Draft

Recent Experiences with Hospital Autonomy in Developing Countries -- What Can We Learn?

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Data for Decision Making

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1. Introduction

Since the early 1980s, public sector hospitals around the world have come under intense scrutiny in policy circles due to the complexity of these institutions, the heavy burden they impose on public funds, and the perceived difficulties in ensuring their efficient and effective functioning under centralized government control. One policy option that has found particular favor with governments is the grant of greater autonomy to these public sector hospitals in running their operations. As a result, in many developed countries (e.g., Denmark, France, Singapore), and in many developing ones (e.g., Ghana, Indonesia, Kenya), "hospital autonomy" initiatives have been proposed as an integral part of a broader health sector reform process.

However, despite the implementation of hospital autonomy in a number of public sector hospitals around the world, relatively little research has been directed towards evaluating the experiences of these hospitals, and assessing the overall merits and limitations of hospital autonomy as public policy. As part of the overall strategy of US Agency for International Development (USAID) to conduct research into matters of critical importance to policy makers in developing countries, the Data for Decision Making (DDM) project at Harvard University was commissioned by the Health and Human Resources Analysis for Africa (HHRAA) project of the Africa Bureau to conduct five case-studies on hospital autonomy. These studies were conducted in Ghana, Kenya and Zimbabwe within sub-Saharan Africa, and in India and Indonesia outside Africa.

The studies had two broad goals: a) to provide a description and analysis of the experience of the public sector hospitals with hospital autonomy in each of these countries; and b) to draw on the experience of these countries to derive broader lessons about the viability of hospital autonomy. In line with this overall mandate, the specific objectives of each study were:

- To assist policy makers in each country in evaluating their policy on hospital autonomy, and determine the feasibility of its full implementation.
- To critically examine strategies to successfully implement autonomy in the public sector hospitals in each country.
- To provide lessons for other developing countries, that are contemplating the introduction of hospital autonomy in the public sector, on how to

approach the issue.

- To provide guidance and direction to international agencies and bilateral aid organizations in their support of similar initiatives in developing countries around the world.
- To serve as the basis for further research on hospital autonomy.

At the onset of the project, a provisional conceptual framework was proposed by the principal investigators at Harvard University. This framework was intended to guide the assessment of the autonomy effort in each participating country, and assist in organizing the presentation of the data and results, and focus the discussion, for each study (see Chawla and Berman, 1995). This general framework was subsequently modified by the project teams, based on the exigencies of each study. The five studies consisted of a combination of qualitative and quantitative analyses of the experience of the study hospitals with autonomy. The four evaluative criteria used in assessing hospital autonomy in each country, based on the project guidelines, were: **efficiency**, **equity**, **public accountability**, and **quality of care** (see Chawla, et al., 1996). The research methodology employed in undertaking the studies included secondary data collection and analysis, direct observation by the study teams, interviews, and field surveys.

One issue that the project researchers had to confront in some countries was that many of the study hospitals did not enjoy full autonomy, even within the legislative framework for autonomy in that country, i.e., there is often a large gap between de jure and de facto autonomy. Many of the stakeholders interviewed as part of these studies questioned the premise that the hospitals were "autonomous" entities.

Despite the limited implementation of autonomy in many of the hospitals studied, we felt there were important lessons to be learned from their experiences, for several reasons. First, the studies were also evaluating the move towards full hospital autonomy, in each instance, in addition to the outcomes of the partial implementation of autonomy in the hospitals. Second, even though the study hospitals did not have full autonomy, they did enjoy considerably greater latitude in running their affairs than other public-sector hospitals in these countries. Furthermore, as discussed later, it is an open question as to whether public-sector hospitals can (or should) ever achieve the level of autonomy that might potentially exist, for example, in the private sector. Third, if the autonomy process had stalled in some of these countries, this might, in fact, reflect general problems in implementing autonomy in any setting (e.g., generic institutional and political bottlenecks), or contradictions inherent in the autonomy initiative (e.g., balancing public sector goals with a blind emulation of the private sector). In other words, the autonomy process may be directly and inextricably linked with the outcomes of autonomy. Without a detailed

evaluation of autonomy in specific settings, however, these issues may well be overlooked.

An incontrovertible overall conclusion of the five case-studies undertaken as part of this project is that autonomy in public sector hospitals has not yielded many of the hoped-for benefits in terms of efficiency, quality of care, and public accountability - although there have been occasional and isolated successes. To some extent, this situation might be explained, simply, by the relatively short duration of "autonomy" enjoyed by the public sector hospitals, or the instability that often accompanies systemic reform.

However, the evidence from the case-studies suggests that problems are far more deep-rooted. It would seem that a flawed conceptual basis for hospital autonomy in the public sector, as much as the poor implementation of the autonomy measures, is to be held responsible for this failure in the five countries. Thus, among other things, i) an inability to successfully transplant private sector structures and incentives to the public sector hospitals, ii) institutional conflicts and inertia, iii) limited decision-making and management capacities, iv) the absence of a comprehensive and sustainable financial plan, and v) inadequate information systems, have all contributed to the limited success of the "autonomous" hospitals to achieve significant change either in their functioning or performance.

An important caveat for readers to keep in mind is that it is hard in empirical field studies, such as this one, to clearly separate out the impact of a poor (or good) conceptualization of autonomy from a poor (or good) implementation of autonomy measures. After all, the two are inextricably linked. Moreover, unlike in laboratory settings, or even in a social experiment, it was not possible for us to control for one or the other (or eliminate confounding variables). Moreover, in the absence of counterfactual evidence, it was not possible for us to assess what the outcomes of hospital autonomy would have been if the approach to autonomy had been different. Moreover, the range of autonomy measures implemented in the five study countries (and the approaches adopted) were sufficiently different that scientific comparisons between initiatives and outcomes were rendered difficult.

The five country reports present, in detail, the results, conclusions, and recommendations of each study. Executive summaries from these studies are included as appendices to this paper. In this synthesis paper, we draw on the conclusions of these five studies to derive broader lessons on formulating and implementing hospital autonomy in developing countries. The rest of the paper is organized as follows: in Section II, we provide a background on the underlying rationale and motivations for the hospital autonomy concept; in Section III, we review, briefly, the conceptual basis for autonomy, and some of the hypothesized benefits and drawbacks of hospital autonomy cited in the

literature; in Section IV, we summarize the key findings of the five case studies; and in Section V, we advance certain testable hypotheses about the process and outcomes of hospital autonomy, in the form of propositions.

2. Motivations for Hospital Autonomy

Governments are major players in the health sector in virtually all countries — developed and developing — although the exact role played by the government varies from one country to another (Govindaraj, et al., 1996). Governments in developing countries have traditionally been major providers of health services, in addition to financing health care delivery. However, in recent years, public resources for health care delivery (as indeed for most of the social sectors) have either leveled off or declined in a number of developing countries (Murray, et al., 1994). These financial constraints have forced these governments to reassess their priorities in the health sector. Cost containment and increased efficiency in the financing and provision of health care have thus become major concerns of governments around the world, and this had led to the institution of major health sector reform efforts in a number of developing countries (e.g., Mexico, Colombia, Egypt, Zambia, etc.) Similarly, hospital reform has been an important component in many countries.

Hospitals are an integral part of any health system. However, an issue that policy makers constantly grapple with in allocating resources between alternative activities in the health sector (e.g., primary care, hospital care, etc.) is that of economic efficiency. Economic efficiency within the health sector is defined as the allocation of resources among alternative activities in such a way that will produce the same output at a lower cost. Thus, policy makers are concerned about the returns (in terms of improvements in health status) that accrue from investments in each of the competing health activities. This is the basis of cost effective analysis that has gained currency in recent years, particularly since the publication by the World Bank of the World Development Report: Investing in Health (World Bank, 1993). Based on such analysis, there seems to be a rough consensus that primary curative care and preventive services are much more cost-effective than hospital services (Barnum and Kutzin, 1993). Therefore, many governments particularly in developing countries are moving towards decreasing their investments in hospitals and channeling these resources in more cost-effective health activities.

Moreover, government hospitals absorb a very large (and arguably disproportionate) share of government health resources in the form of capital infusions, outlays for recurrent expenditures, and various other direct and indirect subsidies (Mills, 1990). For example, the study by Barnum and Kutzin (1993), show that the share of hospitals in the total government recurrent health

expenditures has been greater than 60% in more than half of 29 countries included in the study. Almost two-thirds of the countries spent 50% or more, while only 4 out of the 29 countries spent 40% or less of government health resources on hospitals. Besides the question of whether such huge claims on the public purse can be justified against competing claims in the health sector, governments have been concerned that these investments are not sustainable. Moreover, it has been argued that such huge investments on hospitals, that are usually located in the urban areas of most developing countries, was unjustified on equity grounds.

Finally, there seems to be a consensus among a wide spectrum of experts that many public hospitals are functioning inefficiently, both in terms of technical and allocative efficiency. Technical efficiency refers to the situation where the hospitals produce the maximum possible output that is technologically sustainable from a given set of inputs. On the other hand, allocative efficiency refers to the situation in which the hospital uses the available inputs in the best possible manner such that no further output or welfare gains are possible. It has often been suggested that the government's involvement in the provision of health care has been the major contributory factor to the inefficiencies observed in public hospitals (e.g., World Bank, 1993), and thus a movement away from centralized decision-making and provision of health by the public sector has been recommended (World Bank, 1993).

In short, there is wide consensus that public hospitals need urgent reform. There is less consensus, however, on how to go about this reform. With privatization of health services not being socially or politically acceptable and therefore, not a realistic option, governments have experimented with other "remedies", many of which are largely untested (and in some cases lack a sound theoretical basis). One such initiative that has gained in popularity recently is the provision of increased financial and managerial autonomy to public hospitals under continued government ownership of these facilities.

We have noted that hospital autonomy initiatives have been proposed as a component of broader health reform initiatives. The main themes underlying the health sector reforms (McPake, 1996), that apply equally to the hospital autonomy policies, have been:

- encouragement of competition,
- achieving a 'split' between purchasers and providers of health services,
- restructuring public-sector institutions to (at least partially) mimic private organizations,
- cost recovery (not so much a feature of hospital autonomy in the developed countries),

- managerial and budgetary reform,
- decentralization and increased community involvement in health management, and
- reallocation of public sector budgets towards an "essential" package of cost-effective services.

As mentioned in the introductory section, there has not been much documentation of the successes and failures of these initiatives. The five country studies undertaken as a part of this research attempted to fill this gap. Given the significant international support gained by hospital autonomy, it is critical that the policy be adequately evaluated from both a theoretical and empirical perspective (McPake, 1996). This paper is a step in that direction.

3. Conceptual Basis for Hospital Autonomy

While many of the hospital autonomy initiatives are of relatively recent origin, and, therefore, have not been fully evaluated, a substantial literature exists on the potential benefits and pitfalls of providing greater autonomy to public hospitals (see reviews by McPake, 1996: Chawla, et al., 1996). While, *a priori*, one can only conjecture as to whether, on balance, the positives of providing increased autonomy outweigh the negatives, the popular consensus seems to be that greater hospital autonomy can lead to significant gains in efficiency, effectiveness, public accountability, and the quality of care, without a significant compromise of equity.

It has been suggested in the literature on hospital autonomy that it may lead to gains in both **technical and allocative efficiency.** Various reasons have been cited for these efficiency gains: the incentive structures and other reforms that usually accompany autonomy; the assumption of greater responsibility by autonomous hospitals; the greater freedom of autonomous hospitals to choose their optimal production function, the types and levels of inputs, throughputs, and outputs, and the overall strategic direction and development agenda. The counter-argument, of course, is that when autonomy is not associated with incentive structures, or the incentives are inadequate, any potential benefits of autonomy are unlikely to be fully realized. Furthermore, autonomy may lead to a loss of the benefits of economies of scale and scope; this would actually increase the *inefficiency* of the hospital.

Autonomy is also conjectured to increase **public accountability and consumer satisfaction.** The argument is that autonomous hospitals, vested with greater authority, can be expected to be better able to respond to local community needs. This, in turn, is expected to increase public support and acceptance, and greater community participation in hospital decision-making. Moreover, the delegation of authority, it is reasoned, "may be accompanied by a matching system of control and supervision to ensure the responsible use of authority", thereby "leading to improvements in patient satisfaction" (Chawla and Berman, 1995). There is, of course, the very real possibility that greater hospital autonomy will not be translated into an increased concern and responsiveness to community needs. In fact, it is not implausible that freedom from central control will allow hospitals to place their self-interest, or the interests of local politicians, above that of consumers. The most important potential drawback of providing autonomy to public hospitals may be a compromise of **equity** in the

financing as well as the delivery of health care (Chawla and Berman, 1995).

Finally, it has also been suggested that autonomy is likely to lead to improvements in the **quality of care** provided by hospitals. Greater autonomy, it is argued, when accompanied by appropriate incentives, consumer responsiveness, and public accountability, would lead to optimal employment of personnel, improvements in staff performance and attitude towards patients, increased availability of drugs and services, improved maintenance of facilities and equipment, etc. - all of which would contribute to improving the quality of care.

4. Summary of Case-Studies

As mentioned earlier, the Data for Decision Making (DDM) Project at Harvard University carried out five international case studies on the experiences in different developing countries with efforts to give greater financial administrative and managerial autonomy to public hospitals. Three of these case studies were in sub-Saharan Africa, in Ghana, Kenya and Zimbabwe, and two outside of Africa, in India and Indonesia. In each of these countries at least one hospital was given autonomy in the recent past: in 1987 in Ghana, Kenya and India, in 1993 in Indonesia and in 1975 in Zimbabwe. In three of the countries selected, Ghana, Kenya and Zimbabwe, tertiary hospitals were given autonomy, while in India and Indonesia secondary and primary level facilities were made autonomous. In keeping with the HHRAA guidelines, each of the case studies was conducted in collaboration with a local researcher in the host country.

Table 1

Autonomous Hospitals in Selected Countries

Country	*Autonomous Hospitals*	*Level of Facility*	*Autonomous Since*
Ghana	Korle Bu Hospital; Komfo Anokye Teaching Hospital	Tertiary	1987
Kenya	Kenyatta National Hospital	Tertiary	1987
India	Andhra Pradesh Vaidya Vidhan Parishad	Secondary	1987
Indonesia	Swadana Hospitals	Primary, Secondary	1993
Zimbabwe	Parienyatwa Hospital	Tertiary	1975

Each case study was guided by five main objectives:

- analysis of reasons why autonomy was given to the selected hospitals
- description of the approach and process for giving autonomy
- description of the nature and extent of autonomy
- assessment of the impact of autonomy on resource mobilization, efficiency, equity, accountability and quality of care

- suggestions for successful implementation.

In this section we present a brief account of the main findings from these five studies. This account is drawn from the study reports of the authors, and appropriate credits follow the first time each study is cited.

1. Why Autonomy?

A recurrent theme in most government decisions on giving autonomy to hospitals is the expectation that autonomy would enable the hospital to mobilize revenue and lessen the budgetary pressure on governments. With the exception of Zimbabwe, hospital autonomy in all countries seems to be motivated by the this objective.

In a study of hospital autonomy in two teaching hospitals in Ghana, namely the Korle Bu Hospital (KBU) and the Komfo Anokye Teaching Hospital (KATH), Govindaraj, Oboubi, Enyimayew, Antwi and Ofosu-Amaah (1996) find that probably the most significant reason for granting greater autonomy to these hospitals was financial. Other reasons included separating the policy formulation function of the MOH from health services delivery, freeing the hospitals from the constraints of civil service regulations; increasing management efficiency, improving the quality of care, and improving the overall public image of the teaching hospitals.

Similar concerns of resource mobilization and efficiency motivated hospital autonomy in Kenya. In a study of hospital autonomy in Kenya, Collins, Njeru and Meme (1996) argue that public hospitals in Kenya consume large portions of scarce health sector resources and do not always use them effectively or efficiently. Moreover, the Kenyatta National Hospital had, for some years, been experiencing problems with overcrowding, quality of care, and shortages of equipment, supplies, and committed, well trained staff. This was attributed mainly to management weaknesses, both in structure and staffing; to the absence of good controls and systems; and to the fact that decision-making was centralized in the Ministry of Health. Faced with difficulties in funding health services and to facilitate managerial improvements, the Government of Kenya granted greater autonomy to KNH in 1987.

The case of hospital autonomy in APVVP hospitals in India is no exception. Faced with the problem of meager budgetary allocation, government's inability to raise resources, and poor maintenance of hospitals, the Government of Andhra Pradesh decided to make all the district level hospitals autonomous in the expectation that the "autonomous body would be able to augment resources by mobilizing donations, charging fees for diagnostic and treatment services, through paying wards and through commercial projects" (Chawla and George, 1996). Other reasons included gains in managerial efficiency and freedom from

government interference.

In a study of hospital autonomy in Indonesia, Bossert, Kosen, Harsono and Gani (1996) evaluated a sample of ten hospitals which included five autonomous (Swadana) hospitals, three public provincial or district non-autonomous hospitals, and two private hospitals, and concluded that cost recovery and resource mobilization were the motivating factors behind autonomy.

Perhaps one country where autonomy was introduced for reasons different from those of resource mobilization is Zimbabwe. As Needleman and Chawla (1996) note, hospital services were segregated in pre-independence Zimbabwe. In the early 1970s, a decision was made to create a major teaching hospital for white patients, and the Andrew Fleming Hospital opened in 1974. The next year, governance of this hospital and three other hospitals was vested in an autonomous body, the Salisbury Hospitals Board of Governors. The Board had authority to administer the property of the hospitals, to manage and control the hospital, and to control the funds received by the hospital from patients. While it is by no means clear why the Board was given so much autonomy, the most probable reason seems to have been the need to create an institution free from government interference for provision of high quality medical services for the elite consumers.

Table 2

Reasons for Hospital Autonomy

Country	*Reasons for Hospital Autonomy*
Ghana	Resource mobilization, distancing from government, managerial efficiency, improvements in quality of care, better public image
Kenya	Resource mobilization, managerial efficiency, improvements in quality of care
India	Resource mobilization, distancing from government, managerial efficiency
Indonesia	Resource mobilization, cost recovery
Zimbabwe	Special provisions for elite consumers

2. Organizational Model of Autonomous Hospitals

The case studies show many differences in the choice of organizational models and level of facility to which autonomy was granted. Thus, in Ghana, Kenya and Zimbabwe the large tertiary and teaching hospitals were granted autonomy, while in India and Indonesia autonomy was given to district hospitals. In Indonesia, even the primary facilities were made autonomous. Further, while

individual hospitals were made autonomous and decision making was transferred to independent boards in Ghana, Kenya, Indonesia and Zimbabwe, an organization of hospitals was set up in India as a quasi-governmental organization and this body was made autonomous. In all the five case studies we find that the introduction of autonomy required enactment of an enabling statute or an amendment in existing laws.

Two distinct organizational models can thus be identified: the corporate, individual facility model, and the parastatal, multi-facility model. The corporate model seems to favored by four of the five countries studied while only India employs the parastatal model. The model used by the Government of Andhra Pradesh to grant autonomy is based on creation of a parastatal organization and giving that organization autonomy, as distinct from giving autonomy to each and every hospital. APVVP was set up as a quasi-government organization with the express objective of managing all district hospitals in the state of Andhra Pradesh in India. By 1993, APVVP had 162 hospitals and 9646 beds, and effectively replaced that branch of the Department of Health that was entrusted with the administration of hospitals. No autonomy percolated down to the level of the hospital.

This model has many advantages. First, the government has to deal with only one organization instead of many different autonomous hospitals. Second, it is simpler to monitor and regulate one organization instead of many smaller units. Third, one autonomous organization requires only one good management team as opposed to a much larger requirement of trained personnel for many autonomous units. At the same time, there are many disadvantages also. First, the hospitals continue to be non-autonomous, and thus the gains from autonomy do not get fully realized. Second, effective autonomy is always in danger of being diluted simply because it is easy for the government to exercise control over the single organization. Third, an ineffective leadership of one big organization can have larger adverse consequences and will affect all hospitals in comparison with ineffective leadership in few small hospitals.

Table 3

Models of Hospital Autonomy

Country	*Autonomous Facility*	*Organizational Model*
Ghana	2 Tertiary/Teaching Hospitals	Individual Boards
Kenya	1 Tertiary/Teaching Hospital	Individual Boards
India	162 Secondary Hospitals	One Autonomous Organization
Indonesia	22 Primary and Secondary Hospitals	Individual Boards
Zimbabwe	1 Tertiary/Teaching Hospitals	Individual Boards

3. Nature and Extent of Autonomy

(Chawla et al, 1996) define hospital autonomy along two dimensions: the extent of centralization of decision-making ("extent" of autonomy); and the various policy and management decisions (including both policy formulation and implementation) relevant to operating hospitals ("nature" of autonomy). Extent of autonomy is defined along a zero-one continuum, where a centralized system is ranked closer to zero and a decentralized system closer to one. Nature of autonomy includes participation in decision making on overall health as well as hospital goals, and implementation of hospital specific functions, like strategic management, administration, procurement, financial management and human resource management.

One consistent finding in all the case studies is the little or no involvement of the hospital in overall health goals and even in hospital specific goals. In all the countries where hospital autonomy was studied we find that the government almost exclusively decides and lays down the national health goals and presents the hospitals with a statement of expectations, despite the fact that the hospitals have so much more direct experience of patients' needs and demands. In all cases therefore we rank the extent of autonomy on health and hospital policy formulation as being very low.

Within the hospital domain, however, there is considerable variation in the nature and extent of autonomy. Insofar as strategic management is concerned, our case studies indicate that while Ghana, India, and Indonesia have some autonomy in defining the overall mission of the hospital, setting broad strategic goals, managing the hospital's assets, and bearing ultimate responsibility for the hospital's operational policies, the KNH hospital in Kenya and Parienyatwa hospital in Zimbabwe have very little freedom.

Hospital autonomy in almost all countries studied has meant at least a fair degree of financial autonomy. In all cases we find a change in budgetary allocations from line item grants to block grants, though government control within broad expenditure categories has varied from little in India and Indonesia to substantial in Zimbabwe and Ghana. Autonomous hospitals can thus construct their own internal budget without regard to the controlling ministry or treasury allocations to specific line items. All hospitals shifted from treasury accounts to commercial banking, and were no longer required to follow government accounting systems. The hospital management in all cases was encouraged to mobilize resources, though many restrictions were put on raising revenue through fee collection. With the exception of Indonesia, where hospital managers are allowed to set fees for all charges except those charged for beds reserved for the poor, decisions on user charges are still made by the governments. However, in all cases the hospitals have been allowed to retain their fee collections, though with the exception of Indonesia this has not

amounted to much. In Indonesia, hospitals under the Swadana system are allowed to use fee-collections for salary incentives, operations (drugs, spare parts), hiring of contract personnel, and food service and laundry, though there continues to be some centralized control over the planning/budgeting process for the revenue from fee collection.

Similarly, autonomous hospitals in some countries have enjoyed considerable autonomy in procurement of supplies, including purchase of drugs, medical and non-medical supplies for the hospital, as well as purchase of hospital equipment. Autonomous hospitals in India and Indonesia have effectively set up their own procurement protocols, though following government rules and procedures in principle. Procurement autonomy is somewhat limited in Zimbabwe and Ghana, where the hospitals still purchase from central stores.

Another area where most autonomous hospitals have enjoyed considerable freedom is routine day-to-day administration. The newly created boards provide

Table 3

Nature and Extent of Autonomy

Policy and Management Functions	***Extent of Autonomy***				
	Fully Centralized	---------->			***Fully Decentralized***
	Low Autonomy	***Some Autonomy***			***High Autonomy***
		a	***b***	***c***	
A. Health Domain					
Overall Health Goals	Kenya, Ghana, India, Zimbabwe				
Hospital Specific Goals	Kenya, Ghana, India, Zimbabwe				
B. Hospital Domain					
Strategic Management	Kenya, Zimbabwe		Ghana, India		
Administration		Zimbabwe, Ghana, Kenya	India		
Procurement	Ghana	Kenya, Zimbabwe		India	
Financial Management		Ghana, Zimbabwe	Kenya	India	
Human Resource Management	Ghana	India, Zimbabwe, Kenya			

effective buffers between the management and the government, and in all cases the autonomous hospitals have been able to locally take decisions regarding most operational activities, other than financial, personnel and procurement management, involved in the day-to-day running of the hospital and the discharge of the functions defined by the mission statement.

One area where autonomy has been limited is human resource management. In almost all cases government has retained the power of hiring and firing, even in cases where the hospital staff ceased to be government employees after autonomy. In India, Indonesia, Ghana and Zimbabwe, hospital employees continue to be civil servants, and governed by public service commissions that have restricted the ability of the hospital to redefine it staffing needs and hire or lay off workers in response to those needs.

4. Impact of Autonomy

Each case study used five criteria for evaluating hospital performance: efficiency, quality of care, public accountability, equity, and resource mobilization (Methodological Guidelines, Chawla et al, 1996). We discuss the impact of hospital autonomy along these five parameters.

(a) Efficiency

Another common finding in all the case studies is that there was no change after autonomy in the traditional efficiency indicators, like bed occupancy rates and average length of stay. However, many hospitals recorded significant improvements in management, finance and accounts, inventory control, and general maintenance. At the same time autonomy has had little or no impact on personnel decisions. We discuss these in detail.

Technical efficiency seems to have improved after autonomy in the Kenyatta National Hospital, mainly due to the increased availability of supplies and improvements in building and equipment maintenance, and the beneficial impact of these factors on staff productivity. The supplies situation also improved, mainly due to increased financial resources, speedier payment of bills, freedom to procure directly, and some internal decentralization of supplies management.

Autonomy seems to have had little impact on efficiency, and there seems to be no difference in the functioning of the autonomous Parienyatwa hospital and the state-run Harare Central Hospital. With respect to individual areas of hospital operations, performance appears comparable or associated with the budget levels for the function. Drugs and supplies are purchased using the same systems and sources, and staffs in both hospitals report overspending in recent years. When drugs are not available through central stores, Parirenyatwa reports

sometimes going to outside vendors; Harare Central to having patients or their families buy drugs and bring them to the hospital. This may reflect the difference in funding levels between the two institutions. Food service is one area of identified difference between the two institutions, with outside sources rating the Parirenyatwa Hospital food service as superior to that at Harare Central. This may, however, reflect the higher level of spending on provisions per day at Parirenyatwa as compared to Harare Central. Maintenance and equipment repair is handled similarly at both hospitals. Both hospitals report problems with respect to the responsiveness of the ministries responsible for maintaining plant and vehicles. The process of equipment purchase is similar at both hospitals. The principal difference is that the equipment budget at Parirenyatwa Hospital is fixed internally, while that at Harare Central is based on its appropriation for equipment. Over the past several years of tight budgets, donor funds have been the principal source of financing for new equipment and these have been administered through the ministry for both Parirenyatwa and Harare Central.

The experiment to give hospital autonomy to teaching hospitals in Ghana has not yielded many of the hoped-for benefits in terms of efficiency, quality of care, and public accountability - although there have been some isolated successes.

Autonomy has led to considerable improvements in many managerial decision making situations in APVVP hospitals. One significant achievement of autonomy has been the reduction in down-time due to equipment repair and overhaul, that came down from over six months in most cases to less than two weeks. Financial management has also improved, and APVVP has rationalized and reorganized the classification of expenses to follow a more functional categorization. Concurrent audit and review systems have been introduced, and financial powers for minor and routine repairs have been delegated to hospital superintendent and district coordinators. In the critical area of supply of drugs, APVVP introduced monthly central monitoring of stock for about 55 drugs.

In many other areas the success of APVVP has been rather limited. Even though the pattern of government funding changed from line grants to block grants after autonomy, the government continues to retain substantial control over how funds were allocated. As a result, no major innovations and improvements in spending have happened as a result of autonomy. Even the planning and budgeting processes have not changed much, despite the formal autonomy that APVVP enjoys in this regard. Allocations to the different heads of account and expenditure continue to be made on a historical basis, and no long-term plans have been drawn up for any major changes in process or focus of the organization.

Hospital autonomy has had little impact on personnel decisions in Indonesia, India, Ghana and Zimbabwe. In all of these countries autonomy did not allow the management of the autonomous hospital to hire or fire the permanent salaried

staff, as a result of which in all cases the management continues to follow the government norms, that are the same for other hospitals directly managed by the government. In no case did we find any evidence of new incentive systems, and in general autonomy has not meant much to hospital employees.

In Kenya, however, autonomy has had some impact on personnel decisions. Given a choice after autonomy, some staff elected to leave KNH in order to remain MOH employees, while the majority elected to become KNH employees and remain at the hospital. Those government staff who elected to become KNH employees retained the right to their government pension, but also joined the new KNH contributory pension scheme in 1991. Later increases in government salary grades meant that KNH could begin to attract nurses away from the private sector, although it still could not compete with the private sector for skilled staff in areas such as computers, finance, and information management. All administrative managers and staff continue to be from the public sector, in part because even the upgraded government salaries are too low to attract people from the private sector.

(b) Quality

The limited evidence from the five case studies indicates that the impact of autonomy on quality was limited to improvements in overall supply position. Supply of drugs improved in Kenya, India and Indonesia, though little change is recorded in Ghana and Zimbabwe after autonomy. Similarly, supply and maintenance of equipment also improved in Kenya and India, increasing the availability of usable equipment. As far as hospital staff was concerned, with the exception of Indonesia, there has been little or no change in their attitudes, work schedules, involvement, etc., probably because autonomy was not accompanied by any changes in incentives in any of the countries studied. Thus, while there is some evidence that autonomy led to improvements in some of the processes affecting quality, we do not have any evidence on any of the outcome parameters.

(c) Accountability

While autonomy has made the process of financial accountability more transparent in most countries, it has had little effect on public accountability for nature and quality of services provided by the hospital. The change of government funding to block grant has been accompanied by responsibility and financial accountability of hospitals, who have typically responded with more timely, detailed, and accurate financial statements.

There has not been much change in accountability to the general community, however. In most countries the board of directors has been nominated by the

government in power, and the hospital management has simply responded to representatives of the government. While this has had its positive effects in that it permits a quick and favorable government response to the requirements of the hospitals without the accompanying interference, it has also had its drawbacks in that it has effectively kept the hospital insulated from public scrutiny. The only exception to the above seems to be Zimbabwe, where the board has very recently been able to establish its independence, though it is probably too early to be sure that this display of independence will endure.

(d) Equity

The limited evidence from the five case studies indicates that equity and access issues have either worsened or not improved after autonomy. In Indonesia equity issues worsened after autonomy mainly due to increases in user charges, which doubled, tripled, and in some cases even quadruped after autonomy. Similarly, in Ghana also the introduction of user charges after autonomy had an adverse impact on equity. In Kenya the decision to charge user fees was taken by the government for all hospitals, but the autonomous KNH had better incentives and was better prepared to implement user charges. There was no effect on equity in Zimbabwe, where high exemption limits set by the government in Zimbabwe coupled with a surprising indifference of the hospital management to collecting fees from those who were not exempted, did not change the situation after autonomy. Similarly, the creation of APVVP had no effect on equity, since the government did not allow the autonomous hospitals to introduce any new fees.

(e) Resource Mobilization

Evidence from most of the case studies indicates that autonomy led to a significant improvement in the hospital's ability to mobilize resources, though there are considerable variations regarding the source of revenue. Thus, while the autonomous hospital in Kenya was able to get substantially larger allocations from government budgets, the autonomous hospitals in Ghana and Indonesia increased fee collections significantly. A third variant is provided by the autonomous organization in India, where improvements in resource mobilization came from financial institutions. We discuss these in detail.

In Kenya the share of government development and recurrent funding allocations to the Kenyatta National Hospital has risen significantly since it became a state corporation, probably at the expense of other allocations in the health sector. Moreover, since it became a state corporation, KNH has been able to retain all of its cost sharing revenue, which has become an important additional source of funding, increasing from 1% of KNH's recurrent income in 1986/87 to approximately 10% in 1993/94.

5. Hospital Autonomy: Some General Propositions

A. Conceptualizing Autonomy

Proposition 1: Hospital autonomy is a relative not an absolute concept

As noted, the recent health economics and management literature has been critical of government involvement in the provision of health care (although not in the financing of health services), and government "interference" in the operations of health care facilities (see, for example, World Bank, 1993). Instead, a greater involvement of the private sector in service provision, as well as the decentralization of decision making in the public sector health facilities, have been forcefully advocated. Thus, "autonomy" has been presented as a cure for many of the ills of public sector hospitals. Let us examine this recommendation more closely.

Autonomy has been defined in the dictionary as "the quality or state of being self-governing, especially, the right or power of self-government", "existing or capable of existing independently", and "subject to its laws only". However, using these absolute criteria to define hospital autonomy leaves us with very few or no examples of autonomy, as no public sector hospital in any country is either completely self-governing or totally independent - at least to the extent that all public sector hospitals (whether government-owned or parastatal) are subject to regulatory constraints in one form or the other. In fact, even private sector hospitals, it could be argued, are not truly autonomous by this definition, as they are also subject to government regulation.

In other words, the issue is one of "degree of autonomy rather than an absolute autonomous state" (Austin, 1984). Nor is this issue merely one of semantics. The latter situation, we would argue, is neither feasible nor desirable. Our assertion finds resonance in some recent attempts to define hospital autonomy. Thus, implicit in the definition of autonomous hospitals as ones that are "at least partially self-governing, self-directing, and self-financing" (Hildebrand and Newbrander, 1993), is the realization that public sector hospitals are not and

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cannot be truly autonomous. This is also borne out by the hospitals and countries covered by this study. While we found some degree of hospital autonomy in all five countries studied (see appendix 1a), in no country was the autonomy absolute.

Proposition 2: Autonomy is a means to an end, not an end in itself

Quite often, arguments have been made in favor of decentralized decision structures and processes, and greater autonomy, in the public sector (e.g., World Development Report, 1993), as though there were something intrinsically valuable about the absence of controls and regulation. We believe that this view (intentional or otherwise) is a fallacy that clouds, rather than clarifies our thinking.

As an "institutional state of being" (Austin, 1984), autonomy for a public sector hospital has little or no value *per se*. What is relevant and important is the effect of the degree of autonomy on the performance of the hospital, i.e., the extent to which it a) reduces negative outcomes, and b) promotes positive outcomes. And, in this regard, autonomy does not automatically enhance performance. In fact, our experience in the five countries in which this study was based would suggest that autonomy, in the absence of appropriate regulation and accountability, can lead to abuses of power and an overall poorer performance.

This proposition has important implications. It suggests that what is required to improve the operations of public sector hospitals is not necessarily autonomy, but a more efficient system of management structures, processes, and incentives, a point that we further discuss later in this paper.

Proposition 3: Autonomy is not synonymous with privatization

In many conceptualizations of hospital autonomy, the authority that individual hospitals enjoy in decision-making is assumed to be synonymous with the ownership of the hospital, i.e., government ownership of the hospital is automatically assumed to imply a lower level of autonomy than private ownership. In such an "autonomy continuum", full autonomy necessarily implies privatization.

However, counter-examples to this assumption - both theoretical and "real world" - are not hard to provide. In our opinion, the ownership characteristics of the hospital have little to do with how much autonomy a hospital has (or can have). An autonomous hospital can exist just as easily under government ownership, as under private ownership, and all the hospitals examined in this

study are government owned. It is the extent of decentralized decision-making that occurs within a hospital, and the extent to which such decision-making is feasible for each of the hospital's management functions, that are the relevant considerations.

To put it differently, we do not believe that in order to introduce decentralized decision making in public sector hospitals, these hospitals must be converted into private institutions. In our opinion, privatization is not necessarily the most obvious, or even the most appropriate, endpoint of autonomy, since certain desirable aspects of public health care delivery (notably, ensuring equity) might be unachievable under privatization. In fact, we believe that the efficiency gains resulting from such a policy initiative are likely to be, at least partially, offset by losses in equity (the example of user charges is well-known). Moreover, privatization of public-sector hospitals in developing countries is likely to be interpreted as an abdication of social responsibility on the part of the government, and will probably be politically very risky.

Proposition 4: There is no such thing as an "optimal" level of autonomy

Even among researchers and policy-makers who recognize that privatization may not be the appropriate objective for public sector hospitals, there seems to be a lurking sentiment that, if only one could tinker around enough with the level of autonomy, we could balance the pros and cons of "mimicking the private sector" (McPake, 1996), and optimize the outcomes. In other words, there is a notion that an "optimal" level of autonomy exists, and that it is possible to move just the correct distance away from centralized decision-making so as to achieve an "optimal" balance between the governments efficiency and equity objectives. Unfortunately for policy-makers, neither theory nor our empirical experience offers any evidence that such an optimal point can be uniquely identified.

In any case, even if an optimal solution exists for individual institutions or situations, it would seem highly unlikely that there exists a universally optimal level of autonomy that was applicable across the vast spectrum of public sector hospitals even within a single country, given the highly varied missions, goals, structures, and activities of these institutions. A search for such an optimal level of autonomy seems to us quite futile, and, as has been pointed out by other authors writing on public enterprises, might reflect "a preoccupation with procedures rather than performance" (Austin, 1984).

It is thus no surprise that the different countries participating in out research have conceptualized autonomy in different ways, as is obvious from the statutory provisions made in these countries. For instance, while the enabling

Act in Zimbabwe guarantees only financial autonomy; in Ghana and Kenya, decisions on personnel related matters (such as, appointments) are also delegated to the facility. Autonomy in the hospitals studied in one state of India has meant independence of the managing organization and not the hospitals themselves, while in Ghana, Kenya, and Zimbabwe autonomy is understood, albeit to varying degrees, as implying facility level autonomy.

Proposition 5: It may be inappropriate to use a private sector premise for autonomy in public hospitals

The involvement of governments in the production and provision of health care has been justified in the literature on various accounts: public and merit good arguments, externalities arguments, asymmetric information arguments, arguments based on distributional objectives, social solidarity arguments, etc. There is considerable merit in many of these arguments, and it would be cavalier to reject them out of hand. Even if one were to ignore these arguments, however, the political reality cannot be ignored that health care in many countries is considered a basic human right, and, therefore, a direct obligation of governments.

In other words, in the foreseeable future, it is very unlikely that governments - particularly in developing countries - will withdraw from the provision of health care. As alluded to above, arguments have been made (e.g., World Bank, 1993) that governments should restrict themselves to the financing of health care delivery, and not get involved in the actual provision of services. However, this recommendation assumes that governments are equipped to adequately regulate the private sector so as to ensure that social welfare objectives are met. But the regulatory environment in most developing countries is such that it seems unlikely that effective controls could be imposed on the private sector. Indeed, experience around the world, including in the US, has shown that leaving the provision of health care entirely to the private sector adversely affects the poorest and most disadvantaged sections of the population. At least for this reason, policy makers have felt an overwhelming need for the public sector to continue to play a role in the delivery of health care.

It is important to stress here that by arguing in favor of government involvement in health care delivery, we are by no means recommending a preservation of the status quo. In instances where the public sector is unable or unwilling to play its role effectively, there is clearly a need to pursue creative solutions. And it is also clear that many government hospitals, particularly in the developing world, function very inefficiently. The question, however, is whether hospital autonomy, and a direct transplantation of private sector initiatives to the public sector on which it is premised, is the appropriate response to the problem.

The primary rationale for hospital autonomy in the public sector is that by creating organizational arrangements that mimic the private sector and encourage competition, one can induce increased efficiency, greater public accountability, and improved quality of care at these facilities (McPake, 1996). Thus, for autonomy to succeed, it is important that the hospitals be exposed to the very same conditions that private hospitals face, i.e. relatively unfettered competition, unambiguous efficiency goals, freedom to raise and expend revenue in line with a set of well-defined and quantifiable objectives, greater accountability, and incentives, such as the linkage of the tenure and compensation of employees to their performance (judged on some predetermined criteria). However, these expectations are not very realistic for hospitals in the public sector. Also, it is not at all clear that the conditions necessary for competition to "work its magic" really exist in the public sector.

Public sector hospitals, by their very nature, function both as business entities as well as public policy instruments. As such, they are required to function, admittedly schizophrenically, as both business enterprises as well as instruments of the government - with an obligation to serve national policy objectives and social goals (such as ensuring access and catering to the needs of poor consumers). A pure profit maximization, or cost minimization, goal clearly cannot be assumed in this situation; and, we believe, rightly so.

Given their dual role, public hospitals can only pursue profit maximization or cost minimization goals (which lie at the heart of autonomy initiatives) unmitigatedly at the risk of compromising their social welfare obligations. Also, the split personality of the public hospitals substantially limits their ability to function independent of the government, far less "mimic the private sector". Furthermore, given the almost total financial dependence of public hospitals on government resources in most developing countries, autonomy is probably an unattainable goal in practice. In this regard, the empirical results from this study (see, for example, Ghana) belie the expectations of policy makers in many countries that hospital autonomy will reduce the budgetary burden of governments. Autonomy initiatives (in spite of increases in out-of-pocket payments by consumers) have only increased the government expenditures on public hospitals — both in absolute terms, as well as, as a share of government health expenditures. Thus, in this case, equity suffered, while allocative efficiency (though not technical efficiency) was also compromised.

Further, the fact that the larger public sector hospitals, in at least four of the five countries studied (India being the one exception), are the only institutions, public or private, that can provide many "high-tech" services implies that, even if they were to become autonomous, there is little likelihood they will face much competition in the provision of these services. In other words, the near monopoly situation of the hospitals removes any incentive for them to be competitive, and, in effect, reduces the probability that their efficiency will

addition to their objective of running their operations efficiently, the yardstick used to evaluate performance and measure success in public hospitals needs to be appropriately designed. It is not at all clear that the currently used hospital performance standards, most of them financial efficiency measures, constitute the apt (or, at least, adequate) measures (see, for example, Titmuss, 1973).

After all, in the context of public hospitals, what constitutes an efficient service? Is it the one that provides a service at minimum cost, or is it one that most nearly meets the needs of its intended recipients (i.e., the poor)? Is it the one that most fully implements government policy, or is it one that empowers users and involves them in its management? Also, as has been pointed out by other authors (see, for example, Johnson, 1995), it is easy to reduce public expenditures on a service by transferring the costs to users. But this does not reduce costs, it merely redistributes them. Similarly, the transfer of a public service to private contractors may appear to produce savings, but this may not lead to increased efficiency if the savings are made at the expense of the care provided to the poor (the primary objective of public hospitals). Finally, in the context of public hospitals, there is the danger that "only the measurable will be taken into account". The question arises whether "social services have any features that make judgment by ordinary commercial criteria inappropriate" (Johnson, 1995).

Proposition 7: Both autonomy and intervention carry costs

An important fact to keep in mind in designing a managerial system for public hospitals is that both autonomy as well as too-much interference by the government in the operations of the hospital are associated with certain costs. We argue that the ultimate consideration in choosing between the two should always be the effect of the government's action (or inaction) on the performance of the hospital.

Too little intervention can sometimes have more severe consequences for hospital performance than too much interference. In particular, autonomy without proper accountability can lead to managerial abuse of the system. At the same time, every intervention involves an investment of time and resources. It is important that this investment be justified in terms of the benefits accruing to hospital performance. If the government is unsure of the benefits of the intervention, or lacks the ability to make this determination, it is better off refraining from intervention. Under these circumstances, it might be desirable to let the hospital managers deal with the issue, or better still, to make a joint decision.

The bottom line is that while centralized planning does suffer from serious deficiencies (see Johnson, 1995), this does not mean that all planning is to be avoided. As we have noted above (and discussed further in a later section),

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what is called for is a system of decentralized, participative, and goal-oriented planning, among government officials and hospital managers.

B. Implementing Autonomy

Proposition 1: The seeming popularity of autonomy stems from the radically differing visions of autonomy, and differing expectations from it, among stakeholders

Despite all the conceptual problems that we have discussed so far, there is seemingly broad and enthusiastic support for the autonomy initiative, as a concept, among stakeholders in all five study countries (as well as in various international aid agencies). This "consensus", however, masks the reality that autonomy means very different things to different people; and that the expectations among key stakeholders of autonomy are quite different. In fact, the seeming support of the various stakeholders for autonomy is for different, often conflicting, reasons. The objectives of autonomy in the hospitals in India, for instance, were understood and expressed in a variety of ways by the different stakeholders (see Chawla and George, 1996).

In general, there is a tendency among stakeholders to focus almost exclusively on the perceived benefits (usually to them) of autonomy, neglecting, in the process, some of its potential pitfalls. As an example, it is interesting to contrast the positions on autonomy of the officials of the MOH, in the five countries studied, with those of the hospital managers. Most managers repeatedly pointed to increased flexibility, control over finances and administration, initiative, creativity, and a results orientation as the main benefits of autonomy. The MOH officials, on the other hand, saw autonomy as the route to ending the enormous subsidies being provided currently to the hospitals. In addition (though few officials were willing to directly make such a statement), MOH officials also saw autonomy as a buffer against public criticism over the performance of these hospitals.

To compound this problem, many of the stakeholders interviewed during the five studies seemed to believe that autonomy is a panacea for all that is wrong with the functioning of the health system in general and tertiary hospitals in particular. Both the MOH officials and the hospital managers seemed to be in agreement that autonomy would augment the hospitals resources, and improve efficiency and hospital performance, though they had different views on how this would happen.

Furthermore, despite agreeing on the outcomes of autonomy, the two differed significantly on the form that autonomy should take, the MOH officials having a

far more conservative vision of autonomy than the hospital managers. This was the direct result of a tendency among the managers to view the hospitals as business entities first, and the MOH officials to view the hospitals primarily as policy instruments. Both positions, of course, are rational, and merely reflect the split personality of these institutions, as discussed above.

In itself, the fact that stakeholders view autonomy as serving their self-interest, and a solution to their respective problems, is not necessarily a problem. In fact, this sentiment could well assist the government in pushing the initiative forward. However, the fact that stakeholders have such a divergent conception of autonomy and what it implies, and their tendency to overstate the benefits of autonomy and underestimate the problems, are definite bottlenecks in the autonomy process. This has been clearly reflected in the implementation of the autonomy in the public sector hospitals in the five countries. Thus, although the major stakeholders have embraced the autonomy concept, there is a growing uncertainty about how to move the process forward from conception to implementation.

Proposition 2: Implementing autonomy is at least as much a political as a technical exercise

There is a tendency, at least among researchers, to view the hospital autonomy issue as a purely technical or economic problem. It is important to point out, however, that autonomy is a political issue with major political implications, as is clearly demonstrated in all the five case-studies.

Autonomy is a political exercise for several reasons. The implementation of autonomy in public sector hospitals reveals a choice by policy makers of a one value system over others. Also, autonomy measures directly affects several stakeholders, many of whom are powerful and well-entrenched. More importantly, the opposition to autonomy can be traced to groups that are highly cohesive and have substantial resources at their command, while the support groups are relatively dispersed and less-endowed. For example, the evidence accumulated as a part of the five studies suggests that, while lip-service is being paid to autonomy by the MOH, there is a general lack of motivation and incentive among MOH officials to see the initiative through. After all, totally relinquishing control of the hospitals does represent a considerable loss of power and prestige for the MOH.

Moreover, the benefits of autonomy, at least to some stakeholders, are far less tangible and immediate than the disadvantages. For example, many of the consumers of the hospitals services do not think full autonomy would lead to improvements in the quality of care and public accountability. One prevailing view seems to be that autonomy would lead to higher fees without necessarily

resulting in an improvement in the quality of care (e.g., in India, Kenya, and Zimbabwe). It is interesting to note that consumers (e.g., in Ghana) expect this situation to occur whether the institution is under government ownership or under private ownership.

In short, it is important to keep in mind the political nature of the autonomy initiative. Ignoring or underestimating the political aspects of autonomy is almost guaranteed to doom the initiative. After all, neither technical sophistication nor economic rationality assures political viability.

Proposition 3: De jure autonomy is only the first step towards de facto autonomy

Our research found that most of the laws introducing autonomy in public sector hospitals in the five countries do spell out a framework for autonomy, albeit somewhat broadly. It is true that the laws rarely lay down a precise timetable for the implementation of autonomy, set priorities in the implementation process, provide systematic operational guidelines on the implementation of the phases of autonomy, or assign specific institutional responsibilities for the implementation of its various facets. However, much of the relevant legislation is enabling. The laws also make important concessions to public-sector hospitals, which, ostensibly, are quite radical within the context of the existing organizational arrangement.

But a major lesson from the case studies was the need to differentiate between "what is supposed to be" and "what is". Laws and regulations may lay down the de jure position, but the de facto position is brought about by the prevailing circumstances (Chawla and George, 1996). This statement may seem obvious, and even trivial; but this fact often seems to be forgotten during the implementation of hospital autonomy. Interpretations of the law may vary between one individual to another, and at different points in time. Also a variety of pressures contribute to the implementation of measures quite different from the spirit or even the letter of the law. In other words, de facto autonomy often ends up being very different from de jure autonomy, as is evident from all the five case studies.

Governments often rely on legal devices to ensure that new initiatives are implemented in a certain manner. Traditionally, however, governments have constructed the laws so as to restrict their role to setting overall policy, while eschewing the operationalization of these policies. Also, the implementing bodies rarely participants in, and rarely have an input into, the decision making and goal-setting process. For the most part, the implementing bodies are expected to faithfully follow the government policy directives in the implementation of these initiatives, subject to periodic government audits.

Unfortunately, making these initiatives work takes more than mere rules and regulations. Furthermore, the assumption that managerial functions can be neatly divided into policy making and policy execution is questionable, as the two are inextricably linked. Therefore, in the absence effective government-institution coordination, the government initiatives often end up not meeting either the government's or the institution's expectations.

In sum, the lesson to be learned here is that the government's responsibility begins, not ends, with the promulgation of a law or policy legislation.

Proposition 4: Individual initiative and leadership may be the key to the success of autonomy, although autonomy may be an enabling factor in bringing about change

A striking finding of the five studies was that, while hospitals may be autonomous since their creation, some managers were able to bring about significant improvements within the hospital, but others could not. In many of these cases, the achievements could be directly attributed to the leadership of one person, rather than to the autonomy enjoyed by the hospital. Autonomy, thus, is greatly influenced (and confounded) by the success or failure of the hospital leadership. In other words, improvements in the performance of an autonomous hospital cannot unequivocally be attributed to the autonomous nature of the organization, since individual initiative and leadership clearly play a critical role.

One case in point is India, where the autonomous organization of hospitals studied had five chief executive officers (CEO) since its formation. Of the five CEOs, however, only one could bring about significant changes in the functioning of the hospitals, while the others could not. This is despite the fact that the amount of autonomy enjoyed by the CEOs was relatively unchanged over time. Similarly, it was difficult, in the studies in Kenya and Zimbabwe, to separate the performance of the autonomous hospitals in Kenya and Zimbabwe from the performance of their leadership.

It is debatable, however, whether the achievements of the hospitals would have been possible in the complete absence of autonomy. Our studies do suggest that some of the changes and improvements brought about in the autonomous hospitals were facilitated by the autonomous character of these hospitals. Thus, shifts in the locus of control and decision-making from the level of government to the facilities, changes in the organizational design, clearly defined responsibilities, adequate information flows, and simplified financial and procurement procedures, all supported and complemented dynamic and results-oriented leadership. This might suggest that hospital autonomy is a necessary, but, by no means, a sufficient condition.

Proposition 5: Improved management structures, processes and incentives may be more important than autonomy per se

An intriguing possibility that emerged from the case-studies is that all the positive changes along the four evaluative dimensions considered in this study might be achievable within the existing system in public hospitals, and without the grant of autonomy. What is required might simply be restructured and improved management and incentive systems. As we have argued earlier, autonomy *per se* has little intrinsic value; what counts is the effect of autonomy on hospital performance. And autonomy (if it works at all) has been hypothesized to work precisely by restructuring the managerial and incentive structures in public hospitals to mimic the private sector. However, we have questioned the assumption that autonomy will enable private sector incentives to be transplanted to public sector hospitals. The question then becomes: can the public sector incentives be restructured within the existing environment of these institutions, so as to achieve the desired outcomes, namely improved efficiency, better quality of care, and enhanced public accountability without a compromise of equity?

Such a possibility cannot be rejected out of hand. After all, as we have argued, the government and public sector hospitals are inextricably linked, and their shared interests far exceed their points of conflict. We see no reason to believe that the interaction of these two entities cannot be a "positive sum game", and "subject to a systematic management process" (Austin, 1984). Based on this premise, we propose below a plausible system of collaborative management that we believe will work in hybrid institutions such as public hospitals.

Proposition 6: Focus should be on consensus-building, goal attainment and greater accountability

One theme that consistently runs along all the five studies is the importance of consensus building, role definition, and a results orientation. As noted earlier, the public hospital is a complex organization delivering a wide array of services, and functions as both a business entity and a government policy instrument. This "hybrid" organization thus has a number of players at both the government and the facility level, who necessarily have to interact in the provision, delivery and finance of hospital services. The other key players are the medical personnel, who traditionally have been rather independent of hospital management. And finally, and most importantly, there are the patients, who are the eventual consumers of hospital services. Each of these stakeholders plays an important role in decision-making and operations, and each in its own way contributes to the success of a health sector reform initiative.

Within any government or hospital, there are several distinct power centers -

each of whom is likely to play a role in the evolution of hospital autonomy, and the impact of this autonomy on efficiency, equity, revenue mobilization, public accountability, and patient satisfaction. At the same time, there are many potential points of conflict between the government and the hospital, e.g., in defining the relationship between physicians and the autonomous management, between the various departments of the autonomous hospital and the various arms of government, etc. For example, in all the countries that we studied, we found that the ministries of health and finance have tended to think of the hospitals as being an extension of the government, and have, knowingly or inadvertently, ignored the autonomy of the hospitals. At the same time, the hospitals' management - long used to the protection of the government and its style of functioning - have either, rather opportunistically, tended to assert their independence, or have fallen back on the government cushion.

Thus, while the government has found it difficult to let go of its controls, the management of the hospital has also behaved like short-term caretakers. In such a situation, neither side has taken on any responsibility for defining or achieving any goals, and have been preoccupied with procedures rather than results. For these reasons, any potential benefits of autonomy have remained largely unattainable; and autonomy has been seen as merely another managerial and organizational buzzword, without tangible gains.

Our research suggests that an important starting point is a broad agreement between the key stakeholders on the overall mission of autonomy, and on the specific mandate of the public hospital. Just as important is a focus on results and outcomes, rather than on rules and procedures. And, finally, it is critically important to lay out clear and unambiguous guidelines on the roles, responsibilities, and powers of each player, as well as the sanctions to be imposed for failure to fulfill these responsibilities.

Proposition 7: Adequate planning and preparation are also critical

One persuasive argument in favor of greater autonomy for public sector hospitals is that, while governments often strive to do the "right thing" (like providing good quality health care for all), they flounder when it comes to "doing things right" (i.e., government production is typically not very efficient). Autonomy has been seen as a solution to this problem, insofar as it is considered an institutional combination (of public and private sector virtues) that permits the achievement of social objectives in an efficient, quick, and innovative manner.

Unfortunately, governments have not invested adequately in planning and preparation for the transition to autonomy. In some countries, like Kenya, there has been little or no planning. In others (e.g., in India, Ghana, and Zimbabwe), there has been a tendency to either rely on legal devices to ensure that the

autonomous concept would work as intended, or borrow heavily from the existing systems of management in the government. Unhappily, neither of these approaches has worked.

As we have argued earlier, making the concept of an autonomous hospital work takes more than just rules and regulations. New and creative management structures and processes are necessary to effectively administer and coordinate the activities of the government and the autonomous hospitals. New approaches for strategic planning, financing, budgeting, monitoring and evaluation, and personnel management in public hospitals need to be developed. In short, in order for hospital autonomy to work, new systems need to be created (or existing ones overhauled) that are compatible with, and appropriate for, these complex, hybrid institutions. And these reforms need to be to be instituted as integrated components (rather than as piecemeal initiatives) of an overall reform of the health sector in developing countries.

6. Conclusion

In this paper, we have examined the issue of autonomy in public sector hospitals in five developing countries. These case-studies suggest that success with autonomy in public sector hospitals in developing countries has been limited, and there have been few gains in terms of efficiency, quality of care, and public accountability. We have drawn on the lessons learned from these studies to advance several testable hypotheses regarding the conceptualization and implementation of hospital autonomy. In general, we have argued that it is as much the confused and erroneous ideas of autonomy, as the poor implementation of the autonomy measures, that have been responsible for the relative lack of success of the autonomy initiative. However, an important caveat is in order. Given the limited sample size of this study, and the fact that in many of the countries hospital autonomy is a relatively new concept, the findings of our research must be viewed as preliminary. In our opinion, therefore, further inquiry into the issue of autonomy in public sector hospitals is a research imperative.

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Appendix 1: Executive Summaries of four Case-Studies

Hospital Autonomy in India: The Experience of APVVP Hospitals

Executive Summary

As part of its overall strategy of conducting policy-relevant research into matters that are likely to be of importance to government policy-makers and USAID missions in Africa, the Africa Bureau in USAID under its Health and Human Resources Analysis for Africa project commissioned the Data for Decision Making project (DDM) at Harvard University to conduct five case studies on hospital autonomy. One of these studies was done in India in the state of Andhra Pradesh.

The overall objectives of the DDM-HHRAA project on hospital autonomy are (a) to describe different approaches which have been taken in different parts of the world to improve performance of public hospitals through increased autonomy, and to improve allocative efficiency of government health spending by shifting public funds away from public hospitals; (b) to analyze factors which contribute to successful implementation of a strategy to increase hospital autonomy; and (c) to formulate a set of guidelines to support the design of policies to improve hospital performance through greater autonomy.

The primary goal of the present study of the experience of Andhra Pradesh Vaidya Vidhan Parishad (APVVP) hospitals with autonomy is thus to provide a description and assessment of the process and impact of autonomy on performance of these hospitals. More particularly, the objectives of the study are to (a) document and analyze the evolution of APVVP as an autonomous body; (b) describe the process and type of autonomy of APVVP; (c) describe the legal and administrative system supporting autonomy of APVVP; and (d) evaluate the impact of autonomy in terms of its effect on efficiency, quality of care, patient satisfaction, etc.

Located in South India, Andhra Pradesh (AP) is the fifth most populous state in India, and has a population size of 66.3 million. The health status of AP is

marginally higher than the Indian national average. In 1992 AP recorded a birth rate of 24.1, death rate of 9.1, and infant mortality rate of 71 per 1000 live births, which compare favorably with the corresponding national figures of 29, 10 and 79 respectively. Life expectancy for AP in 1981-86 was 58 as compared to 56 for India as a whole. Only 40.8% of the births in AP took place in health institutions or were attended by health personnel, which is very close to the corresponding national figure of 41.2%. The decennial growth rate of AP population during 1981-91 of 24.2% compares closely with India's figure of 23.85%. At the same time, the total fertility rate of AP in 1988 at 3.3% was slightly less than that of 4% for the country as a whole.

The public health care system of Andhra Pradesh comprises three levels of service delivery and finance. Primary care services provide the people with preventive and promotive care for minor health problems, maternal and child health, and family planning. With the exception of family planning services that are managed by the Directorate of Family Welfare, all primary care services and facilities are managed by the Directorate of Health Services. The referral hospitals and secondary level hospitals make up the second level of public health care. These facilities provide in-patient and out-patient care for illnesses that are too complicated to be treated at the primary level. These facilities are under the general management of the Andhra Pradesh Vaidya Vidhana Parishad (APVVP), an autonomous governmental agency which was created in 1986. Tertiary hospitals, which include teaching hospitals, are the third and final level of public health system. Managed by the Directorate of Medical Education, the tertiary hospitals provide more technical and specialized care.

The Andhra Pradesh Vaidya Vidhan Parishad (APVVP) [translated: Andhra Pradesh Council for Hospital Management] is an autonomous body established in 1986 by an Act of Parliament with the express objective of managing all district hospitals in the state of Andhra Pradesh in India. The APVVP replaced the Department of Health, Government of Andhra Pradesh, in the management of the district hospitals. Motivated by a desire to grant greater (and eventually complete) autonomy to the district hospitals, APVVP was set up as a quasi-government organization with freedom to set its managerial objectives and style of functioning, subject to the overall mission of granting greater autonomy to district hospitals. At the same time, APVVP was entrusted with the task of ensuring greater efficiency of hospitals, improvement in quality of care and patient satisfaction, and improvement in financial sustainability and management. Starting with 140 district and community hospitals, APVVP soon took over all area hospitals as well, and by 1993 had 162 hospitals and 9646 beds.

The APVVP is governed by a "Governing Body", which comprises of (appointed) representatives from the government, (elected) representatives of the people, and representatives of the financial institutions. The APVVP is headed by a

Commissioner, who is supported by a number of Joint and Deputy Commissioners, and administrative and legal staff. A large number of physicians are also on the payroll of APVVP, and are principally located at the various district hospitals.

The model used by the Government of Andhra Pradesh to grant autonomy is based on creation of a parastatal organization and giving that organization autonomy, as distinct from giving autonomy to each and every hospital. APVVP effectively replaced that branch of the Department of Health that was entrusted with the administration of hospitals. However, there is no evidence to indicate that autonomy has percolated down to the level of the hospital. The delegation of financial and administrative powers to the hospital superintendents does provide them with some element of decision-making, but as compared to the overall size of hospital operations this delegation has not been quite insignificant.

This model has had many advantages. First, the government has had to deal with only one organization instead of 160 different autonomous hospitals. Second, the government has been able to effectively monitor flow of funds, appointments, staff remuneration, etc. fairly closely. Third, when this autonomous organization has worked under the general direction of a dynamic leader and supportive board, it has seemed to perform very well. Fourth, the fact that there is only one organization has effectively led to the system of one-window for all inputs, processes and outcomes.

At the same time, there are many disadvantages associated with a single organization. First, the hospitals continue to be non-autonomous, and thus the gains from autonomy may well not have been fully realized. Second, it has been easy, both administratively and politically, for the government to exercise a great deal of control over the single organization, so that the effective autonomy has been diluted in several instances. Third, the organization has experienced many periods of ineffective leadership, as a result of which the performance of all the hospitals has been less than optimal. As a result of all these factors, on several occasions and for long stretches of time APVVP has enjoyed little autonomy despite the legal and administrative framework provided by the Act. APVVP has not always been able to take independent decisions about its finances and day-to-day administration, and has often been tied down by bureaucratic and hierarchical constraints, that are usually typical of government organizations. While the legal framework for autonomy has been in existence since the earliest days of the organization, de facto autonomy has tended to be influenced by a host of factors including the relative situation and strength of APVVP management vis-a-vis the government. In effect, the organization has often been only as autonomous as the management has been able to make it or as much as the government has permitted it to be, or some combination of both.

On the more positive side, APVVP has had commendable success in many managerial decision-making situations. Under APVVP the down-time due to equipment repair and overhaul came down from over six months in most cases to less than two weeks. This reduction in downtime on equipment has been the direct result of simplified and result-oriented policies on repairs and maintenance.

APVVP introduced several innovative ways of raising resources to augment funds it receives from the government. These include charging user fees, the Annadana schemes, donations, lotteries, and external assistance. User fees raised only Rs. 45 million (between 1988 and 1994). Donations proved to be highly successful, and raised substantial funds (over Rs. 100 million between 1988 and 1994) from the general public. The Annadana schemes also did well, and mobilized over Rs. 2 million (between 1988 and 1994) in the form of contributions from the general public toward the cost of food.

Probably the biggest achievement of APVVP has been the approval in 1993 by the World Bank for a loan of US$133 million for a special project that will help APVVP and the government of Andhra Pradesh finance activities that will strengthen institutions for policy development and implementation capacity, and improve quality, access, and effectiveness of health services at district area and community hospitals.

APVVP has taken many steps to improve the preparedness of hospitals to meet emergency situations. These include identification and improving availability of equipment required for emergency services, like oxygen cylinders, suction apparatus and refrigerators. When APVVP took over the hospitals, a large number of facilities did not have adequately functioning water supply systems. APVVP improved water supply in all 162 hospitals by installing borewells, augmenting municipal sources, overhauling existing water distribution systems, adding overhead storage tanks, and providing safe drinking water for patients. APVVP also adopted a multi-pronged strategy to address power shortages, and installed direct feeder lines and standby generator sets, changed the electrical wiring in old hospitals, and provided adequate number of fans to each hospital. Moreover, APVVP constructed several additional wards, outpatients centers, rooms for diagnostic services, and areas for patients' attendants.

APVVP has taken many innovative steps to manage and control funds at its disposal. First, APVVP reorganized the classification of expenses to follow a more functional categorization. Second, APVVP created a concurrent audit system and an internal audit wing. Finally, APVVP delegated a number of financial powers to the hospital superintendent and district coordinators, especially for minor and routine repairs. APVVP initiated several steps for effective inventory control. In the critical area of supply of drugs, APVVP introduced monthly central monitoring of stock for about 55 drugs. New rules and procedures were introduced, which required the purchasing officers to take

the existing stock account before placing fresh orders, which restricted purchase of most items for one quarter at a time only. These improvements in financial and inventory management were slow to materialize, but once the changes were set in motion they proved to be very effective. The initial reluctance of the staff to change from their well-entrenched habits from government days was overcome over time and through a process of training, and better and more functional systems of bookkeeping, accounting, record-keeping, inventory control, purchases, and computerization were put into place.

In many other cases the success of APVVP has been rather limited. Even though the pattern of government funding changed from line grants to block grants after autonomy, the government continues to retain substantial control over how funds were allocated. As a result, no major innovations and improvements in spending have happened as a result of autonomy. Even the planning and budgeting processes have not changed much, despite the formal autonomy that APVVP enjoys in this regard. Allocations to the different heads of account and expenditure continue to be made on a historical basis, and no long-term plans have been drawn up for any major changes in process or focus of the organization.

APVVP's autonomy vis-a-vis personnel matters has been rather limited, as a result of which the management has not had the flexibility of appointments and dismissals. With the exception of some rationalization of posts (256 posts were declared non-essential, and were abolished) no innovations have been brought about in creation and filling up of vacancies. APVVP continues to follow the earlier norms set by the government, that are the same for other hospitals directly managed by the government. No system of incentives has been put into place following autonomy, and despite the enunciation of a new corporate mission, there has been no change in attitudes and actions of the employees of the organization, to whom autonomy has not meant much.

In sum, it appears that because of its autonomous nature APVVP has been very successful in mobilizing institutional finance and resources from public. Autonomy has also been useful in ensuring gains on other fronts, like maintenance of equipment and buildings, and to some extent, quality of care. However, autonomy has meant little or nothing to the staff employed in the organization, and has not been accompanied by any incentives for those working in the organization.

The achievements of APVVP cannot unequivocally be attributed to the enabling environment created by the autonomous nature of the organization, since leadership also appears to have played a critical role. APVVP enjoyed the same autonomous environment since its creation, and while some commissioners could bring about many significant changes, others could not. Most of the changes and achievements can be attributed to the leadership of just one

commissioner, and it is a moot point whether these achievements would at all have been possible had it not been for the autonomy that APVVP enjoyed. It is evident that autonomy alone has not been able to guarantee the best results, and has remained highly vulnerable to leadership failures.

Hospital Autonomy in Zimbabwe

Executive Summary

Introduction

This report is one of five case studies examining the experience of different developing countries to give financial, administrative or managerial autonomy to government-owned hospitals. It looks at experience with hospital autonomy in Zimbabwe. The issue of hospital autonomy has grown in importance in Zimbabwe as the government in 1995 announced its desire to decentralize hospital financing and to promote privatization of selected hospital functions.

The Government of Zimbabwe has organized the public health facilities and most non-government health facilities into a national four-tiered system for delivering health services. The upper tier consists of six central hospitals. Among the six, Parirenyatwa Hospital has been granted a degree of autonomy that other government hospitals do not have. Parirenyatwa Hospital is a 987 bed hospital in central Harare. In 1995, it provided 272,330 days of care and 231,531 outpatient visits. It is the principal teaching hospital for the University of Zimbabwe School of Medicine and a major referral center. The principal focus of this study is comparison of the governance and operation of Parirenyatwa Hospital to that of other central hospitals.

In addition to this principal case, two other cases are examined -- Wankie Colliery Hospital in Hwange and Avenues Clinic in Harare.

Parirenyatwa Hospital

History of Parirenyatwa Hospital

In pre-independence Zimbabwe, hospital services were segregated. In the early 1970s, a decision was made to create a major teaching hospital for white patients. The Andrew Fleming Hospital opened in 1974. The next year, governance of this hospital and three other hospitals, including the black Harare Central Hospital, was vested in a new body, the Salisbury Hospitals Board of Governors. The Board had authority to administer the property of the hospitals, to manage and control the hospital, to control the funds received by the hospital

from patients, and, subject to conditions established by the Minister of Health and some other restrictions, appoint medical staff, clinical teaching staff, and residents. The Minister of Health was to consult with the Board prior to appointing the Medical Superintendent of the Hospitals and other nonmedical staff. Funds were provided by the Ministry of Health as a block grant.

Following independence, the new government took steps to reduce the autonomy of the hospital. The apparent motive was to gain control over an elite white institution and expand access to care at the hospital to the black population. In 1981, the legislation creating the Board of Governors was amended to reduce the size of the Board of Governors and change its composition, eliminate the requirement that the Minister of Health consult with the Board prior to the appointment of a Medical Superintendent or other staff or the removal of non-medical staff, and expand the authority of the Minister of Health relative to the Board by making the Minister's direction binding on the Board. The legislation also removed Harare Central Hospital from the control of the Board. The next year, the Andrew Fleming Hospital was renamed the Parirenyatwa Hospital in honor of the first black Zimbabwean to qualify in medicine.

Throughout the 1980s, the MoHCW maintained substantial interest in decision making at Parirenyatwa Hospital. In 1992, the Board resigned or was forced to resign following a series of press reports on the hospital's substantial deficit, and alleging mismanagement and economic discrimination in access to the hospital. A committee of MoHCW officials was appointed to run the hospital and review the issues in the management and governance of the hospital. It presented a report in 1993 calling for the upgrading of the hospital and its continued operation as an autonomous institution. The MoHCW official who was lead author of the report was appointed Medical Superintendent. The Board was reconstituted in 1995. Shortly after the field work on this study was completed, the Medical Superintendent was forced to resign because of personal use of a hospital ambulance.

The Scope of Autonomy at Parirenyatwa Hospital

Formal MoHCW supervision of government hospitals in Zimbabwe is highly centralized. Senior officials are appointed by the Ministry of Health and all employees are civil servants. Hospitals are allocated line-item budgets for inputs such as salaries, supplies and provisions based on historic levels of spending. Purchasing is controlled. Medical supplies and drugs must be obtained by requisition through the Government Medical Stores (GMS). Other purchases are made by issuing requisitions to government-approved vendors. The requisitions are submitted to Treasury for payment, and are eventually debited against the appropriation for the hospital. Capital funds are provided by MoHCW for government owned hospitals. Maintenance of plant is the responsibility of the

Ministry of Construction and Housing, and maintenance of vehicles is the responsibility of the Ministry of Transport. The Ministry of Health and hospital staff share responsibility for equipment maintenance. Hospitals are expected to bill patients insured through Medical Aid Societies and patients whose monthly incomes exceed Z$400 according to a Ministry of Health and Treasury-established fee schedule, but any funds recovered through billing revert to Treasury. Within this system, the Medical Superintendent and senior staff of the hospital make day to day operational decisions.

Placed within the context of other hospitals, the autonomy of Parirenyatwa Hospital is limited. Senior staff have been appointed by the MoHCW without Board approval or consultation. Staff are civil service. Budgets, while block grants, are also determined based on historic levels. The hospital must follow the same tender process as other hospitals, and maintenance procedures are the same. The hospital must adhere to the MoHCW fee schedule.

The principal areas of autonomy are the following. First, fee income can be retained. Furthermore, unlike other hospitals, Parirenyatwa is authorized to bill the government for patients eligible for free care because their incomes are less than Z$400 per month. It should be noted, however, that while fee income can be retained, fee levels established by the MoHCW have traditionally been set below cost. This policy creates a structural deficit that can only be met through public appropriations.

Second, the hospital receives its funds as a block grant, and can construct its own internal budget without regard to MoHCW or Treasury allocations to specific line items. However, the autonomy of internal budgeting is limited because employees are civil servants and the Public Service Commission has restricted the ability of the hospital to redefine it staffing needs and hire or lay off workers in response to those needs.

Third, while the Board of Governors' role has been diminished by the 1981 amendments and subsequent actions of the MoHCW, it has some potential to foster the independence of the hospital. Nonetheless, autonomy is constrained by continued MoHCW efforts to directly influence the scope of services and operation of the hospital, and by limited initiative and leadership within Parirenyatwa Hospital.

If the autonomy of Parirenyatwa Hospital is limited, it is also the case that in the past several years, actual supervision of other hospitals by MoHCW has been less than is suggested by the formal description presented above. Personnel costs and employment have been strictly enforced by the Public Service Commission but often budget limits have not been tightly administered. Some hospitals made purchases substantially in excess of budgeted amounts, which have simply been paid at the start of the next fiscal year and debited against the new year's appropriation. Parirenyatwa Hospital has done the equivalent, i.e.,

withheld payment until it had the funds to pay. Vendors have seemed willing to extend credit both to the government and Parirenyatwa, thus reducing the discipline of a fixed budget.

Likewise, when GMS is out of stock, both Parirenyatwa and other hospitals were authorized to use standard tender processes to obtain needed supplies in the outside market.

MoHCW supervision of its hospitals has also been limited by the way in which expenditure data and utilization statistics are separately collected and maintained. It has proven extremely difficult to construct estimates of unit costs either over time in the same hospital or comparatively across hospitals. Without such data, it is hard to establish reasonable expectations for hospital managers.

Managerial and Organizational Responses to Autonomy

As autonomy is limited, so are modifications to the management, organization and systems in place at Parirenyatwa Hospital. The management structure of the hospital is similar to that of other central hospitals, but the Medical Superintendent at the time of our study was seeking to upgrade his senior accounting staff and add a position of Technical and Estates Executive in the expectation that the hospital would gain responsibility for maintaining its own plant, equipment and vehicles.

Given the hospital's opportunities to retain fee income, it might be expected that its accounting and billing functions would be well developed, as gains in this area might pay for themselves. Parirenyatwa Hospital does a better job of collection than other central hospitals. In 1994, for example, it reported collecting 18.2 percent of its expenditures, compared to 6.4 percent for Harare Central. While better than other hospitals, the billing and collection process at Parirenyatwa Hospital has been poor. In 1993, it was estimated that bills were produced six to 12 months after discharge, and it was estimated there was a 14-month backlog in billing.

The problems in the billing area have been attributed to two factors -- failure to computerize this function and civil service restrictions on staffing and hours. A more general factor contributing to the billing problem was lack of management focus on the issue. This may have reflected an orientation during the 1980s toward expanding access and reliance on MoHCW direction and appropriations.

Impacts of Autonomy on Operational Performance

The study compares the performance of Parirenyatwa Hospital and Harare Central Hospital for evidence that the autonomy of Parirenyatwa has contributed to a higher standard of performance. Such comparisons are difficult,

however, because Parirenyatwa has historically been funded at a much higher level than Harare Central and Harare Central serves a poor area, and differences may be attributable to differences in resources or case mix, rather than autonomy. Overall, few differences are observed.

With respect to overall financial management and cost control, evidence of superior performance by Parirenyatwa Hospital is mixed. For the three years (1993-1995) for which comparable data are available, the nonpersonnel expenses at Parirenyatwa grew substantially more slowly than at Harare Central but Harare Central started and ended the period with costs per day lower than those at Parirenyatwa. Parirenyatwa may have better controlled its costs during this period, but it also had greater room for maneuver. Ratings of the two hospitals in the area of financial management and cost control in the 1992 and 1995 Best Central Hospital Competitions were comparable.

With respect to individual areas of hospital operations, performance appears comparable or associated with the budget levels for the function. *Personnel* functions are comparable at the new institutions. *Drugs and Supplies* are purchased using the same systems and sources, and staffs in both hospitals report overspending in recent years. When drugs are not available through GMS, Parirenyatwa reports sometimes going to outside vendors; Harare Central to having patients or their families buy drugs and bring them to the hospital. This may reflect the difference in funding levels between the two institutions. *Food service* is one area of identified difference between the two institutions, with outside sources rating the Parirenyatwa Hospital food service as superior to that at Harare Central. This may, however, reflect the higher level of spending on provisions per day at Parirenyatwa, Z$16 in 1995 compared to Z$10 at Harare Central. *Maintenance and Equipment Repair* is handled similarly at both hospitals. Severe shortages of staff and supplies were reported at Harare Central, however. Both hospitals report problems with respect to the responsiveness of the non-MoHCW Ministries responsible for maintaining plant and vehicles. The process of *Equipment Purchase* is similar at both hospitals. The principal difference is that the equipment budget at Parirenyatwa Hospital is fixed internally, while that at Harare Central is based on its appropriation for equipment. Over the past several years of tight budgets, donor funds have been the principal source of financing for new equipment and these have been administered through the MoHCW for both Parirenyatwa and Harare Central.

Few measures of overall quality are available. Ratings of the two hospitals in the Best Central Hospital Competitions of 1992 and 1995 are slightly higher for Parirenyatwa Hospital, but the differences are small. Mortality rates at Parirenyatwa are lower than at Harare Central, but these differences could reflect case mix differences, the higher poverty level in the population treated by Harare, or the greater resources available at Parirenyatwa, rather than management differences. Mortality rates rose between 1989 and 1995 at

Parirenyatwa in both maternity and nonmaternity services, but this may reflect declines in the economy in Zimbabwe or the growing burden of HIV/AIDS.

Wankie Colliery Hospital

The Wankie Colliery Hospital is located close to the coal mines of the Wankie Colliery in Hwange in western Zimbabwe. The hospital has more than 150 beds, and is well equipped and well staffed. The hospital is an operating department of the colliery, originally established to provide care to company employees and their families. Annual budgets and a five year equipment plan are submitted by the hospital to colliery officials, who set the final budgets. The colliery purchasing department handles procurement for the hospital.

The colliery contracts with several large regional employers to provide hospital services to their employees. Reimbursement is on a negotiated fee schedule. The negotiated fees are cost-based and the hospital has implemented internal cost accounting and computerized billing systems to support this process. This illustrates the potential for the implementation of such systems at other hospitals in Zimbabwe.

The hospital also contracts with the Ministry of Health to provide district hospital-level services under a similar cost-based negotiated fee schedule. This relationship has become strained for several reasons. First, the costs at the colliery hospital are higher than at MoHCW district hospitals, and the MoHCW Provincial Health Officer has therefore encouraged patients to go to other hospitals. The hospital has complained that without a predictable flow of patients from the MoHCW, it has been hard to staff appropriately. There have also been conflicts over the hospital's billing the government for patients with incomes greater than Z$400 who come to the hospital with referral letters from district health clinics. Similar conflicts might emerge with respect to other hospitals if the government grants hospitals greater autonomy and shifts its payment from line-item or block grants to fee-for-service for eligible patients.

Avenues Clinic

Avenues Clinic is one of the few private general hospitals in Zimbabwe. It has one hundred forty-eight beds and is located within a short walk from Parirenyatwa Hospital. The hospital describes itself as operating much as a nonprofit and has applied for nonprofit status. The stated philosophy is to keep fees as low as possible, consistent with paying the recurrent costs and providing for equipment and upgrading.

More than 80 percent of the patients are members of Medical Aid Societies. Most of the rest are either foreign insured patients or cash paying patients. The

hospital charges for care on a fee-for-service basis. It has implemented computerized cost accounting and billing systems, using the same software as the Wankie Colliery Hospital. The hospital illustrates the potential for fee-supported hospital care in Zimbabwe and that systems are available within the country to effectively manage in such an environment.

Lessons and Implications of the Zimbabwe Cases

The motivation for creating Parirenyatwa Hospital as an autonomous hospital in the pre-independence period is not entirely clear. In the post-independence period, the MoHCW sought to restrict the limited autonomy originally established. In the past year, the government of Zimbabwe has expressed interest in decentralizing hospital management and expanding autonomy not just at Parirenyatwa Hospital but at hospitals throughout the country.

Several lessons emerge from the experience of Parirenyatwa Hospital, Wankie Colliery Hospital, and Avenues Clinic for implementing effective efforts to decentralize hospital management and increase hospital autonomy. **First,** hospital leadership must be appointed that is committed to implementing expanded autonomy and can effectively articulate a vision of autonomy to the hospital staff and other hospital constituencies. The hospital leadership must be able to gain the confidence and cooperation of the hospital staff. **Second,** the financial and managerial accounting and billing systems currently in place in hospitals are not adequate to allow hospitals to effectively price their services, bill in a timely fashion, budget, manage against budget, or adjust budgets in real time to reflect changing demand or economic circumstances. Upgrading these systems and the staff administering them will be a critical element in implementing any policies that put hospitals at risk for balancing revenues and expenditures. **Third,** control must be ceded by Ministry of Health. In a decentralized hospital system the MoHCW must be willing to relinquish authority over senior appointments, staffing, service offerings, and operational management of the hospitals.

There are several critical transitional issues that MoHCW must resolve if it will move toward decentralized financing and management. **First,** it must resolve the question of whether hospital employees will remain civil servants. **Second,** a new basis for flowing funds to hospitals must be articulated and implemented. If hospitals are to be expected to generate their funds from fee income, then the payment rates must be more closely aligned with costs. This will require prices substantially higher than the current fee schedule for the central hospitals. A strategy may also have to be developed to reduce the current disparities in payment among comparable hospitals. **Third,** a system of hospital financing that is based upon uninsured individuals with incomes greater than Z$400 being fully responsible for their own bills has the potential of confronting hospitals with structural shortfalls in payment. Attention should be paid to developing financing

mechanisms that prevent this. **Fourth,** currently hospitals determine whether individuals are above or below the Z$400 cutoff for free care. Most make these decisions without a direct financial incentive in the decision. To the extent the government seeks to shift funding of hospitals to fee-for-service while a sizable portion of the population remains without coverage, both individuals and hospitals will have an incentive to qualify patients for government assistance. The MoHCW needs to identify systems and mechanisms for assuring that appropriate decisions on qualification are made. **Finally,** even as the MoHCW role in operational management of hospitals shrinks, MoHCW roles in the areas of financing, monitoring and quality assurance are likely to grow in importance. Systems must be developed to allow the Ministry to effectively carry out these new or expanded roles.

Hospital Autonomy in Kenya: The Experience of Kenyatta National Hospital

Executive Summary

Introduction

In Kenya, as in many other countries, public hospitals consume large portions of scarce health sector resources and do not always use them effectively or efficiency. Faced with difficulties in funding health services, some governments have granted greater autonomy to some hospitals to facilitate management improvements, which are expected to lead to better quality of care, increased revenue generation, and/or reduced cost. An example of this was Kenya's conversion of Kenyatta National Hospital (KNH), the government's large national referral and teaching hospital, to a state corporation in 1987.

For some years, KNH had experienced problems with overcrowding, quality of care, and shortages of equipment, supplies, and committed, well trained staff. This was attributed mainly to management weaknesses, both in structure and staffing; to the absence of good controls and systems; and to the fact that decision-making was centralized in the Ministry of Health. With the change to a state corporation, overall ownership of the hospital was retained by the government through the Minister of Health, but a hospital board was given responsibility for the assets, liabilities, and development and management of the hospital. The government continued to provide annual development and recurrent funding, and retained control over board appointments, funding levels, fee structures, and staff remuneration levels. The Board was given the authority to generate revenue through cost sharing; to procure goods and services, including hiring and firing staff; and to use available resources to accomplish the

mission of the Hospital.

Implementation

Although the new Board took legal responsibility and authority in April, 1987, a *lack of preparation* for the change to state corporation meant that it was some months before the Board was operational. Longer delays occurred in strengthening KNH management, due to the reluctance of some managers to accept change, and to salary limitations which made it difficult to attract experienced managers from outside the MOH. With this situation, the hospital continued to be run by the MOH and the hospital director for some time. Delays in implementation also resulted from the *limited experience and ability* of staff to take on more responsible roles, and from the lack of preparation to strengthen the critical areas to be taken over by KNH from the MOH, such as planning, personnel, finance and accounting, procurement, and benefits management. This was compounded by the lack of information provided to staff about the changes and the resulting unease felt by many staff about job security, pensions, and pending promotions.

With increasing government concern about slow progress in achieving the desired improvements, a *management contract* was awarded by the government to a European hospital management firm in late 1991 to speed up the implementation of change. There was considerable internal resistance to the management firm, due partly to the exclusion of the Board and senior management in the development of the contract and partly to the inexperience of some members of the contracted management team, and the contract was rescinded in August 1992.

Until 1992 the Board had little involvement in management, with the director, in conjunction with the MOH, making most of the decisions. In mid-1992, however, a new director was appointed, and he involved the Board more in the managerial decision-making process. The Board, with its blend of experienced private sector representatives and senior civil servants, began to help with internal issues, such as personnel, and with external issues, such as government funding. A number of *management improvements* resulted. Senior administrative management was strengthened with the transfer of qualified personnel from other government departments. Clinical management was also improved with greater involvement of medical specialists from the College of Health Sciences in hospital management, a more clearly defined departmental structure, and more delegation of authority to department heads. KNH specialists were no longer subject to transfer by the Ministry of Health and their salaries were leveled with those of their public university colleagues.

While some staff elected to leave KNH in order to remain MOH employees, the majority elected to become KNH employees and remain at the hospital. Those

government staff who elected to become KNH employees retained the right to their government pension, but also joined the new KNH contributory pension scheme in 1991. Later increases in *government salary grades* meant that KNH could begin to attract nurses away from the private sector, although it still could not compete with the private sector for skilled staff in areas such as computers, finance, and information management. All of the administrative managers and staff are still from the public sector, in part because even the upgraded government salaries are too low to attract people from the private sector.

The *supplies situation* also improved, mainly due to increased financial resources, speedier payment of bills, freedom to procure directly, and some internal decentralization of supplies management. Nevertheless, problems with slow, inappropriate, and irregular procurement and with internal leakages have persisted because some staff continue to resist change and because staffing skill levels are inadequate for handling more sophisticated, computerized systems.

Government funding to KNH has changed to a block grant, which has increased budgetary flexibility, and this, with greater control, has resulted in more effective internal use of funds. *Financial management* improvements have been reflected in more timely, detailed, and accurate financial statements. Financial accountability has improved, as demonstrated by a satisfactory audit of USAID funding. As a state corporation, KNH gained the ability to prosecute staff for fraud, and several staff have been prosecuted, which has served as a deterrent to others. Further improvements, such as computerizing the accounting system and decentralizing financial responsibility, have been constrained by the limited ability of existing staff and the difficulty of attracting experienced new staff because of low government pay scales.

KNH's share of MOH development and recurrent *funding allocations* has risen significantly since it became a state corporation, which may have helped KNH to improve quality of care, but gives rise to concern about the impact on funding for other MOH services, such as primary and preventive care. The main problem seems to be that the allocation of funds to KNH and to other MOH services is made in somewhat of a vacuum, since there is no clear definition of the range, level, and volume of services for each type of facility which can be used as a basis for determining the most cost-effective distribution of resources.

Since it became a state corporation, KNH has been able to retain all of its *cost sharing revenue*, which has become an important additional source of funding, increasing from 1% of KNH's recurrent income in 1986/87 to approximately 10% in 1993/94. A wider, more complex, and higher schedule of fees has been introduced by the Board.

The *role of KNH in the national health care system* has benefitted somewhat from its increased autonomy. Reductions in outpatient attendances and in the size of the hospital have freed hospital resources and increased KNH's ability to

serve as the national referral hospital. Although a shift of primary health patients to other facilities in Nairobi was planned, it is clear neither if the reduction in use related to poor or other vulnerable groups nor where those patients actually went for services. Staff believe that improvements in *technical efficiency* and *quality of care* have occurred, mainly due to the increased availability of supplies and improvements in building and equipment maintenance, and the beneficial impact of these factors on staff productivity. An example of this is the restoration of respiratory support to the newborn babies unit.

The overall bed occupancy rate appears to have increased slightly, but has varied considerably among departments, with Pediatrics having risen significantly. The overall average length of stay figure has stayed fairly constant over the years - although the Medicine Department and Private Wing show a clear reduction. The overall number of staff seems to have declined compared with the services provided, and staffing imbalances have been addressed to some degree, with increases in nursing, for example, and decreases in subordinate staff. Expenditure on staff has risen in local currency terms, but has fallen as a percentage of total recurrent expenses, and appears to consume a much smaller share of the total budget than the equivalent figure for the MOH. Operating costs appear to have fallen in real terms, but it is not clear to what degree that relates to efficiencies, funding shortages, or other reasons, and financial and service data have not always been reliably or consistently collected and reported by KNH.

Increased autonomy at KNH has improved its ability to *negotiate, plan, implement, and be accountable* for donor assistance projects and to report on performance. At the same time, the increased managerial flexibility and skill achieved as a result of autonomy has helped KNH to appreciate and apply lessons learned under such donor projects. The increased autonomy has also allowed KNH to deal directly with public relations issues, which has enabled the hospital to achieve a greater balance of press coverage, with fewer disaster stories and more positive ones.

The role of *donor assistance* has been an important factor in the changes which have occurred. The use of agreed-upon conditions on grant and loan assistance has helped to encourage the government and MOH to adhere to funding agreements and to encourage the Board and management to focus on both long-term structural and system needs and capacity building. In addition, while increased autonomy has provided a foundation for management improvement, the provision of donor-funded *technical assistance* has contributed to improvements in system development and capacity. This technical assistance includes the early assistance in developing management options and priorities (under the REACH project), assistance of management consultants engaged under the World Bank project, and assistance with cost sharing, financial

management, efficiency, management, and training provided through the USAID's Kenya Health Care Financing Project, which includes the development of KNH's own management training unit.

Recommendations for KNH

Although KNH has derived significant benefits from its increased autonomy, a number of steps can be taken to progress further towards the goals of improved quality of care, revenue generation, and cost containment. **First**, government control may need to be further relaxed to allow KNH to pursue external funding and to hire better-qualified staff. **Second**, given the type and level of services provided at KNH and the difficulty most patients have in covering these costs through fees, the government must ensure that as much of the cost as possible is covered by social insurance, leaving the balance to be covered through targeted government funding. **Third**, the role of the Board remains critical, and the government must seek to maintain a good balance of skilled, experienced private-sector representatives and civil servants, and should continue to avoid appointments resulting from patronage. **Fourth**, KNH continues to need stronger mid-level management capacity and better systems, especially in the areas of finance and supplies, so that efficiency and quality can be maximized. **Fifth**, KNH's role in the national system, and its desired type, range, and volume of services and expected client profile, must be defined so that there is a sound basis for determining donor inputs and government capital and recurrent funding levels. **Finally**, the government should establish and monitor coverage, efficiency, quality of care, and financial performance targets for KNH.

Recommendations for Replication

A number of lessons and questions emerge in terms of the replication of this model of autonomy at other hospitals in Kenya. **First**, it is not clear if the government can or should follow the model of KNH, since it may not make sense to expand the number of parastatals by making each hospital a state corporation. Therefore, there is a need to explore alternative legal mechanisms for granting autonomy, perhaps within the context of other reforms, such as decentralization. In addition, hospitals which serve specific communities will need to have boards with local representatives which are accountable to both the national and/or local governments and the communities. **Second**, the benefits of autonomy will not be achieved unless sufficient funding is generated. No hospital in Kenya will be able to fully finance the development and operation of services from fees while ensuring access to all those in need. Given the constraints on public funding, social insurance must be mobilized more effectively and government allocations must be targeted in accordance with need and performance. Funding ceilings must be more flexible so that hospitals

can seek, negotiate for, and receive funds from other bodies, such as donors, without affecting government funding for health. **Third**, as part of strengthening its policy-making and coordination roles, the government must define the role of the hospitals, in terms of both the type and volume of services provided and the range of patients served to ensure that public and donor funding is used cost-effectively. **Finally**, there must be a significant investment in preparation for autonomy to be implemented successfully. New boards and managers must be appointed in advance and in a fair and open way to ensure that the best-qualified persons are chosen. Standard systems should be developed in advance for critical management areas so that each hospital does not have to reinvent the wheel. Board members, managers, and staff will have to be properly oriented and trained, and the MOH should set and monitor targets for key aspects of financial performance and service coverage, efficiency, and quality.

Hospital Autonomy in Ghana: The Experience of Korle Bu and Komfo Anokye Teaching Hospitals

Executive Summary

Since the 1980s, public-sector teaching hospitals around the world have come under intense scrutiny in policy circles due to the complexity of these institutions, the heavy burden they impose on public funds, and the perceived difficulties in ensuring their efficient and effective functioning under centralized government control. One policy alternative that has found favor with policy makers in many countries is the grant of greater autonomy to these public-sector hospitals in running their operations. However, despite the implementation of "autonomy" in a number of public-sector hospitals around the world, very little research has been directed towards evaluating the experiences of these hospitals. Accordingly, as part of the overall strategy of the USAID to conduct policy relevant research into matters of importance to African policy makers and USAID missions in Africa, Harvard University was commissioned to conduct five case-studies on hospital autonomy. Ghana was identified as one of the sites for this cross-national, comparative, study.

Ghana, with an area of 238,537 square kilometers and a population of about 16.5 million (1994 estimate), lies along the west coast of Africa. For administrative purposes, the country is divided into ten regions, and one hundred and ten administrative districts. There are "four main categories of health care delivery systems in Ghana - the public, private-for-profit, private-not-for-profit, and traditional systems. Ghana was one of the first African countries to attempt giving greater autonomy to public sector hospitals. Since the 1970s, the government has gradually moved towards greater decentralization of the health

system, creating a new Ghana Health Service (GHS), and providing management teams in hospitals at various levels greater flexibility in allocating resources according to their own priorities, within the overall context of the national policy. As part of this general reform of its health sector, the two teaching hospitals in Ghana, namely, the Korle Bu Hospital (KBU), and the Komfo Anokye Teaching Hospital (KATH), have also been encouraged by the Government of Ghana to become "self-governing".

By far the most significant reasons underlying the grant of autonomy to teaching hospitals in Ghana are financial, the two teaching hospitals account for a disproportionate share of the Ghanaion MOH expenditures. Other reasons also cited by stakeholders include: separating the policy formulation function of the MOH from health services delivery; freeing the hospitals from the constraints of civil service regulations; increasing management efficiency; improving the quality of care; and improving the overall public image of the teaching hospitals.

In 1988, a legal framework, the Provisional National Defence Council (PNDC) Law 209, was developed by the Ministry of Health in Ghana as a key step towards providing full autonomy to the two teaching hospitals. Subsequently, several measures proposed by Law 209 were implemented at the two hospitals, beginning with the inauguration of the "autonomous" Teaching Hospital Boards in August, 1990. Encouraged by the initial "success" of the autonomy initiative, the Ghanaian government even proposed January 1, 1996 as a possible date for conferring on KBU and KATH the status of 'fully autonomous' institutions.

KBU, with nearly 1600 beds, functions as the teaching hospital for the University of Ghana Medical School, Accra, and has a staff component of more than one hundred and fifty doctors. KATH, with just over 750 beds, is the second largest hospital in this country. In 1975, in pursuance of an MOH policy to establish a second medical school in Ghana, Komfo Anokye was converted into a teaching hospital, and the medical school of the University of Science and Technology, Kumasi was provided an attachment to the hospital. As teaching hospitals, Korle Bu and Komfo Anokye Hospitals have three primary goals: the provision of high-quality medical care, teaching (including the training of students in medicine, nursing, pharmacy, and a variety of other para-clinical and technical disciplines), and research.

The main goals of the study in Ghana were: a) to provide a description and analysis of the experience of KBU and KATH in their move towards autonomy; and b) to draw on the Ghanaian experience to derive broader lessons about the viability, and the pros and cons, of hospital autonomy, in general. The study primarily entailed a qualitative analysis of the hospital autonomy experience in Ghana, supported by simple quantitative assessments. The four evaluative criteria used in assessing hospital autonomy in Ghana were: **efficiency**, **equity**, **public accountability**, and **quality of care**. The research methodology employed

included secondary data collection and analysis, interviews, and conducting of field surveys.

For the purposes of the study, we found it necessary to propose a new conceptual framework, which was intended to guide our assessment of the autonomy effort in Ghana, assist us in organizing the presentation of our data and results, and help focus our discussion on how the Ghanaian government's initiative can be steered towards a successful realization of its objectives. In our model, autonomy is conceptualized as a continuum from fully centralized decision-making to a fully decentralized system for each of four management functions, namely: **governance, general management, financial management,** and **human resource management.** For both hospitals, each of these management functions, as well as the legal basis for hospital autonomy in Ghana, has been assessed, using the four evaluative criteria.

Our study reports several interesting findings, of which the more important are as follows. First, Law 209 does spell out a framework for autonomy, albeit somewhat broadly. Also, much of the relevant legislation is enabling. The Law makes important concessions to public-sector hospitals, which, ostensibly, are quite radical within the context of the existing organizational arrangement. However, the law has also placed such strategic and fundamental restrictions on the Board that, in effect, all key decision-making powers and overall control are still retained at the ministerial and cabinet levels. Also the Law does not lay down a timetable for the implementation of autonomy, set priorities in the implementation process, or provide systematic operational guidelines on the implementation of the phases of autonomy.

Second, while as a concept there is broad and enthusiastic support for the autonomy initiative, autonomy means different things to different people, and the expectations, among key stakeholders, of autonomy are quite different. In other words, there is no common vision of autonomy. In fact, the support of the various stakeholders for autonomy is for different, often conflicting, reasons.

Third, there is a tendency among stakeholders to focus almost exclusively on the perceived benefits of autonomy, neglecting, in the process, some of its potential pitfalls. Indeed, whatever opposition there is to autonomy is mainly because of autonomy's perceived negative impact on equity, and due to concerns about the administrative capacities at the hospitals.

Finally, the experiment to give hospital autonomy to teaching hospitals in Ghana has not yielded many of the hoped-for benefits in terms of efficiency, quality of care, and public accountability - although there have been some isolated successes. Clearly, the establishment of hospital Boards, while necessary, is not a sufficient step in the autonomy process. To some extent, the existing situation in KBU and KATH might be explained, simply, by the relatively short duration of "autonomy" enjoyed by the two hospitals, or the instability that often

accompanies systemic reform. However, the evidence would suggest that problems are far more deep-rooted.

The inability or unwillingness of the MOH to allow the two hospitals to function as fully autonomous institutions has contributed significantly to the failure of the autonomy process in Ghana. The ambiguities surrounding the autonomy initiative, and the absence of any clear sense of direction and purpose - either at the MOH or in the hospitals, have only compounded this problem. But the two HospitalBoardshavenotbeenabletousetheautonomyprovidedtothem - however incomplete and circumscribed the autonomy - to bring about improvements at the hospitals. An inability to successfully transplant private sector structures and incentives to the two hospitals, institutional conflicts and inertia, limited decision-making and management capacities, the absence of a comprehensive and sustainable financial plan, and inadequate information systems have all contributed to the failure to achieve significant change.

We emphasize in our report that if hospital autonomy in Ghana is to have a chance, some of the steps that must be taken are:

- A comprehensive conceptual model of hospital autonomy should be developed, adequately discussed among key stakeholders, and adopted;
- A series of national consensus building meetings must be initiated with the goal of exposing the hospital autonomy concept, as well as the specific initiatives designed to provide autonomy to hospitals, to constructive criticism and debate;
- Law 209 should be revised, based on the discussions among stakeholders, and the new legal instrument should be backed up by specific guidelines, provided to the hospitals, on how to proceed with the implementation of autonomy;
- External and internal organizational arrangements to support autonomy should be designed. In particular, the relationship between hospital Boards, the proposed Ghana Health Service (GHS), the Ministry of Health, and the two medical schools should be clarified and formalized;
- The costs of running the various operations of the hospitals must be assessed, and alternative funding mechanisms devised to enable a system-wide financing of health care services in Ghana, including the teaching hospitals;
- Management training should be provided, so that a cadre of managerial staff equipped to handle all the key management functions at the hospitals is developed; and
- The autonomy initiative should be gradually and methodically phased in,

providing the hospitals ample time to prepare for autonomy, develop clear mission statements, and introduce strategic management in their institutions.

We also argue in the report that the failed experiment with autonomy in Ghana does not, by itself, demonstrate the non-viability of the autonomy concept. The success of the Ghana Education Service, an autonomous institution created by the Ministry of Education, would suggest that at least part of the problem with hospital autonomy in Ghana is a lack of a similar vision and initiative among policy makers in the health field. While the results of this study do not allow us to either unequivocally validate, or categorically reject, the hypothesis that autonomy -- implemented systematically and in full -- can lead to improvements along the four dimensions considered in this study, it is certainly clear that for autonomy to succeed, it needs to be given a fair chance.

The primary rationale for hospital autonomy in the public sector, as discussed in the report, is that, by creating organizational arrangements that mimic the private sector and encourage competition, one can induce increased efficiency, greater public accountability, and improved quality of care at these facilities. This does mean, however, that the hospitals must be converted into private institutions. We believe that any efficiency gains resulting from such a policy initiative are more than likely to be offset by losses in equity.

Finally, one needs to consider the intriguing possibility that many of the changes along the four dimensions considered in this study to evaluate autonomy might be achievable without the grant of autonomy to the hospitals. Maybe what is required, simply, is better management and incentive structures within the existing structure! If this contention is true, then the failure to bring about changes in the functioning of the two study hospitals might reflect more of a management problem, than an autonomy issue. Unfortunately, however, the findings of this study do not allow us to either substantiate or reject this claim.

Hospital Autonomy in Indonesia

Executive Summary

Indonesia initiated a program of hospital autonomy (Unit Swadana) in 1991 to encourage hospitals to recover some of their costs. Indonesian Unit Swadana hospitals are still government-owned with a high level of supervision and control by both the Ministry of Health and by local authorities at the provincial and district levels which depend on the centralized Ministry of Interior. Nevertheless hospital directors are given some control over the portion of their total revenues that comes from the fees they collect at the facility. Unlike many other countries, the fees collected by Indonesian hospitals have been significant — 30-

80% of total income — the rest coming from subsidies from the national and local governments. Prior to being certified as Unit Swadana, a hospital was required to turn over all of the own source revenues to the governmental level which administered them.

Under the new Swadana system, hospitals are allowed to retain their fees, and they can, within some percentage limits, use these funds for salary incentives, operations (drugs, spare parts), and hiring of contract personnel. Fee revenue cannot be used for equipment or construction; however, the autonomous hospitals are allowed to use the funds to contract services such as food service and laundry. Hospital managers may set fees for all charges except those charged for beds reserved for the poor (Class III beds). While these fees must be approved by higher authorities, in almost all cases, they are approved.

There still is a degree of centralized control over the planning/budgeting process for the revenue from fee collection. The hospital management is required to submit a yearly plan for the use of their own source revenues, incorporating them into the planning-budgeting exercise that includes the government subsidies from national, provincial and district sources. The hospital management in the newly autonomous hospitals indicate that this supervision of their budget is not a major obstacle to their ability to decide how to use their funds.

The management structure of the hospital is a decision that can be made at the hospital level — changing the uniform norms of the centralized system, and allowing a variety of organizational forms. However, the Hospital Director continues to be appointed by the central Ministry of Health (DEPKES) and not by any locally accountable authority.

The hospital management can also change some of the services provided. They can reallocate beds among different classes of services, except for Class III beds which are reserved for the poor and by law must be at least 50% of the beds.

The DDM Study

The DDM study evaluated a sample of ten hospitals which included: five Swadana hospitals with 2-3 years experience of hospital autonomy (two in Jakarta, one in West Java and two in Central Java); three public provincial or district non-autonomous hospitals — one in Central Java and two in Jakarta; and two private hospitals one large and one small — one in Jakarta and one in Central Java

A survey instrument was prepared to evaluate process and impact changes in financing, equity, quality, and efficiency that could be attributed to hospital autonomy. A series of hypotheses on the likely effects of autonomy on process

and impact and the results of these tests are reported below.

This methodology allowed us to evaluate trends in budgets, personnel, utilization, bed class assignments, bed occupancy rates, length of stay for autonomous public hospitals, non-autonomous public hospitals and private hospitals. The survey also gathered interview data on management changes, incentive structures, and budgetary processes. Attempts to gain data on quality were not successful.

Conclusions

Funding for all public hospitals has increased — both government subsidies and retention of fee revenue. This finding was somewhat surprising since, although we expected fee revenues to increase, we also expected subsidies to drop when hospitals were allowed to retain fee revenue, especially for provincial or district hospitals where local governments depended on hospitals for local government revenue. However, there was no identifiable relationship between Swadana status and funding trends. We found Swadana status alone provided little incentive to shift from dependence on subsidy to dependence on their own fee revenue.

Equity issues appear to have worsened in general and in some cases — especially in the increase in fees, Swadana status may have contributed to this inequity. There was a recent trend of doubling, tripling, and in some cases more than quadrupling of fees among all types of hospitals. The autonomous hospitals however, charged higher fees and had greater increases than did the non-autonomous public hospitals. The fees of the Swadana hospitals were approaching the fees collected by the private hospitals at both the high and low ends of the fee schedules.

Among the hospitals in our sample, there was a general reduction in access for the poor — regardless of autonomy — with a decline in the absolute number of beds reserved for the poor. In addition, the fees charged for the Class III beds in Swadana hospitals are approaching those charged by the private sector for the same type of beds. As expected, the non-Swadana hospitals were less likely to increase fees than the autonomous hospitals. While national, provincial and district authorities have control over the allocation of Class III beds, they appear not consistently requiring their hospitals to maintain the number or percentage of beds allocated to the poor.

Although data on unit costs in the hospitals in the study is of questionable validity what was available suggested that public hospitals could be subsidizing the VIP beds that are used by wealthier patients and hardly subsidizing the beds for the poor. It is the beds with modest tariffs (for the near poor) which appear to be charged more than unit costs. By contrast the private hospitals were more

successfully using fees to cross-subsidize the beds for the poor. Public hospitals might examine the fee schedules and costing structures of private hospitals which allow them to achieve this kind of cross subsidy.

We did not find evidence that hospital autonomy had an impact on personnel decisions. The numbers of personnel in each staff category remained relatively stable over the period studied. Since autonomy did not allow the management to hire or fire the permanent salaried staff, this finding is not unusual.

We measured efficiency by length of stay and bed occupancy rate and again found little indication of change in any type of hospital. We were unable to evaluate the impact on quality — data on intra-hospital infection rates and patient satisfaction was not available. There also did not appear to be any difference between centrally controlled hospitals and those controlled by local authorities (provinces and districts).

The only clear evidence of improvements that have occurred from hospital autonomy were that management systems improved in autonomous hospitals and incentive systems for physician payments in these hospitals appear to have improved physician attendance. These changes have not yet demonstrated an impact on our indicators of efficiency as noted above, however they suggest that more refined measures of efficiency and quality might show this impact.

These findings should be taken with caution. The sample of hospitals is still quite small and the experience with autonomy relatively recent. In addition, since many hospitals are now engaged in a process of obtaining autonomy, there may be a halo effect in the non-Swadana hospitals in our sample. However, the trends toward limiting access and higher fees suggest that some mechanisms should be put in place to assure that autonomy can be compatible with maintaining access for the poor.

DATA DECISIONS

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