks for Assessing the Rural Health System . 13
  - 3.1.1. The Organizational Framework 13
  - 3.1.2. A Rural Health System Framework 14

4.0. ALTERNATIVE RURAL MODEL: FINDINGS, RECOMMENDATIONS, AND ISSUES 16
- 4.1. General 16
- 4.2. Organization of Health Services 17
  - 4.2.1. Findings 17
  - 4.2.2. Options and Recommendations 18
- 4.3. Financing 19
  - 4.3.1. Recurrent Expenditure by Facility and Program 20
  - 4.3.2. Patient Load 22
  - 4.3.3. Unit Costs 23
  - 4.3.4. Current Sources and Size of Revenues . . 25
  - 4.3.5. Options for Health Services to be Offered and Associated Personnel Requirements . . 26
  - 4.3.6. Costs of Alternative Service, Personnel, and Infrastructure Options 29
  - 4.3.7. Financing Options: Sources and Size of Revenues 30
    - 4.3.7.1. Government Operating Allocation . . 30
    - 4.3.7.2. User Contributions 30
    - 4.3.7.3. Analysis of Willingness and Ability to Pay 35
    - 4.3.7.4 Zakat and Other Religious Charities. 36
    - 4.3.7.5. Summary of Revenue Sources and Size 38
    - 4.3.7.6. Summary 38

5.0. INTEREST AND ROLE OF POTENTIAL PROVIDERS 39
5.1. Findings 39
5.2. Recommendations 39

6.0. REFERRAL SYSTEM 41
6.1. Findings 41
6.2. Recommendations 41

7.0. COMMUNITY ROLE 45
7.1. Findings 45
7.2. Recommendations 46

8.0. LEGAL FRAMEWORK FOR THE RURAL HEALTH INITIATIVE 48
8.1. Overview 48
8.2. Sanctions 48
8.2.1. Grievance Structure 48
8.2.2. Ombudsman System 48
8.3. Laws Related to the Rural Health Initiative 49
8.3.1. Community Organizations 49
8.3.2. Operating Expenditures 49
8.3.3. Services Offered 49
8.3.4. Capital Replacement and Acquisition . . . 49
8.3.5. Rights of Personnel 50

9.0. IMPLEMENTATION PLAN 51

10.0. MONITORING AND EVALUATION 57

APPENDIX 1: INVITATION TO SUBMIT "EXPRESSIONS OF INTEREST" 63

APPENDIX 2: SAMPLE REQUEST FOR PROPOSALS (RFP) 65

APPENDIX 3: MODEL CONTRACT BETWEEN THE GOVERNMENT OF PAKISTAN AND PRIVATE PROVIDER 73

BIBLIOGRAPHY 81

LIST OF EXHIBITS

Exhibit 1 Illustrative Range of Forms of Rural Health, . . .
Public-Private Organizational Mix by Aspect . . . 15
Exhibit 2 Gains and Losses of Interested Parties With Alternative Model of Organization of Rural Services 19
Exhibit 3 Recurrent Expected Expenditure by Facility for the Year 1992-93 21
Exhibit 4 Summary of Actual and Forecast Patient Attendance for the Year 1993-94 22
Exhibit 5 ICT Outpatient Unit and Total Costs 24
Exhibit 6 ICT Sources and Volumes of Revenues (1992-1993) . . 25
Exhibit 7 Options for Services, Personnel, and Infrastructure 28
Exhibit 8 Estimated Annual Cost for Options A,B,C, & D . . . 32
Exhibit 9 Indicative Fee Schedule to Meet the Additional Costs of Various Options 33
Exhibit 10 Illustrative Estimates of Fees Needed to Cover the Costs ofVarious Options 34
Exhibit 11 Ability to Pay 36
Exhibit 12 Illustrative Effects of Cross-Subsidies on Fees Charged Under the Various Options 37
Exhibit 13 Summary of Sources and Size of Revenues by Service Option 38
Exhibit 14 Proposed Referral Structure for ICT Health Facilities 43
Exhibit 15 Diagram of Relationships Among Parties in Rural Health Model 52
Exhibit 16 Rural Health Summary Implementation Plan 54
Exhibit 17 Alternative Rural Model Monitoring and Evaluation Plan 60

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ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID	U.S. Agency for International Development (Washington, D.C.)
AKHS	Aga Khan Health Services
AKU	Aga Khan University
AKUH	Aga Khan University Hospital
AKUHS	Aga Khan University Health Services
Amir	Head of a Muslim State
ARI	Acute Respiratory Infection
Bait-ul-Mal	Welfare funds established by the Amir
BHUs	Basic Health Units
CCU	Cardiac Care Unit
CDA	Capital Development Authority
CDD	Controlling Diarrheal Diseases
CHW	Community Health Worker
CRHP	Cost Recovery for Health Project, Cairo, Egypt
chowkidar	Watchman
CV	Curriculum Vitae
CZA	Central Zakat Administration
CZC	Central Zakat Council
DHO	District Health Officer
DOH	Department of Health (provincial level)
EPI	Expanded Program of Immunization
ESSI	Employee Social Security Insurance
Fatamid Foundation	Blood Donor Agency
FGSH	Federal Government Services Hospital
FJMC	Fatimah Jinnah Medical Center
FMOH	Federal Ministry of Health of Pakistan
FP	Family planning
GDP	Gross Domestic Product
GMO	General Medical Officer
GNP	Gross National Product
GOP	Government of Pakistan
GP	General Practitioner
Hakims	Traditional health practitioners
HCFA	Health Care Financing Administration, U.S. Government
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
HPAC	Healthcare Provider Accreditation Council
HPN	Office of Health Population and Nutrition
HT	Health Technician
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IPA	Independent Practice Association
ISL	Islamabad
JCAHO	Joint Commission for the Accreditation of Health Care Organization
JPMC	Jinnah Postgraduate Medical Center
Katchi Abadis	Squatter Settlements
KEMC	King Edward Medical Center
KHI	Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMOH's new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMOH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through

paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan's health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS Project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health,

through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of rural health services.

VOLUME V

ORGANIZING AND FINANCING RURAL HEALTH SERVICES

EXECUTIVE SUMMARY

ORGANIZING AND FINANCING RURAL HEALTH SERVICES

PURPOSE

The purpose of the rural health component of this study is to develop an initiative to test an alternative organizational and financing approach to providing cost-effective health services to rural populations.

PROBLEMS

Typical problems associated with government-provided and financed rural services include the general "non-availability of `free' health care;" absenteeism among health staff; hours that are short or inconvenient to consumers; an absence of essential drugs, medicines, and supplies; and insufficient funds. All of these factors contribute to poor health status indicators among rural populations.

DESCRIPTION OF THE INITIATIVE

Specific objectives within the overall initiative include: (a) developing alternatives for financing rural health services, (b) developing a workable referral system, (c) developing a strong community role in the health system, and (d) assessing the interest and role of potential contract providers in managing a set of health facilities. Although the initiative was developed for initial testing in Islamabad Capital Territory (ICT), the methods used for developing it can be applied to any area of Pakistan.

The initiative proposes developing, testing, revising, and replicating an alternative model of organization and financing of rural health services. The alternative recommended to be tested involves assigning current government operating allocations to rural communities for their use in competitively contracting, on a fixed-price basis, with private providers. The contract would require the providers to offer a basic package of services while operating government rural health facilities and equipment in the community. At the option of the community, additional services to the basic package may be asked of the contractor in return for the right to charge limited user fees. Zakat and other charities would help pay for the services used by the poorest, when fees are applied. Government, in addition to supplying the funds, facilities, and equipment, would act as a technical advisor to the community in the choice of services to ask for and in monitoring and evaluating provider performance.

METHODS

In the context of several broad working principles agreed on with the Federal Ministry of Health (FMOH), a variety of methods were used to develop the alternative approaches that follow, including interviews with a wide variety of health service consumers, government officials, and donors, as well as the conduct of numerous site visits.

RECOMMENDATIONS

Financing

To illustrate what the concept would mean in terms of the package of services communities could purchase, four model packages of services were developed and analyzed for the test site, ICT. The packages were analyzed for their implications concerning services available, costs, and user payments. The most basic package of services is that which is currently offered (in principle, although often not in fact) and paid for by government allocations. The three additional service packages proposed each offer the basic package plus supplementary services at additional cost. To obtain more than the basic package would require the community to agree to pay some user charges. The estimated average user charges required per visit vary according to the set of services contained in the optional packages; this charge ranges from Rs. 6 to Rs.27 for Rural Health Center (RHC) services and from Rs. 4 to Rs. 15 for Basic Health Unit (BHU) services.

It is recommended that the contents of each of the service packages and the associated estimated user charges be explained to the communities involved in the test of the concept. Once the packages and their financial implications are understood, the community can specify which package, packages, or hybrid packages it wishes to include in its request for proposals (RFP) from potential providers.

Referral System

The referral system has been built around the principle that the foundation of any effective referral system is the availability and accessibility of high quality and affordable services at the primary level. The current locations of such services lend themselves to a natural referral structure for primary, secondary, and tertiary facilities which is presented in the main body of this report. Specific referral-related recommendations include:

- Differentiate among primary (BHU), secondary (RHC), and tertiary (hospital) levels of care and provide appropriate and affordable services at each level.

- Institute progressively higher fee schedules at each level.

- Create disincentives for "jumping the queue."

- Provide referred patients with direct access to professional staff at the referral facility.

- Install a formal communication system with standardized referral forms to ensure coordination among the different levels of care and facilities involved.

Community Role

Experience with substantial and successful community involvement in oversight and management of health services in Pakistan is limited to that of Aga Kahn Health Services (AKHS) in the Northern Areas and Chitral. However, the experience of AKHS, as well as experienced in other countries, demonstrate that such involvement is possible and that it is an important component of many successful health service systems.

In the rural initiative communities are to be empowered to choose and oversee the performance of a private provider of their basic health services. The operating funds allocated by the government for the facilities serving the community, the facilities themselves, and their associated equipment will be assigned to the chosen provider for use in providing services. The services to be provided are to be those currently offered (theoretically) by the facilities under government management, subject to some negotiation with the community. The community may wish to negotiate the provision of supplemental services in return for the right of the provider to charge specified fees. The government, in addition to providing financial and tangible resources, will act as an advisor to the community in evaluating proposals from providers and in monitoring their performance of the agreed-upon services.

To help the communities in test areas (ICT or elsewhere) carry out their role under this initiative, the following steps are recommended:

- Develop a training program for communities in their role under this approach with the assistance of specialists in community development and the participation of community leaders from the test areas.

- Train the test communities in the concept of the initiative and on their role in carrying out the process. This would include training on:

  - selection of community representatives

- △ definition of the basic package of services
- △ decisions regarding charging supplementary fees
- △ evaluation of proposals
- △ oversight of providers
- △ evaluation of performance
- △ decisions on renewal of contract

- ▲ Conduct a conference to explain and seek feedback on the concept of this approach from interested providers, communities, and government units.

- ▲ Work with the test communities to enter into cooperative agreements with providers for the test period.

- ▲ Assist the test communities in choosing whether or not to ask for additional services and to permit fees to be charged; if fees are charged, help set up Zakat and other charity assistance to pay for the poorest.

- ▲ Assist the test communities to monitor and evaluate provider performance and to decide whether to renew a contract or open it up for new bids.

- ▲ Revise the community training program in light of lessons learned during the test period.

- ▲ Assist the test communities with competitive bidding for subsequent contracts.

Interest and Role of Potential Contractors

Private providers have indicated some interest in contracting to operate government rural health facilities in the proposed arrangement. This interest, however, is tempered by concerns about the government meeting its obligations to provide the funding. Thus, in testing the approach, measures by government are needed to build provider confidence in its seriousness. In light of this, the following recommendations are made:

- ▲ Use, initially, a cooperative agreement-type arrangement in which the provider, community, and government together work out the specific terms and conditions of the contract, including the option (or mix of options) to be tested and jointly determine how performance is to be judged.

- ▲ Publish a solicitation of "expressions of interest" in major newspapers to solicit potential providers.

- ▲ Conduct a conference to explain and seek feedback on the concept of the approach from interested providers, communities, and government units involved in test sites.

- Assure providers of full authority over personnel policies and procedures including hiring, discharging, and determining salary levels.

Implementation, Monitoring, and Evaluation

Recommendations related to implementing this initiative as well as to monitoring and evaluating contractor performance are:

- Contract initially on a cooperative agreement basis with private providers to manage a set of rural health facilities in rural ICT and, if there is interest, elsewhere.

- Formulate a competitively bid contract following the initial contract period, using lessons learned from the execution of the cooperative agreement.

- Use a fixed-price contract in which the government provides the provider chosen by the community with funds at least equal to the real (inflation-adjusted) amount currently budgeted for the subject facilities in return for a basic package of services that are roughly comparable to what now is offered (in principle) by government-operated facilities.

- Supplement, at the involved community's option, government funding of the contract with user fees and Zakat funds for the medically indigent in return for services additional to the basic package.

- Contract for management of a related group of facilities, such as an RHC with its associated BHUs, as opposed to a single facility.

- Exclude no party from submitting a bid, although the ideal provider would have sound business skills and a strong sense of being responsive to the public interest in health.

- Use more than one provider (if there is sufficient interest and capability) so that different arrangements can be tested and evaluated simultaneously.

- Provide training and technical assistance to communities involved in these tests to help them organize and play the expected role in choice and oversight of the provider.

- Monitor and evaluate the tests to draw lessons for modifications to the concept and for wider replication within Pakistan.

1.0. INTRODUCTION

1.1. Background

The Federal Ministry of Health (FMOH) recognizes that there is an imbalance in health status and health services availability between urban and rural areas. Rural health indicators are far worse than urban. The government health services system has been biased toward urban hospitals for years. The result is both inequitable and inefficient. The higher-income urban populations have benefitted more from government health spending. Less reduction in morbidity and mortality has been achieved than possible, given the resources allocated to health.

Recently, the FMOH and Departments of Health (DOHs) have taken steps to try to rectify these imbalances by making large investments in rural health. In terms of infrastructure, they have built an extensive network of Rural Health Centers (RHCs) and Basic Health Units (BHUs). These facilities have been assigned staff, including medical officers.

However, the increase in facilities has not been matched by an increase in availability of services. The staff assigned to RHCs and BHUs are frequently absent, and operating supplies, especially pharmaceuticals, often are unavailable.

One explanation for the absenteeism is that rural living conditions do not match urban, thus there has been little motivation for staff to take rural assignments. Health authorities have tried to address this issue by paying bonuses to medical officers assigned to rural posts and by building better housing for staff than is available in most rural areas. Unfortunately, this policy has had little effect on absenteeism, but has raised the bill for salaries.

The operating supplies budgeted for a health facility frequently do not even arrive at the intended facility. Whether the budget allocations for these supplies are adequate to meet needs remains an open question. The supplies that do reach the facilities clearly are inadequate to serve the rural populations.

Given this situation, the FMOH is looking for new approaches to help the DOHs to right the imbalances and to make the infrastructure investments pay off. The problems remain: high absenteeism and scarcity of operating supplies.

Thus, to address these issues one must look beyond the simple availability of facilities and budget allocations to the incentives and disincentives intentionally or unintentionally present in the current system. The suggestions made here attempt to put in place incentives for desired performance, in addition to generating sufficient resources to meet needs.

1.2. Rural Health and Primary Health Care in Pakistan

Within Pakistan, there are wide variations in income and substantial pockets of poverty. Life expectancy is 55 years; infant mortality is 104 per thousand; population growth is 3.1 percent with a total fertility rate of 5.7; maternal mortality is estimated to be 500 per 100,000 live births; more than half of all children under age five suffer from stunting and/or wasting. (World Bank Report No. 10391 - PAK, 1992).

According to a 1988 UNICEF study, Situation Analysis of Children and Women in Pakistan, the major causes of child deaths in Pakistan in 1986 were as follows:

Major Causes of Child Deaths, 1986		
Cause	Number	Percent
Diarrheal Disease	313,400	45
Neonatal Tetanus	109,500	16
Acute Respiratory Infection	80,000	12
Malaria	50,000	7
Measles	35,500	5
Diphtheria	14,600	2
TB/Polio/Pertussis	12,200	2
Other	74,600	11
TOTAL	689,300	100

Some 55 percent of the population in Pakistan has physical access to health facilities. The review of government-provided primary health services in Islamabad Capital Territory performed for this analysis indicated low quality of services; limited availability of drugs, laboratory tests, water and electricity; and uneven performance of the Zakat fund to help support health services for the indigent.

1.3. The Rural Health Care Study

The FMOH wants its rural health system to address the major sources of morbidity and mortality among vulnerable populations in a cost-effective and affordable way. Thus, the ministry is proposing an alternative approach which relies on private delivery of services; financing primarily coming from government allocations, with an option for some user fees; and on substantial

community participation in choosing services to be offered, in deciding which provider to engage, and in determining whether or not to charge fees.

The FMOH decided to design an initiative to test this alternative in the rural areas of Islamabad Capital Territory (ICT). Rural ICT consists primarily of the rural areas surrounding the city of Islamabad. It is a federally administered territory. The three Rural Health Centers (RHCs) and thirteen Basic Health Units (BHUs) serving ICT's 190,000 people are supervised by the District Health Office, which reports to the Chief Commissioner under the Ministry of Interior - not the FMOH. Administrative control of other health services which serve as referrals to the RHCs and BHUs fall under other authorities:

- Health services in the urban area of Islamabad are under the administrative control of the Capital Development Authority (CDA) in the Cabinet Division.

- Hospitals such as the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH) are under the administrative control of the Federal Ministry of Health, while Rawalpindi General Hospital falls under the administrative control of the provincial authorities.

The following sections lay out the design of an initiative to test an alternative approach to organizing and financing rural health services. The design is done to explore the alternative by trying it out in the government rural health facilities in ICT. The design includes: a statement of purpose and objectives (Section 2.0), a description of methods used to formulate the design (Section 3.0), a detailed description of the organization and financing of the initiative (Section 4.0), findings about the interest of providers (Section 5.0), recommendations about referrals (Section 6.0), recommendations concerning the role of the community (Section 7.0), a legal framework for implementing the rural initiative (Section 8.0), an implementation plan (Section 9.0), and a monitoring and evaluation plan (Section 10.0).

2.0. PURPOSE AND OBJECTIVES

The purpose of the rural health study is to develop for testing an alternative organizational and financing approach in providing health services to rural populations. The approach would be tested first in the ICT, and then, if successful, could be modified and extended to the provinces.

In the early stages of the study of this initiative, several working principles were identified by the FMOH that were used to guide the development of this alternative approach:

- Communities should be empowered to hire and oversee the performance of providers of rural health services.
- The means for community hiring and oversight would be to contract with a private provider for a specified set of services on a fixed-price basis.
- Current government operating allocations would be made available to communities to fund contracts with private providers for services offered within government facilities using government equipment.
- At the option of the community, the government allocation could be supplemented with user fees to fund the provision of services additional to the basic package.
- The solicitation of providers should be competitive among all organizations interested, whether commercial (for-profit) or voluntary (not-for-profit).
- Government should assist communities in evaluating the quality of services provided.
- The incentives embodied within the concept are to encourage overall performance and quality of care (the carrot of contract renewal) and to emphasize cost minimization as well as promotion of preventive services (the fixed-price is an incentive to minimize costs, including helping those covered to avoid illness).
- Zakat and other charitable funds could be made available to pay for the medically indigent where user charges are put in place.

Within the context of these working principles, specific objectives were identified for the development of an approach, including options and recommendations for the following:

- Financing model: Develop alternatives for the delivery and financing of health services in ICT that are equitable, effective, and sustainable.

- Providers' interest: Assess the interest and role of potential private providers to operate the health facilities under contract to the community.

- Community participation: Develop an approach for communities to participate in the oversight and management of their health services.

- Referral system: Develop a workable system for referring patients from one level of care to another.

- Implementation: Recommend steps to test the design in ICT, or elsewhere, including monitoring and evaluation to prepare for wider replication.

Variants on the concept defined by the principles and systems proposed are developed within the context of preparing an initiative for testing in ICT.

3.0. METHODS

The methods used to accomplish the objectives for the rural initiative included the following:

- Review of relevant literature of experiences from both Pakistan and other countries;
- Discussions with a variety of interested parties and expert observers, including those representing:
  - Health providers from the ICT, CDA, and government hospitals;
  - Consumers in rural ICT from villages around rural health facilities;
  - Health policy makers from the FMOH;
  - Donor representatives such as those from USAID and the World Bank; and
  - Potential contract providers such as the Pakistan Institute for Medical Sciences (PIMS), the Federal Government Services Hospital (FGSH), and the Aga Khan Health Services (AKHS);
- Site visits to numerous health facilities including BHUs, RHCs, AKHS in Gilgit, and, briefly, two hospitals;
- Work by external and national consultants to develop the approach as well as model contracts, referral systems, and descriptions of community roles;
- Once the approach was developed, it was tested with the various interest groups, and modified accordingly;
- Preliminary observations were presented at an interim workshop held on November 21, 1992; and
- Detailed options and recommendations were presented at the final workshop held on February 16 - 17, 1993 and revisions were made accordingly.

These methods were carried out in the context of two trips to Pakistan by an external Rural Health Financing Specialist. The objectives of the first trip were to:

- Develop a framework for achieving the rural health financing objectives;

- Prepare Scopes of Work for the local consultants to do data collection and analysis and to prepare draft reports;

- Assess the type and quality of data available, particularly the cost recovery related data; and

- Begin the process of quantitative and qualitative data collection through meeting with Government of Pakistan (GOP) and USAID officials, health providers and consumers, and related individuals.

The objectives of the second trip were to make final the draft approach, test it out with the various interest groups, present the findings at the final workshop, and revise the recommendations, as appropriate.

Although all models and systems proposed are developed within the context of ICT, these same methods can be used for developing models and systems for other areas of Pakistan.

3.1. Frameworks for Assessing the Rural Health System

This section describes two frameworks for assessing the rural health system and developing the approach and recommendations for achieving the objectives described in Section 2. They are the organizational framework and the health system strategy framework.

3.1.1. The Organizational Framework

The organizational framework identifies the degree to which the structural aspects of the organization of the rural facilities (RHCs and BHUs) are public or private. This framework is derived from other HFS work done in Pakistan by William Newbrander and in the Philippines by Charles Stover. The components of the framework are:

- *Ownership*, which refers to who owns the physical assets;

- *Governance*, which refers to who has the authority for overall policy development, allocation of resources, and guidance of management of the facilities;

- *Management*, which refers to whoever implements policy and manages the facilities, including outpatient and inpatient services, administration, training, and allocation of resources;

- *Finances*, which refers to who pays for the operations of the facilities, including both operating and capital costs.

Each of these aspects has a range of forms it can take with varying degrees of autonomy from government, illustrating the multidimensional nature of public and private organization mixes. In matrix form, the range of options is shown in Exhibit 1. For example, ownership can range from the government to para-statals to non-profit organizations to for-profit organizations. Similarly, health services can be fully financed by the government (via taxes, etc.), by user fees, by insurance, or with any combination of these. The value of viewing the issue of public-private organizational mix this way is that it reduces the tendency to see private participation as an either/or choice, thus providing decision makers a broader array of options.

3.1.2. A Rural Health System Framework

The second framework, the rural health system, describes the type of health approach used. The system assumed here is primary health care (PHC) and involves emphasizing programs that address the major causes of morbidity and mortality. The primary health care systems can be understood in contrast to the "medical approach" which emphasizes treatment over prevention, hospitals over community-based health, and curative care over preventive care. It should be noted that although PHC emphasizes prevention, it includes a substantial amount of basic curative services. Effective implementation of a PHC system is expected to result in improving health status indicators of the broad majority of the population.

In contrast to the medical approach, primary health care emphasizes:

- Immunizations
- Promotion of proper nutrition
- Maternal and child health and family planning
- Local control of endemic diseases
- Provision of basic curative services
- Health education
- Provision of essential drugs and medicines
- The development of clean water supplies and basic sanitation

All but the last element (water and sanitation) are considered in the system being proposed in this initiative.

Primary health care also is characterized by:

- Equitable access to health services (geographic, financial and cultural);
- Coordination and integration of services; and,
- Decentralized management and community participation.

EXHIBIT 1
Illustrative Range of Forms of Rural Health
Public-Private Organizational Mix by Aspect

Aspect	Range of Autonomy Forms			
	Fully Public <))))))))))))))))))))))))))))))))			> Fully Private
1. Ownership	* Government <S)))	* Government Corporation (Para-statal) S))))	* Non-government Organization (NGO) S)>	* Private Individuals or Corporation
2. Governance	* MOH (non-profit) <S))))))	* Board of Trustees from government (non-profit) S)Q	* Board of Trustees from non-profit private sector (non-profit) S)>	* Private Individuals or Board of Directors from for-profit private sector (for-profit)
3. Management	* Government employees <S)))	* Para-statal employees S))))) * wage or service contracts	* Employees hired from private sector S)> * wage or service contracts	* Employees hired from private sector * wage or service contracts
4. Financing	* 100% government <Q	* mostly government with some user fees S) * insurance	* user fees with government subsidy S))> * insurance	* 100% fees * insurance

4.0. ALTERNATIVE RURAL MODEL: FINDINGS, RECOMMENDATIONS, AND ISSUES

This section describes in detail the alternative approach designed for rural health care organization and financing in Pakistan. It covers general issues pertaining to the design, it specifies how services would be organized, and it shows how they would be financed.

4.1. General

On the basis of discussions held with the FMOH, there seems to be consensus among government officials on several basic parameters of the organization and financing approach to be tested. These parameters include (a) government funding of contracts with private providers to operate health facilities in a limited geographic area, (b) possible introduction of user fees, (c) retention and use of user fees at the collection point, (d) continuing government allocation of funds to the rural facilities at current levels.

Responses from the different interest groups to questions on these and other issues were mixed. Discussions with members of the community in ICT indicate a lack of confidence in the current health system: the hours are too short or inconvenient (no evening hours, for example); medical officers are often absent; and drugs, medicines, and supplies are typically unavailable. Health consumers are aware of the general "non-availability of free health care." In contrast, the so-called "quacks" are user friendly, have convenient hours, stock drugs and medicines on their shelves (even though the treatment provided may be inappropriate), offer 24-hour care, and are easily accessible. Given the popularity of the "quacks" (unlicensed, often untrained practitioners), it may be instructive to investigate the reasons for their popularity and, where appropriate, use some lessons from their experience in reforming the structure and functions of alternative models.

A major concern among health facility staff is with respect to job security issues. Several medical officers from the rural facilities stated that "no government doctor in Pakistan will work under a private provider." This kind of statement may be self-serving. Many (if not most) government doctors have private practices; many are employed by other private providers. Further, government service guarantees employment regardless of performance (indeed, regardless of even reporting for work). It is not surprising that many government servants would not want to give this up.

Affordability and not marginalizing the poor is another concern expressed by nearly everyone interviewed.

In general, it appears that, with some exceptions, there is a cautious willingness to test out alternative approaches so long as

the availability of quality services, in fact, improves, is affordable, and is carefully explained.

4.2. Organization of Health Services

4.2.1. Findings

At the present time, in terms of the autonomy framework presented in Exhibit 1, the rural ICT facilities are fully public. The physical assets are fully owned by government, policies are established and implemented by government employees with operating and capital costs financed by government, although a small share of revenue (1 percent) is generated through user fees. By testing alternative organizational and financing models, the objective of the government is to find a way to make more effective and less costly the health system while still maintaining overall responsibility for improving the health status of the population. This means that government is willing to experiment with forms of organization other than fully public. Such a form of organization should put in place incentives for desired performance.

Exhibit 1 outlined the range of options for ownership, governance, management, and financing of health systems. Which option, or mix of options, is optimal? The immediate answer is that it depends on a number of variables. However, it is agreed by all concerned that the current "fully public" arrangement has not performed well and that alternatives are to be developed.

Analysis of the four aspects of organizational mix suggests that changes in governance, management and, perhaps, financing, could improve performance by changing incentives. The entities given charge of each aspect should be motivated to use that charge for desired performance.

Ownership. The fourth aspect, ownership of the facilities by government, seems to have little effect on performance, although the government often performs less maintenance on assets it owns than do private owners. No change is, therefore, proposed in the ownership of rural health facilities.

Governance. The direction (governance) of a particular rural health facility or set of facilities involves (at least) three sets of interests. Government is interested since its assets and financing are being used. Government also has a role to play in providing technical support to the community in terms of knowledge and analytical capacity regarding what and how medical services are provided. Government also often is interested in issues regarding equity of access (physical, financial, and cultural) to the services offered among population groups. The community served is interested in seeing that the services provided meet its priority needs and in assuring that the resources put at its disposal (or

generated by it) are used properly and efficiently. Finally, service providers have an interest in participating in setting the direction under which they work. Thus, some form of mixed governance, where all three parties might be represented but the community would have the dominant role, would seem appropriate.

Management. Management receives its overall direction from the governing entity. Responsibility for operational management would seem to be best placed in the hands of the providers as long as they are responsive to the governing entity. This could be accomplished by having the governing entity control the employment, rewards, and discipline of the providers. Government management of facilities is done through service providers (government medical officers). However, government servants are virtually guaranteed employment and the ability of government to reward and discipline on the basis of performance is weak. Hence, some form of provider-managers being hired, fired, rewarded, and disciplined by the governing entity would seem to offer possibilities for improving performance.

Financing. Financing provides the resources needed to operate and maintain facilities (eventually, financing also is needed to replace facilities and equipment). Government uses its power to tax and borrow to generate financial resources, some of which it allocates to health services. It does so to try and ensure that basic health services are available to the population. In the current, fully public arrangement, these financial resources have been badly used, mostly for reasons of governance and management. Therefore, there would seem to be no reason to change from government as the basic source of financing. However, the financing from government is limited. It cannot meet all conceivable needs, even if other changes in organization achieve efficiency in the use of available resources. Thus, the populations served may wish to supplement government financing through charging some kind of user payments to allow more services to be offered.

4.2.2. Options and Recommendations

In sum, the performance of rural health services has been unsatisfactory under government ownership, governance, management, and financing. An alternative model is proposed based on continued government ownership and basic financing, but also based on community-dominated governance, including government and provider participation, or having provider management responsible to the governing entity, and or having optional supplemental financing through user charges. Any provider representation on a governing board would be on an *ex officio* basis. Clearly, the provider representation would be excluded from participation in the choice of the provider. This model would put parties interested in the performance of the system in key positions of authority and would also put incentives in place for performance by others.

The proposed organizational mix would result in gains and losses and in changes in authority and privileges for each interested party (see Exhibit 2). Government would maintain its key role in providing resources and advice and would be more likely to achieve its objectives of providing access to all basic, cost-effective services. Communities would gain much more influence over what and how services are provided and over the proper and efficient use of funds allocated for their health services. Providers would lose the guarantee of employment regardless of performance, but would gain the power to be rewarded for good performance, the flexibility of management under the direction of the governing entity, and the availability of complementary resources (e.g., drugs, supplies) needed in their work.

EXHIBIT **2**

GAINS AND LOSSES OF INTERESTED PARTIES WITH ALTERNATIVE MODEL OF ORGANIZATION OF RURAL SERVICES

Interested Parties	Gains	Losses
Government	▲ Performance of System	▲ Some Governance
Community	▲ Role in Governance ▲ Priority Services ▲ Proper Use of Funds	▲ No-charge Services (at its option)
Providers	▲ Ability to Earn Rewards ▲ Management Flexibility ▲ Complementary Resources	▲ Guaranteed Employment ▲ Weak Discipline

One way to test the proposed approach to reorganization is to create a community-dominated, mixed-membership governing entity which would then contract with an organization or group of individuals outside the public sector to operate the rural health system in a geographically limited area. The basic funding for the contract would be the current government operating allocation for the subject facilities. The ideal provider would be one that has sound business skills and a strong sense of the "public interest" in health. Ideally, several variants on the model would be tested simultaneously. It is proposed that such an initiative be tested first in rural ICT.

4.3. Financing

This section examines the adequacy of current government operating allocations to meet the costs of a basic package of health services delivered to the rural population of ICT through its RHCs and BHUs. It does so using the following process: analyzing allocations of operating funds to the facilities, their patient loads, and unit costs of services. This information then is integrated to establish to what extent expected government allocations would cover service needs. Following this analysis,

alternative financing options and services packages are presented and analyzed, including supplementing government allocations through user payments to allow additional services to be provided. The latter is proposed to be done at the option of the community concerned.

4.3.1. Recurrent Expenditure by Facility and Program

Exhibit 3 shows recurrent expenditure by type of facility in ICT based on expected costs for the fiscal year 1992-93. Expenditures are broken out by four program areas (RHCs, BHUs, mobile dispensaries, Expanded Program of Immunization [EPI]/Controlling Diaharreal Diseases [CDD]/malaria control, and seven line items such as personnel, drugs, and transport. Management expenditures are those incurred to operate the District Health Office. They have been allocated over the four program areas. Except for personnel expenditures which have been estimated on the basis of the government's 1993-93 pending personnel budget net of increment, all other expenditures have been allocated from the "new item statement," "additional new item statement," and "budget order" for the year 1993-93.

As is often the case, the two largest expenditure categories are personnel (79 percent of the expected total costs) and drugs and medicines (18 percent of the expected total). However, when divided by total patient attendance, the Rs. 1.2 million drug budget amounts to Rs. 7.2 per patient attendance. This is considerably less than, for example, the Rs. 15 per patient of the Aga Khan Health Service in the Northern Areas and Chitral* or that of other developing countries, which also is around Rs. 15.**

* Personal communication with Stephen Rasmussen, General Manager, Northern Areas and Chitral, Aga Khan Health Service, 5 February 1993.

** Personal communication with Abdelmajid Tibouti, Senior Advisor, Bamako Initiative. UNICEF: New York, 10 February 1992.

EXHIBIT 3
Recurrent Expected Expenditure by Facility for the Year 1992-93

EXPENDITURES	N=3 RHC	N=13 BHU	MGMT.	MOBILE DISPENSARY	EPI, CDD HYGIENE & MALARIA CONTROL	TOTAL
CURRENT/NON-DEVELOPMENT						
Personnel/Establishment	1,558	2,586	367	163	486	5,160
Drugs/Medicines	256	806	0	60	66	1,188
Supplies	11	16	35	0	0	62
Repair & Maintenance	16	0	5	5	0	26
Transport	18	0	12	12	0	42
Utilities	17	0	11	0	0	28
Other	0	0	33	0	0	33
Allocation of management costs	100	314	(463)	23	26	0
GRAND TOTAL	1,976	3,722	0	263	578	6,539

NOTES:
+ Personnel cost for sanctioned positions in the year 1992-93 has been estimated on the basis of average salaries for the required position taken from the pending personnel budget for the year 1992-93 net of increments.
+ Budgeted drugs & medicine cost plus pending bills has been allocated to cost centers on the basis of their respective patient attendance.
+ Management and other operating costs are allocated to RHCs and BHUs proportional to utilization.

4.3.2. Patient Load

Exhibit 4 projects the number of outpatient visits for 1993-94 for the three RHCs, 13 BHUs, the Mobile Dispensary program, and the EPI/CDD/Hygiene/Malaria Control program. These projections are calculated on the basis of actual outpatient attendance in the year 1991-92, plus 20 percent. The 20 percent is added because of population increase (including in-migration) plus a growth in utilization in response to improved quality of services). While the RHCs all have inpatient facilities (10-20 beds per facility), no current inpatient use is recorded. The RHCs see an average of 55 outpatients per day while the BHUs see an average of 40 outpatients per day (assuming 260 workdays per year). Exhibit 4 includes data for the ICT Mobile Dispensary program. This program reportedly is weak and probably contributes little to the health of the rural population. It constitutes only 4 percent of operating costs.

EXHIBIT 4
Summary of Actual and Forecast Patient Attendance for the Year 1993-94 Based on Actual Attendance in 1991-92

FACILITIES	Actual Attendance 1991-92	20% Forecast Increase in Volume*	Attendance Forecast 1993-94
RHCs	35,614	7,123	42,737
BHUs	111,917	22,383	134,300
Mobile Dispensaries	8,267	1,653	9,920
EPI, CDD, Hygiene & Malaria Control	9,157	1,831	10,988
TOTAL	164,955	32,990	197,945
Attendance/capita**	0.87	0.17	1.01

* Increase in volume expected because of population growth (2.7%) and greater attendance because of improved quality (17.3%).

** ICT rural population in 1992 was 190,000; The World Bank Mission in Islamabad, Islamabad Capital Territory Family Health Project, February 1992.

4.3.3. Unit Costs

The data in Exhibit 5 show outpatient unit costs for 1992-93 in the ICT. Average cost per RHC outpatient treated is Rs. 55.5 while for the BHUs it is Rs. 33.2. This is higher than the results of a 1988 study which found an average cost (adjusted to 1993 rupees) per outpatient treated of Rs. 26 at Manga RHC in Lahore District in 1986/87 and Rs. 23 at Maraka BHU in 1986 (GOP. A Health Financing and Expenditure Study. April 1988). However, outpatient costs in the ICT are less than, for example, in Haiti, where outpatient costs ranged from the equivalent of Rs. 62 to Rs. 103 in 1988 (Wong, 1988). Personnel account for a large share of costs: 79 percent at RHCs, 70 percent at BHUs, and 74 percent of costs for all outpatient services.

EXHIBIT 5

ICT Outpatient Unit and Total Costs						
Facility-Type or Service	Annual Attendance	Cost per Attendance (Rs.)				Avg Cost per Facility Type or Service (Rs. 000)
		Personnel	Drugs/Med	Admin	Total	
RHCs (3)	11,871	43.7	7.2	4.5	55.5	1,975
BHUs (13)	8,609	23.1	7.2	3.0	33.2	3,721
Mobile Dispensary	8,267	19.7	7.3	5.0	31.8	263
EPI, CDD, Hygiene, & Malaria	9,157	53.1	7.2	2.8	63.1	578
Total	164,955	29.1	7.2	3.4	39.6	6,537
Percent of Total		73.5	18.2	8.6	100.0	

4.3.4. Current Sources and Size of Revenues

The data in Exhibit 6 show the current sources and volumes of revenue for the ICT health programs along with expected costs. Total revenues are approximately Rs. 5.4 million. They come from three sources: (a) Rs. 5.3 million from the government budget, (b) Rs. 101,000 from user fees, (c) Rs. 50,000 from Zakat funds. It is the Rs. 5.3 million which the government would provide to the community (i.e., community-dominated governing board) for use in a contract(s). For 1993-1994 the government operating allocation is expected to rise to accommodate inflation and the filling of vacant personnel posts. With these adjustments, the amount available for rural ICT community contracts is expected to rise to Rs. 6.3 million (see section 4.3.6).

The user fee revenues are from a Rs. 1 per patient "parchi fee" (registration or door fee) that was introduced in 1988. Revenues from this fee are remitted to the District Health Office. There have been no observable or reported benefits at the facility level as a result of this fee. This is not unexpected in that these revenues are less than 2 percent of the total resources available.

Zakat funds are one of four major types of religious or Muslim charity funds, with the others being Ushr, Wafq Property, and Bait ul Mal. Currently, of the Rs. 90 million Zakat Funds collected in 1991-92, 3.5 percent, or Rs. 2.6 billion, are used for health-related services throughout Pakistan. Within the ICT, the Zakat fund, which is intended to be used by the indigent, has averaged Rs. 50,000 from 1986 to 1991.

EXHIBIT 6

ICT Sources and Volumes of Revenues (1992-1993) (Rs. 000)				
Facility Type or Service	Government Allocation	User Fees	Zakat	Total
RHCs (3)	1,826	25	12	1,863
BHUs (13)	2,864	76	38	2,976
Total RHCs and BHUs	4,690	101	50	4,841
Mobile Dispensaries	199	0	0	199
EPI, CDD,* Hygiene, & Malaria	404	0	0	404
TOTAL ALL Facilities and Services	5,293	101	50	5,444

* See acronyms list

<u>4.3.5. Options for Health Services to be Offered and Associated Personnel Requirements</u>

Exhibit 7 outlines four illustrative packages of services that could be purchased by ICT communities. The most basic package (option A) is current practice. Each other option (B to D) specifies additional services that could be offered and the corresponding personnel. As more services and personnel are provided, costs rise. This is discussed below along with its implications for user fees.

The sequence used for developing these options should be noted. The first step was to identify the major causes of morbidity and mortality. The second step was to define the services to be offered at the BHUs and RHCs to address the identified major causes. Once these services were defined, personnel required to provide these services were identified. The combination of services and personnel is the basis for preparing cost and revenue estimates. The options presented are indicative of the combinations of services which could be offered at ICT's rural facilities. Other options could be defined as appropriate.

The first eight services listed under "Basic Elements" represent the essentials of a primary health care strategy. The remaining

services are optional supplements to these essentials.

Option A shows the current situation (i.e., what services and personnel now are provided in the BHUs and RHCs by the government). Although RHCs are intended to be referral facilities for BHUs, in fact, services available at both types of facilities are nearly identical; these services are limited primarily to maternal and child health (MCH), family planning (FP), the expanded program of immunization (EPI), and some curative services.

Option B, termed "complete PHC," includes all the eight essential elements of primary health care. Beyond this, both the RHCs and BHUs have laboratory services, staff training, and community health. The RHCs are open eight hours per day, plus they are on call. Personnel available are matched to the services provided. The numbers in some categories of personnel rise and some fall as compared to the current situation. The BHUs are staffed by a Lady Health Visitor (LHV), a Health Technician (HT), and a "chowkidar" (watchman). The RHCs have two medical officers (M.O.s), one male and one female, two LHVs and two HTs (one each for on-call duty), along with support staff.

Option C, termed "PHC+," includes all services and personnel offered under Option B plus x-ray, inpatient, ambulance, and 24-hour services at the RHCs. The BHUs have no inpatient, no ambulance, and only eight-hour service plus "on call." The RHCs are staffed by two M.O.s, three LHVs and three HTs, an x-ray and laboratory technician, as well as additional support staff.

Option D, termed "PHC++," builds on Option C, provides the greatest number of services, and has the most personnel. In addition to all the primary health care services, the RHC has x-ray, dental, inpatient, and ambulance services. There are a greater number of laboratory tests available and a larger formulary of drugs and medicines. Personnel to provide these services are also the greatest in number. At the RHCs, there are two M.O.s, four LHVs, and four HTs (to handle the second and third shifts), along with a variety of other technical and support staff. Staffing at the BHU is similar to that of Option C.

In all the above options, staffing levels are indicative, not prescriptive. It is important that the contracted provider(s) have the option of making adjustments as appropriate.

Additional Improvement

There are some improvements recommended which fall outside of the package of services that could be purchased by communities using the government-operating allocations. These improvements would have to be paid for by government capital allocations. They are: running water, electricity, wireless communications, and residential facilities for medical staff.

EXHIBIT 7
Options for Services, Personnel, and Infrastructure

ITEM	Option A (Current)		Option B (Complete PHC)*		Option C (PHC+)*		Option D (PHC++)*	
	RHC	BHU	RHC	BHU	RHC	BHU	RHC	BHU
8 BASIC ELEMENTS (SERVICES) OF PRIMARY HEALTH CARE (PHC)								
Health Education	no	no	yes	yes	yes	yes	yes	yes
Nutrition Promotion	no	no	yes	yes	yes	yes	yes	yes
Water & Sanitation	no	no	yes	yes	yes	yes	yes	yes
MCH/FP**	yes	yes	yes	yes	yes	yes	yes	yes
Endemic Disease Control (Malaria, TB, ARI, etc.)	no	no	yes	yes	yes	yes	yes	yes
Basic Curative Services	some	some	yes	yes	yes	yes	yes	yes
Immunizations (EPI)	yes	yes	yes	yes	yes	yes	yes	yes
Essential Drugs & Medicine	some	some	yes	yes	yes	yes	yes	yes
SERVICES ADDITIONAL TO THE ELEMENTS OF PHC								
Laboratory	no	no	yes	simple▲	yes	simple▲	yes	simple▲
X-Ray	no	no	no	no	yes	no	yes	no
Training (Staff)	some	some	yes	yes	yes	yes	yes	yes
Community/Home (TBA/VHW)	no	no	yes	yes	yes	yes	yes	yes
Dental	no	no	no	no	no	no	yes	no
Inpatient	no	no	no	no	yes	no	yes	no
Ambulance	no	no	no	no	yes	no	yes	no
24-Hour Service	no	no	no	no	yes	no	yes	no
8-Hour Service + On Call	no	no	yes	no	N.A.	yes	N.A.	no
PERSONNEL:								
Medical Officer (m & f)	3	1	2	0	2	1	2	1
Lady Health Visitor (LHV)	4	1	2	1	3	1	4	1
Health Technician (HT)	4	1	2	1	3	1	4	1
Sweeper (part-time)	1	0	2	0	2	0	3	0
Dental Technician	0	0	0	0	0	0	1	0
X-Ray Technician	0	0	0	0	1	0	1	0
Lab Technician	0	0	0	0	1	0	1	0
TBA/CHW (volunteers)	?	?	45	130	45	130	45	130
Storekeeper	1	0	0	0	1	0	1	0
L.D.C.	1	0	0	0	0	0	1	0
Dispensor	1	0	1	0	1	0	1	0
Driver	1	0	0	0	3	0	3	0
Naib Qasid (orderly)	3	1	0	0	3	0	3	0
Chowkidar (watchman)	1	1	2	1	2	1	2	1
Mali (gardener)	1	1	0	0	0	0	1	0

* Primary health care
** Maternal and child health/family planning
▲ Blood and urine tests
(See main list for acronyms used in this chart.)

4.3.6. Costs of Alternative Service, Personnel, and Infrastructure Options

The total annual estimated costs associated with each of the four options for the ICT rural health facilities are summarized in Exhibit 8. As expected, Option D has the highest cost since it provides the largest number of services with more highly trained personnel, while Option A is the least costly. Options B, C, and D are 12, 44, and 57 percent more costly than Option A.

The following is a more-detailed explanation of how these costs are estimated, focusing on personnel and drugs.

Personnel. Personnel costs have been estimated on the basis of average salaries for each position as per the government's pending budget for 1992-93 net of increments. While comparative private sector salary data are not available, private salaries often are higher than those in the public sector. On the other hand, the productivity of private sector health workers may be much higher than that of public sector workers (see below), allowing the contracted provider to hire fewer workers to provide a comparable volume of services. Further, attracting personnel such as Medical Officers at relatively low salaries may not be difficult in light of their unemployment rates. Until practical experience with operating rural services shows otherwise, the best estimate is that the costs of personnel to provide comparable services to those now offered (in principle) is current personnel spending.

The current productivity of provider personnel (MOs, LHVs and HTs) is low. The 11 providers at RHCs saw an average of 4.2 patients per day in 1991-92. The 3 provider personnel per BHU saw an average of 11.0 patients per day. Option B is costed assuming that provider productivity can be approximately doubled at both types of facilities (to 8.3 and 20.0 patients per provider per day) while a complete PHC package is offered. Compared to Option B, lower productivity in terms of patients seen per provider is assumed for Options C and D, since extra technical personnel are added to offer additional services and to raise quality by improving diagnostic capabilities.

As quality is improved throughout the system serving the rural ICT population, shifts in utilization patterns should be expected. Improved services and a more-effective referral system (described below) will increase attendance at the BHU level and decrease it at the RHCs. In the longer term, as the quality of care increases and people become aware of this, it is likely that total demand at both BHUs and RHCs will increase. To account for these changes, as well as for population growth (2.7 percent annually), the cost estimates assume that overall utilization will increase by 20 percent for all four options.

Drugs and Medicines. The second major expense at a health facility is the cost of drugs and medicines. It was noted in Section 4.3.1 that the government currently budgets Rs. 7.2 per patient attendance. For Options B, C, and D, estimates for drug and medicine expenditures have been increased to Rs. 15 per patient for the RHCs and Rs. 12 for the BHUs. These estimates are in line with drug expenditures of AKHS in the Northern areas and Chitral (which has considerably higher transport costs) as well as those of other developing countries.

Since procurement of drugs, medicines, and other supplies is to be the responsibility of the contract provider(s) operating the ICT facilities, they will be free to select their own suppliers. This could include government suppliers, private suppliers, joining up with other buyers to take advantage of economies of scale through bulk purchasing, or other cost-effective sources of supply. Given the proximity of the ICT to Islamabad, logistical problems should be minimal compared to those of provincial buyers.

4.3.7. Financing Options: Sources and Size of Revenues

In light of the service options outlined in Exhibit 7, and their associated costs, the question to be addressed is how to finance these options. Since the options B, C, and D cost more than current government operating allocations, if communities wish to have those services available , consideration will have to be given to using a combination of government operating allocations and user contributions. Both of these are discussed in turn.

4.3.7.1. Government Operating Allocation

As part of the process of experimenting to improve the performance of the health system, the government has stated that it will continue to make available operating funding at least equal to the same real amount (adjusted to keep up with inflation) currently budgeted for the rural ICT (i.e., Rs. 6.3 million). However, the government's allocation is sufficient only to pay for the cost of the services, personnel, and infrastructure currently available. As discussed above, simply changing the method by which providers are compensated without changing the amount of resources is expected to improve performance. This should arise from the change in incentives (see section 4.2.2). However, to be able to pay for any of the options that offer more services, other sources of revenue must be considered, specifically, user contributions.

4.3.7.2. User Contributions

The second possible source of financing revenue is user contributions. The community could agree (in its negotiations with the contract provider) to supplement the available government allocation with user contributions to obtain more or better services. User fees are employed here to illustrate the magnitude

of user contributions needed to supplement government allocations. User contributions could take any number of alternative forms such as local taxes or prepayment premiums. A precedent has been set for charging fees through the Rs.1 "parchi" (registration or door), fee.

Exhibit 9 shows an indicative schedule of user fees that could be charged to meet the costs additional to the government allocation needed to pay for each of the Options B, C, and D. The fee schedules are broken down by RHC and BHU as well as by the type of service provided. It should be noted that this is not a definitive fee schedule. Rather, it is an illustrative schedule that is expected to allow sufficient fee revenues to be generated to cover the additional costs of the options.

Factors considered in the fees proposed include: (a) patients' perceived ability and willingness to pay, (see section 4.3.7.3), (b) number and type of staff employed, and (c) cost of services provided.

The indicative fees are charged according to services provided. While this would be administratively more complex than charging a single flat fee per visit, the charges will reflect the costs of the services used. This is intended to help guide consumers in choosing the appropriate level and type of service for their illness and to reduce queue jumping. Thus, for options offering more services provided by more qualified staff, the fees are higher. Similarly, the fewer services available from less-qualified staff will be charged at a lower fee rate.

The fee schedules shown in Exhibit 9 and the estimates of the fees needed to cover the mix of services used by consumers are used in Exhibit 10 to show how revenues would be generated to meet the cost of the supplementary services. The average payments required per attendance also are shown. These range from Rs. 4 to Rs. 15 for BHU attendance and from Rs. 6 to Rs. 27 for RHC attendance. The lower average charges are for Option B, the higher for Option D.

EXHIBIT 8
Estimated Annual Cost for Options A, B, C, & D (in Rs. '000)

FACILITY	Option A (Current)	Option B (Complete PHC)	Option C (PHC+)	Option D (PHC++)
RHC Tarlai	805	741	1,049	1,209
Barakau	751	671	973	1,127
Sihala	419	678	947	1,068
Sub-Total RHCs	1,975	2,090	2,969	3,404
BHU Sohan	282	308	384	408
Tumair	252	280	352	374
Jagiot	285	324	395	420
Jang Sayydan	277	317	384	409
S.A.D.	266	294	368	392
Shahdara	241	248	320	343
Phulgran	313	358	434	461
Pind Begwal	275	306	377	403
Bhukkar	244	265	333	355
Gagri	293	337	408	434
Bhimber Trat	286	337	403	428
Rewat	429	566	635	669
Chirrah	278	345	411	434
Sub-Total BHUs	3,721	4,287	5,206	5,529
Sub-Total RHCs & BHUs	5,696	6,378	8,175	8,933
EPI, CDD, HYGIENE & MALARIA CONTROL	578	726	726	726
Grand Total	6,274	7,104	8,901	9,659

EXHIBIT 9
Indicative Fee Schedule to Meet the Additional Costs of Various Options

SERVICES	Option B Complete PHC		Option C PHC+		Option D PHC++	
	Fees Recommended at		Fees Recommended at		Fees Recommended at	
	RHC	BHU	RHC	BHU	RHC	BHU
	Rupees		Rupees		Rupees	
Consultation Only	2	1	4	3	5	4
Medicines	3	2	7	5	10	7
Injection (if prescribed)	3	2	6	5	10	6
Antenatal exam (per visit)	2	1	2	1	3	2
Postnatal exam (per visit)	2	1	2	1	3	2
Delivery Package (a)	35	15	161	71	200	80
Minor Surgery (stitching & dressing)	3	n.a.	13	7	12	9
Dressing of Wounds	2	1	3	2	5	3
Lab test (per test)	2	1	9	2	7	5
X-ray (per X-ray)	n.a.	n.a.	13	n.a.	13	n.a.
Inpatient bed charges per day	n.a.	n.a.	27	n.a.	39	n.a.
Dental Services (b)	n.a.	n.a.	0	n.a.	12	n.a.
Vaccinations	Free	Free	Free	Free	Free	Free

(a) Includes Delivery with 3 ante & postnatal exams + medicine 7x + 2 overnight stays.
(b) Services offered only at RHC under options C and D.
n.a. - Not applicable because the service is not offered.

EXHIBIT 10
Illustrative Estimates of Fees Needed to Cover the Costs of Various Options

PAID SERVICES	Estimated Patient Volume		Option B (Complete PHC)				Option C (PHC+)				Option D (PHC++)			
			Prices (Rs.) (Exhibit 9)		Revenue (Rs. 000)		Prices (Rs.) (Exhibit 9)		Revenue (Rs. 000)		Prices (Rs.) (Exhibit 3-8)		Revenue (Rs. 000)	
	RHCs	BHUs	RHC	BHU	RHC	BHU	RHC	BHU	RHC	BHU	RHC	BHU	RHC	BHU
Consultation & medicine	21,333	67,186	5	3	107	202	11	8	235	537	15	11	320	739
Consultation, medicine & injection	10,666	33,593	7	4	75	134	17	13	181	437	25	16	267	537
Delivery with 3 ante & postnatal exams + medicine 7 times + 2 overnight stays	853	2,688	35	15	30	40	161	71	137	191	200	80	171	215
Minor surgery (stitching & dressing + medicines (a)	853	2,688	6	0	21	0	20	12	17	32	22	16	19	43
Consultation + lab tests + medicine	4,267	13,437	5	3	21	40	20	10	85	134	22	16	94	215
Consultation + X-Ray + medicine (b)	8,852	0	0	0	0	0	24	0	212	0	28	0	248	0
Consultation + lab test & X-ray + medicine (b)	3,541	0	0	0	0	0	29	0	103	0	30	0	106	0
Dental (c)	1,770	0	0	0	0	0	0	0	0	0	12	0	21	0
Dressing of wounds + medicines	853	2,688	5	3	4	8	10	7	9	19	15	10	13	27
Inpatient - Average 1 overnight stay + lab test & X-ray + medicine 3x (b)	1,770	0	0	0	0	0	84	0	149	0	115	0	204	0
Total	54,759	122,279			258	425			1,128	1,350			1,462	1,776
Total revenue RHCs+BHUs (Rs. 000):					683				2,479				3,238	
Average charges per patient attendance (Rs):			6	4			21	11			27	15		

(a) Not offered at BHUs under option B, so all patient volume assumed met at RHCs.
(b) Services offered only at RHCs under options C and D.
(c) Service offered only at RHCs under option D.
NOTE: Inpatient or overnight stay facility available at Options C and D only.

4.3.7.3. Analysis of Willingness and Ability to Pay

Are these fees affordable? Will the poor be excluded because of inability to pay? Or, if poor patients do choose to use and pay for these health services, would they make other basic-needs trade-offs such as forgoing food? These are difficult questions, but the following text summarizes indications about each. In addition, some other considerations are addressed.

Willingness to pay. Discussions with key community informants in rural ICT suggest that so long as quality services are provided (of particular concern is the availability of drugs), the population is willing to pay, although "how much" is unknown. (This is supported by a recent study in Cameroon. See Social Science and Medicine). These same informants state that the so-called "quacks" charge Rs. 50 to Rs. 100 for a consultation and Rs. 500 to Rs. 1,000 for a delivery. More generally, there is considerable evidence that consumers are already making significant out-of-pocket payments for health services, including both payments to private providers (quacks, private practitioners, pharmacies) as well as "under the table" charges paid to providers at public facilities (peon fees, gatekeeper fees, and bedpan-cleaning fees.). A 1986-87 household survey found that consumers were paying out-of-pocket up to 6 percent of their average monthly income for health care, and that low income households were paying more than 6 percent. (Health Sector in Pakistan, Final Report. April 1988).

Ability to pay. To examine the ability to pay the prices corresponding to Options B, C, and D, two scenarios are examined (see Exhibit 11). These scenarios help to analyze the effect of paying the prices on the resources of two households typical of the rural ICT population. The first is called a "lower income" household, which has an average per capita income of the lowest 40 percent of households in Pakistan. (World Bank Report No. 11127-PAK. 1992). This household type is expected to represent the bulk of the rural ICT population. The second household is called "very poor" and has a per capita income of one-fourth of the "lower income" households. It is intended to represent the lower extreme of the rural ICT population.

The scenarios examine the burden imposed on its income when the household makes more than three times the average use of ICT health facilities (3.0 visits per capita versus the current 0.9 visits per capita). The prices associated with one BHU visit and two RHC visits per capita under each of the options are compared with per capita income. This comparison shows that the burden on the "lower income" household is less than 2 percent of income for all options. For the "very poor" household, the burden surpasses 5 percent of income only for Option D (reaching 6.2 percent of income). (Household income is approximated by the household expenditure data reported in World Bank Report 11127-PAK. Five percent of income spent on health services is often used as a threshold of

affordability. Spending more than 5 percent of income is believed to begin to require cutbacks in spending on other basic needs, such as food, clothing, shelter, and education of children.) Thus, there may be a need to forgive at least some portion of payment for some very low income households at high levels of utilization of services when prices approach those estimated to be needed to pay for Option D's package of services.

In light of the foregoing, paying less than 2 percent of income for health services for the bulk of the rural ICT population seems reasonable assuming that quality services are, in fact, received and that "unofficial" payments discontinue.

EXHIBIT 11
Ability to Pay

Household Type	Per Capita Income (Rs)	Percent of Income for Use of ICT Health Services		
		Option B	Option C	Option D
Lower Income	4,420	0.4%	1.2%	1.6%
Very Poor	1,105	1.4%	4.8%	6.2%
Price of BHU + 2 RHC visits		16	53	69

Protecting the poor. In spite of this expectation of affordability for the majority of the population, there are likely to be people, such as very poor household members, who would find fees unaffordable. They then would be excluded from access to health services or they would face other basic-need tradeoffs. To handle such cases, two additional sources of revenue could be tapped: Zakat and other religious charities, and cross-subsidization.

4.3.7.4 Zakat and Other Religious Charities.

The Zakat fund already is used in rural ICT to help pay for drugs for the poor. However, those interviewed in the community perceived Zakat badly and the amount of Zakat funds currently allocated for health in rural ICT is probably inadequate to provide much help for the very poor. If a greater share of Zakat funds allocated for health were to reach rural ICT, or if more of Zakat's allocations went to health, it could play a more significant role in helping the poorest when fees are charged.

When interviewed, ICT community members and junior-level Zakat Fund administrators expressed considerable dissatisfaction with the Zakat fund. For example, many community members interviewed did not know of any cases where Zakat was used. Community members who did know of the Zakat fund felt the beneficiary selection process was politicized so that deserving people were not beneficiaries of the

fund while undeserving people were. This same feeling was expressed by some junior-level Zakat Fund administrators at the facility level. At the same time, several of the facilities visited in ICT had some "Zakat drugs" available on the shelves which were intended for use by Zakat-qualified patients.

Zakat's current spending of Rs. 50,000 in rural ICT represents about one-quarter of a rupee per capita. This is clearly inadequate to have an impact. However, rural ICT does not seem to receive its fair share of Zakat funds allocated to health. Rural ICT's share of the total Rs. 90 million of Zakat allocated to health would be Rs. 147,000 or Rs. 0.78 per capita. With such an amount of Zakat funds, exemptions from payment could be given, for example, to the lowest 10 percent of the income distribution for two attendances per year under Option B (one each to a BHU and a RHC) or to the lowest 5 percent for one BHU attendance per year under Option D. If, as the Central Zakat Administration has indicated is possible if requested by the FMOH, allocations of Zakat spending for health-related purposes can be increased from 3.5 percent to 6 percent of its total funds, more can be done. The lowest 13 percent could be exempted for two Option B attendances or 9 percent for one BHU attendance under Option D.

The figures cited above indicate that Zakat could play an important role in helping protect the interests of the poor if its administration in rural ICT could be improved to make it less politicized and better targeted to those in need.

Cross-Subsidization. An alternative to reliance on Zakat funding to help protect the financial access of the poor to services would be to charge higher fees to those able to pay higher prices. This would allow cross-subsidization. The extra revenues generated from the more able would make up for the exemptions given to the poor. An example of how this might be done is shown in Exhibit 12. It is assumed that 12 percent of the total patient load will be provided free services, with another 6 percent of patients paying 50 percent of the fee. Thus, the net fee remission covering people's inability to pay comes to 15 percent of the total fee income. The resulting fees appear to remain within the reach of most of the rural ICT population.

EXHIBIT 12

Illustrative Effects of Cross-Subsidies on Fees Charged Under the Various Options (in Rs.)

	Option B		Option C		Option D	
	RHC	BHU	RHC	BHU	RHC	BHU
Average charge per visit without cross-subsidy	6	4	21	11	27	15
Average charge per visit with cross-subsidy*	7	5	24	13	31	17

**Assuming 12 percent of patients are provided services at no charge, 6 percent are provided services at 50 percent charge, and the charges for the remaining 82 percent are increased to make up for the lost revenue.*

Fees guide utilization. Fees have the potential to reduce unnecessary utilization and to encourage patients to use the most appropriate and cost-effective level of care. The latter is achieved by charging higher fees for higher levels of care, thus encouraging patients to seek the lowest and least-costly to provide the level of care that is appropriate for their illness.

Fees elsewhere in the health system. It is important that fees be introduced simultaneously at all facilities, including the hospitals available to the rural ICT population. To introduce fees only at the rural ICT facilities could have the effect of providing substantial numbers of people with further incentives to jump the queue by by-passing the rural facilities (even more than they currently do) to go directly to hospitals in Islamabad or Rawalpindi (Yoder, 1989).

4.3.7.5. Summary of Revenue Sources and Size

Exhibit 13 summarizes the sources and size of projected revenues of the three RHCs and 13 BHUs for each of the options.

EXHIBIT 13
SUMMARY OF SOURCES AND SIZE OF REVENUES BY SERVICE OPTION (RS.000)

Revenue Source	Option A (current)	Option B (complete PHC)	Option C (PHC+)	Option D (PHC++)
Govt Allocation	5,696	5,696	5,696	5,696
User Fees	0	682	2,479	3,237
Zakat*	0	(102)	(372)	(486)
TOTAL	5,696	6,378	8,175	8,933

N.B. These budgets are for the operation of the 3 RHCs and 13 BHUs only.
** Ideally, Zakat would provide sufficient funds to allow total exemption for 12 percent of patients and 50 percent exemption for an additional 6 percent of patients. The user fee revenues shown do not count on realization of this ideal.*

As can be seen from Exhibit 13, the government allocation remains constant for each of the options. User fees are the variable income source and increase from Option B to Option D. The amount of Zakat contribution that would allow total exemption for 12 percent of the population and partial exemption for 6 percent more also is shown. The user fee revenue shown includes enough to cover all estimated costs of the options without a Zakat contribution.

4.3.7.6. Summary

There are a variety of financing choices available to communities. They would choose, in negotiations with candidate contract providers, the combination of services and user contributions, if any, that best suits their needs and means. The price/service combinations presented here are indicative of how the communities' choices are likely to look.

5.0. INTEREST AND ROLE OF POTENTIAL PROVIDERS

5.1. Findings

For the alternative approach to organization and financing for rural health services to work, there must be an interest by potential contract providers in playing the role indicated. This section describes the results of an inquiry into this interest.

In assessing the interest of potential contract providers, a variety of options were considered and organizations contacted. Contacts were made with government-related institutions such as Pakistan Institute for Medical Sciences (PIMS) and Federal Government Services Hospital (FGSH), with for-profit groups such as Shiifa International, with not-for-profit non-governmental organizations (NGOs) such as the Aga Khan Health Services, as well as with private individuals who might have an interest in forming or linking with a legally recognized body to manage health facilities.

On the basis of such explorations, the extent of provider interest in operating rural health facilities appears limited. Some organizations were not at all interested while others wished to be kept informed as progress is made toward implementation of this initiative. Confidence that government would meet its obligations appears to be a major concern of potential contract providers.

However, it also appears that with appropriate incentives and contractual arrangements, providers will emerge. For example, there is reason to make further explorations with the Aga Khan Health Service. In addition, there has been some discussion of several individuals representing different skills and backgrounds coming together and perhaps linking themselves to an existing organization that has credibility in order to bid for a contract.

What seems important is not to close doors. Government should be open to considering NGOs, for-profit groups, hospitals, and groups of doctors and managers. Contrary to conventional wisdom, it is possible that a well-run and cost-effective for-profit group could provide high quality services at prices competitive to not-for-profit groups. In light of the experimental nature of this innovation, flexibility in determining clear terms of reference and in establishing sound monitoring and evaluation systems is important.

5.2. Recommendations

In light of the above-described discussions and findings, the following recommendations are made for government action:

- Use a "cooperative agreement"-type arrangement where the provider, community, and government together work out the specific terms and conditions of the contract (a model contract is in Appendix 3).

- Publish an "Expressions of Interest" notice in a variety of news media in order to ensure that it reaches the widest possible coverage of potential contract providers (see Appendix 1).

- Offer to make advance payments to providers equal to semi-annual or quarterly projected expenditures, with some amount held back to ensure contract completion, as a confidence builder.

- Conduct a conference to explain and seek feedback on the concept of the approach from interested providers, communities, and government units involved in the test sites.

- Exclude no provider from submitting a bid, although the ideal provider type to operate under the contract is one which has sound business skills and a strong sense of the "public interest" nature of health.

- Assure providers that they have full authority over personnel policies and procedures, including hiring, discharging, and determining salary levels.

- Offer the following options to government employees currently posted in the ICT facilities:

  - During the testing period, allow those who wish to try to be employed by the contract provider to go on a "leave of absence" without pay or other benefits.

  - Following the first contract period, choose to:

    Remain government servants and be transferred to another post.

    Leave government to apply for a position with the contract provider.

    Leave government service and seek other employment.

6.0. REFERRAL SYSTEM

This section examines the role of referral systems as a means of strengthening the efficiency and effectiveness of the rural health system. It presents findings on the current status of the referral system in the ICT, identifies the essential ingredients of a sound referral system, and then presents recommendations for developing a workable referral system.

6.1. Findings

A common occurrence in ICT is long queues of patients at hospitals such as Federal Government Services Hospital or Rawalpindi General Hospital, and no queues and few patients at the RHCs and BHUs. Although there are a variety of reasons for this, the main reason is that patients feel they can receive better care at the hospitals. Consequently, their staff and facilities often are overburdened while there is substantial underutilization at the RHCs and BHUs.

A referral system is designed to redress the imbalanced, and often inappropriate use of staff and services at the different levels of care. It can lead to better care, lower prices for patients, and lower costs for providers.

The foundation of an effective referral system is the availability of quality services at the primary level. At the present time, this is not the situation. Quality of care at the primary level is low. Referral systems are essentially non-existent in the ICT. While some facilities have referral forms, they are not used. There is currently no differentiation of services between the BHUs and the RHCs. The latter has implications for staffing patterns and support services and, consequently, budgets. Matters are complicated further in ICT since administrative control of health services falls under three different ministries or divisions (see section 1.3.).

Health service objectives could be better achieved if a workable referral system were developed and enforced. This would include coordination among the various institutions involved; disincentives for queue jumping (see Sections 4.3.7.2. and 4.3.7.3. for more on using the fee structure to impede queue jumping); differential fee structures at the primary, secondary, and tertiary levels; and provision of appropriate services at each level. As with the introduction of user fees, it is important that the introduction of a referral system be coordinated and that all relevant facilities be involved including Rawalpindi General Hospital outside ICT which, along with PIMS and FGSH, is among the referral hospitals for the rural ICT population.

6.2. Recommendations

A first step in developing a workable referral system is to differentiate among the services offered at the community level such as traditional birth attendants (TBAs) and community health workers (CHWs), and at primary (BHU), secondary (RHC), and tertiary (hospitals) levels. Since communities will be choosing the package of services to contract for, the government should help promote to them this kind of differentiation of services. In general, the following set of services is recommended (also shown in Exhibit 7):

- Services offered at the community level:

  Through TBAs and CHWs health promotion and education, home delivery, basic medicines, nutrition education, oral rehydration therapy (ORT), and malaria prevention.

- Services offered at the BHUs:

  Maternal and Child Health and Family Planning: immunizations, nutrition education, endemic disease treatment such as ORT, essential drugs, basic curative services, and health education.

- Services offered at the RHCs:

  All the above services offered at the BHU plus the following: an expanded drug supply, basic diagnostic services (x-ray and laboratory), minor surgery, basic dental services, and 24-hour indoor services.

Once the set of services to be offered is made final, staffing patterns along the lines shown in Exhibit 7 would be expected to be proposed by potential contract providers. The staffing pattern used is significant because appropriate staffing patterns can result not only in considerable cost savings but also in provision of better services and, consequently, in an improvement in health status indicators.

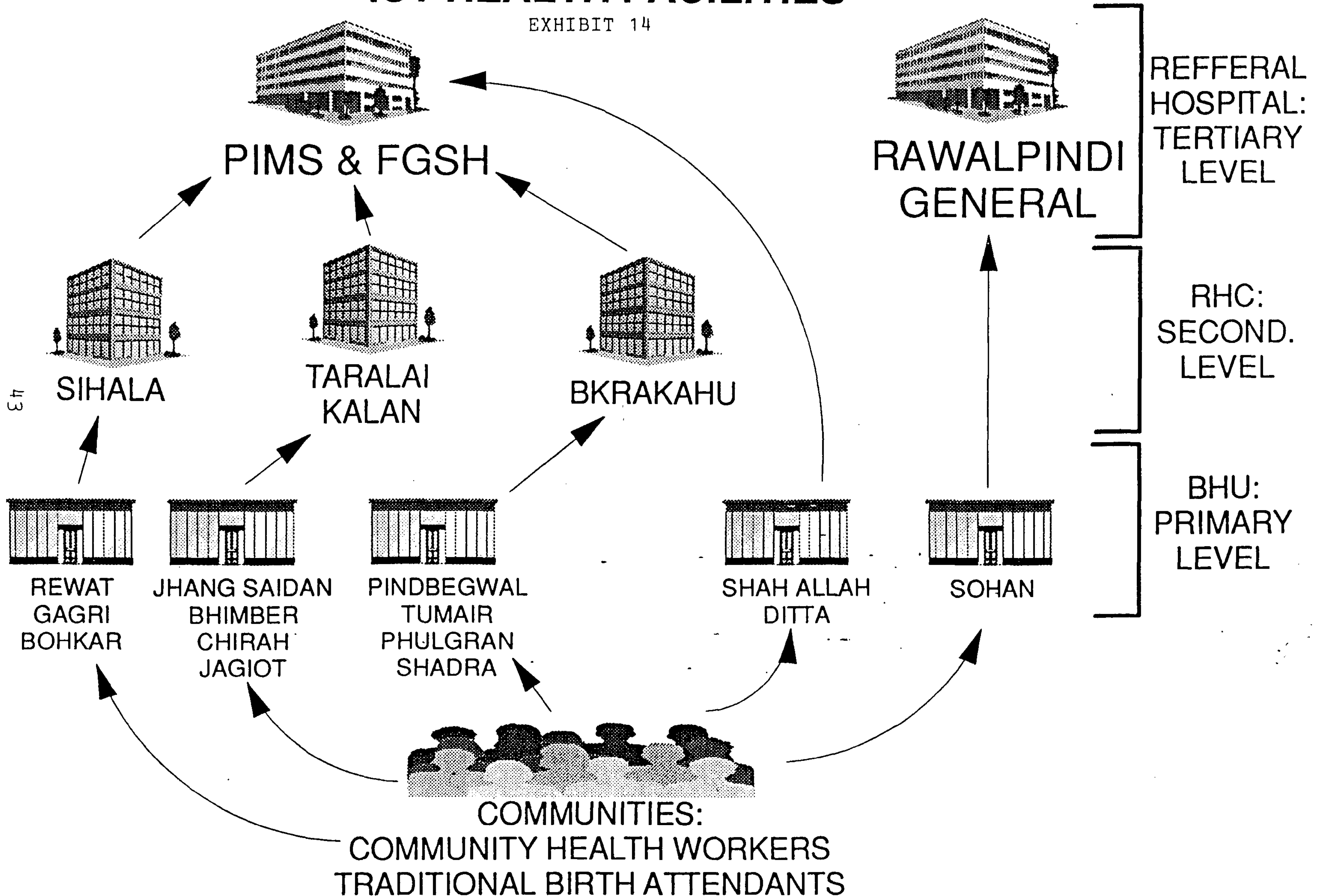
Within the context of services offered at the primary and secondary levels and in light of the current physical plant infrastructure (which in most cases is adequate), the existing location and distribution of RHCs, BHUs, and hospitals lend themselves to a natural referral structure. This structure is shown in Exhibit 14.

It is recommended that, due to the easy accessibility of Rawalpindi General Hospital and the absence of an easily assessable RHC, BHU Sohan refer patients directly there. For similar reasons, it is recommended that BHU Shah Allah Ditta refer patients directly to PIMS or FGSH.

For the proposed referral structure to function properly, it is further recommended that:

- Quality services be available at the primary level.
- Running water and electricity be made available at all RHCs and water at the BHUs.
- Fee structures be differentiated, and made progressively higher, at each of the three levels of care.

PROPOSED REFERRAL STRUCTURE FOR ICT HEALTH FACILITIES



- Patients who "jump the queue" and go directly to an RHC or a referral hospital should be penalized by paying, for example, a "by-pass charge" of an amount triple the normal fee. Further, as a disincentive for the provider to see the patient, two-thirds of this fee could be returned to the facility where the patient should have first gone with the remaining one-third staying at the facility providing the care. Rules for exceptions to this by-pass charge, such as life threatening situations, should be developed.

- Funds be built into each facility budget (particularly for BHUs) to transport (for example, by public means or rental of private vehicles) legitimate cases to the next referral level rather than providing in-house ambulance services (which are very costly).

- Provide referred patients direct access to the M.O. of the referral facility, rather than joining the queue of general outpatients.

- Develop a formal communication system with standardized forms between levels of care to ensure continuity of care; this should include not only referrals up the system (from primary to secondary and tertiary) but also downward so that the attending health professionals will know what treatment was provided.

7.0. COMMUNITY ROLE

7.1. Findings

Currently, there is no community participation in rural ICT health facilities nor are there examples of community participation in the oversight and management of government health facilities elsewhere in Pakistan, although there are some Pakistani examples in the non-government sector. Consumers interviewed informally in rural ICT tended to be interested in playing a role in health facilities, although they are fully aware of the political hazards involved such as health committees being co-opted by local power structures. ICT health providers, on the other hand, are considerably more skeptical, mostly for reasons such as fear of losing some control. Many of the potential contract providers who were interviewed also were skeptical and would dislike having anyone else, particularly "lay people," telling them how to run their business.

The Aga Khan Health Service (AKHS) in the Northern Areas and Chitral appears to have demonstrated that community participation is not only possible, but also can be an important component of a successful health service system. Through their village organizations, women's organizations, and local and regional health boards, a sense of ownership in the health facilities has evolved. More importantly, and for a variety of reasons (some of which are the roles communities play) health status indicators have improved considerably (Le Sar, 1990). AKHS staff emphasize, however, echoing experience around the world, that the process of building up this institutional base at the community level is complex, time consuming, and has had many setbacks in addition to the successes.

A common critique of the AKHS is that its success results from the homogeneity of the population it serves. However, AKHS staff and reports indicate that some 40 percent of the population served are non-Ismaili. Further, there appear to be no differences between health status indicators of the Ismaili and non-Ismaili communities.

There are many roles which communities can fulfill in primary health care, including:

- Providing, recruiting, and/or supervising volunteer community health workers and trained traditional birth attendants.
- Mobilizing the community for immunization, health education, and other activities.
- Monitoring and evaluating health services.
- Providing land, and even buildings, for health facilities.

- Providing funding through such things as user fees and drug revolving funds.

- Doing the bookkeeping for, and monitoring the management of, funds raised by the community.

- Advising on community needs and priorities and on how funds raised by the community are to be spent.

- Participating in health planning activities.

- Identifying community members too poor to pay for health services.

- Participating in management and/or advisory boards.

These activities can serve to help identify and solve problems, hold providers accountable, increase utilization and participation in activities, facilitate trust and empathy, and develop a sense of ownership by the community.

7.2. Recommendations

For the primary health services management and financing approach being proposed here, it is recommended that the community play a key role. Communities are to be empowered to choose and oversee the performance of a private provider of their basic health services. The operating funds allocated by government for the facilities serving the community, the facilities themselves, and their associated equipment will be assigned to the chosen provider for use in delivering services. The services to be provided are to be those currently offered (theoretically) by the facilities under government management, subject to some negotiation with the community. The community may wish to negotiate the provision of supplemental services in return for the right of the provider to charge specified fees. Government, in addition to providing financial and tangible resources, will act as an advisor to the community in evaluating proposals from providers and in helping communities measure their performance of the agreed-upon services.

Because community participation in the provision of health services is relatively new in Pakistan, a considerable amount of education will need to be done, including education of the contract provider as well as of the communities and their representatives. Because of the complexity of developing effective community participation, it is essential that this process not be left to chance. Rather, an institution with demonstrated competence in working with communities should be engaged to help develop the community participation system and conduct training. Two organizations to consider in this regard are the National Rural Support Program and AKHS.

The following are specific recommendations for the government to take into consideration to help the communities in test areas (ICT or elsewhere) carry out their role under this initiative.

- Develop a training program for communities in their role under this approach with the assistance of specialists in community development and the participation of community leaders from the test areas.

- Train the test communities in the concept of the initiative and their role in the process:

  - Selection of community representatives
  - Definition of the basic package of services
  - Decision regarding charging supplementary fees
  - Evaluation of proposals
  - Oversight of providers
  - Evaluation of performance
  - Decision on renewal of contract

- Conduct a conference of interested providers, communities, and government units to explain and seek feedback on the concept.

- Work with the test communities to enter into cooperative agreements with providers for the test period.

- Assist the test communities in deciding whether or not to ask for additional services and in determining fees to be charged; if fees are charged, help set up Zakat and other charity assistance to pay in the place of the poorest.

- Assist the test communities in monitoring and evaluating provider performance and in deciding whether to renew the contract or to open it up for new bids.

- Revise the community training program in light of lessons learned from the test period.

- Assist the test communities with competitive bidding for subsequent contracts.

In addition to the above recommendations, the following general recommendations are made:

- If possible, test various options of community representation for the health initiative.

- Monitor and evaluate the tested community representation options to assess which elements are more conducive to success.

- Adopt the community participation concepts at the BHU and RHC levels and on the autonomous hospital boards recommended elsewhere in this report.

8.0. LEGAL FRAMEWORK FOR THE RURAL HEALTH INITIATIVE

8.1. Overview

The team carrying out the overall Health Financing and Sustainability study found that no law currently exists in Pakistan under which the initiatives in the four program areas can be implemented. It is therefore recommended that a single Health Policy Law be enacted as a comprehensive Central Statute to provide a permanent legal framework for these initiatives. Within this statute, the details of each initiative would be worked out. These details would include specific regulatory provisions, sanctions, administrative structures, and financing.

Having a comprehensive statute would remove the need for going back to the legislature on a regular basis. The proposed law would encompass all four of the health financing initiatives and would be applicable to the whole of Pakistan.

8.2. Sanctions

The Health Policy Law should identify reasonable sanctions that could be invoked to ensure that the various initiatives are implemented. The HFS team believes that these sanctions should be corrective and remedial rather than punitive.

This law also should mandate the creation of mechanisms that provide ways for grievances and complaints to be addressed. This would help the consumers of health services provided through the four initiatives not to feel helpless and in need of resorting to litigation.

Possible mechanisms could be a local-to-federal grievance structure and a system of ombudsmen to serve as advocates and adjudicators of issues.

8.2.1. Grievance Structure

A self-contained adjudicatory system could be established to handle grievances. One possible way of designing it would be to:

(1) Have grievances against an individual brought to the notice of an authority at the divisional level.

(2) Have grievances against a hospital also be brought before this divisional-level authority.

(3) Create an appellate authority at the provincial level.

(4) Establish a final adjudicatory authority at the central level.

8.2.2. Ombudsman System

An ombudsman system could be established to serve as an advocate for consumers and an arbiter of issues. Within this system, all except trivial matters would be dealt with at the local level by a tribunal made up of at least two members, one of whom would be a medical specialist. More serious matters would be dealt with through the ombudsman structure: Deputy Medical Ombudsmen would serve at local and regional levels, Provincial Medical Ombudsmen would serve at the provincial level, and a Central Medical Ombudsman would serve as a final arbitrator at the federal level.

8.3. Laws Related to the Rural Health Initiative

The law should allow the federal and provincial governments to permit community organizations to make contracts with private organizations of health providers for the operation of rural (and urban) ambulatory health facilities and equipment. (See appendices for sample Request for Proposal [RFP] and contract.)

8.3.1. Community Organizations

The law should identify the methods by which the community organizations' members would be selected and allow for government representation in these organizations. Such government representation would be kept to a minority in terms of voting strength.

8.3.2. Operating Expenditures

The community organizations would be permitted to use the operating expenditure allocations of the relevant governments to fund contracts with health services providers. At their option, the community organizations would be permitted to supplement the government funds by allowing providers to do such things as charge fees for services used or accept charitable donations. Government funds made available would be no less than the real (adjusted for inflation) value of the average operating allocation for the subject facility(ies) over the last five years.

8.3.3. Services Offered

The law would provide that government would be able to specify a minimum set of services to be offered under such contractual arrangements, but this should set be kept to an absolute minimum in order to grant the communities the greatest possible flexibility in using the resources to their advantage. The communities would be constrained to using government funds only for provision of health services. A definition of health services should be contained in the law.

8.3.4. Capital Replacement and Acquisition

The government should provide funds for all capital replacement and new capital acquisition by the facilities. (Capital is durable equipment and structures with a lifetime of three years or longer.) The community organization should request desired capital replacement and acquisition funds from the government.

8.3.5. Rights of Personnel

The proposed approach to organizing and managing rural health services necessitates that the contracted provider possess the power to engage, reward, discipline, and discharge personnel as do private-sector enterprises. However, the current personnel of the rural facilities are government servants, with all of the (different from private-sector employees') rights and privileges of that status. To allow the contracting providers the power to control personnel requires that some variant on the following be done: Offer current employees the choice of being transferred to other government jobs where they would maintain their government servant status, or applying for jobs with the contracting provider while changing their status to private-sector-type rights and privileges. The contracting provider could be asked to give priority to initial hiring of personnel already working at the facilities. The contracting provider would retain the right to treat such employees just as any others following initial hiring. This would allow contracting provider management to control its personnel and it would allow those who want to continue to work in the facilities while requiring that other jobs be found within government for personnel unwilling to convert their status.

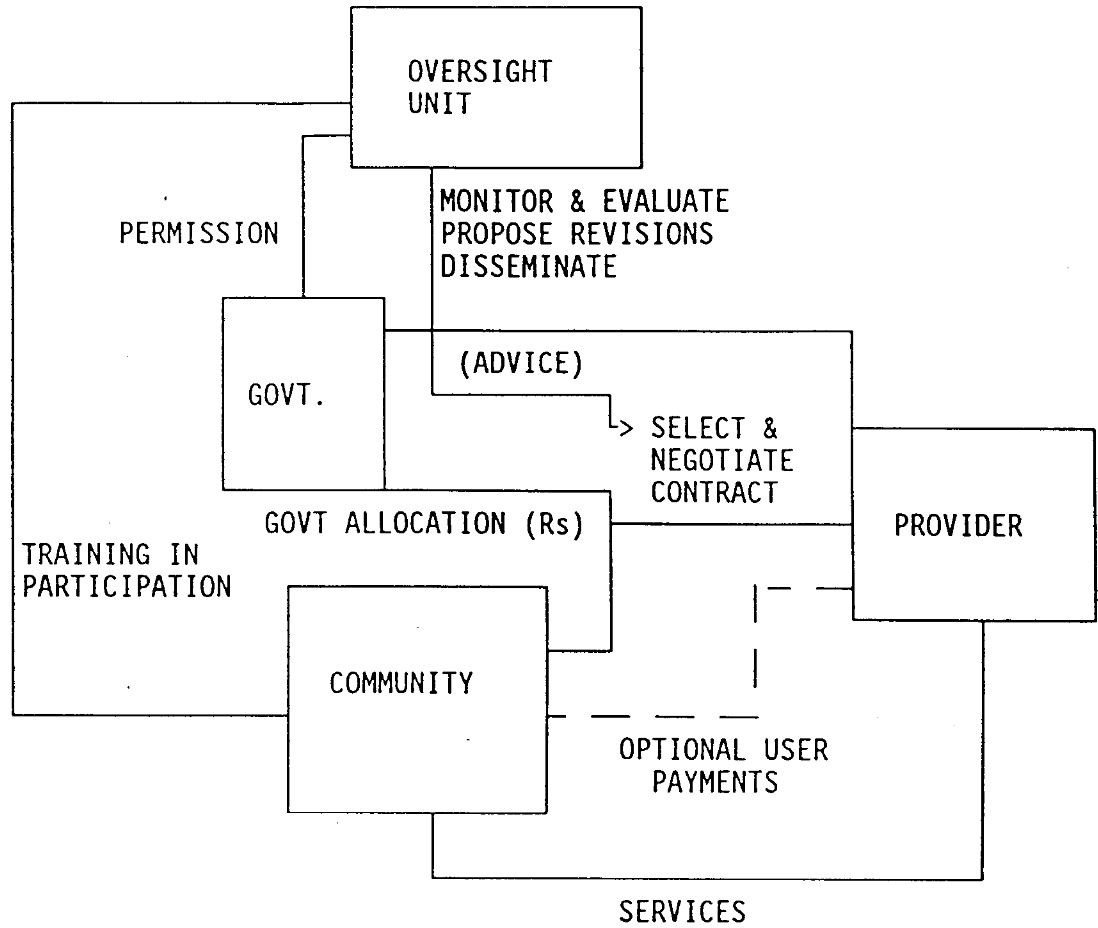
9.0. IMPLEMENTATION PLAN

The following is an outline of the steps it would take to implement a test of the proposed model of rural health services organization and financing in rural ICT. The implementation of the test begins with assignment of responsibility for its oversight to a FMOH unit and continues through the evaluation of monitoring data to assess performance and make modifications in the policy (see Exhibit 16 which is a table summarizing the implementation plan).

The unit which would oversee the implementation of this plan would contain or would be able to hire on a consulting basis an economist, a public health physician, and a sociologist. This unit would assist with all aspects of the test, setting up needed administrative arrangements among the government units involved; negotiating with communities and potential contract providers; hiring needed consultants; conducting baseline, monitoring, and evaluation data collection; performing analysis of data and policy formulation; and disseminating results.

The first step to be taken by such a unit would be to follow all of the necessary protocols with the units of government currently involved with the operation of the ICT rural health system to gain their permission to go ahead with the planning and execution of the pilot tests. Exhibits 15 diagrams the relationships among the parties involved. This would include developing referral relationships with hospitals in Islamabad and Rawalpindi.

EXHIBIT 15
DIAGRAM OF RELATIONSHIPS AMONG PARTIES IN RURAL HEALTH MODEL



The first step of implementation is to inform and train the concerned communities in their roles and responsibilities within the approach. The community training would be assisted by an organization with experience in fostering community participation in social activities. The training should be interactive so that the community can suggest modifications to its expected role where the recommended approach appears difficult or unwieldy. This process would help shape the ultimate design of the community role, using that described above as a base. Concurrently, the oversight unit would prepare a draft of a cooperative agreement including the provider, the community, and the local government.

Once the communities have been organized and trained, they and the local government, with the help of the unit, would solicit interest from and would select among interested provider organizations as contract providers. The communities, the selected provider organization, and local government representatives, with the assistance of the oversight unit, would then negotiate the terms and conditions of a cooperative agreement for the operation of the facilities. The "cooperative agreement", used only during the initial testing phase, would permit the oversight unit, local government, and community special access to the books and records of the contract provider. In return, the oversight unit would make some financial guarantees (such as indemnification of financial losses) to the provider. This approach allows maximum learning from the tests (about costs, utilization, and service quality) while minimizing risks to both the community and provider. This process would include negotiating whether or not additional services would be provided, accompanied by financial contributions from the community (often fees) to supplement the government allocation of funds.

During the execution of the test, the unit would assist the community and provider to solve problems that might arise and would monitor performance. Near the end of the test, the unit would evaluate its performance, disseminate results, make modifications to the approach, and prepare for replication.

Towards the end of the period of performance of the initial contract, the oversight unit would assist the communities and local government to prepare for the next contract, whether it be renewal of the first contract or competition among new provider organizations. Once sufficient testing has been done (one or more rounds of "cooperative agreements") to be satisfied that the approach performs well, when modified by lessons learned from the testing, broad-scale replication may go forward. This would be done using competitively bid contracts with providers, allowing them and the communities to be flexible in how they organize health services delivery. The competitively bid contracts would be awarded on a fixed-price-plus-community-option-for-supplementary-contribution basis. Possible renewal would act as the incentive for good performance by the providers.

EXHIBIT 16
RURAL HEALTH SUMMARY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	DURATION (MOS)*	BEGIN-END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
MANAGE, MONITOR, & EVALUATE TESTS	CREATE & STAFF OVERSIGHT UNIT	1	1-1	FMOH	NONE	
	OPERATE OVERSIGHT UNIT	INDEFINITE	1-ONWARD	FMOH	FMOH & DONOR	FMOH FOR STAFF & OPERATING COSTS; DONOR FOR CONSULTANTS
	OBTAIN PERMISSION & COOPERATION FROM GOVERNMENT UNITS	2	2-3	OVERSIGHT UNIT	NONE	
	DEVELOP REFERRAL RELATIONS	3	2-4	OVERSIGHT UNIT	NONE	RELATIONS WITH HOSPITALS IN ISLAMABAD & RAWALPINDI
PREPARE FOR TESTS	CHOOSE COMMUNITY PARTICIPATION APPROACH	1	4	OVERSIGHT UNIT, COMMUNITY, LOCAL GOVERNMENT	NONE	

*From start of initiative.

EXHIBIT 16
RURAL HEALTH SUMMARY IMPLEMENTATION PLAN
(Continued)

OBJECTIVES	ACTIVITIES	DURATION (MOS)*	BEGIN-END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
	TRAIN COMMUNITY IN PARTICIPATION APPROACH	2	5-6	OVERSIGHT UNIT, COMMUNITY, & TRAINERS	FMOH	HIRE TRAINERS FROM A GROUP LIKE AKHS
	SOLICIT & SELECT PROVIDER	2	7-8	COMMUNITY & LOCAL GOVERNMENT	FMOH	ASSISTANCE FROM OVERSIGHT UNIT, FMOH FUNDING FOR ADVERTISING
	PREPARE DRAFT COOPERATIVE AGREEMENT	1	5	OVERSIGHT UNIT	FMOH	HIRE LEGAL CONSULTANT
	COLLECT BASELINE DATA	3	6-8	OVERSIGHT UNIT & CONSULTANTS	FMOH & DONOR	DONOR FUNDS FOR CONSULTANTS
EXECUTE TESTS	DELIVER SERVICES	12-24	9-21 OR 9-33	PROVIDER	LOCAL GOVERNMENT & OPTIONAL USER FEES	

*From start of initiative.

EXHIBIT 16
RURAL HEALTH SUMMARY IMPLEMENTATION PLAN
(Continued)

OBJECTIVES	ACTIVITIES	DURATION (MOS)*	BEGIN-END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
	PROBLEM SOLVING	ON-GOING	9-21 OR 9-33	OVERSIGHT UNIT	FMOH	
	MONITOR & EVALUATE	12-24	9-21 OR 9-33	OVERSIGHT UNIT	FMOH & DONOR	DONOR FUNDS FOR CONSULTANTS
	DISSEMINATE LOCALLY	2-4	EVERY 3 MONTHS, BEGINNING WITH 12	OVERSIGHT UNIT	FMOH	
	DISSEMINATE NATIONALLY	2-4	EVERY 6 MONTHS, BEGINNING WITH 15	OVERSIGHT UNIT	FMOH	DONOR FUNDS FOR CONSULTANTS
REVISE POLICY	FORMULATE ALTERNATIVES	2-4	16-20 OR 28-32	OVERSIGHT UNIT	FMOH & DONOR	DONOR FUNDS FOR CONSULTANTS

*From start of initiative.

EXHIBIT 16
RURAL HEALTH SUMMARY IMPLEMENTATION PLAN
(Continued)

OBJECTIVES	ACTIVITIES	DURATION (MOS)*	BEGIN-END	WHO/WHAT	BUDGET RESOURCES	COMMENTS
RE-CONTRACT	SOLICIT & CHOOSE PROVIDER	2	20-21 OR 32-33	COMMUNITY & LOCAL GOVERNMENT	LOCAL GOVERNMENT	ASSISTANCE FROM OVERSIGHT UNIT TO DRAW UP NON-COOPERATIVE AGREEMENT CONTRACT

*From start of initiative.

10.0. MONITORING AND EVALUATION

The monitoring and evaluation of the rural initiative should measure how the test performs relative to goals and objectives. These goals and objectives have been set by the FMOH for both the overall health sector and for the health system serving the rural population. The tested approach should be monitored and evaluated to determine to what extent it addresses current problems without creating larger, new problems.

The FMOH's overall vision for the sector calls for more resources to be allocated to health, improved cost-effectiveness, and targeting of government resources to the poor. It seeks a financially more sustainable system, where the growth of the resource burden on government would be reduced. The principles enunciated to achieve the vision include requiring contributions in order to obtain payment for services from those who are able to pay; developing systems with incentives for efficiency, cost-effectiveness, and quality; and targeting resources to lower socio-economic status groups.

The FMOH would like the rural health services system to address the major sources of morbidity and mortality in the population in a cost-effective way. Further, this effort should be affordable. Problems with the system currently which inhibit achievement of the vision are staff absenteeism, short and inconvenient hours of operation of facilities, and the absence of essential drugs and supplies.

Objectives. The proposed monitoring and evaluation plan (summarized in Exhibit 17) reflects these goals, objectives, and principles. It sets out four categories of objectives:

- Addressing major morbidity and mortality sources
- Improving efficiency and cost-effectiveness
- Targeting of government resources
- Improving quality of service

These objectives encompass what is expected in the FMOH's overall and specific vision statements, address the identified problems with the status quo, and support the principles set out to guide solutions. Overall, the objectives should be met in the context of a financially sustainable model of organization and management.

Measuring indicators of each of the objectives would permit analysts and decision makers to watch how well or how badly the approach is performing (monitoring) and to determine whether it should be modified, replicated, or abandoned (evaluation).

Major sources of morbidity and mortality. Service statistics need to be developed to indicate to what extent the approach addresses major sources of morbidity and mortality. Complementary epidemiological information would be needed to identify the sources. Monitoring of services used could be done quarterly, with annual evaluations.

Cost-effectiveness. If the services provided address the major sources of morbidity and mortality, then they meet the effectiveness side of cost-effectiveness. To monitor costs and efficiency, annual estimates of the unit costs of providing services should be compared with the costs of providing similar services using other organizational approaches such as the traditional direct government provision approach. It would be important to compare services similar in quality, so that the cost comparison is fair. The elements of quality that might be considered are the qualifications of personnel providing care (although some substitution of nurses or other paramedics for doctors may be done without affecting quality of care), the diagnostic procedures applied, and the drugs and supplies used. Lower cost-per-patient visits would indicate that the approach was achieving greater efficiency. A combination of lower costs per visit and visits which meet major morbidity and mortality causes would indicate cost-effectiveness.

Targeting of government resources. The scarce resources of government are supposed to be targeted to those in greatest need, while those who are able may be asked to contribute to meeting the cost of services. To judge how the rural initiative approach contributes to these objectives, two indicators may be monitored: the level of fees agreed to by participating communities, and how well the system works to waive those fees for those unable to pay. The proposed approach suggests that any fees charged to supplement government allocations (in order to pay for more services) be agreed to by the community board. That should ensure that they are affordable to the majority of the population. However, one way to check on this would be to conduct a baseline survey to find out how much families are spending on health services before the new approach is applied, then again later to see how their health expenditures change. The aim is to provide them with low-cost, higher-quality services than those currently available to them in either the private or the public sector. It is possible that some families may save money, while enjoying better care.

Protecting the poor. To ensure that the prices charged do not pose an insurmountable barrier to use of services or cause a hardship, systems to identify and reduce or waive payments by the poor are recommended. The services used by such people would have to be paid for either through cross subsidies or payments made by Islamic charities. Indicators of low socio-economic status (SES) could be used to monitor whether those benefiting from lower charges were those truly in need. Data on such indicators could be

gathered regularly for quarterly monitoring and annual evaluation.

Financially sustainable model. One objective of the approach is to find a financially sustainable model of delivering quality services. This would require that the contracting organization at least break even on its costs of providing services. Break-even-or-better financial performance would allow the provider to continue to be interested in such contracts. Financial losses would discourage further participation. Earning surpluses also would attract interest from other organizations. The entry of other organizations into the pool of possible contract providers would tend to compete away large surpluses. It is recommended, during initial testing of the approach, that a cooperative agreement type of arrangement be used. Under a cooperative agreement, the contracting organization would agree to keep its financial books open to government and to the community in exchange for greater flexibility in terms of what the provider is to deliver and in terms of its compensation. A one-time supplemental allocation of government funds could be needed for the latter, if costs were dramatically underestimated. This would allow the government and community to know more about what are the true costs of operating health services under such an arrangement. Quarterly financial reports would allow financial performance to be monitored, with an in-depth evaluation performed at the end of the year.

Quality services. The objective of improved quality of services relates closely to the problems identified with the status quo. The indicators of improved quality recommended are the presence of staff at the facility, the convenience and number of hours the facility operates, and the use and availability of a set of critical essential drugs and supplies. The first and last indicators could be monitored through quarterly unannounced visits to the facilities. The satisfaction of the population served with the hours of operation could be judged by an annual survey.

Relationship to MEDEX PHC indicators. The indicators recommended here parallel many of those suggested by MEDEX's primary health care planning and management manual (1983). MEDEX's indicators are designed to be used for the primary care system as a whole, while the indicators needed here are for the monitoring and evaluation of the test of the initiative. The above-recommended indicators of efficiency, cost effectiveness, and sustainability overlap with MEDEX's Measures of Financial Health. The indicators of targeting of government resources parallel MEDEX's patient costs indicators. MEDEX's output indicators are similar to those recommended for addressing morbidity and mortality causes. The recommended indicators of quality are similar to MEDEX's for primary health care training (staff presence) and performance standards (drug and supply availability).

Implementation of Monitoring and Evaluation. The unit within the FMOH assigned responsibility for oversight of the test also should be assigned the duty of monitoring and evaluation. The unit would either conduct it itself or hire consultants to perform the data collection and analysis tasks enumerated above. This unit would be responsible for sharing and disseminating the results of the analyses with the communities, providers, involved governments, and wider health-sector community. With input from all of the foregoing, the unit would make modifications to the approach before wider replication.

EXHIBIT 17
ALTERNATIVE RURAL MODEL MONITORING AND EVALUATION PLAN

OBJECTIVES	MONITORING INDICATORS	EVALUATIONS
ADDRESS MAJOR SOURCES OF MORBIDITY & MORTALITY	SERVICES PROVIDED GIVE EMPHASIS TO MAJOR MORBIDITY & MORTALITY	QUARTERLY MONITORING, ANNUAL EVALUATION OF SERVICE STATISTICS
EFFICIENCY & COST-EFFECTIVENESS	QUALITY-ADJUSTED COST PER VISIT	ANNUAL ESTIMATES OF COSTS
TARGET GOVERNMENT RESOURCES	ANY FEES CHARGED ARE AFFORDABLE & WERE AGREED TO BY THE COMMUNITY	ANNUALLY COMPARE PER- CAPITA EXPENDITURES WITH PRE-CONTRACTING EXPENDITURES
	LOW SOCIO-ECONOMIC STATUS (SES) GROUPS BENEFIT FROM WAIVERS	QUARTERLY MONITORING OF SES OF THOSE WAIVED & ANNUAL EVALUATION
SUSTAINABILITY	PROVIDER FINANCIAL PERFORMANCE	QUARTERLY MONITORING & ANNUAL EVALUATION
IMPROVE QUALITY	PRESENCE OF STAFF	QUARTERLY UNANNOUNCED VISITS
	CONVENIENCE & NUMBER OF HOURS OF OPERATION	ANNUAL SURVEY OF PATIENTS
	DRUGS & SUPPLIES AVAILABLE & USED	QUARTERLY UNANNOUNCED VISITS

**Compare costs of visits for a set of common illnesses where similar inputs were used in terms of personnel, diagnostics, drugs, and supplies.*

APPENDICES

APPENDIX 1

INVITATION TO SUBMIT "EXPRESSIONS OF INTEREST"

The Federal Ministry of Health of the Government of Pakistan has developed alternative organizational and financing models for providing health services to people living in rural areas. Implementing some of these models will involve contracting with private individuals or organizations to manage Rural Health Centers and Basic Health Units under terms and conditions which are designed to improve people's access to health services. In addition to receiving a government subsidy, the provider who is contracted with will also be able to charge a user fee in order to cover operating costs. Mechanisms will be built into the model that will ensure access to the rural health facilities by low-income people. It is intended that this model will first be tested in the Islamabad Capital Territory, although consideration will also be given to testing it in other geographic areas. Based on lessons learned from this test, the model could then be modified and used in other parts of Pakistan.

Individuals, groups, companies, non-governmental organizations, and other entities interested in putting themselves forward as potential managers of Rural Health Centers and Basic Health Units are invited to submit in writing their Expression of Interest, including a brief statement of their organization's experience in the health care field. It is expected that a meeting will then be held with interested parties at which general operating information and financial data relating to the rural health models will be made available and issues/questions will be discussed.

Expressions of Interest should be submitted by (date) to the following address:

Director General
Health/Additional Secretary
Federal Ministry of Health
Government of Pakistan
Pakistan Secretariat, Block "C"
Islamabad

APPENDIX 2

SAMPLE REQUEST FOR PROPOSALS (RFP)

The following sample contains the major elements of a request for proposals. It is intended to be the beginning of a model that could be adapted for use by communities (assisted by their local government) wishing to receive proposals from private contractors interested in operating rural health facilities. When combined with the sample contract (Appendix 3), these models provide the base for implementing aspects of the rural health initiative described in this report.

ISSUED BY: The Community of ____________________
Address:
Telephone No.:
Fax No.:

Assisted by:

The Government of ___________________
Address:
Telephone No.:
Fax No.:

PURPOSE: The management of one or more Rural Health Centers (RHCs) and its (or their) dependent Basic Health Units (BHUs)

ISSUE DATE: __________________________

DUE DATE: Responses to this RFP should be forwarded to the address of the community identified above. All responses must be delivered no later than ________________. Only completed responses meeting the criteria outlined in the Requirements section of this RFP will be honored.

Background

The community of _____________________ in collaboration with the Government of Pakistan, Ministry of __________________ (or provincial Department of Health ______________________) wishes to procure the services of a local Pakistani health services provider organization to manage ______________ rural health facility(ies).

Description of Activities

The specific activities to be carried out under this contract are described in the attached Scope of Work.

Relationship of the Parties

The firm that is selected shall operate as an independent contractor. This firm shall be solely responsible for any and all claims, damages, or lawsuits arising out of the acts or omissions of the firm, its employees, servants, or agents. The firm shall be liable for compliance with all laws, regulations, ordinances, rules and orders as they may affect its employees and any third-party relationships.

Request for Proposals

The community of _____________ hereby invites your firm to submit a proposal for services outlined in the attached Scope of Work. Your submission should be received at the address noted above no later than _____date_____.

Interviews and follow-up meetings may be scheduled with firms that are deemed (1) qualified to perform said services, and (2) competitive in terms of cost.

Requirements

Please furnish the following information as part of your proposal:

Technical Proposal

1. A description of your firm, including date of incorporation, principal services provided, and annual revenues.

2. A description of services similar to those required by this project which your firm has provided to other clients. Please furnish references from these clients, including: (a) contact person and title, (b) name of firm, (c) telephone number, (d) dates when services were performed. References provided will be contacted.

3. Other client references that may be contacted.

4. A description of your proposed approach to the assignment outlined in the Scope of Work section. This description should demonstrate an understanding of the technical, administrative, and managerial issues involved in carrying out this project.

5. A description of the Project Director who would head up this assignment, including both a curriculum vitae (CV) and a Biographical Data Sheet. Also include CVs for all individuals filling program leadership positions (no Biographical Data Sheet is necessary for these candidates).

6. If government employees (civil servants) are to be used in carrying out this assignment, please enclose with your proposal a signed form that certifies that, during their period of performance with this contract, these civil servants will not receive salaries from the Government of Pakistan.

7. A description of the additional resources (both personnel and materials) that are available to your firm which will be used to conduct this project's activities. For example, this description should include available staff, vehicles, data processing capabilities, etc.

Cost Proposal

8. An estimate of the cost of providing services for the project. This estimate is due on the same date as the technical proposal, but should be submitted in a separate package.

9. A list of personnel who will participate in this project and the estimated level of effort (number of working days) for each team member. For the Project Director position, please specify the percentage of time that person will devote to working on this assignment.

10. Please ensure that your cost proposal takes into account all phases of this project from designing the management approach, to training staff, to providing services, to maintaining data, to assuring quality of care, to writing final reports.

11. Cost estimates should explicitly detail the following information:

    a. Personnel costs including salaries, allowances, fringe benefits, and overhead charges.

    b. Drugs, medicines, and supplies, including laboratory reagents, x-ray films, and spare parts (refer to Scope of Work, Section IV, concerning whether laboratory, x-ray, and other services are to be provided).

    c. Repair and maintenance costs.

d. Transportation (including ambulance services or rental, if specified in the Scope of Work).

e. Utilities charges (e.g., water and electricity), if applicable.

f. Management and administrative costs.

g. Other costs.

h. Fee charged.

Questions

All questions regarding this Request for Proposals should be directed to _______________ .

SCOPE OF WORK

I. Background

The community of ____________________, in collaboration with the government, is planning to contract for the operation of (number and name) Rural Health Center(s) and (number and name) Basic Health Unit(s) to private health services provider organizations.

The scope of work that follows is intended to specify the exact responsibilities that the contract provider will undertake while operating the above-specified rural health facility(ies).

II. Tasks and Activities

The following is a list of tasks to be undertaken by the winning provider under this assignment:

A. (Tasks would be identified that apply to the specific management and service provision responsibilities of a given health unit or units).

B.

C.

D.

E. Keep records on all services provided.

F. Provide appropriate equipment and materials to implement these activities including vehicles, computers, office

space, and other appropriate office machines.

G. Ensure proper accounting, control, and reporting procedures in accordance with GOP requirements.

III. Personnel

Personnel requirements for this assignment include:

1. Project Director: The project director must be available to work on this contract at least __ % of his/her time. The individual filling this position has overall responsibility for the operation of the specified health facility(ies) including ultimate accountability for service delivery and quality. Additional responsibilities include organizing the training of other personnel, ensuring the availability of needed drugs, medicines, and supplies, the delivery of high quality services, and serving as a liaison between the winning organization, the community, and the government. Minimum requirements for this position are (a) previous experience managing a health facility, (b) previous management of working groups, and (c) "x" educational requirements <u>or</u> a minimum of "x" years' experience in this field.

2. Medical Services Staff: (Described here would be the medical, nursing, and technical skills needed to operate Rural Health Centers and Basic Health Units.)

3. Support Staff: (Fill in as appropriate.)

IV. Contractor Obligations

<u>Contract</u>:

The obligations of the contractor are as follows:

A "fixed price" contract will be set up in which the government gives the provider chosen by the community an amount at least equal to the inflation-adjusted amount currently budgeted for the specified facilities.

<u>Fee Schedule</u>:

At the option of the community, the fixed price may be supplemented by a fee schedule. If the community chooses this option, it should request the following information:

1. List of charges proposed for each service. The charges should be higher for similar services offered at the referral RHC(s) compared to the primary BHU(s). No charge should be proposed for preventive services.

2. Expected utilization of each service charged for.

3. Expected revenues generated by the charges both by service and overall.

4. Expected total costs and total revenues, including "fixed price," and the sum expected to be received from users.

   Where user fees are included in the agreement, the provider will be responsible for collecting user fees and for making available to the monitoring and evaluation team related financial reports.

   Keep the user fees that are collected.

   Negotiate with the community the combination of Zakat and other charitable funds and cross-subsidization that will be used to pay fees for the medically indigent.

Services to Be Provided:

(Specific services would be identified here using Options A,B,C, and D in the Rural Chapter, Exhibit 7, as models).

Staff:

The provider will recruit, train, supervise, and evaluate an appropriate mix of personnel to provide the services at the specified facilities. The provider will have full authority over personnel policies and procedures.

Facilities:

The provider is responsible for routine maintenance of facilities and equipment.

The government is responsible for capital replacement and major repairs at the facility.

Monitoring and Evaluation:

The provider will be responsible, working in collaboration with the government and communities, for cooperating with an independent monitoring and evaluation unit.

Monitoring will be done on the basis of an agreed-on, limited set of indicators to measure: inputs, outputs, health status, and financial information.

Referral System:

The provider will be responsible for developing and following a referral system. (Self-referrals and other conflict of interest practices are not acceptable.)

V. Government Obligations

The government of _______________ will be responsible for:

Guaranteeing an allocation of Rs._______ to the provider selected by the community (the equivalent real amount allocated for operating costs in 1993-1994 for the specified facilities).

Advancing the proportional amount of funds quarterly if the provider is in compliance with the terms and conditions of the contract.

Retaining ownership of the physical plant.

Retaining ownership of the existing furniture and equipment with the provider being responsible for greater-than-normal wear and tear.

Providing for capital expenditures and major repairs.

Establishing an independent monitoring and evaluation body.

Permitting a leave of absence to those health staff that currently are in the government service who wish to work with the contracted provider for the first contract period without loss of servant status. These people will be under the full authority of the provider.

Organizing (with technical assistance from an institution with demonstrated competence) community health committees.

VI. Other

Locations for testing the alternative rural health models will not be limited to the Islamabad Capital Territory, but will be open to other geographically limited areas.

Preference will be given to offering contracts for the management of a system rather than a single rural health facility.

A survey will be conducted that will develop a set of baseline data to measure changes that occur over the life of the contract.

Contracts will be let for one to two years.

VII. Deliverables

Services:

The services described herein are specific outputs to be offered by the provider and serve as measurements for this assignment. Each service area will be monitored on a regular basis. Payments under this contract will be based on the successful completion of each component service.

Timeline:

The time period covered by this contract is the (one or two year) period beginning ___________ and ending _____________.

Supervisory Party:

The party(ies) responsible for overseeing the deliverables and the timeline of activities are the community of _______________________ and the government of _______________.

Contract Amendments:

Any changes the winning provider may wish to make in its contract agreement once it has been finalized and signed (including a revision of the timeline and/or deliverables) can be made only with the approval of the designated representatives of the community of ___________________ and government of _______________.

APPENDIX 3

MODEL CONTRACT BETWEEN THE GOVERNMENT OF PAKISTAN AND PRIVATE PROVIDER

THIS DEED OF CONTRACT AGREEMENT is made the _____ day of __________, 1993 BETWEEN the President of Pakistan (hereinafter referred to as "the Federal Government") on the one part AND M/s (hereinafter referred to as "the Providers") on the other part as follows :

WHEREAS the Government of Pakistan has introduced a plan to provide general medical/health coverage to the people of Pakistan (hereinafter referred to as "Health Care");

AND WHEREAS the Providers have available with them requisite medical, para-medical and administrative personnel, medical care equipment, medical care medicines, units, and infrastructure (hereinafter referred to as "Health facilities");

AND WHEREAS the Government of Pakistan under the scheme of providing medical care, has introduced a system of providing health care to the people of the country under various schemes fully described in the Medical and Health Care Act, 1993;

AND WHEREAS the Government of Pakistan has agreed to award a contract for implementation of one such scheme known as: Providing health services at health facilities within the rural areas of the provinces of Pakistan;

AND WHEREAS the providers have available with them complete requisite health care equipment and infrastructure;

AND WHEREAS the providers have agreed to provide health care facilities in accordance with the aforesaid scheme at the Rural Health Center of (place) and Basic Health Units of (place);

NOW, THEREFORE, THIS DEED WITNESSETH AS UNDER:

1. Definition:

   1.1. All terms used in this contract shall have the same meaning as provided in the Medical Health Care Act of 1993.

   1.2. In case of any inconsistency or difficulty in the definition under the Act and in terms of any terminology in this contract, the terminology as defined in the Act shall have precedence.

1.3. In case any term used herein is not defined in the Act and, if the term used is technical, then it shall have the same meaning as is understood technically in its field; and if the undefined term is not of technical nature then it shall have the ordinary dictionary meaning.

2. Duration of the contract:

2.1. This contract is valid for a minimum period of ____ years.

2.2. The contract, unless it has become terminable for reasons described below, shall be automatically renewed on the expiration of one year on a year-to-year basis for a maximum period of three years on conclusion of which the contract shall come to an end.

2.3. On termination of the agreement, the parties may agree to enter into a fresh agreement in accordance with the provisions of the Act.

2.4. The providers shall not have a right to seek extension of this contract after the expiration of the three-year period. However, a fresh agreement may be executed between the parties.

3. Health Facilities:

3.1. The Medical Unit at (place) is owned by the government and consists of land and buildings as described in Schedule "____."

3.2. The existing Medical Unit is equipped with such equipment as is identified in Schedule "_____."

3.3. The providers have available the requisite qualified medical staff, para-medical staff, and administrative staff as specified in Schedule "_____."

3.4 The providers also have available the requisite equipment and medicines as specified in Schedule "_____."

3.5. The providers also have available the requisite infrastructure for effectively running the Medical Care Center as defined in Schedule "_____."

NOTE: All schedules annexed with this agreement are duly signed by the parties and form an integral part of this agreement.

4. Cost-sharing and Finances:

4.1. Estimated cost and expenses of operating a Medical Unit for the first year is Rs. ______.

4.2 The government has made available to the providers the existing Medical Unit along with the existing facilities and, for performance of this contract, the existing facilities are valued at Rs._____.

The land, buildings, equipment, and facilities provided by the government at the Medical Unit shall always remain property of the government, to be returned on conclusion of the contract.

4.3. The government has also agreed to make available to the providers subsidy of the value of Rs. _____ for one year duration, worked out on the present evaluation of the size of the unit and the expected average expenditure.

4.4. The government cash and kind subsidy shall be in the ratio of 50:50.

4.5. The government shall extend the cash and kind subsidy to the providers on a month-to-month basis. If the government delays the payment, the providers will be entitled to per diem compensation @ 0.5 % of the amount due. If the government fails to make the payment, the providers may discontinue the services and would be entitled to claim their dues from the government and shall have lien on the government property in the provider's possession, to that extent.

4.6 The remaining expenses (i.e., Rs.____) for operating Medical Care Unit for one year shall be borne by the providers.

4.7. The providers have been authorized to charge the patients for the medical services provided.

4.8. The providers can charge the patients treated only at such rates as are previously agreed between the government, the providers, and consumer representatives which shall be prominently displayed at the Medical Care Center. Such list of rates shall also form part of this agreement.

5. Termination:

5.1. This contract is valid for such period/periods as are mentioned above.

5.2. The contract may not be terminated by either party except for reasons mentioned below.

5.3. If the government receives complaints of non-availability of facilities, unsatisfactory medical treatment, and gross negligence on the part of the providers in providing agreed-upon health services, then the government may call upon the providers to remove the deficiencies and/or to show cause as to why the contract may not be terminated. The complaint may also be referred to the Adjudicatory Body set up by the government under the (Medical and Health Care) Act.

5.4. If the providers fail to improve their performance despite shown-cause notice, the government may terminate the contract forthwith.

5.5. If the government receives serious complaints of professional negligence and misconduct from the patients and the providers are found to be guilty of gross negligence and misconduct, then the contract may be terminated forthwith in addition to any other liabilities to which providers may be attached.

5.6. The providers may terminate the contract any time by giving three months notice provided during the notice period the providers shall continue to provide medical facilities as per this Agreement.

6. Indemnities assurances:

6.1. The providers hereby agreed to indemnify and keep the government harmless of any claim of damages or liabilities arising out of negligence or misconduct of the providers.

6.2. Performance Bond shall be issued by any scheduled bank or registered insurance company for due performance of this contract.

6.3. The providers shall also provide the security bond for proper use and return of government property/equipment on conclusion of the contract subject to fair wear and tear. In case of abnormal wear and tear attributable to negligent and improper use, the contractor shall restore the damage to original condition.

6.4. The providers shall also provide guarantees either issued by a bank or acceptable guarantees for due performance of their obligations under this contract.

6.5. The government undertakes not to interfere with the due performance of the provisions of this contract by the providers.

7. Disputes - Claims:

7.1. All disputes, claims, and questions on matters arising from this agreement or touching or relating hereto shall be resolved in such manner as is provided in the Act. Providers hereby specifically agree to submit to the jurisdiction of the authorities designated in the Act for resolution of the disputes.

7.2. The venue of litigation shall be__________________.

8. Insurance:

8.1 The providers may enter into a separate agreement with any recognized insurance company for providing health care at the unit.

8.2. Any policy sold to a potential consumer shall be registered with the Government of Pakistan.

8.3. The provider shall not claim any extra compensation from the government for providing medical service to a consumer who has purchased health insurance policy from a recognized insurance company and whose medical expenses are to be borne by that company under the policy held by him or her.

9. Amendments of the agreement:

9.1. The parties may agree to amend terms and conditions of this contract provided that such amendments should not be in conflict with the provisions of the Act.

9.2. Until an amendment is brought about, the existing provisions shall remain valid.

9.3. Either party may notify in advance of its intent to seek amendment in the contract and shall specify the proposed amendments.

9.4. No amendment shall be incorporated unless it is found to be necessary for the implementation of the contract and is necessitated because of extraordinary circumstances.

9.5. The providers shall not refuse to be bound by the contract for the remaining period even if the amendments are not approved.

10. Personnel

10.1 The provider shall recruit and retain requisite technical (medical and para-medical staff) for the entire duration of the contract.

10.2 The provider shall recruit and maintain requisite administrative staff for the entire duration of the contract.

10.3 The provider shall prepare and implement his own policies for his personnel. However these policies shall not be in conflict with the laws governing employments.

10.4 The provider shall be responsible for maintaining discipline at the unit.

10.5 The provider shall be responsible for payment of all dues, wages, benefits payable to the employees and/or to any public department relating to service benefits.

11. General obligations of the Provider.

11.1 The provider shall not turn away any patient or consumer for the reason of his inability to pay the provider his medical treatment fees.

11.2 Specified preventive services shall be provided free of charge by the provider.

11.3 Zakat fees shall be used for medically indigent.

11.4 Self-referrals and other conflicts of interest are not permissible.

11.5 The contractor shall establish an independent monitoring and evaluation body in collaboration with the government.

Note: Agreed limited set of indicators measuring forming basis of monitoring and evaluation is set out in Schedule _____.

11.6 All monitoring costs shall be borne by the contractor. All evaluation costs shall be borne by the government.

11.7 The contractor will survey at his own expense to develop a set of base line data to determine such changes that may be deemed necessary for the remaining duration of the contract.

11.8 The contractor will enforce the use of a referral system or some acceptable modifications thereof, including any recommendations that may be considered appropriate for purposes of the contract.

11.9 The contractor shall organize Health Committees to be established at the medical unit for appropriate advice or management.

12. General Obligations of the Government:

12.1 To guarantee subsidy to the contractor at a level and rates specified in Schedule ____.

12.2 To make payment of the subsidy on a month-to-month basis
in advance, but in cases of genuine need and subject to furnishing of adequate security, the government may make advance payment of a sum up to three months.

12.3 The government shall always retain ownership of the property mentioned in Schedule ____.

12.4 The government shall ensure that the contract shall not be terminated without reasonable excuse.

12.5 The government shall ensure that the contractor shall have a right of vote in the governing body through the nominee director of the provider.

12.6 The government shall pay costs of the evaluation of the monitoring and evaluation body.

12.7 The government guarantees availability of a sum up to Rs. ___ from the Zakat funds to be used only for treatment of medically indigent.

12.8 The government agrees to pay a sum of Rs. _____ towards capital expenditures each year during the currency of this contract.

12.9 In case the provider employees any medical or para-medical staff who is presently in government service, the government will permit such civil servant leave without pay to serve on secondment under the provider; such civil servant shall retain his lien in government service and will not lose his seniority and civil

servant benefits while in service of the contractor; this person shall remain under his discipline but not liable to disciplinary action affecting his government service.

13. Subletting.

13.1 The provider can sublet the contract or any part hereof.

13.2 Sublet shall have to be approved by the government.

13.3 The sublettee must possess same qualifications as are possessed by the provider.

13.4 The provider shall not be absolved of his liabilities notwithstanding consent of the government to the sublet.

IN WITNESS WHEREOF we, ____________________, for and on behalf of the President of Pakistan and on behalf of M/s _____________ the providers have hereunto signed at ___________ the day, month, and year written above.

WITNESSES	EXECUTANTS
1.	1.
2.	2.

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