

AUTONOMY TO THE TEACHING HOSPITALS IN LIGHT OF MTI 2015 REFORM ACT; WAY FORWARD

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ABSTRACT

The objective behind any health reform should be better quality, efficiency and sustainability of health care. Reform of the system is needed to achieve this. One important aspect of the reform is greater autonomy to the major teaching hospitals, including selected district hospitals. There should be a major effort to agree what is the intention behind autonomy and exactly what is expected to be passed to the control of the major hospitals in terms of autonomy for management decisions, financial procedures and performance, planning and development, human resource management and clinical performance¹. The principle of decisions made at the lowest level practical should prevail. This means that autonomy and decentralization should also be passed down within hospitals to departmental levels². Needless to mention that success of any reform agenda to be implemented rests on the agreement and full backing of the majority of the stakeholders

PROLOGUE

After the promulgation of 2015 Reform ACT, a sense of insecurity is pervasive (in regard to autonomy and decentralization) and this is undermining the commitment. Reasons for apparent resistance to the new legislation could possibly be that;

- They may be ideologically opposed to the new legislation.
- They may have vested interests in the status quo.
- The legislation maybe obscure or ambiguous for at least some of them.
- There may not be the resources or capacity to implement new procedures.

- Implementation of the new legislation may be badly managed and create resentment.
- Regulations if badly framed may contain unexpected consequences or perverse incentives so there is reluctance to implement.
- People may be feeling insecure in regard to their tenure, their practice and insecure about how legislation is supposed to be understood.

Four Cs are urgently needed. These are;

- Commitment to the process from the highest levels;
- Confidence among the board of governors (BoG) members, managers and clinicians that they should be acting autonomously;
- Competence in regard to management skills among managers and senior clinicians; and
- Guiding compassion amongst all levels for the health and wellbeing of the people of the Province that moves beyond lip-service, self-protection and greed.

WHAT IS AUTONOMY OF HOSPITAL?

There is a widespread belief that autonomy means privatization and/or total independence from government oversight. However, autonomy is about maintaining these hospitals within the public system, but releasing them from the stifling bureaucracy and politicization that makes them ineffective. It is a form of decentralization that devolves powers to hospital boards of governors and senior staff to make effective and timely decisions which facilitate better quality medical services. Autonomy is not just about raising fees, although proper fee setting and collection is an important key

element. It is about allowing a hospital to develop its own vision, its own culture and its own strategies for achieving its objectives. Nor is autonomy about total independence. The difference is that they will be held to account for their overall performance rather than being controlled and micro-managed by the Departments of Health and Finance.

To ensure that autonomous hospitals work efficiently, pre-conditions need to be fulfilled which are Role delimitation; Performance Indicators; Reporting and; Clinical governance³. It is important to know the major domains where an institution needs autonomy in the sense of being able to make its own decisions to meet operational and development requirements. These are clinical, financial, human resources, planning, and administrative and management.

PREVIOUS AUTONOMY

The previous autonomy can best be described as "remote control autonomy". Although an autonomy ACT was passed in 1999 and again an Ordinance by the military administration in 2002, it is widely acknowledged that no real autonomy was allowed. Although apparently Management Councils (MC) consisting of institutional managers, government department's representatives and public representatives were formed to run the autonomous institutions but following were the inherent defects;

- a) Nomination of public representatives on the basis of political considerations,
- b) Lack of interest by the government departments members except in recruitment,
- c) Appointment of key officers i.e., Chief Executive (CE), Medical Superintendent (MS) by the government instead of the MC,
- d) Chief Executive being the chairman of MC instead of being answerable to MC would be seen to dictate it and be more responsive & loyal to the government rather than MC,
- e) Transferring in and out of the 2nd line of managers (DMS's) by the government without the knowledge or consent of the MC,
- f) No clear cut demarcation of roles and responsibilities between CE and MS both seemed to be doing the same job one under the other,
- g) No devolution of powers and responsibilities down to the departmental level,
- h) Despite autonomy the government employees' pool continued to increase especially in the medical officers, paramedics and nursing cadre causing serious disciplinary, accountability and manage-

ment issues.

- i) Due to multiple responsibilities of the CE (equivalent of chairman BOG plus MD& HD of MTI ACT) and he being chairman of almost all important committees, i.e. recruitment committees, purchase committee, departmental audit committee etc., the one area he could and would find no time for was the 'Clinical Governance' and nor did the government made him accountable for this important aspect of health care delivery,
- j) Last but not the least was the perpetual interference by the government in almost all areas of hospitals management.

Despite the above mentioned limitations, the previous system of even limited autonomy was a major improvement on the pre-autonomy era. The following areas are positives of the autonomy ACT of 1999;

- a) Human resource management. More efficient & transparent recruitment of staff
- b) Relatively quick procurements, maintenance & repair of equipments & civil services
- c) More efficient & independent financial management
- d) Outsourcing of certain services like laundry, central air-conditioning, canteens, parking etc.
- e) Public-Private partnership in certain disciplines; i.e. CT scan services of LRH is a big success story.

REAL ISSUES AND SUGGESTIONS

A) SERVICE PROVISION TO POOR

There is either considerable delusion or high levels of hypocrisy amongst clinicians and policy makers about the service given to the poor.

A very common statement is that "most of our people are poor, they can't afford higher fees". In this context particular attention used to be paid to the 'registration fees' of 5 rupees paid for out patients attendances, as if increasing these to even 10 rupees would constitute an insufferable burden on the people.

1. The people, especially the poor, are facing much higher charges than are admitted to officially. As a simple example, the OPD charges the patient Rs. 10 but the chowkidars usually charge Rs. 10 or more to let family onto the wards and the orderlies charge variable amounts for wheeling down patients from one department to the other for investigations, surgery, physiotherapy etc. Patients have to pay for everything except the bed, consultation and few medicines.

2. The existing level of fees fails to give an adequate level of care i.e., the people are paying small fees for

virtually no care at all.

3. Free or subsidized care fails the very people it is supposed to help most: the poorest.

The BOG should work out more realistic fee levels. If they do so would the poor suffer? Or might they appreciate actually receiving a better quality service for their fees? Who really benefits from the current situation? The poor or the staff who can refer patients to private services? Is it the poor who really benefit from the current subsidized situation? It is obvious that if everyone in society receives free or heavily subsidized care then many who could afford to pay for some or all of their care will receive the benefits free and consume relatively scarce resources meant for the very poorest.

B) MEDICATIONS & DIAGNOSTICS

Two significant elements of the cost for the average patient and his family are medications and diagnostic tests.

Medications and drugs

- The whole pharmaceutical business in Pakistan, as in many developing countries, is characterized by over prescribing, poor quality drugs (including fakes and counterfeits), and fierce and unethical competition to encourage doctors to over-prescribe branded drugs.
- Hospitals are not running their own commercial pharmacies where patients could buy drugs of tested quality.
- Around every hospital is a bazaar of drug stalls which may or may not be staffed by a qualified pharmacist and may or may not sell genuine effective drugs.
- The patients have to buy the drugs and the medical needs outside of the hospital.
- Patients are encouraged to buy branded drugs, they need no prescription despite the law, and published prices are ignored. An illiterate uneducated person can be charged any price the seller demands.

Dealing with the pharmaceutical companies is not easy but certain steps could be taken:

- Every institution should have its own formulary. Only professors would be allowed to agree prescription of drugs not on the list, and their decisions would be monitored and/ challenged.
- Every hospital should have at least one pharmacy.
- The institution should receive a percentage of the

pharmacy's surplus and/or rent in the case of a contractor.

- The first 24 hours and in CCU, ICU and emergency cases the hospital should cover the costs and provide free drugs.

DIAGNOSTIC SERVICES

Diagnostic services, laboratory and imaging, are essential if a doctor is to be effective.

In our institutions a sizable percentage age of diagnostic testing is carried out in private facilities because doctors either did not trust the reliability of internal services or because the staff receives a payment from the provider or because the facility is not available. The whole situation needs for:

- Doctors to be given an incentive for using internal diagnostic services and to ban private deals with outside providers entirely and make it serious professional misconduct;
- Managers start thinking about basic quality control monitoring and reporting (possibly indicating a need for training)
- Institutions to be allowed to charge realistic costs for diagnostic services so that not only kits and reagents are available, but a budget for training, for regular maintenance, for repairs in a timely manner, and, ideally, for planned equipment replacement;
- Where considered necessary the institution should outsource a particular facility and enter in to a public-private partnership only in the public and institution interest.

C) HYGIENE OF HOSPITALS

The main causes of hospitalization are infectious diseases, and everywhere there is high prevalence of Hepatitis B & C, and increasing rates of HIV. Far from being a therapeutic environment, the hospitals are noisy, disorganized and a source of nosocomial infection, yet there seems to be no shortage of chowkidars, malis, sweepers, and other support staff. The unions tend to facilitate the culture of no work by frequent industrial actions for their petty demands. They probably had patrons who had promised them a pukki sarkari naukari but who had not explained to them the concept of working for their salary and eventual pension. Not to forget, the culture of too many attendants (partly linked to too few nurses and the failure of hospitals to provide food or laundry), and the non-segregation of outpatients.

Autonomous hospitals should enforce a work culture. It is recommended that;

- Improvement of the appearance and hygiene of hospitals should be done through contracting out/

outsourcing the cleaning services.

- The professionally skilled and competent managers be employed.
- No further regular appointments of cleaning staff be done and any prospective vacancies be filled by either the contract staff or a particular service be outsourced to private contractors.
- Re-design of hospital areas to segregate more public areas such as out-patients from sicker patients.
- Particular attention is needed to the proper disposal of clinical waste, preventing health hazards to the public, including preventing "re-cycling" (i.e. re-use) of medical disposable items, in an environmental friendly manner.

D) INFORMATION SYSTEMS

There is a total lack of useful information in our hospitals. There is little or no meaningful financial data. At all levels in the system a few clerks have control over the financial and information system. Even the annual reports are not widely available. Although computerization is valuable, what is needed more urgently is a new managerial culture whose life blood is information. This means introducing rational budget allocation and staff allocation, accountability for performance indicators, and so on, so that managers and senior clinicians will need the data and ensure it is available.

E) FINANCIAL SUSTAINABILITY OF THE AUTONOMOUS HOSPITALS

At present, the more patients hospitals see and the more they use their equipment the more their costs increase and the quicker the equipment become non-functional. A hospital faced with scarce resources has two basic strategies it may follow that include reducing unnecessary costs and overheads; and raising revenue.

There is little scope for the former because of the external pressures on hospital managers, although if they were being managed according to rational management principles much could be achieved. It is difficult to reduce inflationary utilities costs or to regulate medication and consumables costs with such high activity levels.

This leaves us with only one option to run the hospitals which is revenue raising, for which there are a number of ways as follows:

- Put up fees.
- Increase numbers, which will be achieved hopefully with introduction of institution based private practice (IBP) in the evenings.

- Raise money from the private practice of its medical and technical staff through a proper cost sharing exercise of IBP.
- Upgrade some wards and rooms to charge better off patients for hotel services, so-called VIP or amenity beds.
- The BoG need to ensure that fee levels are subsidized for the poor not the other way round.
- Allow hospitals to use their resources such as space and buildings, and even diagnostic facilities, to rent or sell to private concerns. For example, rent space to a pharmacy and land for developing shops. Open hotels or hostels for accompanying relatives, etc.
- Restructure fee levels to match costs and perhaps even cross subsidize the poor.
- Seek philanthropic support.

Hospitals must start preparing business plans and annual reports setting out the real financial situation, and performance levels.

F) CLINICAL GOVERNANCE

By far the most challenging area to improve upon is the patients care. The goal is to have the following;

- High standards of medical education and training of both undergraduate and postgraduate students and doctors.
- Well trained consultant staff.
- CPD/CME activities are up to the mark.
- All Autonomous hospitals should serve as tertiary hospitals.

However, there are a few problems which make these goals difficult to achieve. These are,

- The huge number of patients makes it difficult to deliver the medical and nursing service patients are expecting. An average of medical treatment is provided to patients on the wards and outpatients.
- There is no quality management system in all four hospitals.
- Most of the operations done are primary or secondary health care, only some subspecialty units perform tertiary level care.
- In most of the departments, there are no standard operating procedures or clinical pathways in use.
- Clinical audit non-existent.
- All hospitals are very short on nursing services. The service delivery by the nurses is poor, and the relatives have to provide nursing care and food almost

exclusively. That causes another problem of having so many people hanging around the hospital.

To resolve all these problems and achieve the goals for better clinical governance, the following actions are required,

- Clinical audit committees formed in each institution.
- Clinical guidelines/protocols for evidence based management of patients be prepared/adopted and the clinicians be made accountable for any deviation without reason.
- Standard operating procedures and clinical pathways be introduced in all departments.
- Minimum mandatory teaching/training programme be implanted in each unit to be supervised by the respective Dean.
- Multidisciplinary teams (MDT) be formed in each department.
- Development of culture of consultant led services.
- Large number of primary care patients flocking the teaching hospitals OPDs should be discouraged.
- Punctuality among medical staff should be observed through more contemporary methods rather than insulting biometric system.
- Medical Director primary responsibility should be to ensure gradual transition from the old to new system of service delivery for which he be accountable to BoG.
- A hospital pharmacy must be started where all the prescriptions of in patients and out patients are dispensed.
- In my experience only around 5% of the total LRH budget is spent on free medicine for poor patients whereas almost three times of this amount is spent on paying utility bills (Electricity, gas bills) where there is no control over the use of both these util-

ities. Priorities should be set right and to provide better services the budget allocated for drugs, disposable and appliances must be increased several fold.

- The quality of laboratory reports and diagnostics also need to be improved immediately both in terms of its content and presentation in order to boost the confidence of patients and clinicians.
- Nursing care is the back bone of quality patient care. A major effort should be made to improve the nurses living and working conditions.
- Nursing services must be strengthened by improving the quality, social status, numbers of nurses and promoting special nursing as COT/ICU/PICU and NICU.

SUMMARY

In a nut shell, the teaching hospitals in the light of MTI 2015 reform act will have decisive autonomy which will be used towards positive developments in the infrastructure, human resource development and service provision. There may be some lacunae in it but these can be resolved in due course of time. We need not to forget that the people, the staff and patients alike, deserve better service delivery than they experience at present, at the tertiary care hospitals and that change to the system is the real need of time and could bring quick and desirable results.

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