Improving Hospital Performance through Policies to Increase Hospital Autonomy: Implementation Guidelines

Mukesh Chawla
Research Associate
Data for Decision Making Project
Department of Population and International Health
Harvard School of Public Health

Ramesh Govindaraj
Research Associate
Data for Decision Making Project
Department of Population and International Health
Harvard School of Public Health

August 1996

Table of Contents

Acknowledgements

This study was supported by the United States Agency for International Development (USAID) Washington through the AFR/SD/Health and Human Resources for Africa (HHRAA) Project, under the Health Care Financing and Private Sector Development portfolio, whose senior technical advisor is Abraham Bekele.

Hope Sukin and Abraham Bekele of the HHRAA project at the Africa Bureau reviewed and gave technical input to the report.

1. Introduction

Public hospitals are a significant component of health systems in many developing countries. Generally responsible for 50 to 80 percent of recurrent government health sector expenditure (Barnum and Kutzin, 1993), public hospitals utilize nearly half of the total national health expenditure (Mills, 1990). In many African countries the bulk of hospital spending is tied up in one or two major urban hospital facilities. These hospitals consume a large amount of scarce resources, and many tend to have low occupancy rates. Governments therefore face the task not only of finding new resources to fund the high cost activities of the hospitals, but also of utilizing existing resources more efficiently. Faced with diminishing resources and escalating costs, the need to use public resources more cost-effectively has never been greater.

Some governments have recently taken the decision to grant greater autonomy to hospital operations in the expectation that it may offer a means to both reducing the financial burden of hospitals on governments and strengthening the efficiency and effectiveness of public hospitals. However, 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 objectives of this research were (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.

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 (see Chawla and Berman, 1995). The evaluation framework suggested 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. The research methodology employed in undertaking the studies included secondary data collection and analysis, direct observation by the study teams, interviews, and field surveys.

This general framework was subsequently modified by the project teams in course of their enquiry, and based on the experiences of the research teams, the general framework of 1995 was revised in a later edition (Chawla et al, 1996). Known as Methodological Guidelines for Evaluating Autonomy, the framework suggests that the important issues in evaluating hospital autonomy can be addressed in the form of the following questions:

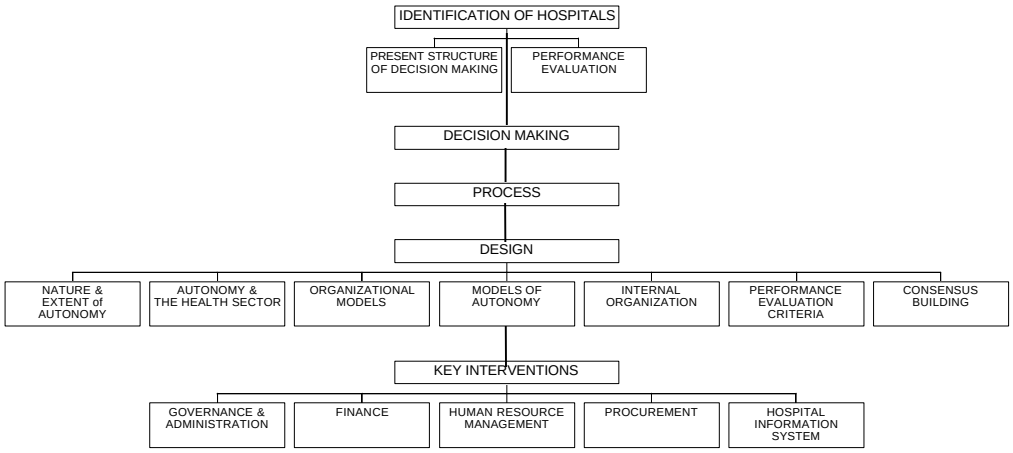
- Description of the nature and extent of its autonomy.
- Description of the process by which autonomy has been extended to the hospital.
- Description of the structure of hospital management, organization, internal systems and practices, and any changes that may have occurred to reflect the level of autonomy the hospital has.
- Description and analysis of the impact of autonomy, in terms of the effect of autonomy on efficiency, equity, quality of care, public accountability, and resource mobilization.
- Identification and description of the major implementation issues in the extension of autonomy to this hospital, and analysis of the main lessons learned in the process.

The results, conclusions, and recommendations of each study were then compiled in a synthesis document (Govindaraj and Chawla, 1996). The synthesis paper presents the summary findings of the five studies and draws on them to derive broader lessons on formulating and implementing hospital autonomy in developing countries. One disconcerting 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 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 a flawed conceptual basis for hospital autonomy in the public sector, as well as poor implementation of the autonomy measures, is to be held responsible for the limited success. Among other things, an inability to successfully transplant private sector structures and incentives to the public sector 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 limited success of the autonomous hospitals to achieve significant change either in their functioning or performance.

The findings of the five country studies point to the need of improved conceptual and implementation protocols for decision makers in developing countries wishing to consider autonomy as an option for bringing about improvements in hospital performance. These implementation guidelines are a step in that direction.

Figure 1.1
Hospital Autonomy: Implementation Guidelines



2. How to Use the Guidelines

The guidelines are designed to be used by countries that are considering ways of improving the functioning of public hospitals. The focus of the guidelines is one particular approach for improving performance, i.e., giving the hospitals greater autonomy. Though the guidelines are organized in a way that reading and using it alone would be sufficient in most cases, interested users are strongly encouraged to read and refer to the two companion documents: *Hospital Autonomy: Methodological Guidelines* (Chawla, Govindaraj, Needleman, and Berman, 1996) and *Recent Experiences of Hospital Autonomy: Lessons from Five Country Studies* (Govindaraj and Chawla, 1996).

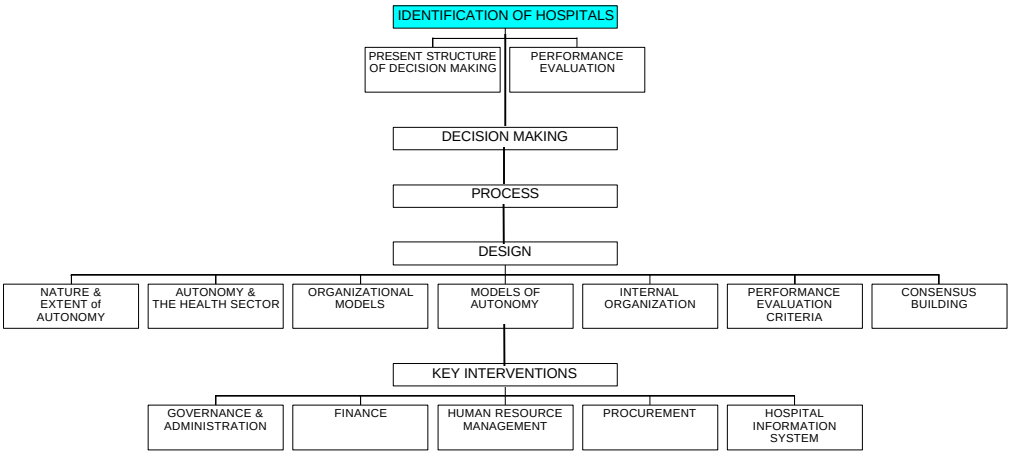
These guidelines aim to lead government officials in the ministries of health and finance and hospital directors through the process of evaluating the need and feasibility of autonomy in the context of existing political, sociocultural, and economic circumstances. The guidelines provide detailed planning advice on issues of design, process and restructuring of key areas to reflect autonomy. It also provides useful advice and insight into the process of effecting change and highlights some of the common obstacles that come in way of successful implementation of autonomy.

It is also useful to understand what the guidelines are *not*. The guidelines are not a book about management principles. There is no attempt here to apply theories of organization and management behavior to public hospitals. We understand that the hospital is a very complex and dynamic organization, producing a wide variety of goods and services, and in such situations managers increasingly need to have a more sophisticated understanding of the organization. These guidelines do not attempt to contribute to this need. This is not a management text, but a guide to help planners and managers improve their performance through a better understanding of the broad scope of issues related to hospital autonomy.

The rest of the guidelines are organized according to figure 1. We recommend starting with an evaluation of the structure and management of the targeted hospital, and assessing the performance of the hospital. Decision making is considered in the next section. If the decision is taken to give greater autonomy to the public hospital, issues of design, process and key interventions become relevant and important. These are discussed in the next three sections.

A checklist is placed at the end of each section, indicating the kind of information that ought to have been collected by the end of the section. The checklist tends to be cumulative, so that a reader examining the list at the end of the last section would get a good indication of what should have been achieved by the end of the guidelines.

Figure 1.2
Hospital Autonomy: Implementation Guidelines
Identification of Hospitals



3. Identification of Hospitals

The process of identification of target hospitals involves seven steps:

Step 1: Make a list of all public hospitals, and classify them according to the level of services they provide, i.e., primary, secondary, and tertiary.

Step 2: Estimate the sum total of government resources each hospital consumes, both in absolute numbers as well as a percentage of total government expenditure in the health sector.

Step 3: Identify hospitals believed to be performing poorly, according to criteria currently being used by the ministry of health or finance, general or medical community.

Step 4: If there are many hospitals that are believed to be performing poorly, rate the hospitals according to criteria such as consumption of government funds so as to choose a manageable number of hospitals that can be targeted for reform.

Step 5: Describe the present structure of decision making and administration in this list of selected hospitals.

Step 6: Evaluate performance of the selected hospitals in accordance with how they meet the criteria of efficiency, equity, accountability, quality of care, and revenue mobilization.

Step 7: Revise, if necessary, the priorities in the list of hospitals targeted for reform.

The information required for steps 1 and 2 should be available from the government in the ministry of health, finance and planning. The preliminary listing according to step 3 can be performed according to any known or used procedure, since in any case this will be revised and updated later on. Prioritizing is recommended since the government reforms are more likely to succeed if they are concentrated rather than if they are dispersed. Steps 6 and 7 need special attention, and we discuss them in more detail below.

The Present Structure of Decision Making

The starting point of the evaluation is the determination of **the present process of hospital administration.** Using the evaluation framework proposed in *Hospital Autonomy: Methodological Guidelines* (Chawla et. al, 1996), the present process of hospital administration can be described along the functional dimensions of hospital management and hospital policy.

Performance Evaluation

The first step in assessing the performance of the hospital is to describe the scope and nature of hospital services, such as present inpatient services (medicine, surgery, pediatrics, maternity, etc.) outpatient services, casualty, and specific clinics. It is also useful to understand (a) the role and place of the hospital in the referral system; (b) the rules and procedures that the hospitals follow for admission of patients to the hospital as private patient, government paid patient, and government nonpaying patient; and (c) the number of beds allocated to private patients, government paid patients, and government nonpaying patients.

Hospital performance can be evaluated in terms of efficiency, quality of care, accountability, equity and resource mobilization. We discuss these in detail in Methodological Guidelines (Chawla et al, 1996), and briefly refer to the concepts here.

Efficiency

The main plank against which performance of the hospital is ultimately assessed is its capacity to deliver high quality clinical care at least cost. Some measure of

Table 1

Characteristics of the Present Process of Hospital Administration

Functions	***Current Status***
Health Domain	What role, if any, does the hospital play in setting goals for the health sector?
	What role, if any, does the hospital play in setting goals for itself?
	What is the nature of formal/informal interaction between the hospital and government?
Hospital Domain	
Strategic Management	Has the hospital defined and described its mission and objectives?
	Has the hospital identified areas of interest and expansion?
	Has the hospital identified target population needing attention?
	What steps, if any, has the hospital taken towards strategic planning and preparing for implementation?
	Who takes these decisions of planning and implementation?
Administration	Is the hospital managed by a governing board?
	If so, how is the board appointed?
	Who constitutes the board?
	What is the scope and authority of the board?
	How is the Chief Executive Officer appointed?
	Who does the Chief Executive Officer report to?
	What is the authority and responsibility of the CEO?
Financial Management	What are the different sources of revenue for the hospital?
	What is the extent of contribution made by the ministry of health and other Government agencies?
	What is the contribution of user fees, if any?
	Who sets the fee?
	Who controls and retains the fee?
	Who bears the risk?
	Is there a system for institutional budgeting?
	Is the budget broken down into recurrent and capital expenditure components?
	If so, what constitute the recurrent budget? the capital budget?
	Is there any difference of government control and supervision in these items?
Human Resources Management	Who has the responsibility and authority for making personnel decisions such as recruitment, dismissal, etc.?
	What are the different levels of positions within the hospital?
	What is the process of determining the salary structure? Is it the same as state employees?
Procurement	Who prepares the list and quantity of drugs required?
	Who purchases these drugs? Is it the government or the hospital? If it is the hospital, are drugs obtained from central stores or from the market?
	What is the process of purchase from the market?
	Who is responsible for the purchase of medical supplies?
	Who is responsible for the purchase of non-medical supplies?
	Who is responsible for purchase and maintenance of equipment?
	Who is responsible for the maintenance of buildings and premises?
	Who is responsible for transportation?

efficiency can thus be obtained by measuring costs and examining the relationship of costs to services provided.

Hospital costs include recurrent costs (such as maintenance, rent, utilities, personnel, catering, laundry, linen, and costs of diagnostic, therapeutic, and other treatment services provided to the patient) and capital costs (such as land, buildings, plant and equipment).

Hospital services are traditionally measured by the number of outpatient visits, and the number of inpatient admissions and discharges. Traditional hospital service indicators are:

- The bed occupancy rate, which is a measure of the percentage of total available beds which are engaged by patients during the year;
- The average length of stay, which is defined as the average number of days a patient remains in the hospital between admission and discharge; and
- The bed turnover rate, which refers to the average number of inpatients per bed per year.

One approach to evaluating efficiency is to select performance indicators such as cost per bed day, output of services, rate of return on capital, etc. and then examine the performance of the hospital in relation to the indicator. It is important to note, however, that the effectiveness of unit cost studies can be seriously undermined by differences in the completeness of data used, and variations in the health, institutional, and economic environment. In order for a study comparing costs per unit of output to indicate which hospital is most technically and economically efficient, the following criteria must hold : (a) the case mix at each hospital must be the same or have been accounted for; (b) the quality of service must be the same or adjusted; and (c) the cost information must take into account the social opportunity costs of resources used. In the absence of these conditions, efficiency implications of unit cost measures are indeterminate or hard to interpret with confidence. High unit costs may be a reflection of a number of things such as high quality, poor efficiency, or the characteristics of patients. On the other hand, low unit costs could be indicative of poor quality or high efficiency.

Quality of Care

Changes in quality of health care can be evaluated in terms of the effects of an intervention on structure, process, and outcome (Donabedian, 1980). These can be judged along six different dimensions: effectiveness, acceptability, efficiency, access, equity, and relevance (Maxwell (1984, 1992). This three-by-

six classification gives eighteen “cells”, or cross-dimensions, and each cell gives information on two dimensions: *where* (structure, process, outcome) and *what* indicator of quality (effectiveness, acceptability, efficiency, access, equity, relevance). Quality of care may be assessed by judging each cell against an established or tested norm, and progress can be assessed by comparing the cells over time.

Structure and Process

Structural issues affecting the effectiveness of hospital services are: the physical state of the facility and the equipment; the administrative process; qualifications, experience and training of the medical and nonmedical staff; and

Table 2

Quality of Care

	Structure	***Process***	***Outcome***
Effectiveness	facilities, equipment, administrative processes, qualifications of medical staff , etc.	clinical history, physical examination, diagnostic tests, technical competence, preventive management, continuity of care, etc.	patient recovery, restoration of function, survival, etc.
Acceptability	physical comforts, cleanliness, privacy, counselling, etc.	explanation of treatment, patient education, etc.	follow up for improvement, meetings, etc.
Efficiency	appropriate staffing and equipment levels, etc.	administration, organization, staffing, operational arrangements, etc.	comparison of costs for similar cases across different units and time periods
Access	location, etc.	capacity, etc.	treatment of wait-listed patients, etc.
Equity		bias in treatment, etc.	bias in outcomes, etc.
Relevance	usefulness of resources, need for specific services, etc.		impact on health status for different groups of people, etc.

accreditation of the hospital Patient acceptability of hospital services is affected by comfort, courtesy, privacy, counseling etc. Appropriate levels of staffing and equipment are likely to affect efficiency parameters, while location of the facility may have some impact on access issues. All these are structural issues in the quality of care paradigm. On the process side are issues like technical management, diagnostic testing, preventive medicine, patient education, general administration and organization, capacity, etc. It is not

always easy to separate structure and process in a complex organization like a hospital, and often it is convenient to assess both together.

Outcomes

Patient recovery, follow up for treatment, and impact on health status for different groups of people are some of the outcome issues that are important for assessing quality. Effectiveness in outcomes can be evaluated by looking at indicators of patient recovery and survival, or alternatively at mortality rates in the hospital. Patient acceptability can be assessed by using indicators of follow up visits for improvement. Cost and case-mix comparisons over time may give some idea of changes in efficiency. Equity and access may be assessed by looking at the hospital use across income groups, gender, age, race, and diseases and conditions treated in hospitals.

Equity

Following Wagstaff and Doorslaer (1993) equity can be defined in terms of finance and delivery of health care. Equity in the finance of health care refers to the requirement that “persons or families of unequal ability to pay make appropriately dissimilar payments” for health care (vertical equity), and the requirement that “persons or families with the same ability to pay make the same contribution” (horizontal equity). Equity in the delivery of health care refers to the requirement that “persons in unequal need be treated in an appropriately dissimilar way” (vertical equity), and the requirement that “persons in equal need be treated equally” (horizontal equity). (All quotes are taken from Wagstaff and Doorslaer, 1993).

Accountability

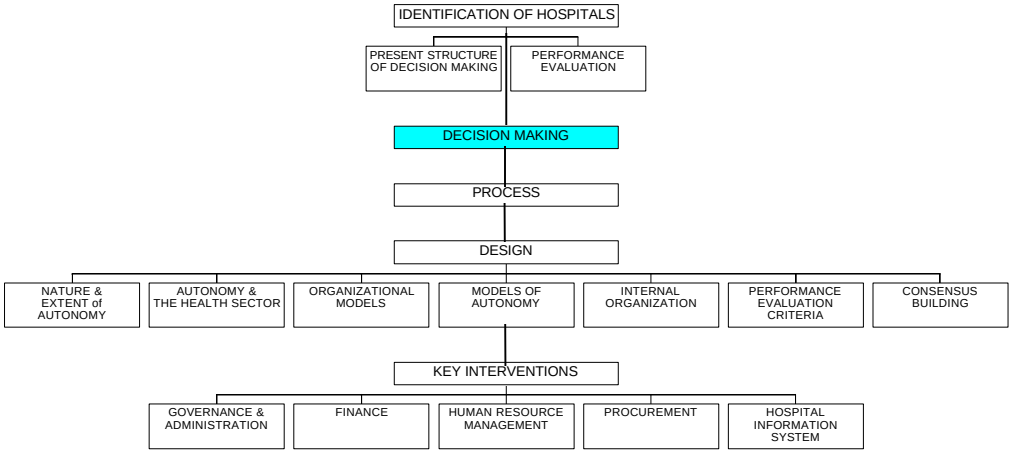
Accountability was of little concern when hospitals were symbolic of humanitarian efforts for community welfare. Today, however, with hospitals using an increasing proportion of scarce resources and not using it so efficiently and effectively, as Schulz and Johnson, 1990, note, there are many questions of quality and effectiveness. Accountability, rather than control is increasingly becoming the important issue, with hospitals being accountable to consumers, individual patients, government and others who provide funds, regulatory agencies, and own employees. Accountability is an important factor in the successful use of public resources for the improvement of community health. According to Bowen (1973), a good system of accountability would have a clear purpose of goals and objectives, with an ordering of priorities; allocation of resources toward maximum return in relation to goals and objectives; evaluation of actual results; and reporting on evaluation to all concerned.

End-of-Section Checklist

Check that the following information is collected by the end of this section:

- √ List of all public hospitals
- √ Government resource allocation to all hospitals
- √ Preliminary list of target hospitals
- √ Description of the present administrative process in these hospitals
- √ Assessment of performance of these hospitals with regard to efficiency, quality of care, equity, accountability, etc.
- √ Final list of target hospitals, prioritized according to some well-defined criteria

Figure 1.3
Hospital Autonomy: Implementation Guidelines
Decision Making



4. Decision Making

If the previous analysis indicates that:

- some government hospitals are generally failing in their bid to maximize public welfare, or are doing so at high cost; and
- these hospitals consume a large share of the government health budget in the form of capital infusions, subsidies and operational expenses;

then it can be concluded that:

- public production of health in government owned and managed hospitals, at least in the present form, is not the most efficient way of using government resources, and an improvement in the present position is likely to have a major positive impact.

Two solutions often suggested for improvement of hospital performance and efficiency are:

- Privatization

- Reforms in the manner of government control and management of hospitals.

Continued government involvement in the production of health care is suggested for many reasons:

- *Socio-political:* There is the popular expectation that governments should be responsive to the needs of health care for all citizens of the country.
- *Operational:* Government investment in production and delivery of health care has failed to deliver the expected result, not because the concept was necessarily weak but because it was not implemented well.
- *Economic:* Government involvement in health care production and delivery is justified on many grounds, including the public and merit good arguments, presence of externalities in health care, and asymmetry of information.
- Governments are generally believed to be doing *the right thing*, such as provide affordable quality health care for all, even if they do not do it in the right manner. On the other hand, while it is reasonable to expect that private firms *do things right*, i.e., efficiently, quickly, correctly, and innovatively, they may not do the right thing. The ideal solution thus is to find an institutional combination that does *the right thing* and *does it right*.

Reforms in the manner of government control and management of hospitals range from fine tuning and marginal reforms in existing structure to more radical changes such as the provision of functional autonomy to publicly owned hospitals. While fine tuning and marginal reforms may produce the necessary improvements in the hospital's performance if the existing problems and issues are equally minor, more fundamental situations would necessarily require more fundamental solutions. One such alternative, though by no means the panacea (see Govindaraj and Chawla, 1996) is providing the hospital greater autonomy of decision-making on a host of functions.

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 it is not very obvious that the benefits of autonomy will 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.

- Hospital autonomy may lead to gains in both technical and allocative

efficiency. Various reasons have been cited for these 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.

On the other hand, when autonomy is not associated with incentive structures, or the incentives are inadequate, the potential benefits of autonomy may not be fully realized. Autonomy may also lead to a loss of the benefits of economies of scale and scope, and may thus increase the inefficiency of the hospital.

- Autonomy is presumed to increase public accountability and consumer satisfaction. Autonomous hospitals, vested with greater authority, can be expected to be better able to respond to local community needs. This is expected to increase public support and acceptance, and greater community participation in hospital decision-making. Moreover, the delegation of authority "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).

  On the other hand, greater hospital autonomy may not be translated into increased concern and responsiveness to community needs. Freedom from central control will allow hospitals to place their self-interest 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).

- Autonomy is likely to lead to improvements in the quality of care provided by hospitals. Greater autonomy accompanied by appropriate incentives, consumer responsiveness, and public accountability, is expected to 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.

It is important to note that many difficulties can arise when governments started implementing autonomy, as is brought about in our evaluation of five countries where hospital autonomy has been implemented (see Govindaraj and Chawla, 1996 for a summary of country experiences). Our studies indicate that for the most part governments have relied on legal devices to ensure that the autonomous concept works as intended. Managerial

autonomy has been secured by making the government hospital legally distinct from the state (Kenya, India), by placing it under an independent board of directors (Ghana, Kenya, India, Indonesia, Zimbabwe), or by excluding their employees from civil service rules and privileges (Kenya), and allowing them to operate their own bank accounts (Ghana, Kenya, India, Indonesia, Zimbabwe) and retain surpluses (Kenya, Zimbabwe). In most cases governments have restricted their own role by legally confining their role to setting policies and staying out of operational matters, merely requiring the hospital management to follow government directives on goals and policies and subjecting them to government audit.

Despite the legal structures in place, however, governments in the ministries of health and finance dealing with public hospitals have tended to think of the hospitals as being an extension of the government. Thus, they have been inclined to focus on issues they are used to controlling in government itself, such as headcounts, discretionary expenses, etc. Where government officials have tried to go beyond these issues, they have been constrained by shortages of time and staff. When government control and supervision has taken this form, many adverse and dysfunctional consequences have followed. First, a lot of time is spent and wasted in frequent interventions. Second, it leaves the managers without any motivation, which reduces operational efficiency. Third, since so many outsiders make so many internal decisions, managers cannot be readily held accountable. Fourth, there is a tendency among managers to spend a great deal of time and effort in finding ways and means of getting around government rules and controls. And finally, minor issues consume so much attention that fundamental questions about objectives and strategy have often remained unaddressed.[1]

An obvious conclusion seems to be that making the concept of an autonomous hospital work takes more than just rules and regulations. New administrative systems, institutions, and personnel are necessary to coordinate government-autonomous hospital relations, and innovative methods of managing public hospitals are necessary. The tendency in many countries of borrowing freely from either private sector (Kenya), or government management styles (Ghana, India), and using available institutions and personnel (Ghana, Kenya, India, Indonesia, Zimbabwe) to manage the newly created autonomous hospitals does not seem to work. Unfortunately, most of these are not appropriate for the hybrid institution delivering goods and services that have: a strong underlying public and merit good component; and established externalities in an environment characterized by a wide diversity between the levels of information available with the providers and consumers of the product.

We realize that the limited success of autonomous hospitals in both **doing the right things** and **doing them right**[2] has led to general disappointment with

---

1/ Arguments of a similar nature are found in Jones (1980, 1991)

2/ This terminology is commonly used in the relevant literature on public economics. Our use of these terms is inspired by Ramamurti (1991).

the concept of autonomy, but maintain that the implementation of autonomy in these countries is more to be flawed than the concept of autonomy itself. New implementation systems and processes have to be brought about through a process of experimentation and creative thinking; otherwise, we run the risk of losing a potentially valuable tool without having applied it properly.

The decision to give greater autonomy to public hospitals should thus be governed not only by the problems with the existing setup, but also by readiness and preparedness of the government to take a number of innovative, and sometimes harsh, steps driven by the will to give the new systems a chance to perform.

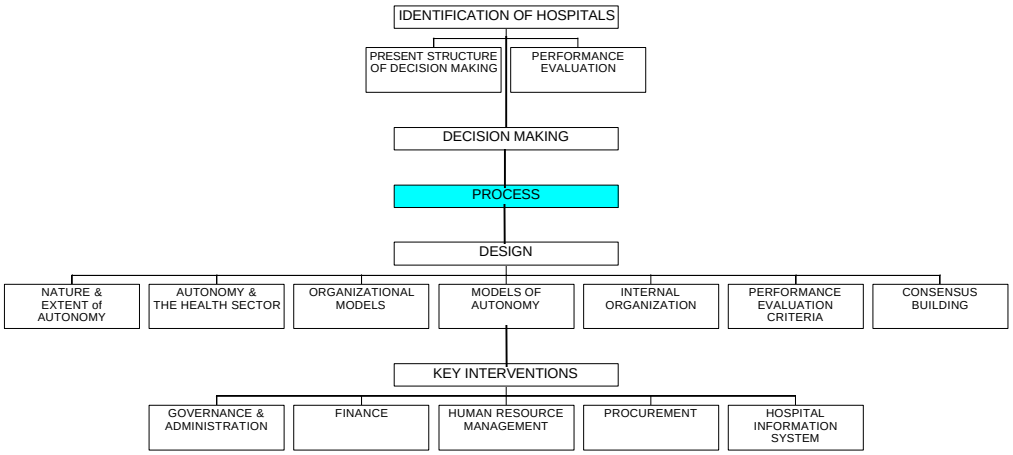
End-of-Section Checklist

By the end of this section it is expected that you would have taken a decision on the future of the hospital. If the decision is to make marginal reforms in the existing administrative and control structure, then the rest of the guidelines offer only academic reading. If, however, the decision in principle is to give the hospital more autonomy, the remaining sections on design, process and key interventions are useful.

√ Final list of target hospitals, prioritized according to some well defined criteria.

√ Preliminary decision regarding autonomy taken.

Figure 1.4
Hospital Autonomy: Implementation Guidelines
Process



5. The Process

Once the decision to give autonomy to a hospital or a group is taken, the next step is to create enabling conditions to facilitate implementation. It is important to recognize that a large number of people and organizations, within the government, the hospital, members of the public, press, etc. would have the potential to affect the decision making process, and ignoring their contribution could well defeat the whole process even before it starts. Within the government there are the issues of decision-making regarding the type and extent of autonomy; an assessment of the likely impact of autonomy on government's finances, administration and people; political issues such as support and opposition from different groups; legal issues such as those concerning the existing laws of the land and the need for change; and personnel-specific issues that concern government employees in the hospitals.

Within the hospital there are employees' concerns regarding their future employment conditions; changing relations between groups of employees, particularly between medical staff and managerial personnel; union and collective bargaining issues; scope and nature of the hospital's services and expansions; and every mission and goal of the hospital under autonomous management.

Similarly, within the general public and the press there are concerns regarding: the role the autonomous hospital will play in meeting community needs and requirements; changes in resource mobilization strategies that may come about with autonomy; and the accountability of an autonomous organization to the community.

Reich (1994) provides a "six-step procedure for describing the issues, key players, resources, and networks involved in a specific health policy decision".

- The first step considers and describes the expected effect of the health policy along the dimensions of identity, size, timing, and intensity of the effects.
- The second step identifies the opponents and proponents of the health policy.
- The third step identifies the major organizations and individuals in the decision-making processing, and assesses the impact of the policy on these organizations and individuals.
- The fourth step identifies the formal and informal linkages between organizations and individuals involved in the policy.
- The fifth step makes an assessment of the major changes in the responsible organization, and covers the general organizational and the political environment.
- The sixth and final step analyzes the strategies for influencing the decision.

End-of-Section Checklist

The process of implementing decisions regarding autonomy thus involve:

√ Final list of target hospitals, prioritized according to some well-defined criteria.

√ Preliminary decision regarding autonomy taken.

√ A clear enunciation of the government's objectives for implementing autonomy, and the expected effect of autonomy on the health sector from a financial and an administrative perspective.

√ Identification of individuals and groups likely to be directly or indirectly affected by the autonomy decision.

√ Identification and description of transitions and changes occurring in the

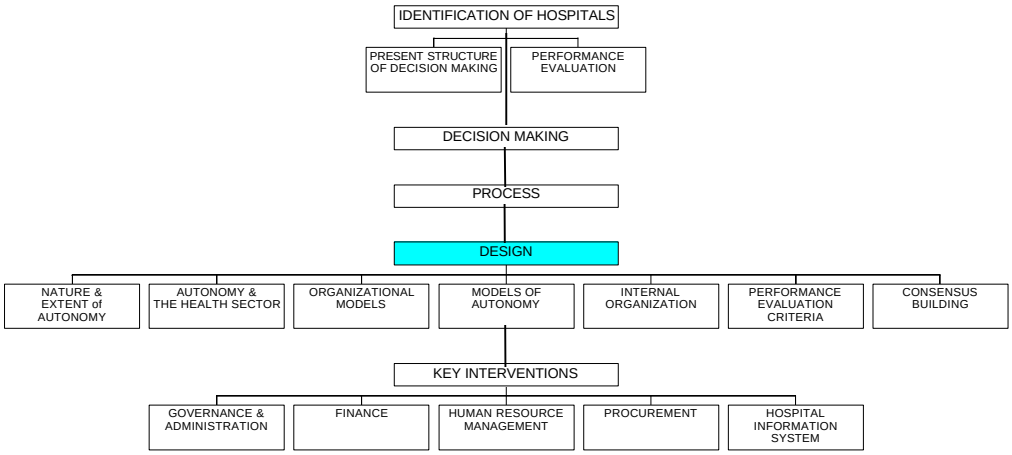
government that could affect the proposed decision; identification and description of transitions and changes occurring in the political and economic environment that could affect the proposed decision.

√ Identification of the major players in the government, political parties, non-governmental organizations, the private sector, the academic sector, international agencies, donor groups, hospital personnel, and the community, who are likely to play a significant role in the decision making or implementation process, and the importance of this decision to them.

√ Analysis of the expected support and opposition from these groups.

√ An understanding of all the processes available to utilize this support and manage opposition.

Figure 1.5
Hospital Autonomy: Implementation Guidelines
Design



6. Design

As we have argued earlier, making the concept of an autonomous hospital work takes more than just rules and regulations. New and creative management systems are necessary to effectively administer and coordinate the activities of the government and the autonomous hospitals. New systems 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.

There are several steps involved in the design of an autonomous organization:

Step 1: Decide the nature and extent of autonomy to be given to the hospital.

Step 2: Identify the role of autonomy in the scheme of health reforms.

Step 3: Decide the level of hospital to which autonomy is to be given.

Step 4: Decide whether any changes are required in the internal organization of the hospital.

Step 5: Establish a performance evaluation criteria.

Step 6: Take steps toward consensus building.

We will discuss each in turn.

Nature and Extent of Autonomy

Once the decision to give the hospital greater autonomy is taken in principle, the next step is to decide *how much* and *what type* of autonomy is intended to be given to the hospital. We discuss these issues in Methodological Guidelines (Chawla et al, 1996), and repeat some of the arguments in the following section.

Autonomy is 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, such absolute criteria are of little help in defining hospital autonomy, and the term "autonomous hospital" has meaning only when used in the sense of fulfillment of specific criteria for autonomy on which consensus is reached. In other words, hospitals can only be autonomous within a predefined context, and in order to gauge the extent of a particular hospital's autonomy, it is important to specify the characteristics for each of the hospital's management functions of each level of autonomy.

In our framework (see Chawla et al, 1996) we define hospital autonomy along two dimensions: the extent of centralization of decision-making ("extent of autonomy"); and the range of policy and management decisions that are relevant to hospitals (including both policy formulation and implementation). We believe that these are the appropriate dimensions along which hospital autonomy should be discussed, for it is the extent of decentralized decision-making that occurs within the hospital, and the extent to which such decision-making is feasible for each of the management functions, that are the relevant considerations.

Table 3 presents our conceptual model in the form of a 6X3 matrix, with the extent of autonomy and the policy/management functions representing the two axes of the matrix. Autonomy is conceptualized as a continuum from a situation where all decisions are made by the owner (public or private), to one where the system of decision-making and policy formulation is highly decentralized. We differentiate between decision-making at the macro level, i.e., in the national health domain; and the decision-making occurring within the domain of hospitals. In this continuum, we define 3 stages (1-3) for each of the policy and management functions.

Table 3

Conceptual Framework for Hospital 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	All decision making entirely by owner	Decision making jointly by owner and hospital management		
Hospital Specific Goals	All decision making entirely by owner	Decision making jointly by owner and hospital management		Decision making entirely by hospital management
B. Hospital Domain				
Strategic Management	Direct control by owner: government, parastatal, or private	Governance through a board appointed by owner, and guided by owners, but not subservient to owner		Independently constituted Board, making independent decisions
Administration	Direct management by owner, who also sets the rules for management of the hospital	Limited powers decentralized to hospital management; owner still weilds some influence over management decisions		Independent management operating under Board's directions, with significant independent decision-making capacity
Procurement	Centralized procurement, with owner deciding on quantities and total financial outlay	Combination of centralized and decentralized procurement		Procurement completely under control of hospital management
Financial Management	Full funding by owner; owner has financial control	Owner subsidy plus funds through other sources, some owner influence but finances generally under Board's control		Self-financing; no owner subsidy; funds entirely under Board control; significant independent decision-making capacity for managers
Human Resource Management	Staff appointed by owner; completely under owner's regulatory control	Staff employed by Board, and subject to the Board's regulations, but also subject to owner's regulations		Staff employed by Board; all conditions and regulation set by Board; managers have significant decision-making capacity

Health domain refers to decisions that are made at the level of the government or at the government-hospital interface, over which hospitals, typically, have only limited control. **Hospital domain**, in contrast, refers to those activities undertaken within the hospital, over which the hospital management usually exercises much greater control.

The two health domain functions are: formulating overall (national or state) health goals (e.g., deciding on national health targets, health programs, allocation of health resources, etc.), and setting hospital-specific goals (e.g. deciding on hospital roles and functions, reporting requirements, evaluation criteria, etc.).

The five hospital domain functions, respectively, are: strategic management, procurement, financial management, human resource management, and administration. **Strategic management** refers to the function of 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. **Procurement** refers to the purchase of drugs, medical and non-medical hospital supplies, and hospital equipment. **Financial management** refers to the generation of resources for the running of the hospital, and the proper planning, accounting, and allocation of these resources. **Human resource management** refers to the training and management of the various categories of hospital personnel. **Administration** refers to all the other responsibilities (i.e., 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. In Table 4, we summarize the specific activities that fall under the purview of the various policy and management functions described in Table 3.

Relationship of Hospital Autonomy and Health Sector Reforms

As we have argued elsewhere (see, for instance, Govindaraj and Chawla, 1996) hospital autonomy forms an important part of the whole health reform package and is inextricably linked to other reforms, such as resource mobilization, increasing competition, encouraging private sector participation, etc. Moreover, since hospitals consume a substantial share of health budgets in many developing countries, reforms related to the functioning of hospitals and the health system overall tend to be mutually reinforcing. Hospital autonomy thus has many linkages with other components of the health system, and often the relationship is such that it is difficult to sustain autonomy without other reforms, or fully realize the potential of other reforms without autonomy.

Table 4

Activities within Various Policy and Management Functions

Policy and Management Functions	***Specific Activities***
A. Health Domain	National goal-setting, Role definition, Laws and regulations
B. Hospital Domain	
Strategic Management	Mission definition, Strategic planning, Operational guidelines, Asset management
Financial Management	Resource mobilization, Resource planning and allocation, Accounting of income and expenditures
Human Resource Management	Hiring and firing of personnel, Creation of posts, Determination of employee rules, Contracts and salaries
Procurement	Purchase of drugs and medical supplies, Purchase of non-medical supplies, Purchase of equipment
Administration	All other day-to-day management activities required in implementing hospital mission and running hospital, such as: time schedules, space allocation, information management, consumer relations, etc.

Table 5 below categorizes the relationship between hospital autonomy and health sector reforms, and illustrates the mutually reinforcing role and nature of the two.

The objectives and impact of increasing hospital autonomy should therefore be evaluated not only within the context of other measures to improve performance of public hospitals, but also within the larger context of health sector reforms.

Organizational Models

The public hospital system can be reorganized to grant varying levels of independence to various sub-units. This reorganization could, for instance, entail the transfer of authority for planning, management, resource mobilization, and resource allocation from the central government and its agencies to:

- field units of central government ministries or agencies;

Table 5

Autonomy as a Component of Health Reform

Reform	***Support Provided to the Reform by an Autonomous Hospital***	***Support Provided by the Reform for Improving Performance of an Autonomous Hospital***
1. Resource Mobilization	Improves performance of fee collection and management of funds	Supports and enables financial autonomy
2. Introduction of National Health Accounts & Budget Tracking	Makes budget tracking and control easier and government expenditure more transparent	Encourages responsible data collection, management and analysis; improves overall hospital management
3. Decentralization & Devolution	Complements and supports decentralization and devolution of decision making	Supports autonomy
4. Market Competition	Provides competition with private hospitals	Contributes to effective cost containment
5. Increasing Private Sector Involvement	Contribute to the creation of a level playing field	Creates a competitive environment

- subordinate units or levels of government;
- semi-autonomous public authorities or corporations;
- area-wide, regional or functional authorities; or
- non-governmental private or voluntary organizations.

Reorganization of authority to grant greater autonomy can be done through the processes of deconcentration and delegation (Rondinelli et al, 1984 and Mills, 1990). Deconcentration, or the reorganization of authority in general, refers to the redistribution of some amount of administrative authority to lower levels in the hierarchy. Within guidelines established by the central agency, district hospitals are permitted some element of discretion to implement projects and proposals, and to adjust directives to local conditions. Deconcentration can lead to two kinds of hospital administration structures: a vertical pattern of local administration, and an integrated, or prefectural pattern. In the vertical pattern, the local staff of each ministry are responsible to their own ministry. The public health and revenue collection officials in a hospital, for instance, would report to different superiors. Coordinating structures such as a district committee may be sanctioned in order to ensure alliance between local and central ministries, and

may be permitted financial discretion to some extent. In the second form of administration, the integrated form, a local representative of the central government is responsible for the enactment of all government actions within the hospital. Minimal requirements for this include a specifically defined geographical sphere for which managers are responsible, at least one senior staff member with strictly defined powers, a budget and staffing establishment, and a method of communicating local needs to the central authority.

Delegation, or the reorganization of authority specific to functions, involves the transfer of decision making and management authority for particular functions to organizations which are not directly controlled by the central government ministries. Functions may be delegated from the central government to organizations such as public corporations and regional planning and development authorities, and other parastatal organizations which are not officially within the government structure.

The nature and extent of autonomy would depend on the degree to which the government continues to retain control over the various functions of the hospital, particularly important functions such as (a) health policy formulation and the establishing of national priorities; (b) the allocation of certain resources, in particular capital funds; (c) control over quality and licensing; (d) regulation of health personnel, including selection and recruitment, training, salaries and wages, discipline and discharge, etc.; and (e) regulation of user-fees, allocation of surplus, and financial accounts and bookkeeping.

Models of Autonomy

There are two popular models of autonomy that countries in our study favored:

- Making individual hospitals autonomous and transferring decision making to independent boards.
- Setting up an organization of hospitals as a quasi-governmental organization and making this body autonomous.

The parastatal model has many advantages:

- the government has to deal with only one organization instead of many different autonomous hospitals.
- it is simpler to monitor and regulate one organization instead of many smaller units.

- one autonomous organization requires only one good management team as opposed to a much larger requirement of trained personnel for many autonomous units.

There are many disadvantages also:

- individual hospitals continue to be non-autonomous, and thus the gains from autonomy do not get fully realized.
- effective autonomy is always in danger of being diluted simply because it is easy for the government to exercise control over the single organization.
- 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.

Internal Organization

The internal organization of a hospital may not need to undergo any change after autonomy, though if a change in the control environment is required for any other reason, this may well be the appropriate time for a reorganization. A reorganization with a change in policies, personnel and responsibilities might bring about new approaches to problem-solving and new attention to chronic problems. At the same time, the reorganization may be simply necessary to communicate the message that something is being done, which by itself may trigger favorable responses. Moreover, organization design is largely an executive function, and the introduction of a new board and new executive leadership may also necessitate appropriate changes in the organization.

It is also useful to note that while legitimate authority is vested in clearly defined centers in the organizational chart, informal organizations can be more influential and important. Personal influence, expertise, control of resources, and informal coalitions might portray lines of coordination and control more accurately. In implementing change the informal sources of authority and power should be recognized and to the extent possible, utilized.

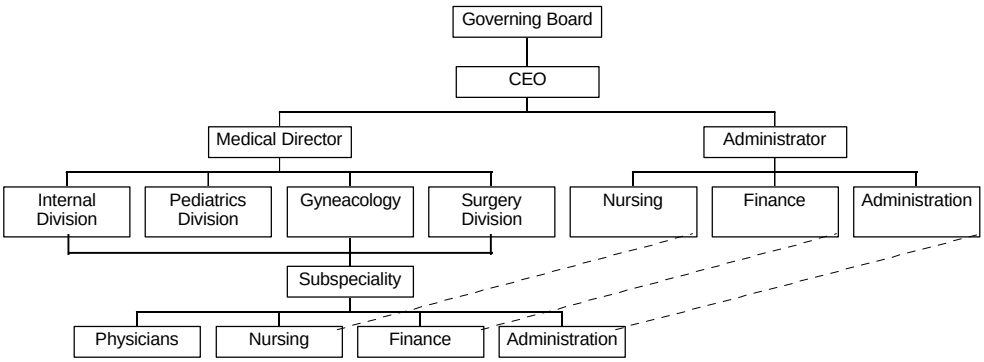
An organization brings together all available resources to perform defined tasks and functions, and thus needs to be arranged in a way that permits effective and efficient performance. A complex organization like a hospital can be organized in a variety of ways. Two of the most popular organizational models are discussed below.

- Functional Organization: Traditionally, small hospitals are organized along functional lines, with labor divided into departments specialized by functional areas like finance, buildings and maintenance, professional

services, nursing services, etc. the actual number of functional departments depend on the size of the hospital (see figure 2).

- Divisional Organization: Large hospitals, particularly teaching hospitals, are typically organized around traditional medical departments, such as internal medicine, surgery, gynecology, pediatrics, etc. They can also be organized around target groups, like women, elderly, cancer patients, tuberculosis patients, etc. In this model decision making is decentralized to the service level and each division has its own internal management structure (see figure 3).

Figure 2
Divisional Organization



Performance Evaluation System

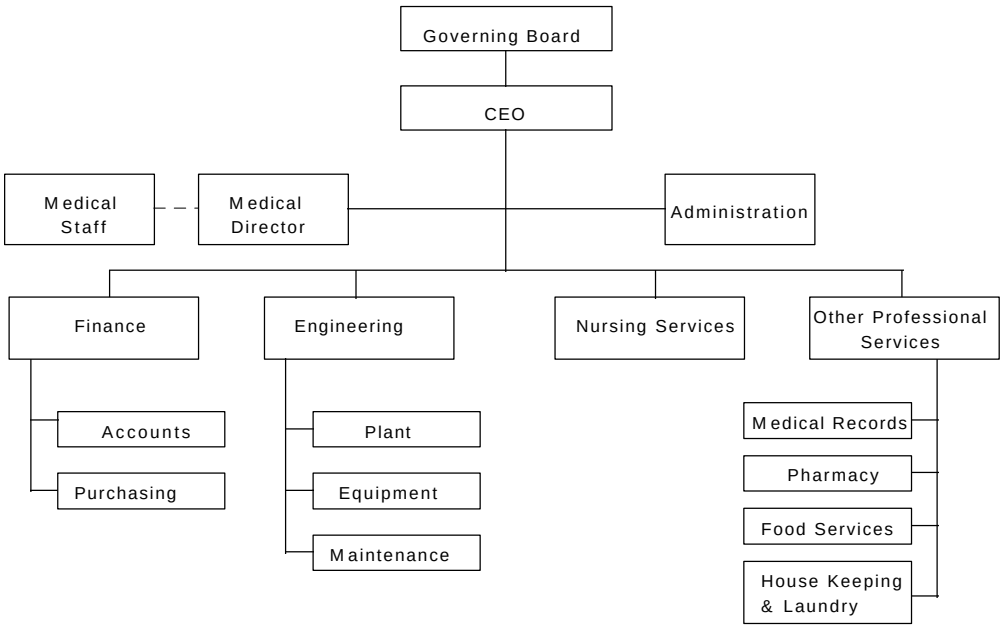
Many of the problems of the public hospital can be traced to inadequacies in performance evaluation. A performance evaluation system is based on *goals, performance criteria* and *criterion values*.[3]

The goals of a public hospital are difficult to specify due to the problems of multiple objectives (including commercial and noncommercial objectives) and plural principals (different organization units having different perceptions of what the goals should be). If goals cannot be specified, then good managers cannot be distinguished from bad ones.

A performance criterion is simply a quantification of an enterprise's objectives. Multiple objectives can be handled by aggregation if they are individually

3/ This section draws heavily from Jones (1991) and Shirley (1991).

Figure 3
Functional Organization



quantifiable and if there is general agreement on the relative importance of each objective. The problem arises when some of the objectives are noncommercial and not quantifiable. The other issue is temporal: single period indicators ignore future effects, and this is a major weakness. Performance indicators thus must allow for dynamic effects.

Given the choice of any performance criterion, the still more difficult task remains of selecting a particular criterion value, i.e., a yardstick against which the performance criterion can be judged. Some sources of information that can assist in setting criterion values are: 1. comparison with similar firms elsewhere, 2. comparisons with the same firm's performance in previous years, 3. professional judgement by third parties, 4. professional judgement at the ministry level, and 5. professional level at the hospital level.

The problem of quantifying noncommercial objectives can be serious, especially in an organization where most of the output is noncommercial. One straightforward solution is to eliminate the problem by simply denying the validity of noncommercial objectives, for it is difficult to impose commercial discipline on a firm that has recourse to noncommercial objectives as an excuse for poor commercial performance. While ignoring noncommercial objectives may be better than recognizing them and allowing managers an excuse, a better solution is to quantify the cost of the

noncommercial objectives and enter them explicitly into the enterprise accounts. Thus costs are measured rather than benefits. While this is not the best solution, costs are usually easier to quantify and value.

A comprehensive performance evaluation criteria would thus have:

- a *primary* indicator, that would cover static operational efficiency plus any noncommercial objectives that can be quantified;
- *supplementary* indicators, that cover dynamic effects and noncommercial effects that can only be rated, but not monetized; and
- *diagnostic* indicators, that are used to explain the movements in the primary indicator.

Performance evaluation of public hospitals is not a simple matter and a workable system cannot be imposed arbitrarily or overnight. Rather, it must be a product of an evolutionary process involving both enterprise managers and government supervisors. Accordingly, a phased system is proposed. Once an acceptable system is in place, however, an incentive system can be operationalized in which the welfare of managers and workers is linked to national welfare by a pecuniary or nonpecuniary bonus system based on achievement of particular target values.

Consensus-Building and Goal Attainment

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.

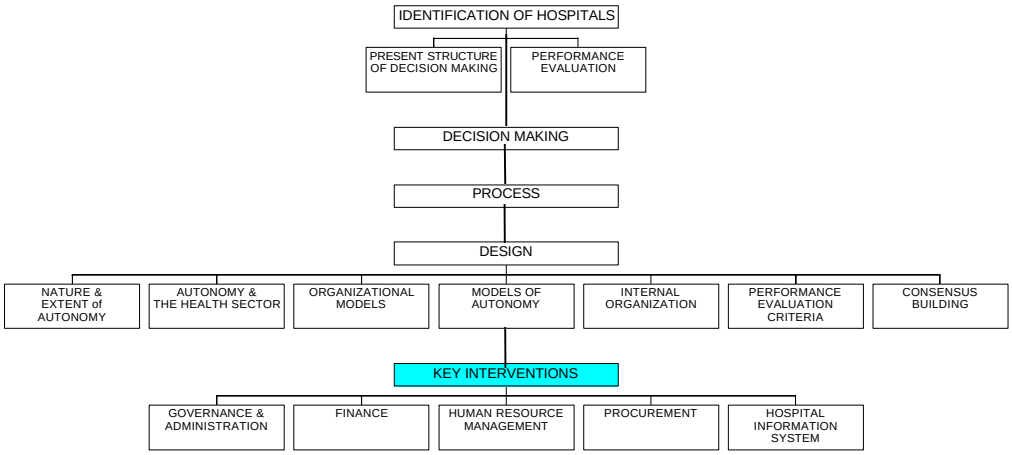
Within any government or hospital, there are several distinct power centers - each of whom is likely to play a role in the evolution of hospital autonomy, and the impact of this autonomy on efficiency, equity, revenue mobilization, public accountability, and patient satisfaction. At the same time, there 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.

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.

End-of-Section Checklist

- √ Final list of target hospitals, prioritized according to some well defined criteria.
- √ Preliminary decision regarding autonomy taken.
- √ A clear enunciation of the government's objectives for implementing autonomy, and the expected effect of autonomy on the health sector from a financial and an administrative perspective.
- √ An understanding of all the processes available to utilize support from favoring individuals and organizations, and manage opposition from those not in favor of autonomy.
- √ Decision taken regarding the nature and extent of autonomy.
- √ Decision taken regarding the level of facility to which autonomy is to be given, such as primary, secondary, tertiary.
- √ Decision taken for creation of a parastatal organization and giving that organization autonomy, or giving autonomy to individual hospital.
- √ Necessary changes made in the internal organization of the selected hospital.
- √ Performance evaluation criteria are established.
- √ Appropriate steps taken toward consensus building.

Figure 1.6
Hospital Autonomy: Implementation Guidelines
Key Interventions



7. Key Areas

Autonomy may lead to a number of changes in the internal organization of the hospital, both because an autonomous organization would need to have better or different systems, and because autonomy has only now permitted the hospital to implement desired improvements. The areas most likely to require change are:

- Governing Authority and Administration
- Finance
- Human Resources
- Procurement
- Hospital Information Systems

We will discuss each in turn.

Governance and Administration

Perhaps one of the first areas that will be affected by the decision to grant greater autonomy is governance and administration, for it is difficult to implement any form of autonomy without affecting changes in the basic patterns and systems of decision making. Of the many aspects of governance and administration, we discuss issues relating to the organizational mission and governing body in greater detail.

Mission

The **mission** of the hospital, like that of any organization, should identify and describe the purpose of the hospital and the relationship of the hospital to the society that it seeks to serve. The mission should be shaped by the hospital's capabilities, future potential, its role assigned by the government or by itself, and the demands and requirements of the community. Schulz and Johnson (1990) suggest that a sound formulation of the mission should be based on considerations of:

- what services is the hospital providing?
- what is the main purpose and objective for the hospital to be in this activity?
- what tasks must be carried out to meet community needs?

A mission statement of a public hospital would typically include:

- The treatment of illness and the conservation of life.
- Ensuring courtesy and patient dignity.
- The education of physicians, nurses and other medical staff.
- The training of all medical staff in empathy and caring.
- The promotion of medical research.
- The promotion of preventive health care.
- The promotion of consumer awareness and knowledge of health issues.

The Governing Board

The **governing board** of a public hospital is appointed by, and is accountable to, the government, and must exercise authority to ensure that the hospital

carries out the mission of the government. The main **functions** of the board are:

- Control and maintain organizational effectiveness
- Ensure that hospital objectives and policies meet community needs.
- Establish a long-range plan for the hospital.
- Approve the annual budget, and ensure strict control over income and expenses.
- Monitor performance against plan and budget.
- Manage conflict and resolve major operational problems.
- Have ultimate legal responsibility to patients for quality of care.
- The **procedures** followed by the governing board should be in compliance with the bylaws and the standing orders, and should include:
  - Convening meetings and setting agendas.
  - Determining in advance the kinds of items that need to be presented for discussion.
  - Using appropriate strategies for routine, creative and negotiated decisions.

Boards are commonly organized along **functional** lines, though in some cases a divisional classification may be more useful. Functional boards, especially in large hospitals, delegate some of their duties to committees established for particular purposes. These committees usually have no executive authority, but make recommendations to the board. There can be many such committees, and typically they include:

- executive committee, which approves all major purchases, appoints auditors, appoints medical staff, and transacts urgent business between board meetings.
- finance committee, which reviews the budget and maintains control over expenses.
- planning committee, which reviews long range and strategic plans.
- buildings committee, which supervises maintenance and repair to hospital property.
- personnel committee, which rules on personnel matters.

Boards organized along **divisional** lines are suitable for large multi-institutional systems, where each component within the system is a distinct entity by itself. A typical example is a structure like that of a holding company, where a large number of hospitals are placed under one parastatal organization. The divisional model applies to such cases, where the holding company has a board and each of the constituent hospitals has its own board.

There is no obvious rule regarding the **optimal size** of the board. A very small board (2-3 members) has the benefit of coming to quick decisions, but it lacks the knowledge and expertise of a diverse group of individuals. On the other hand, a very large board (20 and more) can become cumbersome and difficult to manage. A 7-15 member team appears to be a good representation of the community without overburdening members. A 9 or 15 member board has the added advantage in that it provides for one third of its members to retire each year, thus ensuring that at any given point in time there are some old members providing continuity and some new members adding a fresh perspective to decision-making. In any case, there is a distinct advantage in having an odd number of members in the group to facilitate voting and avoiding stalemates.

There are no hard and fast rules regarding membership criteria, though it is generally agreed that the **members** of the Board

- should represent diverse interests and professional background
- have sufficient time for attending board meetings
- have sufficient time to sit on committees
- have sufficient time to visit the hospital periodically

One possible constitution of the board would include the following members:

- representatives of the community
- representative of the Ministry of Health
- representative of the Ministry of Finance
- representative of the Ministry of Planning
- representative of the private sector (e.g., the CEO of a private hospital)
- representative of a nongovernment organization
- representative of the medical school
- an expert in financial management, accounting, and evaluation

- an expert in health economics
- an expert in community medicine and public health

The board should be **accountable** to the community, patients, regulatory agencies, sponsoring agencies, and those who provide funds. A system of accountability would have:

- a clear statement of goals and objectives
- clear priorities
- a transparent system of resource allocation
- periodic assessment and evaluation of cost and benefits
- periodic performance evaluation based on established and approved indicators
- wide public dissemination of findings evaluation

The **Chief Executive Officer** (CEO, or alternatively, the administrator) could be the chairman of the Board, a voting member of the board, or an employee of the owners and not a member of he board. While there are some merits in all of these arrangements, it is probably in the best interest of the hospital if the CEO is at least a voting member of the board. The CEO is required to coordinate and communicate with the board committees and maintain a trusting and enduring relationship with board members. The CEO is the operational head of the hospital, and is responsible for developing strategic plans, creating a work-culture in the organization, negotiating and resolving conflicts, managing day-to-day administration, communicating with government authorities and financial agencies, and generally carrying out the mission of the organization. A CEO who is also a member of the board will probably have sufficient access to decision-making and thus will carry out these tasks more effectively as compared to a CEO who is not a board member.

Finance

Another area where autonomy is likely to bring about significant changes is the **financial management** of the hospital. Autonomy is likely to lead to a change in government financial allocations from line budgetary allocations to block grants. In addition, there may be increasing opportunities for the hospital to raise their own resources, through user charges, institutional finance, donations, etc. At the same time, changes in the procurement and personnel processes may put additional demands on the financial managers

in the hospital. And finally, reporting and auditing requirements may also be challenging tasks in an autonomous hospital. Thus, changes in financial management may become necessary because of:

- change in the budgetary process of allocation
- nongovernment sources of revenue
- changes in procurement, maintenance and inventory control policies
- changes in personnel policies
- changes in audit and reporting requirements

Non-autonomous public hospitals typically have very small finance departments, since the hospital itself manages very little of its finances. The needs of autonomy will thus require the management to build up this department almost from scratch, and this can be a very challenging task. The areas that will need particular attention are **accounting, auditing, budgeting, financial planning** and **financial reporting**.

Human Resources Management

Another significant addition that autonomy is likely to bring to the hospital's functions is **human resources management**, which is a highly specialized function in the modern hospital. The principal objective of human resources management is to create an environment and mechanisms that enable the hospital management to integrate organizational and employee needs. In a large and complex organization like a hospital this tends to be a very significant and specialized function.

The human resources department will be required to perform many activities, of which probably the most basic and important will be the **transition of erstwhile state employees** to the newly created autonomous hospital. The autonomous hospital may thus be required to transfer all **personnel records** from the controlling offices in the government to the hospital, which by itself will be a huge task. Besides the space requirements that this will entail, the hospital will need qualified and trained staff to manage these records. **Fixing compensation** for hospital employees may also be within the powers of the autonomous organization.

Another significant new activity will be procurement of employees. The responsibility of human resource management will range from preparing and **evaluating job descriptions** to **hiring of employees**. The human resources department should thus be proficient in developing labor market information, developing and validating selection instruments, screening potential candidates, and hiring the required number of suitable employees.

The human resource department should also introduce procedures for **evaluation of employee performance**, which will entail the preparation of evaluation instruments, introducing a system of recognition and rewards, transfers, salary increases, dismissals and resignations.

Training and development is an important activity that the human resource department coordinates. This requires interaction with departmental heads to assess their requirements and future needs regarding employee skills.

Public hospitals are likely to be unionized, and the transition to autonomy may leave some members of the staff dissatisfied enough to be potentially troublesome for the hospital. Skills in **negotiation and labor relations** are thus likely to be of critical importance.

Procurement

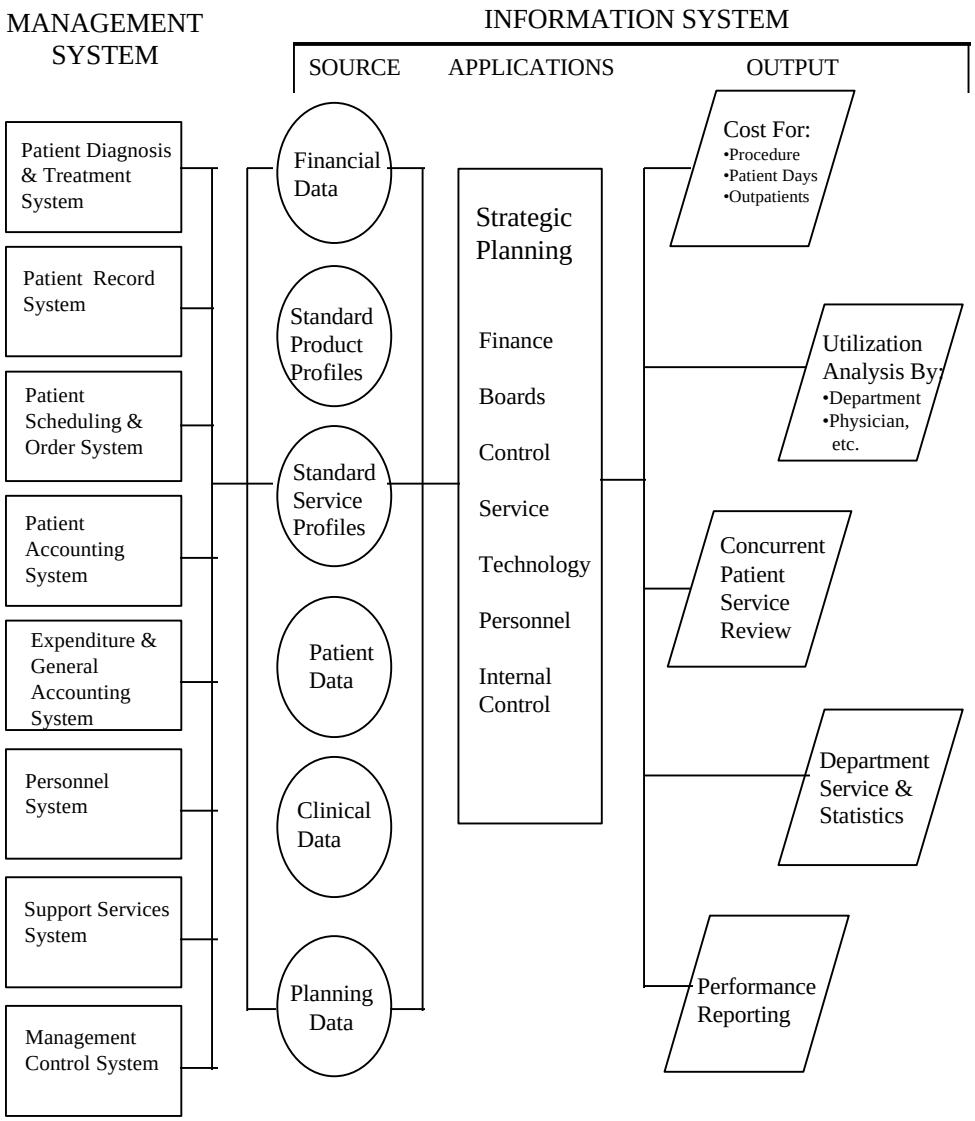
Another activity that may be transferred to the hospital is **procurement** of medical and nonmedical supplies, including drugs. Non-autonomous public hospitals seldom purchase their own requirements of consumables, and thus usually do not have separate procurement departments or procedures. An autonomous hospital may thus be required to create a new procurement department, whose primary objectives would be to purchase or otherwise acquire equipment and materials of quantity and quality consistent with departmental requirements and good patient care. Centralized purchasing within the hospital has the advantages of bulk quantity purchasing, standardization of items, controlled accounting procedures, controlled inventory management procedures, controlled accounting and audit procedures, and strong supervision. Decentralized purchasing within the departments in the hospital has the advantage that specialized departments can procure supplies in accordance to their specialized needs.

Hospital Information Systems

A commonly used term to describe the total data collection and analysis in an organization is **management information systems**. Gillette et al (1970) suggest that a complex organization like a hospital is composed of at least eight subsystems (figure 4):

- Patient diagnosis and treatment system, which includes information derived from various hospital departments such as pathology, diagnostic radiology, pharmacy, rehabilitation, etc.
- Patient record system, which includes medical records, admissions, discharges, insurance details, etc.

Figure 4
Hospital Information System



- Patient scheduling and order system, which includes patient care and support services, such as food, housekeeping, etc.
- Patient accounting system, which includes all financial accounting related to patients, credit and collections, subsidies, etc.

- Expenditure and general accounting system, which includes budgeting, payroll, materials, plant systems, etc.
- Personnel system, which includes information on all employees and positions in the facility.
- Support services system, which includes information on departments such as engineering, vehicles, plant management, etc.
- Management control system, which includes organizational information, inter-group dynamics, internal controls, communication, etc.

Hospital information systems are expected to fulfill the following important goals:

- provide key users with access to timely and comprehensive information about health services delivery, costs and performance;
- provide necessary information for strategic planning;
- provide necessary information to facilitate monitoring and reporting;
- provide concurrent indicators of occupancy, length of stay, repairs, maintenance, etc.

The success of hospital information systems depends on a variety of factors, not the least important of which is how easy it is to use the system. Hospital information systems are in a constant stage of evolution, and interested users are encouraged to seek out the latest developments in this regard.

End-of-Section Checklist

√ Final list of target hospitals, prioritized according some well defined criteria.

√ Preliminary decision regarding autonomy taken.

√ A clear enunciation of the government's objectives for implementing autonomy, and the expected effect of autonomy on the health sector from a financial and an administrative perspective.

√ An understanding of all the processes available to utilize support from favoring individuals and organizations, and manage opposition from those not in favor of autonomy.

√ Decision taken regarding the nature and extent of autonomy, level of facility, organizational model, and performance evaluation criteria.

- √ Mission statement for the hospital or the organization is prepared.
- √ The governing board is appointed, and its duties and responsibilities clearly spelt out.
- √ A new finance department is established, or the existing one strengthened, to perform the functions of accounting, auditing, budgeting, financial management, etc.
- √ A new human resources department is established, or the existing one strengthened, to perform the new functions of hiring, evaluation, personnel records, etc.
- √ A new procurement department is established, or the existing one strengthened to perform the new medical and nonmedical supplies procurement functions.
- √ A new hospital information system is established, or the existing one strengthened, to perform the functions of strategic planning, monitoring and reporting.

8. End Note

These guidelines discuss some broad issues of implementation of hospital autonomy. Needless to say, there will be many differences between country situations, and between hospitals within a country. Guidelines such as these cannot hope to identify in advance all the various issues, and that is not the intention. The objective is to highlight some of the key issues and to provide a relevant framework that can be easily adapted and built upon to take into account country and facility specific situations. Within this caveat, we hope that these guidelines will be useful for policy makers and hospital administrators considering hospital autonomy as a means to improving performance.

References

Alexander, Jeffrey and Bonnie L. Lewis. (1984): *"The Financial Characteristics of Hospitals Under for Profit and Nonprofit Contract Management",* Inquiry, Vol. 2, pp. 230-242.

Austin J.E. (1984): *"Autonomy Revisited,"* Public Enterprise, Vol. 5, No. 3, pp. 247-53.

Barnum H. and J. Kutzin (1992): *"Public Hospitals in Developing Countries: Resource Use, Cost, and Financing",* Population and Human Resources Division, The World Bank.

Bowen, H. R. (1973): *"Holding Colleges Accountable",* Chronicle Higher Education, March 12, 1973.

Chawla M. and P. Berman (1995): *"Improving Hospital Performance Through Policies to Increase Hospital Autonomy,"* Data for Decision Making Project, Harvard University, Boston, MA.

Chawla, M. and A. George (1996). *"Hospital Autonomy in India: The Case of APVVP".* Data for Decision Making Project, Harvard University, Boston, MA.

Chawla M., R. Govindaraj, J. Needleman, and P. Berman (1996): *"Evaluating Hospital Autonomy: Methodological Guidelines",* Data for Decision Making Project, Harvard University, Boston, MA.

Collins, D., G. Njeru and J. Meme (1996). *"Hospital Autonomy in Kenya: The Case of Kenyatta National Hospital".* Data for Decision Making Project, Harvard University, Boston, MA.

Culyer, A.J. and Andrew Meads (1992): *"The United Kingdom: Effective, Efficient, Equitable?",* Journal of Health Politics, Policy and Law, Vol. 17, No. 4, pp. 667-687.

Gillette P.J., Rathbun P.W., and H.B.Wolfe (1970): *"Hospital Information Systems",* Hospitals 44:45.

Govindaraj, R., A.A.D. Obuobi, N.K.A. Enyimayew, P. Antwi, and S. Ofosu-Amaah (1996): *"Hospital Autonomy in Ghana: The Case of Two Teaching Hospitals".* Data for Decision Making Project, Harvard University, Boston, MA.

Hildebrand, Stan and William Newbrander (1993): *"Policy Options for Financing Health Services in Pakistan vol III: Hospital Autonomy",* Health Financing and Sustainability Project, Abt Associates/Management Sciences for Health/USAID.

Jones, Leroy P. (1991): *"Performance Evaluation of State Owned Enterprises" in Ramamurti and Vernon (ed): "Privatization and Control of State Owned Enterprises",* EDI Development Studies, The World Bank, 1991.

McPake (1996): *"Public Autonomous Hospitals in Sub-Saharan Africa: Trends and Issues",* Health Policy: 35 (2), pp. 155-177.

Mills, Anne, J. Patrick Vaughan and Duane Smith and Iraj Tabibzadeh (1990): *"Health System Decentralization",* World Health Organization, Geneva.

Needleman, J. and M. Chawla (1996): *"Hospital Autonomy in Zimbabwe",* Data for Decision Making Project, Harvard University, Boston, MA.

Newbrander, W., H. Barnum, and J. Kutzin (1992): *"Hospital Economics and Financing in Developing Countries",* World Health Organization, Geneva.

Ramamurti, Ravi (1991): *"Controlling State Owned Enterprises"* in Ramamurti and Vernon (ed): *"Privatization and Control of State Owned Enterprises",* EDI Development Studies, The World Bank, 1991.

Reich, Michael R. (1994): *"Political Mapping of Health Policy",* Data for Decision Making Project , Harvard University.

Rondinelli, D.A., John Nellis and G.S. Cheema (1984): *"Decentralization in Developing Countries",* The World Bank, Washington, D.C.

Ross, Randy L. (1988): *"Government and the Private Sector",* Crane Russak and Company, N.Y.

Schulz R. and A. C. Johnson (1990): *"Management of Hospitals and Health Services",* The C. V. Mosby Company, St. Louis.

Shirley, Mary (1991): *"Evaluating Performance of State Owned Enterprises in Pakistan"* in Ramamurti and Vernon (ed): *"Privatization and Control of State Owned Enterprises",* EDI Development Studies, The World Bank, 1991.

Wheeler, J.R.C. and H.S. Zuckerman and J. Aderholdt (1982): *"How Management Contracts Can Affect Hospital Finances",* Inquiry, Vol. 19, pp. 160-166.

Willam, James A. (1990): *"Hospital Management",* Macmillan, New York.

World Bank (1993): *"World Development Review: Investing in Health",* Washington, D.C. Oxford University Press.