

TECHNICAL NOTE NO. CAR/KYR-1/НАУЧНЫЙ ДОКЛАД CAR/KYR-1

Recommendations:
Strategy for Health Facility Autonomy/
Рекомендации:
Стратегия перехода к автономии лечебно-
профилактического учреждения

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RECOMMENDATIONS: STRATEGY FOR ACHIEVING HEALTH FACILITY AUTONOMY

CLARIFICATION OF "AUTONOMY"

An *autonomous* hospital or polyclinic is an organization owned by the government that has the ability to act under its own authority to achieve its primary mission of benefiting the public. Although established by the state, an autonomous facility has some of the characteristics common to private organizations that allow it to operate more efficiently. The central characteristic is *management autonomy*, which decentralizes the control of the functions of the facility to allow greater efficiency of operations. By controlling finance, personnel, and operations locally, facility managers can react faster to changes in its environment, and make decisions that are most advantageous to the facility and its patients.

Perhaps the most important reason for hospitals and polyclinics to seek development of autonomous management systems is the improved ability of facilities to collect revenues through insurance payments and user fees if given the incentive of maintaining control over these resources. Because the present financial crisis has affected severely the ability of facilities to provide adequate levels of patient care, the efficient use of available funds and the collection of adequate revenues is of utmost importance.

Parameters of Autonomy

Autonomy refers to a status where state-owned hospitals and clinics are granted some degree of in-house control over key functions of the facility. These areas include: *governance*, the process of setting overall policies, goals, and objectives; *management*, the day-to-day direction of operations; *financial management*, control of the generation of revenues and the use of funds; and *personnel management*, the selection and use of the facility's staff.

The degree of autonomy granted may vary greatly. In the case of financial autonomy, it may range from budgeting the use of operating funds provided by the state in a facility with limited autonomy, to the total control over the collection, distribution, and use of funds from some form of insurance payments or patient fees. Experience has indicated that the level of autonomy necessary to achieve greater efficiencies is variable, but that certain elements are essential. These necessary elements are:

- Governance, where high-level decisions on policy, goals, and objectives decisions are made by a board of directors composed of representatives of the facility physicians and staff, government, and the local population.
- Management, where authority and responsibility for the day-to-day operations of the facility are given to the head doctor, and delegated to the appropriate management staff members.

- Financial management, where the facility is empowered to collect revenues from outside sources (user fees, insurance, government subsidies, etc.), *keep these funds under direct facility control*, and use them in a manner determined by the board and management staff.
- Personnel management, where the board of directors and the management staff are able to determine the number and type of personnel required by the facility, choose individual employees, and implement an incentives and monitoring mechanism for promoting high-quality employee performance.

Changing Roles in a Decentralized System

In a decentralized system, autonomous facilities are under the *supervision* of the central government authority (ministry of health) rather than under *direct operational control*. The distinction between direct control and supervision is important. While direct control emphasizes the day-to-day direction of facility operations, supervision means the general monitoring of overall activities, the approval of the general operating procedures used by the institution, and assuring that the hospital or clinic fulfills its role in the overall health system.

In a health system composed of autonomous facilities, the roles and responsibilities of facility staff, board of directors, and ministry of health differ significantly from the traditional centralized system. A common misunderstanding is that the ministry of health will have less power or authority because of the delegation of operational control to a local level. It is not the level of responsibility that is different, but rather the functional role and the stratification of responsibility for each party that must evolve.

Facility Staff

The staff (under the direction of the head doctor) are responsible for the day-to-day operations of the facility. They are charged with delivering the highest possible level of patient care, and with assuring that the hospital or polyclinic functions in a smooth and efficient manner. In addition, the staff is responsible for developing draft policies and procedures and submitting them to the board of directors for approval.

Board of Directors

The board of directors is responsible for representing the interests of the patients and of the community as a whole. The board must review each of the facility's policies, procedures, and budgets to assure that the needs of the community are met, and that the long-term needs of the facility are included in any decisions. The board's role is not to become involved in the day-to-day operation of the facility, but to monitor overall performance.

Ministry of Health

Like the board of directors, the ministry of health should not be involved in the day to day operations of the facility. The responsibility of the ministry is to manage and protect the health care system of the nation as a whole. The ministry of health, oversees the provision of health services throughout the country. The ministry must review the overall performance, plans, and policies of the individual facilities to assure that they will fill their specific roles in the overall health care system, and that no gaps exist in services for the entire population.

Benefits of Autonomy

The benefits of autonomy are substantial: the hospital or polyclinic is able to use its funds in the manner most conducive to efficient operations according to locally determined priorities. However, individual facilities must assume responsibility for the generation and use of funds.

With the ability to control finances comes the responsibility of financial risk. The facility will need to reexamine its practices to save money and use resources efficiently. If cost control measures are not instituted, financial resources could decrease under autonomy rather than increase.

The retention of revenues by the facility is one of the most significant changes under the autonomous facility system. As the ability of the central and oblast governments to pay for health care continues to decline, hospitals and polyclinics will have to pay for operations through the collection of insurance payments and user fees. With autonomy, the incentives for the facility to collect fees will be very strong. Rather than depending on the central authority to pay for repairs or buy new equipment, the facility itself will determine priorities, and use funds accordingly.

ACTION PLAN FOR THE DEVELOPMENT OF AUTONOMOUS FACILITIES

General Considerations

In the Issyk-kul Oblast, the question of autonomy is largely a factor of changing the role of the *Oblazdrav*. The relative autonomy of the hospitals appears to be fairly advanced, with much of the management and personnel management functions already controlled by the hospital directors. Particularly at the Oblast Hospital, most of these functions are reported to be locally controlled.

However, these hospitals need more local control of their finance. At present, all funding is given to facilities in strict budget chapters. These chapters specify the amount of revenue that can be used in each category--for example, the amount available for drugs, personnel, equipment purchase, or utilities.

As a minimum, facility autonomy must include financial autonomy in the form of global budgeting, where the facility would control the allocation of funds to specific expenses.

A significant change in the structure and operation of the Oblazdrav will be required to implement of the mandatory health insurance (MHI) program, develop the health facility accreditation system, and formalize hospital and polyclinic autonomy.

As outlined in the previous section describing the changing roles in a decentralized system, the function of the Oblazdrav should be to assure the functioning of the health system as a whole. The Oblazdrav should be removed from any activities in the operation of the individual health facilities. The duty of the Oblazdrav is to assure that the population of Issyk-kul Oblast is covered by health care services at the appropriate level. This function ties into the accreditation of health facilities. As envisioned by the Bishkek outline of accreditation and the MHI, health facilities will be rated into categories according to size and treatment capabilities. The Bishkek outline recommends that the Oblazdrav be responsible for determining the category of the individual facilities under the accreditation system (see *Recommendations: Strategy for Health Facility Accreditation*). This categorization of facilities will assure that the population is served by the appropriate level of facility based on public health and epidemiological factors, and that the facilities will concentrate on achieving improved quality of services given their mission of the facility and its place in the health care system.

Plan of Action

With the above considerations in mind, the following steps are recommended to achieve facility autonomy.

1. Define the mission of the facility.

This is a two-step process. Part of the Oblazdrav role in facility accreditation should be to determine the need for type and size of health care facility for each area based on epidemiological considerations and catchment area size.¹ Once the facility category is determined by this method, the facility itself should develop a *mission statement* based on its role in the total health care system.²

2. Formulate the means of governance.

Autonomous facilities should be controlled by a *board of directors*. This board is responsible for the overall control of the facility (delegated to the head doctor), its financial soundness, and its guiding policies. These boards should be composed of members of the medical staff of the facility, representatives of the population in the facility's catchment area (such as business leaders or the heads of enterprises employing people served by the facility), and a member of the local government. The

¹ Technical assistance should be provided to the Oblazdrav to conduct a study on requirements for hospital beds and outpatient capacities as part of the accreditation effort and as part of the oblast plan to reduce hospital bed capacity by thirty percent. This study should be based on epidemiological factors, facility catchment area, and on stricter admissions policies necessitated by the fiscal crisis.

² A complete explanation of the facility mission statement as well as a methodology for its development is contained in the management and policy training program delivered in Karakol in December 1994.

head doctor would serve in an ex-officio capacity (providing input to board deliberations, but having no vote). Size of the board of directors would vary according to the size of the facility, with as few as three members for a rural ambulatory center, and as many as ten for the Oblast Hospital.

3. Establish financing rules.

An approach to facility financing must be determined. This plan should include, at a minimum, the granting of global budgets to the facilities with funds not tied to specific chapters. In the case of the MHI, rules are needed for the payment of insurance claims. The board of directors will have to develop and adopt internal policies for the financial management of the individual facilities.

4. Formulate management powers.

The head doctor (delegated to appropriate management staff) must be able to raise and deploy resources to meet the mission of the facility with the guidance of the board of directors. This step includes the development of policies to guide the day-to-day management of facility operations.

5. Decide how current personnel will make the transition from government servants to facility employees.

An essential component of facility autonomy is the ability of the head doctor to hire, promote, and fire facility staff. Guidelines for the change in employment status from oblast employee to hospital or polyclinic employee are needed. The board of directors will have to develop and adopt employment policies, and number and composition of facility staff.

6. Train the Oblazdrav staff, facility management staff, and board members in their new roles.

The move to autonomy will mean new methods of operation and job functions for these key parties. Technical assistance and training will be required during start-up phases.

7. Develop new management functions needed under autonomy-- financial and personnel management, planning, and marketing.

Autonomous operation, particularly under the MHI, will mean the creation of new job functions for Oblazdrav. Not only will finances be handled in a different manner, but increased competition and patient choice of providers will require attention to marketing and patient satisfaction.

8. Develop a plan for the implementation of the change in status to autonomy.

A plan for the phased implementation of autonomous facility status, including monitoring and evaluation, will need to be finalized and approved. A suggested approach would be to grant autonomy first to the oblast and city hospital/polyclinic, then to rayon hospitals, and finally to district hospitals and rural ambulatory centers.