EDITORIAL

AUTONOMY OF HEALTH INSTITUTIONS — WHERE DO WE STAND?

Autonomy laws had raised the hopes of those who wanted to see a positive change in the landscape of healthcare provision but the fact is that those dreams have not been translated in to reality. There are problems at three levels i.e. problems with the legislation, problems at the institution level and problems at the stake holders level.

Problems with legislation

The perception of the government is that autonomy would make health institutions self-sustainable. This would allow phased reduction in Grant-in-aid by 20% per year. This reduction in financial load would ultimately help the government to invest in hospitals at rural and district levels. However, the concept of autonomy is not uniformly understood by various stake holders and consequently it has not borne fruit yet. To some it was total independence while for others it was the same old story with difference in mere nomenclature.

Health care providers (Doctors, Nurses, Paramedics and class IV) and consumers (patients) saw it as a step towards privatization. They were probably not wrong. Forcing the doctors to get into Institution Based Private Practice was seen as forced labour and victimization of clinical staff. Promulgation of Khyber Medical University act further enforced this idea. This time it was not only considered to be a financial threat but also a threat to career, mainly targeting teachers of basic sciences. Consumers also got worried when they saw user charges being levied. This was negatively projected by various segments of the society including electronic and print media. God knows whether it was out of love for poor masses or for cheap popularity but it did not help.

Lack of clarity about the type and extent of the autonomy (no common understanding at all levels) has led to disappointment of those who sincerely expected a change. Even people at the very centre seem to be confused in drafting autonomy laws. Autonomy laws (Table 1) are faulty, which is why the government has had to revisit them repeatedly since 1999.

Table 1. Autonomy Laws

- Medical and health institutions reforms Act 1999
- Medical Institutions Rules 2001
- Medical and Health Institutions and Regulation of Health Care Services Ordinance 2002
- Medical and Health Institutions and Regulation of Health Care Services Amendment Act 2006

The implementation of autonomy was also faulty. Financial autonomy should have been given first. This would have given the government a chance to evaluate the capacity of these institutions to raise the expected amount of funds before giving administrative autonomy. Giving partial/half hearted autonomy, both administrative and financial, with old fragile infrastructure is another cause of failure.

Problems at the institution level

There are financial and administrative problems with the current autonomy at the institution level. These can be broadly divided into general and specific problems. General problems are at six levels (Table 2).

Table 2. General problems at the institution level

Problems at six main areas

Strategic management

- The Chief Executive/Management council/ Health department/Regulatory authority/PMDC

Procurement

- Poor accountancy
- Absence of procurement plan
- Absence of stock control system
- Absence of business plan
- Purchase committee/Inspection committee/ Audit (external/Internal)

Financial management

- User charges/Donations/fund raising campaign/ government grant

Human resource management

- Needs of the institution and society
- Inherited problems: Staff prior to an after promulgation of autonomy Act

Administration

- Mainly through transfer of health employees from the health department — the biggest source of failure of the system

Clinical governance

Culture to live within available resources i.e Performance standards

Specific problems in the institution are at the level of financial, administrative and recruitment autonomy. Financial autonomy should not be seen as 'Power to spend'. It should involve increased saving through revenue generation and reduction in expenditure to make these institution cost effective for the consumers. Further financial autonomy should not only deal with monetary policy but should also involve intelligent use of Human Resources (the real wealth of the institution). Most of the teaching health institutions are affiliated to medical schools. All these institutions have teaching staff in the Departments of Pathology, Pharmacology and Biochemistry. Their expertise can be used to improve hospital laboratory and pharmacy without any extra expenditure. In fact it would allow these hospitals to repatriate pharmacists and laboratory consultants to Health Directorate with consequent savings in expenditure on salary and privileges. This would also allow Health Directorate to appoint these repatriated experts at District level – a step towards upgradation of District General Hospitals (a win-win situation for all).Problems with financial autonomy are summarized in Table 3.

Table 3: Problems of financial autonomy

- Regulation and working procedures
- Poor Accountancy (OPD, user charges etc)
- Partial managerial freedom
- Limited revenue generation
- Subsidized treatment to poor patients
- Appointments and transfers
- Prior approval of the government to levy user charges
- Institution not authorized to retain the revenue generated
- Entitlement to free medical services with no limits defined
- Grant-in-aid given but not tailored to the needs of the institution and without considering inflation factor

Problems at the administrative level involve partial managerial freedom. Every decision at local level still goes through the same bureaucratic channels. Power is concentrated in a person where as, given the complexities, autonomous health institutions need collective wisdom which can be provided by a strong body i.e. Board of Directors. These problems are serious and root cause of the failure of the proposed system.

Recruitment has become a nightmare. The precarious system at these institutions has to keep in mind rules laid down by PM&DC, Provincial Civil Servants Rules and Federal Rules. In the mix of it all, the future needs of these institutions either get ignored or diluted, resulting in a poor mix of professionals with no future direction. Such recruitments help in the short term but fail to deliver in the long run. Problems in recruitment autonomy are given at Table 4.

Table 4: Problems of Recruitment autonomy

- As per Government/PMDC rules without due consideration of the future needs of the Autonomous Institutions
- Government interference

  Appointments/transfers
- Maldistribution of Human resource and poor cadre mix

Two major areas, the administrative machinery and the management council, need to be reformed on emergency basis.

- Problems at the institution level (a few of them have been mentioned above) can be overcome by considerate and prudent approach by the administration without requiring extra funds. The most important factor in the failure of the Autonomous Health Institutions is administrative staff. Currently, these institutions get most of their administrative staff through a process of posting and transfer from Health Department. They lack intelligence, creativity, generosity of spirit, dedication, unity, and belief in collective power. In fact they come with their own agenda which is most of the time in conflict with the interest of the institution. This weakens the administrative capacity during this challenging time and contributes to failure in overcoming any obstacles that may come in the way.
- Autonomous Health Institutions need dedicated teams of administrators. To get such a team, either they should be employed on contract basis through advertisement or selected from concerned departments through deputation.
- The management council (MC) is mainly composed of people with little or no experience of running a health institution (a complicated enterprise). It is this immaturity plus shallow political agendas that most of our recruitments ended up in the courts in the past. Though things have changed with the current MC, it still needs to be supervised by a Board of Directors which

should have representatives from Health department, Finance and law departments so that its decisions do not always end up at the secretariat level.

Problems at the level of stakeholders

This most important aspect has been totally ignored in the current autonomy.

- Involvement of teaching staff in decision making is vital for any system to be successful. The most appropriate way of their involvement would be to make an electoral college with all the Professors as members. Policy making decision taken by the Board of Directors (e.g. criteria for recruitment or promotion) should be wetted by this Electoral College before it becomes a rule.
- Public in general and patients in particular see autonomy as privatization. Blanket free treatment for all is impossible even in very rich countries. A line has to be drawn as to how far free treatment can be provided so that the interest of both the institution and poor patients, deserving free treatment, is preserved.
- Entitlement to free medical treatment for government employees has been abused both by the employees and administrative staff of the institution. Entitlement to free treatment should be abolished; however, government employees should be entitled to reimbursement from their parent departments. This would close one door of corruption at the health institutions and give a chance to the government to check the health expenditure of a particular employee/ department.
- Institutions may be asked to allocate budget for poor patients annually or a specific number of poor patients/day be entertained free. To facilitate such a program, government might have to issue Social Welfare Cards/ Zakat Cards/ Benazir Health Cards to poor patients. Data from Benazir Income Support Program may be helpful in this regard.

The continuous failure of these institutions with consequent gradual deterioration in health care provision has been blamed on administrators/Chief executives of these institutions. The fact is that changing the reign of power from teaching staff to administrative cadre has hardly changed any thing. It is because it is not the person but the system which needs to be changed if we want to improve health care delivery and to do that, the following are suggested.

- Autonomy act should be amended to pave way for 'Board of Directors' with explicit constitutional powers and obligations.
- 'Management Council' should continue to run the day to day business of the institutions.
- Most of the problems at the institution level are due to administrative staff, posted from 'Health Directorate'. Autonomous Institutions should be allowed to hire competent consultants to modernize administrative machinery. In the interim, instead of posting and transfer of the administrative staff from the 'Health Directorate', such staff should be acquired on deputation from various departments e.g. Financial personell from Finance department or Auditor General Office.
- Recruitment of staff should be through Management Council according to Provincial Services Rules with heads of the unit/Department given major role in Selection/Recruitment process. Members of Recruitment/Selection committee from establishment/heads of the institutions should be given advisory/supervisory role.
- Teaching staff should not be marginalized. In fact they must be given their due share in policy making. One way would be to include all Professors as members of Electoral College. Any Rule adapted by Board of Directors should be wetted by this Electoral College before it is implemented.
- Entitlement to free treatment should be replaced by reimbursement from parent departments.
- Deserving poor patients with Social Welfare Cards/ Zakat Cards/Benazir Health Cards should be given free treatment but their number/day and the extent of free treatment should be predetermined.
- A high level committee should be asked to look into the problems of existing autonomy, develop proposals to smooth out existing problems, to make these institutions autonomous in the true sense so that they remain autonomous but do not become independent of government control.

This committee should work with a sense of urgency and complete its job within a given time frame.

Prof. Noor ul Iman

FRCPI, FRCP (Edin)