Policy Options for Financing Health Services in Pakistan

VOLUME III
HOSPITAL AUTONOMY

Submitted to:

U.S. AID Mission to Pakistan

and

Health Services Division
Office of Health
Bureau of Research and Development
Agency for International Development

Written by:

Stan Hildebrand
Abt Associates Inc.

William Newbrander, Ph.D.
Management Sciences for Health

September 1993

Health Financing and Sustainability (HFS) Project
Abt Associates Inc., Prime Contractor
4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 U.S.A.
Tel: (301) 913-0500 Fax: (301) 652-3916

Management Sciences for Health, Subcontractor
The Urban Institute, Subcontractor

AID Contract No. DPE-5974-Z-00-9026-00

POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN

A Compendium

Edited by: Marty Makinen

Volume I **Summary Report**
by Marty Makinen

Volume II **Hospital Quality Assurance Through Standards and Accreditation**
by Greg Becker

Volume III **Hospital Autonomy**
by Stan Hildebrand and William Newbrander

Volume IV **Development of Private Health Insurance Based on Managed-Care Principles**
by Zohair Ashir, Harris Berman, and Jon Kingsdale

Volume V **Organizing and Financing Rural Health Services**
by Richard Yoder, Sikandar Lalani, and Marty Makinen

Afzal Siddiqui provided the legal analysis for the study and the component initiatives (Volumes 1-5).

Zohair Ashir studied the use of Muslim religious funds for financing health services for the indigent (Volumes 1, 3, and 5).

ABSTRACT

This report is based on the assumption that concrete benefits would result from allowing hospitals currently owned and run by the Government of Pakistan to begin to operate as autonomous entities. These benefits would include reducing the amount of government funds needed to run these institutions by replacing much of the public subsidy with user fees. Autonomous hospitals would operate using private-sector management principles which are expected to improve efficiency in operations, contain costs, and raise the quality of health services. This would be done while still retaining the hospital's social mission of providing free care to those who are unable to pay.

This document presents principles in the areas of governance, management, and finance that would guide the running of an autonomous hospital. It recommends a phased approach to conversion starting with the Pakistan Institute of Medical Services and the Federal Government Services Hospital.

VOLUME III - HOSPITAL AUTONOMY

TABLE OF CONTENTS

LIST OF EXHIBITS

ACKNOWLEDGEMENTS

This report could not have been completed without the generous support of a large number of people. Special gratitude is due to Dr. Syed Mohsin Ali, the Director General of the Federal Ministry of Health during the key developmental stages of this study.

Following are those whose time and input made this study possible:

Pakistan Federal Ministry of Health
Ahmed Rashid Siddiqui, Secretary of Health, Federal Health Department
Ali Mohammad Ansari, Director General of Health
Allah Ditta
Amin Uddin
Dr. Bari, ARI Program, Rural Health Services
Dr. Najeeb
Dr. Shafiq, Planning and Development Division
Dr. Hashmi, Rural Health Services
Fahim Arshad Malik, Deputy Director General
Faris Rahman Khan, Joint Secretary of Health
Inam Kazmi, Acting Senior Chief/Health, Planning and Development Division
Jhang Sayydan
Khattak Fazuh Hakim, Health Sector Deputy Chief, Federal Ministry of Planning Mehboob Ali Kacho
Mohammed Azhar Khan, District Health Officer
Nadeem Ahmed
Pervaiz Tahir, Chief, Planning Division
Qazi Saboor, Assistant Federal Director of General Health
S. Iman Kazmi, Health Sector Chief, Federal Ministry of Planning and Development
Sultan Hameed, Administrator General of Zakat
Syed Tasneem Gnats Gardezi, Health Minister

Ministry of Labor and Manpower
Karam Elahi, Joint Secretary II

Ministry of Finance
Mr. Akbar Noman, Advisor, Ministry of Finance
Mr. Mahmood Ahmad Lodhi, Secretary

Aga Khan University Hospital and Aga Khan Health Services
Shamsh Kassim-Lakha, President, Aga Khan University Hospital
Levi N. Hilling, Director General, Aga Khan University Hospital
Nurallah A. Merchant, Director of Finance, Aga Khan University Hospital
Steve Rasmussen, General Manager, Aga Khan Health Services
Mohammed Gul, Field Program Manager, Aga Khan Health Services
Azia Currimbhoy, Chairman, Aga Khan Health Services
John Bryant, Chair, Department of Community Health Sciences, Aga Khan University

Nadeem M. Khan, Director of Professional Services, Aga Khan University Hospital

Agriculture Development Bank of Pakistan
Dr. Aibar Badsha, Senior Medical Officer

APPNA SEHAT
Dr. Amir Khan

Asian Development Bank
Toru Tatara, Program Officer
Wan Azmin Bin Ahmad, Health Specialist

Aurat Foundation
Mrs. Shahnaz

Ayub Medical Center
Dr. Azhar Mahmood, Medical Director

Bait-ul-Mal - Lahore
M. Raashid Randhawa, Chairman
Tajammul Hussain, Financial Advisor
S.M. Amjad, Chief Accountant

Baluchistan
Abdur-Rehman Khan, Director General of Health, Quetta

Baqai Medical Institutions
Dr. Farid Baqai, President, Private Hospital Association
Zia-Ur-Rahman, Manager

Businessmen Trust Hospital-Shalamar Hospital, Lahore
M. Afzaal Sheikh, Medical Superintendent
Sohail Manzoor, Deputy Medical Superintendent
Ch. Raisat Ali, Public Relations Officer

Capital Development Authority (CDA)
Dr. Mohsin Mubarak, Director of Health Services
Dr. Mansur

Central Zakat Administration
Mr. Sultan Hameed, General Administrator

Child Survival Project
Mushtaq Chaudhry
Ayyaz Gul Kiani
Theo Lippeveld, HMIS Advisor
Duane Smith, Chief of Party

Children's Hospital
Javed Chaudhry, Joint Executive Director
Harumichi Ito
S.A. Qazi

Federal Government Services Hospital (FGSH)
Dr. Amini-Uddin, Superintendent
Dr. Majid Rajput, Medical Superintendent, Islamabad

The Federation of Pakistan Chambers of Commerce and Industry
Mian Habib Ullah, President

Habib Bank
Anwar Saeed, Senior Vice President
Anwar Jameel, Director of Personnel

Islamabad Capital Territory (ICT)
Najeeb, ADHO
Nadeem Ahmed, Medical Officer, Basic Health Unit (BHU)
S. Allah Ditta
Mehboob Ali Kacho, Medical Officer, BHU Jhang Sayydan

Ittefaq Trust Hospital
Lt. Col. (ret'd) Dr. M. Rafiq Anwar, Medical Director

Jaffer Brothers Limited
Ahsan Durrani, Manager, Human Resources and Administration
Shahzad Sadan, Executive Personnel
Haamid Jaffer, Chief Executive

Karachi
Saeed Ahmed Siddiqi, Secretary of Health, Sindh
Itiaq Ahmed Khan, Pakistan Medical Association
M. Kaleem Butt, Pakistan Medical Association
Sajjan Memon, Director General of Health, Sindh
Hashmi, Pakistan Medical Association
M. Shareef, Pakistan Medical Association
M. F. Ali, General Practitioner
Dr. Iftikhar Salahuddin, Physician Consultant

Lahore
Zulfiqar Ali Shah, Finance Secretary, Punjab
Mohammad Ayub, Commissioner, Employee Social Security Insurance (ESSI), Punjab
Abdul Hayee, USAID Liaison Officer, Lahore
Dr. M. Afzaal Sheikh, Medical Superintendent, Shalamar Hospital (Private)
Tasneem Noorani, Secretary of Planning and Development, Punjab
Dr. Riaz Mustafa Syed, Director General of Health, Punjab
Tariq Saeed Haroon, Secretary of Health, Punjab
Mohammad Shafir Malik, Chairman, Board of Trustees, Mumtaz Bakhtawar Memorial

Dr. Shaheem Khan, Chief Economist, Planning and Development, Punjab
Rauf Beg Mirza, Project Director, Pakistan Child Survival Project, Lahore
Mohammad Rafique Chaudhry, Project Director, Lahore

Love Children Society
Mr. Zaheer Adnan, Social Welfare Officer/General Secretary

Muslim Commercial Bank - Karachi
Azizuddin Khan, Executive Vice President

National Management Consultants
Rafique A. Khan
Juniad Ahnad
Rashid Zubairi

National Institute for Cardiovascular Diseases - Karachi
Kalimuddin Aziz, Executive Director

North West Frontier Province (NWFP)
Ken Davis, USAID Liaison Officer NWFP, and staff
Daud Khan, Medical Superintendent, Lady Reading Hospital (Government)
Nadir Khan, Director General of Health
Shaukat Usman, Director General, ESSI
Hifsa Rahman, Additional Secretary, Finance
Mohammad Yunis Khan, Finance Secretary

Pakistan Institute of Medical Sciences (PIMS)
Javed Chaudry, Joint Executive Director
Dr. Abbass, Pediatrician, Children's Hospital
Dr. Amin Uddin
Ghayyur H. Ayub, Executive Director
Majid Rajput, Joint Director
Mubashur Riaz Sheikh, Deputy Executive Director
Mushtaq A. Khan, Professor and Head of the Department, Children's Hospital
Riaz Malek
Zahid Larik, Assistant Director of Development

Pakistan Medical and Dental Council
Hafeezullah Khan, Assistant Secretary

Save the Children Fund (UK)
Mark Waite, Deputy Field Director, Pakistan
Anne LaFond, Sustainability Research Director (London)
Anne Spencer, Researcher, Pakistan Case Study
Jane Shaw, Family Health Project, NWFP

Sheikh Zayed Medical Institute - Lahore
Lt. General (ret'd) Sohail Abbas Jaffari, Chairman and Dean

Shifa International Hospital
M. Naseem Ansari
Zaheer Ahmed, President

UNICEF
Steven Allen, Senior Program Planning Officer
Christopher Schwabe, Consultant to UNICEF
Dr. Suleyman
Jason Weisfeld, Health and Nutrition Chief

Various Insurance Companies
Saeed Akjtar, State Life Insurance Co.
Syed Asmir Raza, Deputy General Manager, Alpha Insurance Co.
Masood Noorani, Managing Director, New Jubilee Insurance Co.
Ejaz Patel, Deputy General Manager, Adamjee Insurance Co.
H.H. Zubairee, State Life Insurance Co.
Dr. A. Jabbar Khan, Senior Vice President, New Jubilee Insurance Company
Mohammed Chaudry, Managing Director, Adamjee Insurance Company
Parvaiz Siddiq, Deputy Chief Manager, Adamjee Insurance

Welcome
Dr. Arjumand Minai, Director of Corporate Affairs

World Health Organization (WHO)
Abdul Latif, Acting Country Representative
M. Barzegar, WHO representative

World Bank
Bashirul Haq, Health and Population Projects Advisor
Chris Walker, Project Officer
Dale Hill, Adjustment Loan Mission
Fred Golladay, Principal Human Resources Economist

Others
Abdul Ghafoor, Executive Director, NIH
M. Jamil Akhtar, Medical College Principal
Fakhar un Nisa, Fatimah Jinnah Medical College
Iqbal Masood, former Secretary of Health, Islamabad
Lt. Col. (ret'd) Ms. L.M.A. Shah, Registrar, Pakistan Nursing Council
Masood Ahmad Butt, Post Graduate Medical Institute, Lahore
Muhammad Iqbal, Pakistan Medical Association
Nisar Siddiqui, Project Director, PCSP, Karachi
Zafar Iqbal, Manager of Personnel and Industrial Relations, Holiday Inn

USAID/Islamabad
Anne Aarnes, Chief, Office of Health Population and Nutrition (HPN)
Ajaz Ahmad, Office of HPN
Atta Bhatti, HPN
John Blackton, Mission Director
Lois Bradshaw, Health Officer, Office of HPN

Arjumand Faisel, Program Management Specialist, Office of HPN
Corey Gordon, Contracts Office
Ahmed Kassim, Office of HPN
Basharat Qadir, Regional Legal Advisor
Joseph Ryan, Jr., Chief Economist
M.A. Shahid, Manager of Personnel
Nancy Tumavik, Deputy Director
Rvshna Ravji, Program Officer

USAID/Washington D.C.
Robert Emrey, Cognizant Technical Officer, Health Services Division, Office of Health

Health Financing and Sustainability Project (HFS) - Islamabad
Usman Akram, Office Administrative Assistant
Zafar Ahmed, Rural Health Care
Zohair Ashir, Deputy Team Leader and Insurance Specialist
Mohammed Afzal Siddiqi, Legal Specialist
Nasim Ijaz, Driver
Raja Habib, Actuary and Insurance Specialist
Samiullah, Office Aide
Kamran Waheed Khawaja, Local Physician Management Specialist
Masood Hussain, HFS Office Manager
Sikandar Lalani, Rural Health Financing Specialist
Atif Mian, Rural Health Care Specialist

HFS Project Staff and Consultants
Cheryl Bailey, HFS Project Assistant, Abt Associates Inc.
Gregory C. Becker, HFS Quality Assurance Specialist, Abt Associates Inc.
Harris Berman, Tufts Associated Health Plan
Earl Brown, HFS Operations Manager, Abt Associates Inc.
Catherine Crone Coburn, Director, Health Financing Program, Management Sciences forHealth
Hugo Espinoza, Administrative Associate, Abt Associates Inc.
Stan Hildebrand, HFS Hospital Autonomy Specialist, Abt Associates Inc.
Jon Kingsdale, Tufts Associated Health Plan
Robert LeBow, Primary Health Care Specialist, Management Sciences for Health
Liz Lewis, Administrative Officer, Health Financing Program, Management Sciences for Health
Denise Lionetti, HFS Director of Administration, Abt Associates Inc.
Marty Makinen, HFS Technical Director/Pakistan Team Leader, Abt Associates Inc.
Sharon Moerloos, Chief Contracts Officer, Management Sciences for Health
William Newbrander, Health Economist, Management Sciences for Health
Richard Poresky, HFS Task Manager for Pakistan, Management Sciences for Health
Walt Romualdo, HFS Project Assistant, Abt Associates Inc.
Stephen Sacca, Pakistan Coordinator, Management Sciences for Health
Charles Stover, Original HFS Pakistan Team Leader, Management Sciences

for Health
Richard Yoder, Rural Services Specialist, Management Sciences for Health

Editorial Assistance
Nena Terrell, HFS Information Services Manager, Abt Associates Inc.
Marie Keefe, Counterparts
Cappie Morgan, Counterparts
Cathy DeVito Fink, CDF Services

Technical Review
Errol Pickering (Hospital Quality Assurance)
R. Hopkins Holmberg (Hospital Autonomy)
Michael B. Wood, Ken Currier (Insurance)
M. Roy Brooks, Jr. (Rural Services)

ACRONYMS, ABBREVIATIONS, AND GLOSSARY

AID	U.S. Agency for International Development (Washington, D.C.)
AKHS	Aga Khan Health Services
AKU	Aga Khan University
AKUH	Aga Khan University Hospital
AKUHS	Aga Khan University Health Services
Amir	Head of a Muslim State
ARI	Acute Respiratory Infection
Bait-ul-Mal	Welfare funds established by the Amir
BHUs	Basic Health Units
CCU	Cardiac Care Unit
CDA	Capital Development Authority
CDD	Controlling Diarrheal Diseases
CHW	Community Health Worker
CRHP	Cost Recovery for Health Project, Cairo, Egypt
chowkidar	Watchman
CV	Curriculum Vitae
CZA	Central Zakat Administration
CZC	Central Zakat Council
DHO	District Health Officer
DOH	Department of Health (provincial level)
EPI	Expanded Program of Immunization
ESSI	Employee Social Security Insurance
Fatamid Foundation	Blood Donor Agency
FGSH	Federal Government Services Hospital
FJMC	Fatimah Jinnah Medical Center
FMOH	Federal Ministry of Health of Pakistan
FP	Family planning
GDP	Gross Domestic Product
GMO	General Medical Officer
GNP	Gross National Product
GOP	Government of Pakistan
GP	General Practitioner
Hakims	Traditional health practitioners
HCFA	Health Care Financing Administration, U.S. Government
HFS	Health Financing and Sustainability Project
HMO	Health Maintenance Organization
HPAC	Healthcare Provider Accreditation Council
HPN	Office of Health Population and Nutrition
HT	Health Technician
ICT	Islamabad Capital Territory
ICU	Intensive Care Unit
IPA	Independent Practice Association
ISL	Islamabad
JCAHO	Joint Commission for the Accreditation of Health Care Organization
JPMC	Jinnah Postgraduate Medical Center
Katchi Abadis	Squatter Settlements
KEMC	King Edward Medical Center
KHI	Karachi

LDC	Lower Division Clerk
LHV	Lady Health Visitor
Liaquat	Hospital (Karachi)
LZC	Local Zakat Council
Mali	Gardener
MCB	Muslim Commercial Bank
MCH	Maternal and Child Health
M.O.	Medical Officer
Mohalla	Neighborhood
MSH	Management Sciences for Health
Mustaheqeen	Needy People
Naib/Qasid	Orderly/Housekeeper
NGOs	Non-Governmental Organizations
NICVD	National Institute of Cardiovascular Diseases
NJI	New Jubilee Insurance Company
NWFP	North West Frontier Province
ORT	Oral Rehydration Therapy
p.a.	per annum
PAHO	Pan American Health Organization
PCP	Primary Care Physician
parchi fee	Registration or door fee when using a health facility
PCSP	Pakistan Child Survival Project
PGMI	Post Graduate Medical Institute, Lahore
PHC	Primary Health Care
PIA	Pakistan International Airways
PIMS	Pakistan Institute of Medical Sciences
PMDC	Pakistan Medical and Dental Council
PMRC	Pakistan Medical Research Council
PPGP	Pre-Paid Group Practice
PPO	Preferred Provider Organization
PZC	Provincial Zakat Council
RHC	Rural Health Center
Riba	Interest (or usury)
Rs.	Pakistani Rupees (approximately Rs. 25 = U.S. $ 1.00 in 1992)
SAP	Social Action Program
SES	Socio-economic status
SESSI	Sindh Province ESSI
Shariah	Islamic Laws
TA	Technical Assistance
TBA	Traditional Birth Attendant
Tehsil	Zone Within a District
Tehsil Hospitals	Hospitals Within a Zone
UI	The Urban Institute
USAID	U.S. Agency for International Development (Mission)
Ushr	Islamic levy on agricultural production given to the poor
VHW	Village Health Worker
Waqf	Property endowment to a religious or charitable purpose
WHO	World Health Organization
Zakat	An obligatory Islamic religious donation for the indigent

AN OVERVIEW OF THE STUDY
"POLICY OPTIONS FOR FINANCING HEALTH SERVICES IN PAKISTAN"

INTRODUCTION

This is one volume in a set of five reporting on work performed between 1991 and 1993 by the Federal Ministry of Health (FMOH) of Pakistan with the assistance of USAID's Health Financing and Sustainability Project (HFS). The purpose of this study was to design four financial and organizational reform initiatives to improve the delivery of health services in Pakistan.

Volume I of this series summarizes the overall study and presents the recommendations made in each program area. Volumes II through V are technical reports that address the following issues:

- Assuring quality health services by establishing national standards for accrediting hospitals
- Granting autonomy to government hospitals
- Developing private health insurance based on managed care principles
- Providing new models for delivering health services in rural areas

OBJECTIVES OF THE REFORM

The FMOH's new approaches to financing and organizing health services are intended to:

- Make more resources available to the health sector by increasing the share of the gross domestic product allocated to health.
- Increase efficiency in the use of resources by improving the cost-effectiveness of health spending.
- Ensure physical and financial access to basic health services for lower socio-economic status groups, both rural and urban.

GUIDING PRINCIPLES

The FMOH set out the following principles to guide the design of the four initiatives:

1. Those who have the resources must contribute to the cost of the health services they use, principally through paying user fees, often facilitated through insurance mechanisms.

2. New methods must be developed to organize the way in which services are delivered, including offering incentives to service providers for efficiency, cost effectiveness, and quality.

3. Government allocations must target lower socio-economic status groups.

CHOOSING THE APPROACHES

In 1990, a broad-scope study of Pakistan's health care system was conducted by the FMOH with assistance from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA). This study identified a list of areas in which organizational and financial reforms might be made.

In order to narrow down these areas and to design specific initiatives within them, USAID made available to the Government of Pakistan the technical services of its Health Financing and Sustainability (HFS) project. From 1991 to 1993, staff and consultants from the HFS Project gathered up-to-date information, consulting with government and private health service providers, provincial and federal health officials, employers in both the private and public sectors, insurers, and donor agencies such as the World Bank and UNICEF that are interested in health.

This information was synthesized and presented at a workshop organized by the FMOH in February 1992. Also presented were approaches to financing and organizational reform that had been identified in the 1990 HCFA study. After listening to commentary from workshop participants, the FMOH selected for further study the four areas identified at the start of this section. Partly, these were selected because it was felt that changes in one area would support changes in another. For example, granting autonomy to government hospitals (Volume III of this study) would free these institutions to work towards meeting nationally established standards of quality (the initiative described in Volume II). Hospitals would also benefit from the development of private, managed-care insurance plans (Volume IV). Such insurance plans would, in turn, use the information gained by independent assessments of hospital quality to choose facilities with which to associate. Furthermore, strengthened rural services (Volume V) would reduce the burden on government hospitals, and, as government hospitals improve, they would better serve as referral sites for rural services.

DESIGNING THE INITIATIVES

Following the 1992 workshop, the Federal Ministry of Health, through the technical services of the HFS Project, pursued studies in each of the four selected areas. The study team was composed of seven national and nine external experts. Ultimately, three more

workshops were held at which proposals in these areas were presented and feedback was obtained. The goal of this consultative approach was to gain the benefit of the wisdom and experience of all the important actors involved in Pakistan's health sector. This approach was also intended to build consensus concerning how to best address and implement reforms.

What follows is the technical report and the recommendations in the field of hospital autonomy.

VOLUME III

HOSPITAL AUTONOMY

EXECUTIVE SUMMARY

HOSPITAL AUTONOMY

PURPOSE

Pakistan's Federal Ministry of Health (FMOH) would like government hospitals to begin to operate as autonomous entities. They would receive indexed block annual subsidies from government which would diminish over a period of years, with substitute revenues being generated through user payments. With control over their budget, personnel, and service policies, autonomous hospitals' Boards of Directors and senior administrators would have the incentive — and the authority — to increase efficiency in hospital operations, contain costs, and raise the quality of care. Government hospitals would retain their social mission and would continue to provide free care to those unable to pay.

PROBLEM

In the current system, government-operated hospitals consume a share of government allocations for health that is disproportionate to the contribution they make to the health of the population. They are inefficiently operated; many resources are wasted. Quality of care is low.

Many Pakistanis already pay for health services in the private sector, so the concept of user fees is a familiar one in the country. If the quality of health services provided at government facilities were better, these people might well be willing to pay for such services, especially if they were able to avail themselves of a financial risk-sharing mechanism such as insurance.

DESCRIPTION OF THE INITIATIVE

The FMOH anticipates a phased conversion of government hospitals to autonomous status. This would allow hospitals to learn from experience and to revise their plans along the way. The first hospitals to be converted would be the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH), both in Islamabad.

METHODS

To develop a set of recommendations concerning what steps would be involved in moving government hospitals towards autonomy, a study team of Pakistani and outside experts reviewed how hospitals and other enterprises in Pakistan currently operate when granted limited autonomy, how private trust hospitals (non-profit organizations established by endowments from donors and/or private businesses) work, and how autonomy for government hospitals has been pursued in other countries. Consultations also were held with the management of PIMS and FGSH to assess their current operations and to determine what powers and incentives would be needed to achieve FMOH cost-efficiency and service-provision objectives.

RECOMMENDATIONS

Recommendations on hospital autonomy are offered in three categories: governance, management, and finance. The concepts developed in each of these areas are applied to plans for the conversion of FGSH and PIMS.

Governance

In the dimension of governance, this study recommends that:

- The government retain ownership of its hospitals.
- Financing be shared between government and private payments.
- A Board of Directors made up of representatives of government, the concerned community, and the medical profession be granted the power to oversee the operations, management, and financing of the hospital. The mandate of this board is to ensure that:
  - The basic mission of the hospital is defined and accomplished.
  - The current volume and quality of services provided is maintained or improved.
  - The assets of the hospital are protected.
  - Financing is sufficient to provide services of acceptable quality.
  - Efficiency and cost-effectiveness are operational goals.
  - The social mission of the hospital is achieved.
- The board hire a Hospital Administrator who would, in turn, hire staff and operate the hospital.

Management

The team carrying out this study found that, for an autonomous hospital to achieve its desired ends, a new management approach will have to be used, a revised organizational structure put in place, and improved management practices adopted.

Furthermore, autonomous hospitals will have to sell their services to potential paying patients. Thus, hospital management will need to develop the capacity to market services to insurers, employers, and individual patients.

Also, as user fees become increasingly important to the operation of an autonomous hospital, the relationship between it and other medical institutions from which it receives and to which it sends patients on referral will become more critical. It must, therefore, negotiate referral relations with other institutions, including pricing policies.

To stake out an external identity and to guide staff, the autonomous hospital should first define its mission clearly and simply.

The management structure of an autonomous hospital may take many different forms, depending on the specific needs of the individual institution. The following basic structure is proposed as a starting point for adaptation:

- A Board of Directors which hires and oversees the Hospital Administrator.
- A Management Team, hired and supported by the Hospital Administrator. This team would primarily be made up of Deputy Directors for: Administration, Finance, Medical Services, Nursing Services, and Support Services.
- Middle-management personnel overseen by the Deputy Directors.

This study also identifies areas in which training for autonomous hospital personnel will be required. Notable within this realm would be training to help define the roles and responsibilities of the board, the Hospital Administrator, and the Management Team. Training also is recommended in overall management techniques, in personnel and financial management, and in marketing.

Finance

The study team's recommendations in the area of finance are mainly based on a study of costs at PIMS and FGSH. Using this information, recommendations are made regarding the transfer of operating and capital expenses from the government to user payments on a phased basis over a ten-year period.

Additional issues addressed are:

- The management of hospital finances.
- Compensation and incentives for doctors.
- The effects of user fees on the use of urban and rural health services.

- The need to assure quality services in order to sustain cost recovery.

- Ways to fund services for those who are unable to pay.

Concerning the latter issue, it is suggested that:

  - Hospitals seek to develop an enhanced relationship with the Zakat Fund;

  - Patient welfare committees responsible for identifying those who are unable to pay be improved;

  - Poor patients be given first call on remaining government subsidies.

This study also suggests that the management of autonomous hospitals be held responsible for achieving efficiency goals and for improving the quality of services. This could be encouraged by giving the board the power to grant bonuses, to make adjustments in pay to reward high performance, and to hire and fire management personnel in relation to their achievement of the hospital's objectives.

Furthermore, it is recommended that management prepare and present annual financial plans for the board's approval, including both operating and capital spending plans which identify expected revenues from all sources. Performance in meeting these plans would be another criterion used by the board to evaluate management's performance.

Legal

Possible legal constraints involved in moving toward hospital autonomy were examined as part of a larger review of health legislation. That review found that new legislation will be needed to facilitate the movement to autonomy. Nevertheless, the FMOH appears to have sufficient authority at the present time to move ahead in making PIMS and FGSH autonomous hospitals. Doing this would be the first step in moving all federal and some provincial government hospitals toward autonomy.

1.0. INTRODUCTION

At question in Pakistan today is the form which cost recovery for Federal Government-provided hospital services should take and the way this recovery should be implemented while safeguarding the poor from potential adverse effects.

In light of the country's general economic situation, cost recovery for health services is doubly important, first to expand services to rural areas and to address the major preventive and communicable disease problems facing the country. Second, recovering such costs is critical to the sustainability of existing services. A UNICEF report stated that there currently appears to be a general recognition that it will become progressively less feasible for the government to maintain its current subsidy level for publicly provided goods and services (WP, 1992). The result is that practical, achievable ways must be found to supplement and partially to supplant the government's investment in the health care of its people.

The Government of Pakistan (GOP) is committed to having high-quality health services for its people, however, only a small percentage of the Gross National Product (GNP) was spent on health care in 1991/92. This is a low figure compared to other countries in the region and to nations at a similar level of economic development. Public expenditure for health during this period in comparable countries was 3.5 percent of GNP (World Bank Report No. 11127, 1992).

With this small expenditure, the Government of Pakistan manages to provide a large portion of the medical services offered in the country, especially to people of lower socio-economic status. The public sector employs 26,000 government physicians, most of whom also have their own private practices, and it runs 733 government-financed federal, provincial, and special hospitals including facilities for certain groups such as the police, water and power authority personnel, and staff of the forest department (Report to the GOP, 1988). Because the government is responsible for this many health facilities, its actions strongly affect how health care is provided throughout the country.

The private sector accounted for nearly 60 percent of the 22.4 billion rupees spent on health services in 1991/92. At that time, there were 12,000 private practitioners and over 500 private hospitals (including maternity and nursing homes) in the country (Report to the GOP, 1988). Total per capita health expenditure for 1991/92 was approximately 191 rupees, with 115 rupees of this amount being private payments (Tibouti, 1991).

This high level of private expenditure for health shows that the payment of fees for medical care is a commonly accepted

practice in Pakistan. Under these circumstances there is room for the government to experiment in giving greater financial autonomy to government hospitals and to expect that these institutions may increase their level of cost recovery through user fees, insurance, and employer-contracted health plans. A United Nations' report indicated, "There is evidence in the Household Survey of a willingness to pay more for Government services if there were improvements in the quality of these services" (Tibouti, 1991, p.15). Moving more health costs to the private sector, however, must be done with caution to not create financial barriers to hospital services for the poor.

Pakistan's Federal Ministry of Health has supported the idea of providing more autonomy to government hospitals and has proposed that initial activities in pursuit of hospital autonomy be centered in the Islamabad Capital Territory (ICT). Two FMOH institutions in the ICT, the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH) have been selected as the first sites for carrying out this idea.

This report focuses on the conversion of these two facilities from fully government-run institutions to government-owned but autonomously run entities. The FMOH expects that the lessons learned in this conversion will enable it to gradually move other federal and provincial hospitals toward autonomy.

2.0. BACKGROUND

The Government of Pakistan has provided free health care to its population since it became an independent country in August 1947. Unfortunately, as a result of ever-increasing economic pressures, the government has been unable to provide adequate resources to maintain the level of services required by a growing population. As in many countries, under-investment is particularly acute in public health, in prevention programs, and in primary health care services.

The 8 federal and 725 provincial hospitals run by the government are experiencing severe financial strains. Hospital budgets are so inadequate that facilities are unable to provide a reasonable standard of care. As a result, the reputation of these facilities is extremely poor, often making them the provider of last resort. Families with either sufficient personal income or access to government or private employee benefits or to insurance programs generally seek care at non-Ministry of Health facilities. This may have some beneficial effect as those who can afford to pay for services are using private providers. However, another consequence is that it lowers utilization rates at government facilities and may reduce already low rates of efficiency.

The number of alternative service providers from which Pakistani households can choose varies considerably, depending on geographic location, on the type of illness, and on the financial resources available to the patient. In addition to government facilities, there are large numbers of health facilities in urban areas such as Aga Khan University Hospital, Trust Hospitals such as the National Cardiovascular Disease Hospital (NCVD), and other private hospitals as well as thousands of multiple- and single-specialty clinics. The capacity of these facilities ranges from a few beds to hundreds. Only in the rural sectors of Pakistan is there a limited selection.

Although there are currently no legally autonomous public sector hospitals in Pakistan, the country has had some recent experience with the concept. In the 1980s, a number of government hospitals were granted limited autonomy by executive order through Resolutions of Autonomy. Institutions affected were the Pakistan Institute of Medical Sciences (PIMS, October 22, 1986), the Sheikh Zayed Postgraduate Medical Institute (May 29, 1986), and the NCVD (January 7, 1979). These Resolutions did not allow the facilities to establish user fees nor to have much authority to operate in an autonomous manner and in 1990 the Houses of Parliament invalidated all autonomy resolutions.

3.0. FRAMEWORK, METHODOLOGY, AND ORGANIZATION OF THIS STUDY

This section discusses the way the study on hospital autonomy was organized and its findings are presented. The approach used by the specialists on the team reflects other health management studies undertaken in the Philippines and in Egypt (Stover, Almario, & Mendoza, 1991; and Hildebrand & Becker, 1992).

3.1. Conceptual Framework for Understanding Autonomy

Many developing countries have come to the realization that it has not proven to be economically feasible for the state to provide a full range of health services to all citizens. Most are now experimenting with alternative methods of organizing and financing those services. In some, increasing the autonomy of state-owned hospitals has increased the quality of services, reduced the financial burden on the country's government, and redistributed the money that is saved to primary and other health services.

Hospital autonomy generally means that hospitals are at least partially self-governing, self-directing, and self-financing through the generation of revenues from user fees. Hospital autonomy can take a variety of forms. On one end are government-owned, centrally financed and directed hospitals. On the other end are private, fully independent medical institutions. In between is an array of forms which autonomous institutions can take.

Discussions of autonomy often deteriorate into heated debates over whether the government intends to privatize health care. Critics of privatization in health can become uninformed critics of autonomy and often feel that steps toward autonomy mean that government is "abdicating its social responsibility to protect the health of the nation's citizens." It is essential to note that total ownership by non-government is only one of the forms which autonomy can take.

Moving state-owned and operated, centrally directed and financed hospitals toward autonomy does not indicate how far along the spectrum they should or will move. To become fully autonomous, government hospitals would, indeed, have to be more privatized. Indeed, it should be clearly understood that a policy of moving toward greater autonomy does <u>not</u> mean that hospitals need to be fully privatized.

In Pakistan, the FMOH's intention is that government hospitals will continue to be state owned. Giving them some autonomy is a way to empower the hospitals' management and to allow these institutions to become largely self-financing and self-governing.

This report examines how the Government of Pakistan might achieve its health care and financial objectives by providing

considerable autonomy to state-owned hospitals. Three areas of hospital operation are addressed in this study:

Governance refers to the act of setting the goals and objectives of the organization, overseeing its operational policies, and being responsible for the overall management of its assets.

Management refers to the senior group that makes day-to-day decisions about the operations of the hospital in its various functional areas: medical services, nursing care, administration, training, and research.

Finance refers to the methods by which the funds for the hospital's operation are generated, the ways recurrent and capital budgets are established and controlled, and the mechanisms by which costs are projected and contained.

Exhibit 1 illustrates the alternative levels of autonomy possible in each category. Options for governance, for example, range from fully public facilities directed by the Ministry of Health (MOH) to a for-profit institution controlled by a single owner, partnership, or corporation.

The plan proposed by this study recommends initially moving toward hospital autonomy for two hospitals in the Islamabad Capital Territory: the Pakistan Institute of Medical Sciences (PIMS) and the Federal Government Services Hospital (FGSH).

The Pakistan Institute of Medical Sciences is composed of two acute-care, referral hospitals, the Islamabad Hospital and Children's Hospital. It has an affiliation with the College of Nursing and the College of Medical Technology. In 1992, the number of operational beds were 543 in Islamabad Hospital and 213 in Children's Hospital (although the number of sanctioned beds for the hospitals are 573 and 230, respectively). Most PIMS patients are from Islamabad and Rawalpindi. Based on 1992 admissions and an average length of stay of 8.9 days, the Islamabad Hospital had an occupancy rate of 77 percent while Children's Hospital had 81 percent occupancy. Compared to other government hospitals, PIMS is perceived as offering a higher standard of care.

The Federal Government Services Hospital in Islamabad tends to have a greater proportion of patients from the lower-income classes. The perception of the medical establishment is that the quality of care is greater at PIMS, but that FGSH is more "culturally comfortable" for the poor and non-elite who frequent it.

This study recommends that other government hospitals, both federal and provincial, would be converted to autonomy on a phased basis, learning from the experiences gained by PIMS and FGSH. Because of this phased move towards autonomy, PIMS and FGSH are the primary focus of the analysis that follows.

EXHIBIT 1
DIFFERENT RANGES OR DEGREES OF HOSPITAL AUTONOMY
BY OPERATIONAL AREA

	FULLY PUBLIC <) PRIVATE			
GOVERNANCE	MOH HOSPITAL WITH MOH HOSPITAL ADMINISTRATOR	NON-PROFIT CORPORATION; GOVERNMENT OFFICIALS AND COMMUNITY BOARD OF DIRECTORS	FOR-PROFIT CORPORATION; PRIVATE BOARD	PRIVATELY OWNED AND MANAGED
MANAGEMENT	MOH PERSONNEL	BLEND OF MOH AND PRIVATE SECTOR PERSONNEL	HOSPITAL CORPORATION PERSONNEL	PRIVATE SECTOR PERSONNEL AND OWNERS
FINANCING	100 PERCENT GOVERNMENT ALLOTMENT	MODEST INCOME FROM USER FEES AND INSURANCE; MOST INCOME FROM GOVERNMENT ALLOTMENT	MOST INCOME FROM USER FEES AND INSURANCE; SOME GOVERNMENT SUBSIDY	100 PERCENT INCOME FROM USER FEES AND INSURANCE

3.2. Methodology Used in This Study

Field work on this study of granting autonomy to government hospitals began in January 1992 and ended in February 1993. The Pakistani and American HFS team began by gathering information on Pakistan's current systems of hospital organization and finance from sources in both the public and private sectors. An initial workshop was then organized by the FMOH in February 1992 for participants from the groups initially consulted by the study team. These participants were able to reach agreement on the principle issues to be addressed in granting autonomy and on the approaches that most likely would be successful in the Pakistani context.

In workshop discussions, participants concluded that government hospitals should be granted managerial and financial autonomy and should receive indexed block annual subsidies from the government. These hospitals would generate additional revenues through user payments, utilizing a portion of these revenues to improve quality of care and efficiency. It was agreed that the government would gradually reduce its subsidization of these hospitals, permitting the freed-up public resources to shift to primary health care and prevention efforts.

Following the workshop, the study team examined the ways various health-related and non-health-related enterprises in Pakistan have operated when granted limited autonomy. Specifically, team members studied the NICVD's and PIMS' recent, limited experience with autonomy. They also looked at private trust hospitals such as Liaquat Hospital, Shalamar Hospital, and Sheikh Zayed Medical Institute (which had different experiences from NICVD and PIMS). Finally, they consulted with autonomous organizations in sectors other than health such as Pakistan Telecommunications and the Muslim Commercial Bank.

3.3. Organization of Findings

Issues of governance, management, and finance, including recommendations for action, are addressed in Sections 4.0, 5.0, and 6.0 of this document. Section 7.0 presents additional issues associated with autonomy, including the national legislation which needs to be enacted to provide autonomy for government hospitals. Section 8.0 addresses the possible uses of Zakat and other Muslim religious funds to pay for health care for the indigent. Section 9.0 summarizes the implementation plan, and Section 10.0 provides recommendations for monitoring and evaluating progress in establishing autonomy in government hospitals in Pakistan. Appendices A and B support this overall study by providing concrete descriptions of the roles and responsibilities involved in managing autonomous medical institutions.

4.0. GOVERNANCE

In January 1991, the FMOH announced that the administration of hospitals and health facilities in Pakistan would be decentralized by establishing district and *Tehsil* (zones within districts) health committees. This was a key starting point for decentralizing management of public sector health facilities.

4.1. Structuring of Governance

Governance — the control, ownership, and authoritative direction of a hospital — can be structured in many ways as seen earlier in Exhibit 1. There is a range of options concerning where power and responsibility for managing hospitals can reside. At one end of the governance range is a fully public facility of the Ministry of Health. Under this option, the hospital is governed by officials within the Ministry. The Hospital Administrator receives policy direction from and reports to these officials. Since policies are set at high levels of the Ministry, there is no need for a Board of Directors. At the opposite end is a fully private facility whose owners may be individuals, partners, or a corporation. The goals and policies of this institution are set by the owners, subject to government regulations. Such an institution may or may not have social and equity objectives promoted by the government.

The hospitals under consideration for autonomy in this study are fully public facilities of the FMOH. Most have governing Boards of Directors comprised of government officials from various ministries. These boards were established to help move the hospitals gradually toward autonomy, perhaps becoming a quasi-public corporation or a para-statal one. As community participation on the board increases, control over the hospital would be gradually transferred to the community, which is in the best position to assess its needs, make trade-offs between service options, and determine the ability of clients to pay for services.

Under the autonomy scheme proposed in this study, each Board of Directors will assume responsibility for policy making, albeit with the active participation of the Hospital Administrator and key medical staff. To do this, the board must understand the environment in which it operates, particularly the limits on its decision-making powers as determined by the federal and provincial Ministry of Health.

For the governance of hospitals to be successful, hospital leaders will need to make sure that the institution plays an active and positive role in its community. Relationships with community groups and local businesses can provide direct, tangible benefits to the hospital such as contracts to provide health services to

employees and individuals. Indirect benefits could take the form of drawing on local financial management expertise, using community members to help plan and carry out marketing activities, and seeking honest feedback regarding the facility's strengths, weaknesses, and programs. Involvement with the community also strengthens the facility's image with community leaders and should encourage local use of the hospital's programs and services. One of the avenues for community participation is community representation on the hospital's Board of Directors which can also be an active voice for the hospital to the citizens in the catchment area, in addition to guiding the direction of the institution.

4.2. Considerations in Operating Autonomous Hospitals

As hospitals become more autonomous, they will need to become increasingly market and community oriented. Low utilization rates and high unit costs will be unacceptable as they would force changes in the services that are offered. Factors that must be considered in charting a positive direction for the institution include:

- *Mission*) The institution's mission must define the scope and purpose of the hospital, guide its future direction, and establish the boundaries and framework for decision making.

- *Government Regulations and Policies*) Government actions determine such things as the amount of funds received and their allocation. Regulations also affect the extent of mandated access to care, labor policies, and methods of providing care.

- *Financial Limitations*) The amount of money available, the relative cost of providing various services, the availability of capital, and government restrictions on uses of funds affect how hospitals carry out their mandate.

- *Competition*) Hospitals need to determine which services are provided by competitors and decide whether or not to compete in providing these services.

- *Quality of Care*) Institutions must decide if their services meet medical and regulatory norms. Is a certain service provided in sufficient volume to maintain a high level of staff expertise?

- *Community Needs*) Everyone involved in governing a hospital must realize that needs and priorities are likely to be viewed differently by the marketing staff, medical personnel, politicians, and community groups;

efforts must be made to constructively use these various perspectives.

4.3. Mandate of the Board of Directors

Boards of Directors are important vehicles for introducing and considering new ideas. They work best when there is a commonly held vision and a substantial level of understanding among the board members. Boards can lead hospitals as they progress through the conversion to autonomy. The Board of Directors of an autonomous hospital should ensure that:

- The hospital's basic mission is clearly identified and accomplished
- The quality of services provided pre-autonomy is maintained or improved.
- Financing is adequate to meet service requirements.
- The hospital's assets are protected.
- The Hospital Administrator manages the hospital according to board policies.
- The Federal Ministry of Health's social mission is achieved.

In return, the hospital must use the board to further its goals. The board can obtain the additional expertise it needs in areas such as finance, insurance, and marketing by carefully selecting business and community representatives. These members can also be valuable as they provide perceptions of service needs and expectations for quality.

4.3.1. Clarification of the Hospital's Mission

The Boards of Directors of PIMS and FGSH will need to review the services their facilities provide. This can be accomplished by collecting quantitative and qualitative information from hospital records and by interviewing management and selected other people both inside and outside the hospital.

One of the roles of the board is to establish and clarify the hospital's mission. To understand its mission, the board needs to ask:

- How does the care provided at the hospital compare with the mission as specified in the Autonomous Entity Act proposed in this study.

- How does the medical training provided at the hospital fit with its mission?

- What issues faced by the community it serves affect the hospital?

Various interpretations can be made of any hospital's mission. Boards should select the interpretation that best serves the broad needs of the community. (Appendix A.1 provides guidelines for reviewing the mission of the hospital.) One of the purposes of carrying out this clarification task is to more specifically define hospitals as being primary, secondary, or tertiary care facilities and to assure that patients are then appropriately referred to the hospital most capable of treating them.

4.3.2. Oversight of the Hospital Administrator

Another role of a Board of Directors is to hire and oversee the Hospital Administrator. Before it can monitor the administrator's performance, it must first carefully define the role by developing a concise job description. Just as it does for other employees, the job description should explain the duties, responsibilities, and educational requirements of the position as well as the board's expectations in areas such as finance, results reporting, and planning. The job description should also outline responsibilities which the board believes the Hospital Administrator should delegate to deputies or to area managers. The management section of this report provides further discussions on the administrator's role and functions.

4.3.3. Development of Referral Protocols

Referral means the transfer of care from one provider (doctor, clinic, or hospital) to another, either for consultation or to make available clinical or technical expertise not found at the point of origin. This practice is most often used for unusual cases and conditions infrequently, if ever, seen by the referring entity, but treated often by a few select providers. Once the referred patient has been treated, he or she is returned to the referring source for follow-up and ongoing care.

The board's interpretation and clarification of the hospital's mission will provide guidance in determining how each hospital is to receive patients on referral from other hospitals or institutions within Pakistan for specialized or other care. For example, tertiary and specialized-care facilities such as PIMS may not be required to accept the admission referral of primary or secondary care patients.

Whether the autonomous hospital is a primary, secondary, or tertiary care hospital, it must control admissions and monitor referral processes. This can be achieved through developing and communicating to all concerned clear information about referral practices between the autonomous hospital and other institutions. The development or reconsideration of referral protocols and procedures should be a priority task of autonomous hospitals. (Appendix A.2 provides guidelines for the development and enforcement of referral protocols.)

4.4. Recommendations in the Area of Governance

No matter what form the management and financial component of an autonomous hospital takes, the recognition of community, business, and consumer needs will allow the hospital to provide services that are essential to the people of that area.

The following ingredients are necessary for an autonomous hospital to provide appropriate, high-quality care:

- A clearly defined mission which is responsive to the community needs;
- The power to make policy and financial decisions such as increasing salaries for select specialties or rewarding superior performance (these institutions need to be free from government regulations that hamper their ability to achieve their mission);
- A referral system which uses primary, secondary, and tertiary resources appropriately; and
- The capacity and willingness to provide high-quality services that fit the community's needs. A hospital's capital development and service planning process needs to be based on genuine community needs rather than dictated by government budget considerations.

The study team recommends that:

- Ownership of public hospitals remain with the federal and provincial governments.
- These governments delegate policy and management authority to the hospitals.
- Policy making should become the responsibility of the hospital Board of Directors.
- The Board of Directors establish and interpret the hospital's mission and oversee its operations.

Given additional freedom, the board should be able to improve efficiency and deliver appropriate, high-quality health care services.

5.0. MANAGEMENT

The Boards of Directors and management staff of the Pakistan Institute of Medical Sciences and the Federal Government Services Hospital must decide how they want to organize the work of their hospitals to meet the demands of their markets and consumers.

It may help to look at how the management of a hospital compares to that of other organizations. Compared to business executives, Hospital Administrators typically have less authority over the professionals who work in their facility (i.e., physicians and consultants). Also, the goals of hospitals are often more complex than those of manufacturers of finished products; those of public organizations such as water, sanitation, utilities, and telecommunications; or even those of service providers such as banks and insurance companies. Hospital goals include patient care, research, teaching, and community service. In business, the goal is primarily profit, regardless of the function or services of the organization. Greater complexity of goals implies increased problems in directing and managing an organization.

Katz and Kahn (1966), organizational specialists, include within the managerial function the general task of optimizing relations between the organization and its environment. Translated to PIMS and FGSH, this means that the hospital administrator and the managers of departments need to decide issues on the basis of what is good for the hospital as a whole as well as for the community it serves, not on the basis of what serves an immediate departmental or emergency need. They also need this larger view as they make decisions about how to use the resources at hand to improve the quality of services of the entire institution.

Autonomy should be implemented using sound management principles. These principles may challenge traditional management approaches. An environment that encourages creativity must be established, accountability and responsibility must be given to line managers, and employee morale must be considered.

This would be an opportune time to take advantage of current management approaches such as "re-engineering." This idea capitalizes on the characteristics that have traditionally made great business innovations: individualism, self-reliance, a willingness to accept risk, and a propensity for change. It is the notion of "discontinuous thinking" – identifying and abandoning outdated rules and fundamental assumptions that underlie current business operations.

Financial management (accounting/budgeting) will be critical to the operation of the autonomous institution. Hospitals will be accountable for the public and private funds (user fees) received and responsible for keeping track of income and expenses. Personnel management will increase in importance as hospitals will

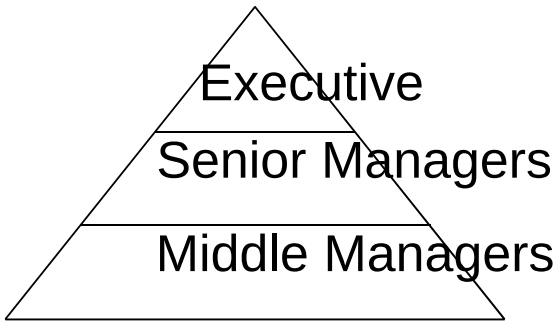
be able to recruit their own staff and will therefore have to develop job descriptions and a performance-based compensation system.

To change from traditional management practices to those needed to reap the benefits of autonomy may require technical assistance. The amount of technical assistance that will be needed depends on existing management skills and the system of governance already in place. PIMS and FGSH have management staff with demonstrated skills, however, training in management principles and practices as well as in technical skill areas such as nursing, laboratory procedures, and maintenance functions could be helpful to all levels of management. Hence, one of the tasks during the first year of conversion to autonomy will be to train upper management, then to define the requirements for training the remaining staff.

5.1. Structuring Management

An organizational structure delineates authority, responsibility, and accountability. Although each organization has different goals and emphasizes different internal functions, there are some aspects of organization that are true for most hospitals. They have one person at the top, a layer of senior managers next, and, below that, middle managers. Organizations must strike a balance between having a structure that has many layers with small spans of control or fewer layers with larger spans of control. Appendix A.3 provides guidelines for the development of a decentralized management organization.

EXHIBIT 2
LEVELS OF MANAGEM



The standard pyramid-shaped organizational structure of most hospitals is well suited for PIMS, FGSH, and other autonomous hospitals because it can be adjusted, depending on the desired

scale of operations. When management requires workers, it simply adds positions at the level required and establishes management-reporting requirements. This structure is also ideally suited for planning and control. It allows the administrator and department managers to ensure consistent and accurate work performance by delegating responsibility and authority throughout the pyramid's structure and establishing monitoring and reporting requirements.

Still, management of PIMS, FGSH and other autonomous hospitals will require certain new ways of thinking such as:

- Clarification of (and sustaining) the mission statement
- Oversight by a Board of Directors
- Use of a management team
- Delegation of responsibilities
- An upgraded role for the financial manager
- Increased skills in personnel management
- A proactive marketing of services

Exhibit 3 describes various management structures for the autonomous hospital, ranging from a fully government operation to a fully private one.

5.2. Role of Management

To better understand the management aspects of a hospital, three dimensions of a manager's role were examined at PIMS, FGSH, and Shalamar Businessmen Trust Hospital, a non-profit. The first dimension studied was the amount of discretion — or autonomy — managers were given within the organization. The second was the amount of authority managers had to determine how actual services were provided in their unit. The last was the amount of responsibility and accountability managers had in their overall service area.

Shalamar differs from the other two hospitals as it is a non-profit institution governed by a Board of Directors comprised of local businessmen and government officials. It was built with private donations and funds on government land. Its mission is to provide quality health care to the community. Those patients that have the financial capability, pay a reasonable fee for services. In exchange for the government land and a small allotment, the hospital provides services to those who are not financially capable. The Hospital Administrator (Superintendent) of Shalamar

is empowered to operate the hospital and provides the Board of Directors with operating statistics and financial information. He receives guidance from them on community services, capital expenditures, resource utilization, staff (i.e., professional, technical, and lay personnel) compensation, and clinical services. The hospital is "customer-service oriented" with the understanding that resources available must equal or exceed the cost of those services.

- Discretion

  On the issue of discretion or autonomy, the team studied how a manager sets and acts on priorities. Did managers initiate work programs and schedules for their area or did they merely react to the initiatives of the hospital administrator or others? At both PIMS and FGSH, managers were given little freedom in setting priorities. On the other hand, at Shalamar, managers were given flexibility and discretion in determining the direction of their departments. Most managers maintained service logs and understood the relationship of time management and service response. The Shalamar Hospital Superintendent received weekly and monthly reports on area operations. This information was then presented to the Board of Directors which provides guidance on service delivery and resource utilization.

- Authority

  The team also studied the amount of authority managers had in determining how services are actually provided. Were they involved in the finite operations of their area, or were they merely supervisors of the service outcome? Involvement could include the review of day-to-day operating needs, understanding the budgets and financing of their area, and/or comprehending the requirements of those to whom they provided support (i.e., physicians, patients, and community.) At Shalamar, managers were responsible for the budget and services provided in their departments. They established departmental operating procedures, scheduled personnel, and exercised control over their department. At both PIMS and FGSH, managers did not oversee budgets for their areas, financial reporting was minimal and only provided in the accounting department. Yet, the managers were cognizant of their day-to-day operating needs because they had a practical working knowledge of their areas.

- Accountability

  Finally, the team studied the amount of accountability managers had. At PIMS and FGSH, true responsibility and authority were not delegated to managers. They were more custodians of their areas. As a result, discipline and morale

were problems, schedules were not adhered to, and resources such as supplies, equipment, and raw materials were not always available. At Shalamar, on the other hand, managers were accountable for the services and resources of their areas and were responsible both for providing quality services and for maintaining harmony within the staff.

EXHIBIT 3

MANAGEMENT
RANGE OF HOSPITAL AUTONOMY OPTIONS
from
FULLY PUBLIC TO FULLY PRIVATE

FULLY PUBLIC <))> FULLY PRIVATE					
Fully government operation with government employees providing all administration, research, and training functions.	Mostly government operation with primarily government employees who contract out for certain services such as medical services, management, and housekeeping.	Quasi-government operation with a mix of government and private employees connected through wage contracts or service and management contracts.	Quasi-government operation with primarily private or contract employees. Services provided by hospital employees on contracts.	Private operation with employees hired from private sector. Some services contracted out. Others provided directly by private hospital staff.	Fully private operation with all employees hired from private sector.

Under autonomy, the Hospital Administrators and managers at PIMS and FGSH must change their thinking from a traditional "hold expenses down" approach to one more appropriately described as "a customer-service orientation combined with financial flexibility." This is not to suggest that there will be freedom to spend as they wish, but the new orientation should allow for more freedom in deciding how resources should be used to provide quality services.

Management responsibility and accountability, supplemented by a quality- service orientation, should make PIMS and FGSH improved hospitals. To do this, the Hospital Administrators and managers will have to be able to promote and reward this new way of thinking and behavior within their staff.

5.3. Clarification and Delegation of Management Authority

In the areas of management, patient services, and medical services, the underlying assumption is that: changes in theory and practice are required. Management restructuring must take place at two levels: in the relations between the MOH and the individual facilities, and within facilities themselves.

- Personnel Management

  In the first category, more authority needs to be delegated by the FMOH to the administrators of autonomous hospitals. In personnel management, for example, autonomous hospitals will employ salaried staff (physicians, nurses, technicians, and laborers) and will abide by the general government rules for personnel deployment, base salary, and benefits. However, autonomous hospitals should be empowered to accept or refuse an employee assigned from the ministries; hire personnel as needed; reward employees for superior performance with incentives (overtime and merit pay); and reprimand, transfer, or dismiss an employee whose work is unsatisfactory.

  Within autonomous facilities, clear lines of authority and responsibility will be needed. In a typical Pakistan hospital, these lines are blurred below the position of Hospital Administrator. This lack of clarity places too much emphasis for the success of the hospital on the abilities of the administrator. Despite the abilities of some administrators, this burden is ultimately detrimental to the efficient operation of the hospital. Suggestions made in this report about clarifying roles, specifying lines of authority, creating job descriptions, and delegating authority can be ways to improve management practices in autonomous hospitals.

- Quality of Services

  A key task of management is to improve the quality of services provided. Facilities must improve all aspects of medical care (including physician and nursing care), they must increase the responsiveness of support departments such as the laboratory and pharmacy, and they must improve the physical condition and regular up-keep of the building.

Furthermore, the autonomous hospital and its administrator will need to aggressively adopt the attitude that patient service is a key goal and priority. Patients who feel cared for will become committed consumers. Equally importantly, they will refer others to the hospital. Viewing service as a priority and implementing systems and programs which further this goal may — in the overall cost recovery effort — be one of the most important elements in making the difference between success and failure.

5.4. Organizational Structure

5.4.1. The Concept of Delegation

The management structure proposed in this report is a mix of the classic American structure and the traditional Pakistani one. In both systems, ultimate authority and responsibility for the functioning of a hospital rests with the Hospital Administrator. As an important change from the traditional system, this report recommends that the Hospital Administrator delegate operational authority of the hospital to Deputy Directors in key program areas. In turn, these Deputies will then delegate day-to-day operational authority to departmental managers. (See Exhibit 4)

The effects of this decentralized approach are twofold:

- The number of persons having a direct reporting relationship with the Hospital Administrator will be reduced. This will limit the number of daily problems that often distract the Hospital Administrator from major issues; and

- The delegation of authority and responsibility effectively institutionalizes managerial responsibility at the hospital, rather than having it rest solely with the Hospital Administrator.

5.4.2. The Concept of a Management Team

The design of an appropriate, workable organizational structure with its policies and procedures for managing operations, finance, personnel, medical, and other departmental operations can best be accomplished by establishing a hospital Management Team. This team would be made up of the administrator and the deputy

directors of the hospital's key departments. This report proposes that consideration be given to having these departments be:

- Administration
- Finance
- Medical Services
- Nursing
- Support Services

Insert Exhibit 4 here

Insert Page 2 of Exhibit 4 here

Insert Page 3 of Exhibit 4 here

At the discretion of the Hospital Administrator or through a consensus decision, the Management Team could expand its membership to include the heads of other key departments such as radiology, pharmacy, or laboratory services. Additional members might be added on a rotating basis. Exhibit 5 describes the qualifications of the management team. The responsibilities of the directors of the five departments are described below.

5.4.3. Management Team Structure

Hospital Administrator

The Hospital Administrator is responsible for assuring that patients receive high quality health services. Working with the Board of Directors, this person is responsible for clarifying the mission of the hospital, for planning policy, and/or developing programs that further this mission, for overseeing the hospital's management, and for delegating appropriate authority to managers at other levels in the organization.

The principal duty of the Hospital Administrator is to oversee the overall operation of the hospital and to supervise the management team. Individual team members should possess skills to manage the diverse technical areas of the hospital and still maintain a larger view of the hospital's overall mission. They also need a willingness to support cost recovery principles and to learn new operating methods for meeting the goals of the autonomous institution.

(The person in this position is called the "Joint Executive Director" at PIMS Children Hospital and the "Medical Superintendent" at FGSH.)

Deputy Director, Administration

It is most critical that the Deputy Director, Administration be well versed in the implementation and operation of management and cost recovery principles. This person will be responsible for overseeing the development, implementation, and operation of management systems for all hospital departments in the areas of: patient records and registration/ admissions, information systems (statistics and reporting requirements of various ministries), personnel, and marketing.

Deputy Director, Finance

The Deputy Director, Finance will oversee all of the autonomous hospital's financial operations, including general and

grant accounting, budget and reimbursement, patient accounts, and financial reporting. This person will be responsible for developing utilization and growth measures that will allow services-area managers to evaluate the financial efficiency and effectiveness of their departments as well as to plan for the future. These measures will be based on historical patient services utilization information as well as on the projected growth of clinical services.

Providing financial management and direction for the hospital will ensure that the board and the Hospital Administrator can obtain the management expertise they need to operate within the financial constraints of the institution. Financial stability will ensure the needed resources are available to maintain quality patient care and to support the expansion of medical services.

Deputy Director, Nursing

The Deputy Director, Nursing will be responsible for the operation of the nursing department and for assuring that all patients receive high-quality, courteous, considerate care given by skillful, understanding personnel. This person will oversee the quality of nursing care, control supplies, and schedule nurses. Senior general nurses who report to this deputy will act as the Head Nurses for each nursing service.

Deputy Director, Medical Services

The Deputy Director, Medical Services will be responsible for overseeing the operation of all Medical Departments and for managing the development of short- and long-term plans for patient service. This person will chair regular meetings of Heads of Medical Services Departments and staff physicians to discuss operations and problems, maintain continuous communication to lead staff to perform their tasks in a satisfactory manner, and establish formal guidelines to assure quality services.

The Heads of Medical Departments will report to the Deputy Director, Medical Services. The physicians who manage the various Medical Departments will need both leadership and managerial skills. They will be responsible for developing programs for their departments, for overseeing the management of these departments, and for understanding their financial operations.

Deputy Director, Support Services

Support Services include those services that are largely "invisible" to the patients, but which are essential to the medical care of the hospital. The areas of responsibility for the Deputy

Director, Support Services are:

Technical Services — Diagnostic services such as Radiology, Laboratory, and Pharmacy. Obviously, these services must be of highest quality for good care to be provided within a hospital.

Hotel Services — The operations that ensure the physical functioning of the hospital: the housing and feeding of patients, the repair and maintenance of buildings and equipment, laundry and linen services, and cleaning of all areas of the hospital.

Under autonomy, hotel services will be particularly important. A basic belief of the self-sufficient health system process is that patients will be willing to pay for good-quality health services. Although the cleanliness and state of repair of hospital buildings and patient rooms are vital to a hospital for health reasons, they gain importance under autonomy because of their impact on patients' perceptions of quality. The same is true of hospital meals. Again, although good nutrition is a critical element in the healing process, patients who are now paying for their meals will demand good taste and presentation as well as nutritional quality.

EXHIBIT 5
KEY MANAGEMENT PERSONNEL

TITLE	QUALIFICATIONS
HOSPITAL ADMINISTRATOR	▲ Qualified as an administrative manager and experienced in managing a hospital in the FMOH system (may or may not be a physician). ▲ Must have a firm commitment to the principals of hospital management and be able to assure that management and quality care principles are followed by the hospital's staff. ▲ Must be able to delegate responsibility and authority to other members of the Management Team.
DEPUTY, ADMINISTRATION	▲ Qualified as an administrative manager of a medium-size hospital. ▲ Must have a working knowledge of Pakistan MOH Administrative System, be able to learn, adapt, and implement the new management, finance, personnel, marketing, information, and medical records systems that will be introduced under the autonomy program. ▲ Must be skilled in managing, motivating, and guiding staff and be able to delegate authority and responsibility to department managers.
DEPUTY, FINANCE	▲ Qualified as a financial manager. ▲ Must have accounting and budgeting skills. ▲ Must have experience in the development, implementation, and operations of a transactional-based accounting system, financial reporting system, and budgetary system, and must provide financial management and direction to the Hospital Administrator.
DEPUTY, NURSING	▲ Degree Nurse experienced in the operation of a nursing department of a medium-size hospital. ▲ Must have administrative and management skills, understand organization structures, and be familiar with advanced nursing techniques. ▲ Must be able to develop and operate a quality- and patient-satisfaction-oriented nursing service, able to manage the Nursing department, and teach other supervisor nurses in management techniques.
DEPUTY, MEDICAL SERVICES	▲ Physician skilled in the management of medical departments. ▲ Must have administrative and management skills to ensure that quality medical care will be provided. Must have experience in the development, implementation, and operation of quality assurance programs; must be skilled in managing physicians and able to assure equitable treatment of all medical services despite internal political pressures.
DEPUTY, SUPPORT SERVICES	▲ Qualified administrator or physician skilled in the administration of diverse hospital services. ▲ Must have administrative and management experience in the development, implementation, and management of hospital diagnostic and hotel services. ▲ Responsible for the operation and quality aspects of diagnostic and hotel services. ▲ Excellent organizational and personnel management skills to assure the quality and smooth functioning of the various hospital departments.

(Adapted from Hildebrand, Lee, & Becker, 1992)

5.4.4. Using a Management Team

The Hospital Administrators of PIMS and FGSH will need to develop a Management Team structure. This team will be responsible for overseeing the tasks delegated by the Hospital Administrator and will also be valuable contributors to decision-making about the management of the hospital as a holistic institution with integrated parts.

This team's success depends on good communication among members and a practical synergy of talents which can be used to move the organization ahead in productive ways. The Management Team should meet regularly and should focus both on planning for and on maintaining the overall direction of the hospital. Working together, they should also address and resolve issues which most directly affect the departmental managers.

The exact composition of the Management Team may vary for each hospital, depending on the strengths of the key staff, but it should generally consist of the Hospital Administrator and Deputy Directors plus any of the managers of the stronger technical departments such as laboratory, radiology, pharmacy, operating theater, or engineering. The group should be selective, based on the particular situation at the hospital. A rotation system is an approach to department-head involvement, allowing one or two department managers to join the management team for three months or so, and then rotating others into team meetings for subsequent three-month periods. Again, the composition is not the key element, the important one is the team approach to planning, decision making, and the completion of tasks.

The Management Team must understand that the staff of their hospital will need clear guidance as the facility moves towards autonomy. To do this, job descriptions and task assignments must be developed that are clear, accurate, consistent, and of high quality.

The role of the Management Team is to review and streamline the hospital's processes. Departments would be arranged to provide patient services or services to other departments based on a cooperative process. The team members would also be advocates of the concept of working for the patient and this would then be reflected in the satisfaction of the hospital's customers with the services they receive.

The Management Team would have the following responsibilities:

- Review present positions and job descriptions with the understanding that this process may lead to the integration and compression of several jobs into one.

- Create new job descriptions with the understanding that most jobs in an autonomous hospital will carry more authority and responsibility than before, very possibly including certain tasks that managers previously performed.

- Review work processes and determine their optimal sequence. Reviewing and daring to change the sequence can speed the process in two ways: First, many jobs can get done simultaneously; second, the amount of time that elapses between each step in the process may be reduced as well as the number of steps in the process itself (Hildebrand, 1992).

- Develop optional functions for processing patients through the hospital. Determine the controls that are necessary to ensure appropriate and efficient treatment. The team will need to find a way to check that appropriate processes are being followed without encumbering the system with excessive authorizations and controls. While the objectives of a system of control may be laudable, the costs associated with strict controls can be exorbitant. An approach that examines aggregate patterns instead of individual instances tolerates modest and limited abuse, and provides adequate checks to accomplish control, reduce abuse, and dramatically lower the costs and encumbrances associated with the control itself.

The Hospital Administrator must acknowledge and promote the key management positions of the hospital and job descriptions must specify both the authority and the responsibility of the employees and identify the key tasks of the departments. The Hospital Administrator must delegate authority so that the Management Team can carry out their responsibilities.

Appendix B provides descriptions of other middle-level management positions below that of the Management Team such as personnel, medical records, information systems, and marketing.

5.5. Personnel

The personnel function within autonomous hospitals will be placed under the Deputy Director, Administration. A personnel system that specifically supports the needs of an autonomous hospital will have to be established.

The management of personnel at Ministry of Health hospitals has always been handled entirely at the MOH. Autonomy would be accompanied by a transfer of certain responsibility and authority to individual hospitals. These include handling performance

review, manpower planning, budgeting for staff, job descriptions, pay and incentives, benefits planning, and employee hiring and firing. Each facility will need to create and support a Human Resources/Personnel Department. This department will be responsible for developing and implementing these activities and other programs and for protecting the rights of all employees of the organization. (Appendix A.4 provides guidelines for the development of a personnel system to employ, retain, and evaluate all levels of salaried staff.)

5.5.1. Key Personnel Issues

The study team recommends that PIMS and FGSH be given considerable autonomy in the management of medical personnel and other hospital staff than currently exists within the FMOH system. The current system presents significant problems, including a lack of local control over the quantity and quality of staff members, an inability to ensure that trained employees will not be transferred by the FMOH, and no way of rewarding employees for good performance (or disciplining them for poor performance).

The following personnel issues must be considered as hospitals move towards autonomy and could result in a memorandum of understanding, a governmental decree, or legislation establishing guidelines in these areas.

Control Over the Selection and Retention of Personnel

In order to improve the quality of medical care, autonomous hospitals may have to retrain many employees and hire new employees to fill un-met personnel needs. This is true for physician, technical, and support staff. However, improvements in quality cannot be maintained if employees are routinely reassigned to other facilities, as is the current practice. Quality improvements are critical, and retaining quality employees is critical to achieving and sustaining these changes.

Control Over Discipline and Firing

In the current system, there is no useable mechanism for "encouraging" an employee to do the job well. Disciplinary measures are rigid and ineffective: employees can perform at totally unacceptable levels (fairly routine absenteeism, for example) and still be within acceptable limits of the current government system. The present system also makes it difficult to fire an employee; even when firing occurs, the government can overrule a Hospital Administrator's decision. In order to maintain quality personnel, the facility must gain control over these activities.

Authority to Evaluate and Reward Performance

Management needs to have a system which relates performance to specific job duties and expectations and which allows rewards for above-average performance. Incentive pay and bonuses can provide substantive reasons for employees to do what is expected in a quality manner or to reach beyond a "normal" level of performance. A performance-based evaluation program can greatly increase the output of a facility's employees, as long as it is fair and provides incentives valuable enough to be interesting to these employees.

In regard to Hospital Administrators, there are provisions in the current FMOH system for bonuses, but there is little relationship between these bonuses and actual performance. The Board of Directors of PIMS and FGSH must directly manage the incentive pay of the Hospital Administrator and tie it to successful performance of the tasks and duties identified in the job description.

Clarity of Job Responsibilities

Many current employees don't know exactly what is expected of them. Historically, communication regarding expectations has been incomplete and job performance may not have been tied to specific tasks or duties. Job descriptions which are clear, concise, and communicated to employees will allow for better employee performance. They will also provide a mechanism for evaluating employees.

Establishment of Higher Pay Levels

Employee morale at MOH hospitals is generally quite poor; much of this can be attributed to low pay. Salary will continue to be a morale and equity issue until pay levels can be improved. Without a financial incentive to come to work and to perform, doctors and staff may not have a commitment to make meaningful contributions to the conversion to autonomy.

Control of Staffing

There is a significant shortage of trained, experienced nursing and technical personnel. Because of the ability of the private hospitals to pay better salaries, this shortage is particularly dramatic within FMOH facilities. A key goal within autonomous hospitals will be to establish staffing levels that assure appropriate patient care and high-quality service. Streamlining personnel operations may result in an actual reduction

of the number of personnel on the payroll. This reduction in staff could result in savings that, in turn, might be applied to other expenses, including increases in salaries and/or an incentive program which relates pay to performance. Clearly, this will require the full and generous cooperation of the FMOH, as they must provide any "released" personnel with other positions.

Nursing and technical staff may be somewhat difficult to find and, in some instances, will be expensive in comparison to the "average" employee. In these circumstances, the facility will need to retrain or upgrade current employees.

Management Training for Middle- and Upper-Level Staff

Management skills are weak at all levels of the hospitals. Little effort has been made to develop top managers besides the Hospital Administrators. Management training for department managers and chief technicians will be important so that they can take on more responsibility and be more active in carrying out the various managerial and financial tasks of the hospital.

5.6. Recommendations in the Area of Management

The team carrying out this study found that, for an autonomous hospital to achieve its desired ends, a new, more decentralized management approach will have to be used, a revised organizational structure put in place, and improved management practices adopted.

Furthermore, autonomous hospitals will have to sell their services to potential paying patients. Thus, hospital management will need to develop the capacity to market services to insurers, employers, and individual patients.

Also, as user fees become increasingly important to the operation of an autonomous hospital, the relationship between it and other medical institutions from which it receives and to which it sends patients on referral will become more critical. It must, therefore, negotiate referral relations with other institutions, including pricing policies.

To achieve the objectives of the FMOH, the current management of government hospitals will need to:

- Work with the Board of Directors to develop and define clearly and simply the mission of each autonomous hospital.
- Adopt a management structure that both reflects the unique needs of that individual institution and espouses a multi-layered management system. In this system, the Hospital Administrator delegates authority and

responsibility to Deputy Directors responsible for various program areas. The basic organizational structure would be:

- △ A Board of Directors which hires and oversees the Hospital Administrator.
- △ A Management Team, hired and overseen by the Hospital Administrator, made up of Deputy Directors for Administration, Finance, Nursing, Medical Services, and Support Services.
- △ A middle-management structure overseen by the Deputy Directors.

- ▲ Develop a new personnel system and staffing structure that will define and support the needs of the autonomous hospital.
- ▲ Train upper- and middle-management personnel both in management techniques and in the technical skills needed to operate an institution which provides high-quality health services. Also provide training in personnel management, financial systems, and marketing.
- ▲ Sell the services of autonomous hospitals to potential paying patients including insurers, employers, and individuals.

6.0. FINANCE

Government of Pakistan expenditures in the field of health were 0.73 percent of GNP in 1991/92, having declined from a peak of 1.08 percent in 1987/88. This is low compared to other countries in the region and to countries at a similar level of economic development where public expenditure for health has been about 3.5 percent of GNP. By contrast, the Government of Pakistan's expenditure on education as a percentage of GNP has been rising and stood at 3.55 percent in 1989/90 (World Bank Report No. 10391, 1992).

Government expenditure for health (development and recurrent expenditure only) for 1991/92 was 8.9 billion rupees which represents only 2.4 percent of total government expenditure (World Bank Report No. 11127, 1992). A report prepared for the GOP's Ministry of Planning and Development in April 1988 showed the public sector as having 26,000 government physicians, most of whom also had their own private practices, and 733 government-financed federal, provincial, and special hospitals such as those run for certain categories of civil servants such as the police.

A large private sector accounted for nearly 60 percent of the 22.4 billion rupees paid out for health services in Pakistan in 1991/92. There were 12,000 private practitioners and over 500 private hospitals (including maternity and nursing homes) at that time, most of which were in urban areas and had fewer than 50 beds. The unregulated pharmaceutical manufacturing and dispensing industry is large. It was estimated in 1985 that 2.2 percent of disposable household income was spent on pharmaceuticals. One reason given for this high level of expenditure for care from the private sector is the perception that the quality of care and the availability of physicians for treatment in private facilities is much higher than in public hospitals. "In terms of use of health facilities, visits to private practitioners are far more frequent than attendance at public health facilities, especially in urban areas" (World Bank Report No. 7522, 1988, p.18).

These figures indicate that there already are significant out-of-pocket payments for health services. The total per capita health expenditure for 1991/92 was approximately 191 rupees, 115 of these rupees were the per capita private expenditure. This level of private expenditure for health indicates that the payment of fees for medical care is a commonly accepted practice in Pakistan. These figures suggest that there is room for the government to experiment in giving greater financial autonomy to hospitals, including increasing the level of cost recovery through user charges, insurance, and employer-contracted health plans for employees. A United Nations' report indicated that "There is evidence in the Household Survey of a willingness to pay more for Government services if there were improvements in the quality of

services" (Tibouti, 1991, p.15). The wide variations in income levels of those needing services, however, requires that any cost recovery efforts must be undertaken with caution so that financial barriers are not created for access to hospital services for the poor.

6.1. Financial Authority

If PIMS, FGSH, and other institutions are to succeed as autonomous hospitals, they must cease to be almost totally dependent on government subsidies. In fact, even if hospitals are to remain as directly administrated government facilities, cost recovery will be necessary. The Pakistan Federal Ministry of Health issued a statement in January 1991 indicating, "Completely free health services are almost impossible to finance by government. It is therefore proposed that user fees be levied in order to recover some of the cost of operating the hospital. Simultaneously, the performance of public health sector facilities will be improved" (p.60). Exhibit 6 describes the range of possible financing structures for autonomous operations.

Guidelines will have to be established to determine equitable and realistic user charges. Regardless of how money is generated, it is critical that the administrator of an autonomous hospital have the authority and flexibility to use the income from user fees to defray operating expenses and notably to promote superior staff performance through rewards and incentives. Beyond this, the Hospital Administrator needs funds to cover unexpected day-to-day emergencies such as the breakdown of important equipment, the unanticipated replacement of essential supplies and temporary replacements for staff.

One of the key responsibilities the Board of Directors of an autonomous hospital should grant to the Hospital Administrator is that of financial management of the institution. Financial management is the life blood of an organization. Without proper financial controls and monitoring, a hospital can lose its assets and its patients, it can develop credit problems and get "cut off" by suppliers and equipment vendors, and it can suffer major payment difficulties. The board and Hospital Administrator are jointly responsible for the financial status of the organization. Clearly, one of the most significant acts of the Hospital Administrator is to obtain the services of a qualified financial manager.

EXHIBIT 6
FINANCING RANGE OF HOSPITAL AUTONOMY OPTIONS
from
FULLY PUBLIC TO FULLY PRIVATE

FULLY PUBLIC <))))))))))))))))))))))))))))))))> FULLY PRIVATE						
RECURRENT/ OPERATING COSTS	Fully subsidized by government -- direct or indirect (100% of operating costs paid from government budget or through payment for services)	Government subsidy of less than 100% of costs	Government revolving funds for operations	User charges of less than full costs with remainder paid from government subsidy combined with health insurance	User charges of full costs with small subsidy from government for things such as teaching or research	User charges of cost plus pricing combined with health insurance
CAPITAL COSTS	Fully purchased by government	Government subsidy for more than 50% but less than 100% of purchase costs (through supplying money, providing import licenses, providing incentives or use of hard currency, or lending money)	Government subsidy for less than 50% of purchase costs	Lending of government buildings and equipment to quasi-government body to operate	Leasing of government buildings and equipment to quasi-public or private corporation or entity	Selling of government buildings and equipment to private corporation or entity

6.2. Financial Functions

The administrator of an autonomous hospital will have more responsibility for finances than the current directors of government hospitals do since overall hospital budgets should increase and more money should flow through the organization. The control of funds will become increasingly complex whether in the cashiering function at discharge, in the outpatient areas, in handling payments for significantly larger pharmacy and medical supply inventories, or in other areas.

Also, more control over the payment system for personnel should lead to the creation of a new, more equitable, incentive program related to employee pay. Having this responsibility, however, will also increase accounting requirements. New or expanded facility departments such as maintenance, engineering, food and catering services, and social services may also require additional procedures, financial attention, and clear lines of managerial authority.

The board and the Hospital Administrator will need to work together to clarify the responsibilities of new or expanded departments and to find appropriate managers for the supervision of service and support units. These clarifications will take time and energy; the traditional way will not be sufficient to move the organization forward with a workable management structure or a financial control system which is responsive and adequate to the new organization.

The hospital has two major financial functions: (1) to identify the sources and amounts of money the hospital receives in revenue; (2) to analyze how the hospital structures its financial operations, handles its cash flow, and works with its capital budget.

The Deputy Director, Finance serves as the overseer of the financial tasks, including the accounting discipline, the accounts receivable function, accounts payable, cash management, inventory management, capital assets management, budgeting, and internal controls. (Appendix A.5 provides guidelines for creating this post.) The importance of this role and function cannot be understated. The Hospital Administrator must have a person in this position who is knowledgeable about finance and dedicated strictly to the financial matters of the organization. It is not a part-time job, and it is not a part of the Hospital Administrator's job description. (Appendix A.6 provides guidelines for the development of financial planning, budgeting, and user-fees accounting controls. Appendix A.7 addresses the establishment of procurement procedures.)

Accounting records describe the financial status of the hospital. Through establishing and maintaining these records from

which the hospital's financial statement can be prepared, the hospital can determine how financially sound it is. The hospital accountant is the principal person assigned the responsibility for the hospital accounting system. The accountant must be familiar with current accounting procedures and statistical financial analyses used in the hospital field.

6.3. Self-Financing Possibilities

It is clear that the majority of Pakistan's population has limited financial resources. The critical factor which determines whether people will spend their resources on health care may depend on their perception of the quality of medical care, its management, and the nature and availability of patient services. Satisfied patients talk to relatives and friends; over time, these conversations create a perception of the facility in the community and develop its "reputation." Having a reputation for quality, service, and commitment will be critical to any long-term success for an autonomous hospital.

There are a number of examples in Pakistan where self-financing of hospitals is working: private-sector hospitals, the Aga Khan Hospital, the Shalamar Businessmen Trust Hospital, health facilities of Islamic charitable organizations, and others. These institutions have developed user fees for utilization of patient beds as well as for patient procedures and services.

At present in Pakistan, there are virtually no indemnity health insurance plans in the pure sense; almost all are services reimbursed on charges or on a negotiated fee schedule. The insurance industry emphasizes property and casualty programs. There are almost no Health Maintenance Organizations or Preferred Provider Organizations (PPOs) like those in the United States, yet private sector hospitals have many of the attributes of a prepaid health plan: periodic prepayment, comprehensive medical care, and incentives to physicians. Health insurance and other financing arrangements for medical care (e.g., direct contracting) vary among companies according to their resources, the type of work force they have, and their history with health insurance programs.

In the long run, the development of a system of largely self-financing hospitals will require a more predictable insurance system funded through per-capita monthly premiums. The conversion to self-financing is a process that will require expanded contracts with insurance companies, individuals, and business. These contracts should lead to arrangements for third-party payment of fees-for-service, to comprehensive per diem arrangements, and to contracts for capitation of services. Each alternative accepts increasing risk and requires more sophisticated management tools, but yields greater stability of revenues for the hospital and greater continuity of care for the patients/enrollers.

Volume V of this compendium discusses the potential for the development of private health insurance programs in Pakistan based on managed care principles.

The number of private businesses in the country is growing; the majority of these companies currently have no arrangements to take care of the health care needs of their employees. Business health service contracts are a large potential market, one that is particularly valuable to hospitals because of the relative predictability of monthly cash payments that would be made. The leadership of PIMS and FGSH will have to develop products and service packages that respond to the needs of these businesses and to present these packages in a way that is attractive to local entrepreneurs and agencies. (Appendix A.8 provides guidelines for the development of service contracts to individuals, businesses, and organizations that include arrangements for third-party payments.) Developing consumer-oriented coverage packages will necessitate the hiring of a marketing staff who will become acquainted with decision makers in companies and unions. Model contracts, strategies for marketing, and analysis of fees and benefits will be important components of a marketing and contracting effort. A hospital's medical staff and specialists also may need to lend their prestige to this outreach program.

Patient satisfaction will be extremely important if the hospital is to sell its services and, thereby, to increase its revenue. Therefore, all complaints from patients must be promptly investigated. The spirit of solidarity should be established among all staff with emphasis on the fact that the success of the hospital and, therefore, of every professional on the staff depends on a team effort. Suggestions for improvements in services and in perceptions of services should be actively solicited and considered.

6.4. Unit Costs

Information on patient utilization and facility expenses were obtained from two PIMS hospitals (Islamabad and Children's) and from FGSH (see Exhibit 7) in order to estimate the actual cost of treatment of patients per day during the 1992 calendar year.

Approximately 30 percent of all admissions during the period for which data was available were paying patients. Forty percent were government employees for whom no fees were collected. Ten percent were patients with Zakat (religious fund) certificates whose costs were paid by Zakat. Twenty percent were considered by the hospital as being too poor to pay. Only approximately 7 percent of operating expenses were recovered from patient fees.

Expenditure information was available for recurrent costs only. The combined recurrent cost for the two PIMS hospitals for 1992 was 175 million rupees. The capital costs of buildings and major equipment were not available. Since the capital investment had already been made in these facilities, there is a need to know the capital replacement costs over the life of the capital investment (i.e., the annualized value of capital). Assuming that buildings have a 20-year useful life, major equipment has ten years, and minor equipment five, it has been found in some developing countries that, using a straight-line depreciation method, annual capital replacement costs are 30 percent of recurrent costs. Based on this, the combined total operating costs and workload of both PIMS hospitals was determined. Assuming annual capital costs represent 30 percent of operating costs, 1992 capital costs were 53 million rupees for a total of 228 million rupees for recurrent and capital costs.

Cost estimates portrayed in Exhibit 7 (see Appendix C for method of calculation) are consistent with user fees charged at the better urban private hospitals in Pakistan and by private physicians for their consultations. They are also within the range of current hospital charge levels by PIMS: private wards: 600 rupees per day; special room: 400 rupees per day: and general ward: 100 rupees per day. Current outpatient consultations fees at PIMS are much lower than in the private sector, at 3 rupees per visit.

EXHIBIT 7
Expenditure, Workload, and Unit Costs for PIMS and FGSH

	PIMS TOTAL (1992)	Islamabad Hospital (1992)	Children's Hospital (1992)	FGSH Hospital (1991)
EXPENDITURE				(ESTIMATED)
Personnel	91.642*	67.586	24.056	N.A.
Minor equipment	0.932	0.902	0.030	N.A.
Maintenance	8.190	8.064	0.126	N.A.
Food Service	3.982	3.230	0.752	N.A.
Pharmaceuticals	27.928	23.054	4.874	N.A.
Supplies	1.132	0.830	0.302	N.A.
Utilities	19.104	19.104	0.000	N.A.
Miscellaneous	22.532	16.652	5.880	N.A.
TOTAL RECURRENT	175.4	139.4	36.0	86.6
ESTIMATED CAPITAL COSTS	52.6	41.8	10.8	26.3
TOTAL COSTS	**228.0**	**181.2**	**46.8**	112.9
WORKLOAD				
Inpatient (IP) Admissions	24,105	15,098	9,007	
Outpatient (OP) Visits	381,690	300,901	80,789	
Total beds available	753	540	213	
Days in a year	365	365	365	
Total bed days possible	274,845	197,100	77,745	
Total bed days	214,029	150,980	63,049	
Occupancy	77.9%	76.6%	81.1%	63.0%
ALOS (Average Length of Stay)	8.9	10.0	7.0	
Total Workload	309,452	226,205	83,246	
IP Days	214,029	150,980	63,049	
OP Equivalent days	95,423	75,225	20,197	
ESTIMATED UNIT COSTS				
TOTALS				
Unit Costs per IP Day	737	801	562	505
Recurrent IP Unit Costs	567	616	432	388
Capital IP Unit Costs	170	185	130	117
Unit Costs per OP Visit	184	200	141	126
Recurrent OP Unit Costs	142	154	108	97
Capital OP Unit Costs	42	46	33	29

(*Rupees = 25 to $1.00 U.S. in 1992)

See Appendix C for Method of Calculation.

Specific, detailed financial and workload information for 1992 was not available for FGSH at the time of this review. The bed occupancy rate at FGSH, approximately 63 percent as of 1991, was lower than at PIMS, although FGSH's daily outpatient load was close to 50 percent greater than that of PIMS. Aggregate expenditure estimates indicated that FGSH's recurrent costs were nearly 37 percent less than PIMS'(World Bank Mission, 1992). FGSH user fee collections represented less than 1 percent of total expenditures. For private wards, the charges were 22 rupees per day. However, fewer than 1 percent of the patients pay any fees at all.

Unit costs were estimated based on global cost data from FGSH and inpatient-outpatient service and cost ratios from PIMS' Islamabad Hospital. The Islamabad Hospital costs will be used as the basis for the estimates because these costs were higher and it will prevent underestimation. This estimate was also considered more accurate since the total costs of FGSH were nearly one third less than PIMS' total expenditures. In addition, the Islamabad Hospital encompasses a full-service acute care hospital which more closely matches the mission of FGSH.

Based on these figures, it is estimated that costs for an inpatient day at FGSH are: 505 rupees (388 rupees for recurrent costs and 117 for capital costs) and 126 rupees for outpatient visits (97 rupees for recurrent and 29 rupees for capital costs). This is considered a reasonable figure since the FGSH administration, with sparse expenditure data, estimated that the expenditures per patient day were 458 rupees. The outpatient visit costs may be overestimated in that FGSH has a much higher outpatient volume and may have lower unit costs due to economies of scale.

From these calculations, it is estimated that the range of full costs at large government hospitals in an urban area stretches from 505 to 801 rupees per inpatient day and from 126 to 200 rupees for outpatient consultations. These estimates include capital and recurrent costs.

6.5. Cost Recovery

Actual user fees which patients are charged for services at PIMS and FGSH are substantially lower than the above-estimated unit costs. The private sector charges high user fees for private hospitals; private physician consultations (which are considered to be of a higher standard) are within this range. Thus, for some segment of the population, full-cost charges might be acceptable if the quality of care were considered equal at government hospitals. However, as charges at most government hospitals are currently substantially lower or nonexistent, institution of high charges for all patients would be unacceptable.

So, what would a reasonable charge for services be and how high and how fast should these charges rise? In designing a cost-recovery scheme to further hospital financial autonomy at PIMS and FGSH, several factors must be kept in mind.

6.5.1. Assuring Quality of Services for Sustainable Cost Recovery

For fee levels to increase until there is full recovery of costs, services will have to be improved to the point that patients value what they are getting for their money. Autonomous hospitals must make sure that some of the funds generated through fees are devoted to improving the quality of care offered. The biggest challenge will occur later when provincial hospitals (which may not have as high a standard of care as urban hospitals) begin to move towards financial autonomy. They will have to make a concerted effort to improve the quality of their services prior to introducing or increasing patient fees.

The government also must closely examine the appropriate regulatory actions needed to establish standards of performance, to monitor these standards, and to enforce compliance in both public and private health facilities. This may lead to regulation not only of public and private hospitals, but also of pharmaceutical services and of medical care provided by private practitioners.

The volume of this compendium (See Volume II) Assuring Quality Health Services Through Hospital Standards and Accreditation) will help PIMS and FGSH during the transition from being FMOH institutions to being autonomous hospitals with quasi-private status. In order to upgrade the quality of their services and programs, PIMS and FGSH will need to set standards for operating and managing their finances. These standards should ensure a quality environment and should clarify for patients the nature and level of services they can expect.

6.5.2. Objectives and Principles of Cost Recovery Policies

First, cost recovery by itself is not the ultimate objective. If it were, hospitals would charge full costs and not be concerned about whether or not that prevents patients from receiving needed care. Rather, cost recovery must take into account people's ability to pay while also ensuring that access and equity concerns are not ignored.

Second, increased levels of cost recovery will come from two sources:

- *User Fees* — Increasing charges so that they more closely reflect the actual costs of delivering services.

- *Quantity of Patients* — Increasing the number of patients who pay user fees since many who can afford to pay and are willing to do so either are in the private system or are not currently being charged for the public services they receive.

Several principles should guide the autonomous hospital's introduction of cost recovery:

- *Ascertain capacity to pay* — The system must design a way to find out which patients are not able to pay. Several hospital administrators have mentioned using patient welfare committees to do this. This study was not able to determine the effectiveness of such committees in the few places where they exist. PIMS, FGSH, and other hospitals need to be aware of the administrative burden the establishment of a welfare committee places on the hospital. Unless the personnel assigned the task of assessing a patient's ability to pay have incentives, they may quickly revert to the old ways of granting near-blanket exemptions for all patients receiving care. One means of addressing this issue would be to insist that all patients, even the poor, pay some nominal amount for their care. Since even the poor are making out-of-pocket payments for care and drugs from the private sector, perhaps a minimum of 25 rupees per day should be collected from all patients.

  Shalamar Hospital and the Aga Khan Hospital have found ways to obtain revenues from those who are able to pay and they have sliding fee scales for others according to the hospital's assessment of their ability to pay. Mechanisms such as these will have to be designed and implemented if cost recovery is to succeed.

- *Improve patients' perception of the quality and value of services provided* — Since most patients using the public sector are not now paying for services, cost-recovery schemes should segment the market by charging higher fees for private wards than for public-ward patients. Patients' perception of quality must also be considered in determining how high charges can be. Thus, fees at PIMS might be higher than at FGSH due to quality-of-care issues as well as to the greater ability of PIMS' clientele to pay.

- *Use a gradual approach* — Hospitals must undertake cost recovery according to a gradual schedule such as the one shown in Exhibit 8. Within this gradual approach, a positive pace must be maintained or the momentum will not be kept to bring about fundamental changes in the Pakistani health system. In light of the current amount

of private expenditure, the plan that appears below may appear shocking, but should not be considered totally unrealistic.

6.5.3. Gradual Cost Recovery Approach

EXHIBIT 8
AN EXAMPLE OF A PHASED-COST RECOVERY SCHEDULE

Year 1	90% Government subsidy for recurrent costs – remainder of operating costs recovered thorough user fees Government fully funds capital expenses (through Year 6)
Year 2	90% subsidy – 10% recovery of recurrent costs
Year 3	80% subsidy – 20% recovery of recurrent costs
Year 4	70% subsidy – 30% recovery of recurrent costs
Year 5	60% subsidy – 40% recovery of recurrent costs
Year 6	50% subsidy – 50% recovery of recurrent costs
Year 7	50% subsidy – 50% recovery of recurrent costs and capital costs (capital costs folded into cost recovery, cutting capital cost subsidy to 50%)
Year 8	No change: 50% subsidy – 50% recovery of recurrent and capital costs
Year 9	40% subsidy – 60% recovery of recurrent and capital costs
Year 10	30% subsidy – 70% recovery of recurrent and capital costs

The basic principles underlying this phased-cost recovery approach are:

- The government's subsidy for hospital care should decline. Money freed from providing hospital services could then be used for other areas of need such as preventive care.
- Initially, cost recovery should be for a proportion of only recurrent costs.
- After five-to-six years, capital costs should be folded into user fees.
- The government subsidies which remain should be used to pay for the care of the indigent and to subsidize those patients who can pay some amount toward their care, even if not the full charges.

- Each hospital's plan should establish overall revenue goals as a percentage of costs, but should give the hospitals flexibility in figuring out ways to achieve their goals. For example, since total revenues are determined by quantity (number of paying patients) multiplied by the price (the established user fees), a hospital should periodically review and adjust the mix of user fees it sets with the number of patients who pay all, some, and none of the costs related to their care.

- The leadership of autonomous hospitals should be "at risk" in the sense that if they fail to meet revenue targets, they will have to find ways to handle the cash-flow problem. No supplemental government allocations should bail out hospitals with financial difficulties. If management is monitoring the fiscal situation throughout the year, it should not be "surprised" by large deficits at the end of the year.

The implications of this cost-recovery schedule in terms of fees for PIMS and FGSH are shown in Exhibit 9. These estimates assume that patient volume will remain constant and that there will be no improvements in operating efficiencies (improvements would reduce user fees since they are based on actual costs). In addition, these estimates do not account for any cost increases due to quality improvements, although these are necessary to continue to attract patients to the public hospitals and away from private facilities. The projections in Exhibit 9 are in constant rupees and are used simply for illustrative purposes.

6.5.4. Some Considerations for Establishing User Fees

Several cautions must be noted in examining the fee-schedule chart in Exhibit 9. First it is only one example of how to phase in cost-recovery levels. The fee schedules are illustrative, rather than definitive. Hospitals could determine other means of dividing the source of revenues. These examples are meant to help decision makers "count the costs" rather than talk of cost recovery in abstract terms. They also try to show the implications of seeking a high degree of financial autonomy for hospitals.

EXHIBIT 9
EXAMPLES OF FEES UNDER PHASED-COST RECOVERY

		PIMS		FGSH	
		Inpatient Fees	Outpatient Fees	Inpatient Fees	Outpatient Fees
Year 1	10% Recurrent Cost Recovery	Rs 57*	Rs 14	Rs 39	Rs 10
Year 2	10% Recurrent Cost Recovery	Rs 57	Rs 14	Rs 39	Rs 10
Year 3	20% Recurrent Cost Recovery	Rs 113	Rs 29	Rs 78	Rs 20
Year 4	30% Recurrent Cost Recovery	Rs 170	Rs 43	Rs 116	Rs 29
Year 5	40% Recurrent Cost Recovery	Rs 227	Rs 57	Rs 155	Rs 39
Year 6	50% Recurrent Cost Recovery	Rs 284	Rs 71	Rs 194	Rs 49
Year 7	50% Recurrent & Capital Cost Recovery	Rs 369	Rs 92	Rs 253	Rs 63
Year 8	50% Recurrent & Capital Cost Recovery	Rs 369	Rs 92	Rs 253	Rs 63
Year 9	60% Recurrent & Capital Cost Recovery	Rs 442	Rs 110	Rs 303	Rs 76
Year 10	70% Recurrent & Capital Cost Recovery	Rs 516	Rs 129	Rs 354	Rs 88

*($1.00 U.S. = 25 rupees in 1992)

6.5.5. Non-Medical Expenses Incurred by Patients

Hospitals should be aware of and sensitive to costs patients have to pay other than user fees. These costs, which include transportation and time, have an effect on people's willingness — and ability — to pay as well as on the choices patients make in choosing where they seek care.

A 1986 survey of households in low-income urban areas of Pakistan reported that the travel time to a government clinic was 60 percent greater than to a private doctor: 0.35 hours travel time to a government clinic compared to 0.22 hours to a private doctor (Alderman and Gertler, 1989). If these travel time costs are also true for private hospitals compared to government hospitals, the costs to patients of government care would be higher than those in private hospitals. As hospitals determine user fees, these comparative cost issues must be considered.

6.5.6. Equity and Access: Effects of User Fees on Utilization

As government subsidies to hospitals are reduced, efforts must be made to determine the effects on access to care and on distribution of services. For example, there are concerns that, due to FGSH's clientele of lower-income patients, user fees would place a greater burden on their patients than such fees would place on people who go to PIMS. Patient Welfare Committees, such as the Love Children Society at PIMS' Children's Hospital, need to be established at each facility to determine the ability of patients to pay for services. Beneficiaries of free or subsidized care must then be monitored to ensure that they are not displaced from receiving hospital care due to an inability to pay.

Further, the introduction of fees for medical services implies that consumers have the resources they need to seek substitute goods. Will increases in fees for services at government hospitals result in patients seeking care from private hospitals, private physicians, or chemists, or will they result in needy people either self-treating or not receiving care at all? These questions need to be answered.

The results of the Living Standards Measurement Study done in Pakistan by Alderman & Gertler in 1989 indicate that raising user fees at government health facilities will result in some reduced utilization of those facilities due to pricing, but that most people will shift to the private sector rather than forego care. This study shows, as expected, that the poor were more price-sensitive than the general population, but it projects that their utilization rates were not expected to drop significantly due to price increases in the public sector. (This assumes that the prices of private providers remains unchanged despite increased demand.) Thus, the private sector and public sector seem to be close substitutes for each other in meeting outpatient care needs. This study, while informative, was not conclusive because it dealt with only clinic visits for treatment of children in urban areas. It will be important for PIMS and FGSH to monitor the effects of user fees on various income groups.

6.6. Recommendations in the Area of Finance

At the present time, only 7 percent of PIMS' recurrent costs are recovered from user fees. FGSH recovers less than 1 percent of total recurrent expenditure from fees. PIMS has set the goal of moving toward 30 percent cost recovery and FGSH has stated the need to increase fees and to recover a greater portion of costs. PIMS and FGSH goals can be initial targets to move towards 30 percent recovery of recurrent costs within four years, as proposed in the phased schedule in Exhibit 9. Within seven years, the expenses of annual capital costs should begin to be folded into user charges which are based on total costs.

Activities which need to be undertaken in the area of finance are:

- *Improve hospital financial management systems so that hospitals can better determine the actual costs of providing various services.* They can control expenditures better, and they can increase efficiency using limited financial resources. (See Appendix A.6)

- *Increase fees for the paying patients and ensure that appropriate charges are billed for Zakat patients.* (See Section 8.0.)

- *Study the effects of user fees on the use of urban and rural health services.* When setting user fees, autonomous hospitals need to be aware of the effect fee rates may have on the rural health system. For example, if fees for outpatient consultations at urban hospitals are set at only marginally higher levels than fees at rural facilities, patients may by-pass the rural facilities and go to urban hospitals. In order to promote appropriate utilization and referral patterns throughout the entire health system, hospital fees must be levied for outpatient visits as well as for inpatient hospitalization services.

- *Weigh incentives to physicians.* The benefits of hospital autonomy for various professional groups will have to be examined closely. The most perplexing group is physicians. Although many staff physicians at government hospitals receive salaries, many also have private clinics and/or associate with other private hospitals where they can refer patients. A way must be found to encourage government physicians to admit patients to autonomous hospitals rather than sending them to private health facilities or to their own clinics. Earlier studies have recommended the establishment of total patient charges at hospitals, with a portion of these fees to be paid to physicians as a way of encouraging them to remain within the government system. This idea deserves to be looked into further.

- *Examine ways to improve efficiency in hospital operations.* The cost of providing the current level of services will be lower and, thus, fees will not have to be as great.

- *Study the operations of the not-for-profit institutions of the private sector* (such as Shalamar Hospital, Aga Khan Hospital, and other mission and foundation hospitals). These can provide models and lessons for the

government in how to provide quality care while charging fees that cover a substantial portion of recurrent costs.

- *Increase usage of the expertise of the private sector.* Private- sector businesses can be a source of and a training ground for hospital managers. Businesses can provide experts to advise hospitals through informal arrangements or by serving on their boards. Business leaders could provide guidance on topics such as financial management and costing, marketing, dealing with governing boards, competing with the private sector, labor relations, and human resource development.

- *Hold the leadership of autonomous hospitals responsible for achieving efficiency goals and for improving the quality of services.* This could be encouraged by giving the board the power to grant bonuses, to make adjustments in pay to reward high performance, and to hire and fire management personnel in relation to their achievement of the hospital's objectives.

- *Have management prepare and present annual financial plans for the board's approval*, including both operating and capital spending plans which identify expected revenues from all sources. Performance in meeting these plans would be another criterion used by the board to evaluate management's performance.

These activities, plus ones undertaken in the areas of quality assurance, governance, and management would be first steps in a long-term plan to move all federal and some provincial government hospitals toward autonomy. This would result in a "cascading" effect for hospital autonomy. As experience is gained, the lessons that are learned can be used to better plan the autonomy of additional hospitals as well as to improve the practices of those already having some degree of autonomy. Funds released from each successive group of hospitals that become financially autonomous may be used to: (1) improve quality at other government hospitals so that the introduction of or the increase in user fees in those hospitals at a later date becomes more palatable to the public, and (2) increase government resources devoted to preventive and primary health services, especially in rural areas.

7.0. LEGAL AND REGULATORY ISSUES

In addition to the issues which fall into the categories of governance, management, and finance, there are legal matters that must be addressed if the Government of Pakistan gives autonomy to Federal Ministry of Health hospitals. The purpose of this section of the report is to identify and begin to address some of these issues.

7.1. Legal Issues

7.1.1. National Legislation Needed to Enact Hospital Autonomy and Other Reform Initiatives

An analysis of existing laws in Pakistan found that there is no current law under which the recommendations on hospital autonomy proposed in this report (as well as the recommendations made in the other volumes of this study) can be implemented. The study team, therefore, suggests that a single Health Policy law be enacted to provide a permanent legal infrastructure for the various initiatives. With such a comprehensive statute, it would not be necessary to repeatedly return to the legislature to enact different aspects of the proposed reforms. This umbrella legislation would encompass all four of the initiatives addressed in this study, and would be applicable to the whole of Pakistan. Since it may not be possible for the government to enforce all four initiatives immediately upon passage of the law, the government may reserve the power to take a phased approach, applying different provisions of the law over time.

The section of this law that would cover autonomy of management and financing for hospitals might be called the Autonomous Entity Act. It would need to include provisions related to governance; the hiring, evaluation, and rights of personnel; and the management of hospital finances. Suggestions related to each of these areas follow.

Governance

Legislation concerning governance would address the role of the Board of Directors, the Hospital Administrator, and community representatives. It would also outline Rules of Governance that would guide hospital operations.

Basically, this legislation would propose that responsibility and authority for managing hospitals be conferred to a Board of Directors made up of government servants (nominated by the Federal Ministry of Health or by the relevant Provincial Department of Health), representatives of the administration of the hospital, and

members of the community it serves. The number of board members in each category would be specified by the ministry. The board would function as an autonomous body. It would be permanent, but its members would retire after a specific time period to be replaced by others from the same category.

The Board of Directors would select and hire a Hospital Administrator who would sit on the board in an ex officio capacity. This administrator would be a person of proven administrative abilities, but not necessarily a member of the medical profession.

Local government would determine the way of selecting community representatives. Representatives of the Ministry of Health would be named by the MOH's Director General. Representatives of the Provincial Department of Health would be named by the Provincial Secretary. The Hospital Administrator would represent its administration.

Model Rules of Governance of autonomous hospitals should be developed by the federal government. Boards also may develop their own rules within the framework of the parent law.

Management

Legislation related to management would specify the responsibilities of the hospital's Management Team and would identify personnel policies, including ones that would move hospital staff from being government to being private-sector employees.

Specifically, this legislation would empower the Hospital Administrator to nominate individuals to the board for appointments to senior management positions. The administrator will have the authority and responsibility to engage, reward, discipline, and discharge personnel as well as to delegate this responsibility to other staff. The administrator's authority would be similar to the power of leaders of private-sector enterprises. At the same time, hospital employees would benefit from all the rights and protections of private-sector employees. Since the current personnel of government hospitals are public servants, plans must be made for making the transition from public to private employee status. Possible ways to make this change-over include:

- Allowing current employees to maintain their jobs and government servant status until they retire, are transferred, quit, or are removed from their job for cause under government servant rules. All newly engaged personnel would be hired under private-sector terms. Under this option, a long time would be needed to reach full private-sector status.

- Offering current employees the choice of being transferred to other government jobs where they would maintain their government servant status or of retaining their jobs at the hospital while changing their status to become private-sector employees . This option would allow hospital management to reach the optimal situation more quickly, but would require that other jobs be found within government for personnel unwilling to convert their status.

Finance

In the area of finance, national legislation would address the issues of decreasing government subsidization, provide guidance in setting user fees, propose ways to cover payments for the indigent, and establish regulations related to the financial management of autonomous hospitals.

This legislation would propose that autonomous hospitals be operated on a non-profit basis. Annual operating expenses would be planned in a budget developed by the Hospital Administrator and approved by the board.

The government would provide a subsidy to the hospital for use in meeting its operating expenditures. In the first few years, this subsidy would be at least the average of the real (adjusted for inflation) allocations of operating funds the hospital incurred during the last five years. The real (adjusted for inflation) value of this subsidy would gradually be reduced to a fraction (e.g., 50 percent) of the real value of the average of the operating allocations of the last five years.

The hospital will have to make up the remaining operating expenses from fees charged to consumers, reimbursements from insurers, contracts with groups of consumers or employers acting on behalf of their members or employees, and from other funds raised in ways prescribed by law, including donations and subsidies from charitable organizations such as the Zakat fund.

Fees to be charged to consumers would be proposed by the Hospital Administrator to the board for approval. The hospital will need to institute a system that judges a patient's ability to pay. No one should be turned away because of inability to pay at the time of treatment. However, efforts should be made to collect fees from those who cannot pay at the time services are delivered, but who have the means to do so later on.

The board will be responsible for ensuring that shortfalls or excesses in earnings should never be greater than 5 percent of operating expenditures. Changes in fees or reductions in costs should be made during the course of a fiscal year to ensure that the foregoing is achieved. Annual excesses or shortfalls should be

adjusted in the following year's operation by changing costs and fees.

Capital is defined as durable equipment and structures with a lifetime of three years or longer. The government should provide funds for all capital replacement and new capital acquisitions by hospitals. In an annual capital budget, the Hospital Administrator should recommend to the board what the capital replacement and acquisition requests to the government should be. The board-approved capital budget would then be submitted to the government and the hospital would be responsible for acquiring capital items against whatever budget is approved by the government.

7.1.2. Legal Issues Related to Hospitals Keeping User Fees

In general, government hospitals in Pakistan are required to remit revenues generated from user fees to the Ministry of Finance. However, PIMS has received an exemption from this requirement and does not appear to have any legal problems in charging and increasing its user fees. Thus, while legal steps are developed to bring a Health Policy law through the legislative process, PIMS can proceed to make changes in its fee schedules and to use the money that is collected. For other hospitals, retention of fees may well be a major barrier to experimentation prior to the passage of the Hospital Autonomous Entity Act.

8.0. USING ZAKAT AND OTHER MUSLIM RELIGIOUS FUNDS FOR THE INDIGENT

Many in Pakistan are concerned that when people are charged for the health care they receive, the poor will suffer the most because they may not have access to free care and their ability to pay is limited. In fact, the government is not willing to grant autonomy if it means reduced access to health care for this section of the population.

When looking for non-government funds to pay the health costs of the poor, many have suggested the option of utilizing religious funds such as Zakat, Ushr, Waqf Property, and Bait ul Mal.

Zakat is an obligatory transfer of funds to poor Muslims by a Muslim who owns or possesses more wealth than the limit prescribed by Shariah (Islamic laws). By doing so, a Muslim purifies his wealth and assets in accordance with the commands of Allah, and also cleanses his heart from greed and lust. Zakat is required to be paid at 2.5 percent per annum on savings, gold, silver and other items of wealth covered under Shariah. Zakat is one of the five basic pillars of Islam.

Ushr, an aspect of Zakat, literally means "one tenth" of something. It is levied on the production of agricultural land (i.e., crops, garden produce). It is paid annually in the ratio of 1:10.

Both the 2.5 percent levy on wealth and the Ushr are part of Zakat, one of the five pillars of Islam. Zakat is obligatory to a true Muslim.

Waqf Property refers to property of any kind which is permanently dedicated by a person professing Islam for any purpose recognized by Islam as religious or charitable. Unlike Zakat, it is not obligatory for all Muslims.

Bait ul Mal refers to welfare funds established by the Amir (head of a Muslim state) for the purpose of providing help to the poor and the needy. It is not obligatory, nor is any fixed rate set for the collection of these funds. The source of these funds is through the state treasury. Bait ul Mal funds have no religious significance and are considered means of helping the poor and needy population, regardless of their religious beliefs.

The Bait ul Mal in Pakistan was only introduced in 1991 and its structure and objectives are still being defined. It is recommended that Bait ul Mal's purpose and initial "teething problems" be solved before any concrete conclusions or recommendations be made on its availability and utilization as an alternative for funding health services for the poor and needy population of Pakistan.

8.1. Administration of Zakat Funds

All of these funds have defined eligibility criteria. Generally, utilization of Zakat funds (the largest fund) is restricted to those Muslims called "mustaqueen" (needy). Non-muslims are not eligible. However, this view is subject to different interpretations by religious scholars and, in some cases, these funds are being dispensed to the needy without any discrimination based on their religious affiliation.

Zakat funds are collected through local banks. On the first day of each Ramdhan month, the banks in Pakistan make a 2-1/2 percent deduction from the bank account of all individual account holders except those who are exempt from paying Zakat (non-Muslims). Also, all other investments made through the government such as bonds and securities have deductions taken from them at the time they are cashed in.

The overall responsibility for the administration, collection, and custody of Zakat funds rests with the Central Zakat Council (CZC), an independent body headed by a judge of the Supreme Court of Pakistan. The CZC is a nine-member council with representation from various federal ministries and agencies. Other Zakat bodies involved in the disbursement and implementation of the funds are:

The Zakat Councils are responsible for policy making with regard to Zakat funds. The Central Zakat Council, through its Central Zakat Administration (CZA), disburses funds through the Provincial Zakat Councils (PZC). The membership of the PZCs is similar to that of the CZC, though at the provincial level. The PZC in each province forwards the Zakat funds to District Zakat Councils which then forward them to the Tehsil Zakat Committees (Tehsils are zones within each district). The Tehsil Zakat Committee relies on the Local Zakat Committee (LZC) to identify people eligible for Zakat funds. The LZC is at the grassroots community level and its members are elected by each "*mohalla*" (neighborhood) in the LZC. There are 39,000 LZCs in existence in Pakistan. Their main objective is to issue eligibility certificates to residents of their neighborhood who are eligible to receive Zakat funds. The LZC mainly relies on the reputation of each applicant regarding his economic status and general condition.

The State Bank of Pakistan retains custody of all the Zakat funds collected by nationalized banks.

8.2. Zakat Health Funds

Zakat funds can and are being utilized for providing both health and educational services to the poor, if they qualify as "mustaqueen" or needy. In the 1991-92 fiscal year, 2.6 billion

rupees in Zakat funds were collected. Approximately 90 million rupees (4 percent) were designated and spent on health-related projects. The Central Zakat Administration indicated that health-related Zakat spending could perhaps be increased to 6 percent, if the Federal Ministry of Health made such a request to the Central Zakat Council.

Zakat funds for health are distributed through two mechanisms: the Patient Welfare Society; and direct disbursements to facilities. The Patient Welfare Society functions in most government hospitals. Patients requiring hospital services who cannot afford to pay for their hospital stay are referred to the Patient Welfare Society. The Society verifies their eligibility (possession of "needy" certificate issued by the Local Zakat Committee). It then may approve using Zakat funds to pay for the patient's hospital expenses. No maximum ceiling on the amount of money available through the Zakat for each hospitalization has been established. Under the current practice, eligible patients are being covered for up to 100 percent of their total hospital expenses.

Direct disbursements of Zakat funds also are made to a number of health facilities on a regular basis. These include the Fatamid Foundation (Blood Donor Agency), the Federal Government Services Hospital, and the Pakistan Institute of Medical Sciences.

Generally speaking, the use of Zakat funds is limited to the provision of services, although there is no such religious requirement. According to Islamic International University, the Zakat funds can also be used for capital and development purposes, including construction and purchase of equipment. They believed that a general consensus is building in the Pakistani religious community that a more liberal interpretation for the use of Zakat funds should be implemented. They also indicated that the amount of Zakat money collected is rather small, and that is why its utilization in the health sector has been limited to providing curative services.

Zakat funds are not adequate to cover the health costs of the indigent in Pakistan since they amount to less than 1/2 of 1 percent of the country's health expenditures. It may be appropriate to recommend that the FMOH develop a system for handling Zakat funds that identifies maximum ceilings to ensure that the benefits of these funds are maximized. Since religious funds and their utilization are sensitive matters in Pakistan, caution should be exercised in making any recommendations regarding the Zakat funds which can be termed "interference" by the Zakat administrative and policy-making bodies.

8.3. Recommendations

Zakat funds can serve as one source for financing hospital and rural health services for poor and needy patients, but they cover only a small percentage of the health care costs of the indigent. Nevertheless, this study recommends to the FMOH that Zakat funds be made available for use both in rural and urban areas, when the recipients of Zakat funds meet the strict requirements laid out for the "mustaqueen." Also, the procedures for dispensing Zakat funds through the Patient Welfare Society at each government hospital should be streamlined and strengthened to ensure that Zakat funds are used optimally and the benefits are enjoyed by a larger segment of the eligible population.

As stated above, the current allocation for health services of 4 percent of total Zakat funds might be increased to 6 percent by making a request to the Ministry of Finance and the Zakat Council. The Federal Ministry of Health should take the initiative and meet with the relevant officials of the Central Zakat Council to initiate this process. However, it is very important to realize that not all Pakistanis are eligible to receive Zakat funds. The funds are restricted to certain classes of Muslims. To ensure availability of funds for the remaining population, close monitoring of Bait ul Mal funds should be maintained and the FMOH should use its influence to make the Bait ul Mal funds available for those people not eligible for Zakat funds.

9.0. IMPLEMENTATION PLAN

Planning provides a structure for the future, taking into consideration specific goals, time frames for achieving these goals, and the activities needed to carry them out. The following pages revisit the issues discussed during the study of hospital autonomy, identify the objectives that have been set, and show the steps that need to be taken to achieve these outcomes.

This plan should be administered by an agency within the government or by an independent organization charged by the FMOH with responsibility for directing and implementing autonomy. The parent body should be a legal entity which will have independent control over policy making, program management, budgeting, finances, personnel, and the internal functioning of autonomous hospitals.

With the exception of the recommendation for the composition of the Board of Directors, it is assumed that implementation of this program can begin prior to the passing of a comprehensive Health Policy law that makes autonomy for government hospitals possible.

EXHIBIT 10

HOSPITAL AUTONOMY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	REPORT SECTION REFERENCE	LENGTH OF TIME IN MONTHS*	WHO/WHAT	BUDGET RESOURCES	COMMENTS
APPOINT BOARD OF DIRECTORS	COMPOSITION OF THE BOARD OF DIRECTORS DEFINED AND RESPONSIBILITIES DEVELOPED	4.3.	1-12	FMOH; PIMS' & FGSH's Boards of Directors	FMOH, PIMS, & FGSH	THE AUTONOMOUS ENTITY ACT WILL DEFINE THE RESPONSIBILITIES AND PROCESS FOR DECENTRALIZING BOARD CONTROL.
ESTABLISH AND CLARIFY MISSION OF AUTONOMOUS HOSPITAL	REVIEW MISSION STATEMENT AND DEFINE THE PURPOSE AND SCOPE OF THE HOSPITAL (APPENDIX A.1)	4.3.	3-9	PIMS & FGSH Boards of Directors and Management	PIMS, FGSH, & DONOR	THE MISSION STATEMENT SHOULD BE A FORMAL DOCUMENT THAT EXPRESSES THE IDENTITY, FUNCTION, AND COMMUNITY/PUBLIC SERVICE GOALS OF THE HOSPITAL.
COORDINATE PRIMARY, SECONDARY, AND TERTIARY CARE	ESTABLISH REFERRAL PROTOCOLS AND PROCEDURES AND DEVELOP IMPLEMENTATION PLAN (APPENDIX A.2)	4.3.	9-21	PIMS & FGSH Management, Private Sector	PIMS, FGSH, & DONOR	ESTABLISH CLEAR AND FIRM PROTOCOLS (CRITERIA) AND PROCEDURES FOR REFERRALS TO THE HOSPITAL.
ESTABLISH MANAGEMENT TEAM	DEFINE ORGANIZATION STRUCTURE AND MANAGEMENT TEAM (APPENDIX A.3)	5.4	9-33	PIMS & FGSH Boards of Directors, Management, & TA	PIMS, FGSH, & DONOR	DETERMINE THE NEED FOR PHASED IMPLEMENTATION OF THE ORGANIZATIONAL STRUCTURE AND DETERMINE THE ACTION STRATEGIES AND STEPS.
ESTABLISH PERSONNEL FUNCTION	ESTABLISH PERSONNEL ADMINISTRATION FUNCTIONS AND DEPARTMENT (APPENDIX A.4)	5.5	24	PIMS & FGSH Board of Directors, Management, & TA	PIMS, FGSH, & DONOR	PREPARE PLAN FOR THE DEVELOPMENT OF THE PERSONNEL FUNCTIONS.

* Time measured from start of the move to autonomy.

EXHIBIT 10 (Continued)

HOSPITAL AUTONOMY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	REPORT SECTION REFERENCE	LENGTH OF TIME IN MONTHS*	WHO/WHAT	BUDGET RESOURCES	COMMENTS
ESTABLISH MANAGEMENT TRAINING PROGRAMS	DEVELOP AND CONDUCT MANAGEMENT TRAINING PROGRAMS INVOLVING PRIVATE SECTOR	5.5	24	PIMS & FGSH Top Management, Private Sector, & TA	PIMS, FGSH, & DONOR	USE PRIVATE SECTOR AS TRAINERS & MENTORS IN FINANCIAL MANAGEMENT, MARKETING, ETC.
IMPROVE FINANCIAL MANAGEMENT	DEVELOP PROCEDURES AND GUIDELINES FOR FINANCIAL OPERATIONS - BUDGETING AND ACCOUNTING (APPENDIX A.5)	6.1 & 6.2	12	PIMS & FGSH Deputy Directors for Finance & TA	PIMS, FGSH, & DONOR	DEVELOP ACCOUNTING, BUDGETING, & PLANNING CAPABILITIES; MONITOR & MANAGE COSTS
IMPROVE FINANCIAL MANAGEMENT CONTROL AND MONITORING	DEFINE FINANCIAL CONTROLS AND MONITORING REQUIREMENTS (APPENDIX A.5 and A.6)	6.2	12	PIMS & FGSH Top Management & TA	PIMS, FGSH, & DONOR	DEFINE STATEMENT OF FINANCIAL PURPOSE AND CHOOSE A STRATEGY THAT ESTABLISHES THE BASIC FINANCIAL DIRECTION OF THE HOSPITAL. RELATE PERFORMANCE CRITERIA TO AUTONOMOUS HOSPITALS' MANDATES
IMPROVE INVENTORY CONTROL	DEVELOP PROCUREMENT SYSTEM (APPENDIX A.7)	6.2	36	FMOH; PIMS & FGSH Boards of Directors, Management & TA	PIMS, FGSH, & DONOR	DEVELOP GUIDELINES TO EXPEDITE THE TENDER PROCESS FROM NOTIFICATION OF AWARD TO SIGNING OF CONTRACT
EVALUATE HEALTH SYSTEM DELIVERY	STUDY PRIVATE TRUST HOSPITALS FOR LESSONS FOR AUTONOMOUS HOSPITALS	6.3	12	PIMS & FGSH Top Management, Trusts Management, & TA	PIMS, FGSH, & DONOR	CONCENTRATE ON USER PAYMENTS, IDENTIFYING WHO CANNOT PAY, & ASSURING QUALITY AND ACCESS

* Time measured from start of the move to autonomy.

EXHIBIT 10 (Continued)

HOSPITAL AUTONOMY IMPLEMENTATION PLAN

OBJECTIVES	ACTIVITIES	REPORT SECTION REFERENCE	LENGTH OF TIME IN MONTHS*	WHO/WHAT	BUDGET RESOURCES	COMMENTS
MARKET CLIENTS AND SET USER FEES	INCREASE FINANCIAL AUTONOMY THROUGH COST RECOVERY	6.4 & 6.5	24	FMOH; PIMS & FGSH Boards and Management; & TA	FMOH & DONOR	LONG- & SHORT-TERM TA NEEDED
MONITOR & EVALUATE PERFORMANCE AT PIMS & FGSH	GATHER DATA ON PERFORMANCE INDICATORS, EVALUATE, THEN REVISE APPROACHES	10	24	FMOH, PIMS & FGSH Management; & TA	FMOH, PIMS, FGSH, & DONOR	LEARN LESSONS FROM PIMS & FGSH TO MODIFY APPROACHES BEFORE UNDERTAKING ADDITIONAL IMPLEMENTATION
REPLICATE AT SELECTED PROVINCIAL HOSPITALS	SELECT TWO OR MORE HOSPITALS IN EACH PROVINCE FOR CONVERSION TO AUTONOMY, THEN ASSIST TO IMPLEMENT	1 THROUGH 10	36	FMOH, PMOHs, & TA	FMOH, PMOHs, & DONOR	BEGIN PROVINCIAL IMPLEMENTATION AFTER ONE YEAR OF LEARNING FROM PIMS & FGSH
MONITOR & EVALUATE PERFORMANCE AT PROVINCIAL AUTONOMOUS HOSPITALS	GATHER DATA ON PERFORMANCE INDICATORS, EVALUATE, THEN REVISE APPROACHES	10	36	FMOH, Autonomous Provincial Hospital Management, PMOHs, & TA	FMOH, PMOHs, & DONOR	LEARN LESSONS FROM HOSPITALS MADE AUTONOMOUS TO MODIFY APPROACHES BEFORE ADDITIONAL IMPLEMENTATION
IMPLEMENT AT ALL REMAINING HOSPITALS	OVER TEN-YEAR PERIOD IMPLEMENT IN ALL REMAINING HOSPITALS	1 THROUGH 10	—-	FMOH, PMOHs, Hospital Management, & TA	FMOH, PMOHs, & DONOR	COMPLETE NATIONWIDE AUTONOMY ON A PHASED BASIS

* Time measured from start of the move to autonomy.

10.0. MONITORING AND EVALUATION PLAN

The following plan can be used for monitoring and evaluating progress in granting autonomy to government hospitals. It indicates what kind of data to collect in order to judge whether the intended consequences of the reform are realized.

The following table spells out the objectives for autonomy, it recommends indicator data that should be gathered for each objective, and it shows how often the data should be evaluated.

EXHIBIT 11

HOSPITAL AUTONOMY MONITORING AND EVALUATION PLAN

OBJECTIVES	MONITORING INDICATORS	EVALUATIONS
REDUCE GOVERNMENT SUBSIDY TO HOSPITALS	REAL (ADJUSTED FOR INFLATION) AMOUNT OF SUBSIDY DECLINING	ANNUAL
	PERCENT OF TOTAL FUNDING OF HOSPITALS FROM SUBSIDIES DECLINING	ANNUAL
BILL THOSE ABLE TO PAY FOR CARE	REAL HOSPITAL REVENUES FROM USER PAYMENTS INCREASING	ANNUAL
IMPROVE EFFICIENCY	UNIT COSTS OF A SET OF COMMON INPATIENT AND OUTPATIENT PROCEDURES ARE DECLINING	EVERY 6 MONTHS
RAISE QUALITY	COMPLY WITH HOSPITAL ACCREDITATION STANDARDS	ACHIEVE ACCREDITATION WITHIN 2 YEARS OF BECOMING AUTONOMOUS, THEN MAINTAIN ACCREDITATION
	PATIENTS SATISFIED WITH CARE	CONDUCT QUARTERLY PATIENT SURVEYS
ENSURE ACCESS TO THE POOR	10 PERCENT OF PATIENTS ARE TOTALLY EXEMPTED FROM PAYMENT, 20 PERCENT MORE ARE PARTIALLY EXEMPTED	ANNUAL
	SIGNIFICANT DIFFERENCES IN SOCIO-ECONOMIC STATUS OF EXEMPTED, PARTIALLY-EXEMPTED, AND PAYING PATIENTS	SURVEY ONCE EVERY 2 YEARS

APPENDIX A

PROPOSED ORGANIZATIONAL STRUCTURE FOR AN AUTONOMOUS HOSPITAL

A.1. MISSION CLARITY

Interpretation of the hospital's mission will help the hospital to efficiently target services to patients and focus on a specific level of care (primary, secondary, or tertiary).

Timeframe

Duration of Initial Steps: Six months for the board to hold meetings to discuss issues related to the care and services provided by the hospital. Within the first six months, the Board should also notify the staff and the public of the "Autonomous Status" of the hospital.

Resources

Personnel: No staff will be needed to review the care and services provided by the hospital. The Hospital Administrator and Deputy Directors will participate in the discussions.

Financial: No financial requirements for implementing the mission statement.

Dependence

Interrelationship: The discussion of the mission statement is preceded by the decentralization of board control to the District and Tehsil health committees. All administrative, medical, and support staff should be aware of the discussions on the care and services provided by the hospital. The Public Relations and Marketing Departments should be well informed, so that they can incorporate the agreed-upon mission into all public relation and planning activities.

External: There may be minimal involvement from the Federal and Provincial Ministries of Health.

Impact

Short-term: Low—
The planning process and preparations for informing the community will have little impact on the current operations of the hospital.

Medium-term: High—
Although careful planning will help minimize disruptions, there will be a period of adjustment as hospital staff get used to the ``new" role of the hospital and patients become accustomed to not going to the hospital for inappropriate services.

Long-term: High—
The hospital will become strictly a primary, secondary, or tertiary care hospital. This will make more effective use of the hospital facilities. Elimination of [primary, secondary, or tertiary] care from the hospital will ease congestion and increase quality of care for patients.

Responsibility

The board will have primary oversight responsibility for the discussions on Mission Clarity.

Implementation Steps

- The board should review and revise the present Mission Statement of the hospital. It should be a formal document that expresses the identity, function, and community/public service goals of the hospital.
- The board should assess the care and services provided by the hospital.
  - ❍ Review the category of services, primary, secondary, and tertiary.
  - ❍ Review the service needs of the community.
- The board should assess how the care provided compares with the mission as specified in the hospitals Act/Ordinance.
- For teaching facilities - The board should assess how the medical training provided compares with the mission as specified in the hospitals Act/Ordinance.
- The board should make sure that the Mission Statement defines the scope and purpose of the hospital.
- The board should make sure that the Mission Statement serves as a means for adding unique direction and shape to the hospital's strategic goals by setting out guidelines for determining what generic activities the hospital should (as well as should not) pursue.
- The board should keep the Public Relations and Planning Departments informed of all activities.

A.2. REFERRAL PROTOCOLS AND PROCEDURES

Develop, communicate, and enforce referral protocols between the hospital and other government and non-government organizations, and private physicians.

Timeframe

Start: The Hospital Administrator should appoint a committee consisting of the top clinicians from the major clinical areas and several key department managers of the hospital.

Duration of Initial Steps: The committee should take approximately three months to carry out the duties described below in the Implementation Steps. The board will take an additional two months to communicate the admissions procedures and criteria to the hospitals in the catchment area.

Resources

Personnel: Physicians, nurses, technicians, and medical records personnel will devote some of their time to reviewing the protocols. Additional staff may be required to monitor the process to assure compliance.

Dependence

Interrelationships: Audits to assure compliance will be required by the Medical Records Department; the Hospital Administrator will monitor the process.

External: A good working relationship with other hospitals in the catchment area; a key element of success will be whether the private physicians, private clinics, and other hospitals adhere to the protocols.

Impact

Short-term: Low—
It will take some time to develop the protocols. Once they are established it, will take a while before everyone becomes familiar with and follows them.

Medium-term: Medium—
The hospital staff should follow the procedures as soon as they are established, but it will take several months of enforcement to get other health care providers to do the same.

Long-term: High—
Once the procedures are running smoothly at all hospitals and physicians' offices, the hospital will begin to achieve its stated mission. Congestion and queues in the hospital will decrease, and the hospital will be more effectively using the skills and expertise of its professionals.

Responsibility

The committee appointed by the Hospital Administrator will be responsible for establishing the protocols. All hospital staff connected with the admissions and medical record process are responsible for following them. The board and the Public Relations department are responsible for communicating the protocols to concerned outside entities. Responsibility for enforcement rests with the Hospital Administrator and board.

Implementation Steps

- The board will authorize the Hospital Administrator to appoint a Committee consisting of top physicians from the major clinical departments and selected department managers.
- The committee's terms of reference will be to:
  - Establish clear and firm protocols (criteria) and procedures for referrals to the hospital.
  - Develop an implementation plan which will include various deadlines for which categories of "unreferred" patients will no longer be seen at the hospital.
  - Develop necessary mechanisms and procedures to enforce the protocols. The mechanisms should allow access to critical groups of patients who require the skill, expertise, and equipment that is available at the hospital.
- The committee should establish guidelines, time tables, and milestones for both the short- and long-term steps and actions in the implementation plan.
- The committee's report on the above issues should be presented to the board for approval within three months after the commencement of its work.
- The board will develop a plan to communicate the criteria and procedures for referral to the hospital and submit copies to all hospitals, private physicians, physician clinics, and other medical groups that refer patients to the hospital.

A.3. ORGANIZATION STRUCTURE

Development of a decentralized management organization structure that delineates authority, responsibility, and accountability.

Timeframe

Start: The board and Hospital Administrator should meet to review the proposed Multiple-Layer Organization Structure against existing personnel resources to determine the extent of promotions and additional personnel required. They should determine the need for phased implementation of this structure and strategies and steps to be taken. The board should communicate the proposed changes to the hospital management.

Duration of Initial Steps: Three months to develop position descriptions and promotion criteria. Three months after this to recruit and employ the senior and line management positions. Six months to recruit and employ the department manager positions.

Iterative Review: Through regular Management Team meetings, the board, Hospital Administrator, and senior management will be able to assess the appropriateness of the implemented organizational structure. Problems that the Management Team identifies should be presented to the board for discussion. The board will then formulate modifications.

Resources

Personnel: Management Team, including senior management and one or several department managers, depending on the judgements made by the board.

Financial: There may be substantial salary costs resulting from hiring new personnel or promoting internally. This, however, could be incurred incrementally over time.

Dependence

Interrelationship: It is important that those on the department- manager level and below completely understand the changes and not be adversely affected by them.

External: To some extent, the elements of all external working relationships that the hospital has with other organizations will be determined by the hospital's new internal structure.

Impact

Short-term: Low—
It will take some time to hire new personnel and write job descriptions.

Medium-term: Medium—
It will take time for new and promoted personnel to feel comfortable in their jobs and for obsolete working relationships to be replaced.

*Long-term:*High—
Hospital management will be strengthened as spans of control are worked out; decision-making will be expedited as decisions will be made by those closest to the situation; the Hospital Administrator's time will be freed- up for activities that only he or she can perform.

Responsibility

The Hospital Administrator will be primarily responsible for organizing Deputy Directors' and department managers' positions, and the Board will have oversight responsibility for the organizational structure changes.

Implementation Steps

- Assess skill of those who will be given additional management responsibilities; determine extent of new hires and promotions.
- Develop position descriptions and promotion criteria for all senior and middle management positions.
- Determine the need for phased implementation of the organizational structure and the associated strategies and iterative steps.
- Implement the new structure, communicating changes to all hospital staff and doctors.

A.4. PERSONNEL ADMINISTRATION

The Board of Directors of autonomous hospitals will be empowered to employ, retain, evaluate, and dismiss all levels of salaried staff. It will be able to accept or refuse an employee assigned from any Ministry, to hire personnel as needed, to adjust salaries, reward employees for superior performance, to impose fines, and to request the transfer or dismissal of an employee whose work is unsatisfactory.

Timeframe

Start: The development of a Personnel Department should begin within three months of the passing of the Autonomous Entity Act. The development of the personnel function should begin immediately thereafter.

Duration: Recruitment of a Personnel Manager should be accomplished within four months. The development of the personnel function, including the writing of job descriptions, designing of a system for maintaining personnel files, the development of a staff appraisal and performance review process, and the development of staff training programs should take one year from the date the Personnel Manager is hired.

Resources

Personnel: The Deputy Director, Administration will write the job description of the Personnel Manager for approval by the Hospital Administrator. The Hospital Administrator and Deputy Director, Administration will interview candidates and employ the most qualified. The Personnel Manager will hire staff for the new Personnel Office from existing staff and from external hires.

Financial: Annual salary for a Personnel Manager.

Dependence

Interrelationship: The writing of hospital personnel job descriptions is preceded by the development of the Personnel Department.

Impact

Short-term: Low—
Will show hospital staff that management is taking control over personnel, but will have little direct effect on day-to-day operations in the short term.

Medium-term: Medium—
Management will begin to gain control over quality of hiring, training, performance, compensation, promotion, and discipline of staff.

Long-term: High—
Management will have maximum control over quality and performance of staff.

Responsibility

The Deputy Director, Administration is responsible for recruiting and employing the Personnel Manager. The Personnel Manager is responsible for developing the Personnel Department.

Implementation Steps

- Develop job description for Personnel Manager position (Deputy Director, Administration)
- Approve job description (Hospital Administrator)
- Interview candidates for Personnel Manager
- Select and employ Personnel Manager
- Assist in writing job descriptions of Management Team (Hospital Administrator, Personnel Manager, and Personnel Department staff)
- Prepare plan for the development of the personnel functions: writing of staff job descriptions; designing a system for maintaining personnel files; developing staff appraisal and performance reviews; and structuring a process for hiring, disciplining, and dismissing employees; developing staff training programs; and developing a system of incentives and rewards for outstanding performance. (Personnel Manager).
- Implement the plan for the personnel function (Hospital Administrator and Personnel Manager).

A.5. FINANCIAL CONTROLS AND MONITORING

Create the post of Deputy Director, Finance to be responsible for the financial operations and management of the hospital

Timeframe

Start: The Hospital Administrator should define the job. The candidates should be screened by the Administrator and select board members.

Duration: The development of a job description should take no longer than 60 days. The goal of the screening and interviewing process should be to select, hire, and employ the successful candidate within 120 days.

Resources

Personnel: The Hospital Administrator will be required to develop the job description and to interview the candidates.

Financial: Additional funds will be required for the annual salaries for one full-time Deputy Director, Finance, one full-time Accountant, and one full-time secretary.

Dependence

Interrelationship: Improvement in the financial operations of the hospital depends on establishing and maintaining appropriate and accurate accounting and fiscal controls.

Impact

Short-term: Medium—
The improvements in financial controls will be helpful in maintaining funds for operations.

Medium-term: High—
Financial controls will lead to fiscal strength.

Long-term: High—
Fiscal strength will provide sound budget and financial operations.

Responsibility

The board will ensure that financial operations are performed appropriately. The responsibility for implementing the financial policies of the board relative to the control and effective utilization of the physical and financial resources of the hospital will reside with the Hospital Administrator. The responsibilities for safeguarding the assets of the hospital, supervising the receipt and disbursement of cash, and ensuring that the operation is adequately financed should be given to the Deputy Director, Finance.

Implementation Steps

- Define a statement of financial purpose and strategy that establishes the basic financial direction of the hospital. (board and Hospital Administrator)
- Create the position of Deputy Director, Finance (board)
- Write job description for Deputy Director, Finance (Hospital Administrator) with the following functions:
  - Establish, coordinate, and maintain, through authorized management, an integrated plan for the control of financial operations.
  - Measure performance against approved operating plans and standards, and report and interpret the results of operations to all levels of management.
  - Interpret and report on the effects of external issues on the attainment of the financial objectives of the hospital.
  - Provide controls to safeguard the assets of the hospital.

A.6. FINANCIAL OPERATIONS ❯ ACCOUNTING AND REPORTING

Autonomy-related financial planning and budgeting, as well as the projected increased dependence on user-fees, requires strengthening hospitals' accounting and reporting programs.

Timeframe

Start: Within 30 days of the employment of the Deputy Director, Finance.

Duration: The duration will continue through the submission of the budget and financial plan to the board for review and approval.

Resources

Personnel: Annually one full-time accountant to support the financial planning and budget function.

Financial: Annual salary for one full-time accountant.

Dependence

Interrelationship: Support and cooperation of senior management and department managers. Planning department should assist in the development of operating statistics, forecasted utilization, rates, estimated work loads, and resource requirements.

Impact

Short-term: Low—
Development and implementation of financial planning and budgeting programs will require several months.

Medium-term: High—
Financial planning and budgeting programs will monitor each department's actual results related to standard requirements.

Long-term: High—
Implementation of financial planning and budgeting guidelines for all departments will result in savings. Having the accounting and budgeting programs should allow hospital management to monitor the fiscal operations of the hospital and to adjust operations to assure financial soundness.

Responsibility

The Deputy Director, Finance serves as the overseer of the financial tasks including the accounting discipline, the accounts payable and receivable function, cash management, inventory management, capital assets management, budgeting, and maintaining internal controls. This person must be knowledgeable and dedicated strictly to overseeing the financial matters of the hospital.

Implementation Steps

- Financial Planning - General estimates of future volume will be refined to provide specific workload estimates necessary to develop the details of the financial plan and to calculate resource requirements.
  - ❯ Accounting system—implementation of a transactional- based, double-entry accounting system.
- Budget Planning ❯ Development of hospital objectives and priorities, identification of factors and trends which affect operations and costs, and preparation of the preliminary budget.
  - ❯ Budget system—implementation of budget guidelines and system.
- Revenue and Expense guidelines — conversion of department managers' detailed resource specifications into actual rupees required.
- Review, modify, and publish - generation of the final revenue, expense, and capital requirements for each department.

A.7. FINANCIAL OPERATIONS) PROCUREMENT

In order to provide an efficient procurement system, tendering and procurement procedures should be reviewed and streamlined.

Timeframe

Start: Hospital Administrator, Deputy Director, Administration, and the manager of the hospital's store of supplies will draft procedures that will provide improved access to tender by major reputable suppliers and improve evaluation and contractual arrangements.

Duration: Process will be constantly upgraded and revised.

Resources

Personnel: Stores manager and one full-time staff will prepare procedures and guidelines. The Hospital Administrator and Deputy Director, Administration will review the procedures and guidelines.

Dependence

Interrelationship: Cooperation between administration, finance, and stores to effectively implement, monitor, and enforce procedures and guidelines.

External: Coordination with major suppliers and other vendors to ensure impartiality of procurement system and to enhance price competitiveness.

Impact

Short-term: Low—
Will require several month to prepare procedures and guidelines and to inform vendors.

Medium-term: High—
Once the procedures are in place the procurement process will be shortened and vendors that can supply the product will be out under contract.

Long-term: High—
Procedures will enhance the hospital's opportunities for volume discounts from vendors.

Responsibility

Deputy Director, Administration, and Stores Manager.

Implementation Steps

- Revise and enforce guidelines for confidentiality of contracting information and vendor sources.
- Estimate utilization of major supply items and plan to order sufficient quantity to obtain volume discounts and to avoid inconveniencing suppliers.
- Develop guidelines for all major suppliers of goods/services to receive notification of proposed hospital contracts.
- Develop evaluation criteria to help deal with price variations.
- Develop guidelines to expedite the contracting-for-supplies process from notification of award to signing of contract to be completed within one month.

A.8. CONVERSION OF AUTONOMOUS HOSPITALS TO SELF-FINANCING OPERATIONS

Develop, communicate, and market health service contracts to individuals, businesses, and organizations that include arrangements for third-party payments.

Timeframe

Start: When the Autonomous Entity Act has passed, the Hospital Administrator should prepare a plan for future contracts with employers and should make arrangements with insurers or other prepaid insurance providers. The Deputy Directors', Administration and Finance and the Marketing Manager should design benefits packages and prepare an estimate of costs for these packages. The Marketing Department should begin marketing contracts to employers and pursue arrangements with Muslim charitable organizations and other insurers. The Finance department should study the feasibility of charging fees to doctors with private practices who utilize hospital services.

Duration of Initial Steps: Three months to design benefits packages and prepare cost analyses. The marketing of contracts and other arrangements will take six months.

Iterative Review: It will be essential to conduct regular cost and utilization analyses for employer contracts and other prepaid arrangements.

Resources

Personnel: One full-time employee from the Marketing Department to work on benefit design and marketing. One full-time employee to perform monthly cost and utilization analyses and do feasibility studies.

Dependence

Interrelationships: The ability to generate revenue from these programs will be dependent on the existence of an accounting and financial information system.

Impact

Short-term: Low—
Some additional revenue will be generated through contracts and other arrangements, but it will be difficult to estimate costs and utilization correctly in the early stages.

Medium-term: Medium—
Services will have to be carefully monitored and contracts recalculated on the basis of past consumption.

Long-term: Medium—
The hospital will be only one of many providing benefit packages. As employers become more experienced with contracting for health care benefits for their employees, they will try to obtain better deals from other hospitals.

Responsibility

Deputy Director, Administration and Marketing Manager will be responsible for development of policies and procedures. The Deputy Director, Finance will be responsible for monitoring costs and utilization of contracts, and for billing and producing financial data.

Implementation Steps

- Develop prototype benefits packages with different price ranges for different size companies.
- Evaluate cost of providing these benefit packages given historical and predicted morbidity and utilization data, and estimated costs of services.
- Prepare marketing strategy and plan.
- Pursue arrangements with insurers and with other Muslim charitable organizations.

APPENDIX B

SAMPLE MID-LEVEL MANAGEMENT FUNCTIONS IN AUTONOMOUS HOSPITALS

APPENDIX B

SAMPLE MID-LEVEL MANAGEMENT FUNCTIONS IN AUTONOMOUS HOSPITALS

ADMINISTRATION DEPARTMENT

Following are the functions of the department managers who report directly to the Deputy Director, Administration. Each will be responsible for the successful operation of that department and will have staff to carry out departmental duties.

Personnel Manager

Under autonomy, the hospital will need complete authority over personnel working at the facility. The Personnel Manager will develop a written set of personnel policies and procedures covering areas such as employee benefits; recruitment and contracting; training and development; promotions; disciplinary system; wages, hours, and salary; administrative rules of conduct; and performance appraisals. These are the basic functions of the employment process. The Personnel Department will also function in an advisory capacity in training and orienting personnel, keeping personnel files, and coordinating personnel assigned throughout the hospital. The Personnel Manager will work with department managers throughout the hospital to develop job descriptions for each of the key positions in the organization. This should allow the efficient hiring of employees whose skills and qualifications match those required by the hospital. It will also give employees an understanding of what their duties and responsibilities are and give administrators ways of measuring employee performance.

Medical Records Manager

Up-to-date and complete patient medical records are vital to control the quality of medical and nursing care. The Medical Records Manager should work with the Deputy Directors of Medical Services and Nursing Services to establish procedures for medical records to be completed by physicians, technicians, and nurses. The Medical Records Manager will be responsible for training medical and nursing staff in the use of the medical records system.

The Medical Records Department is responsible for handling: (1) storage and retrieval of medical information; (2) admission and discharge analyses; (3) coding and abstracting of diagnoses and procedures; (4) information on disease patterns, patient morbidity, and mortality statistics; and (5) patient social services.

The Medical Records Manager will be responsible for the Social Services Department, a major contributor to the mission of the hospital. Specifically, the Social Services Department:

- Aids the health team in understanding the social, economic, and emotional factors that affect the patient's illness, treatment, and recovery.
- Aids the patient and the patient's family to understand these factors and to make constructive use of the resources in the medical care system
- Promotes the well-being of the patient and improves morale of the patient's family by working with both the family and the patient.
- Provides education about social issues to hospital staff and members of the community.
- Offers better patient care by identifying various services, including external aftercare services available to the patient.
- Improves the utilization of the community's resources in order to support patient and family needs when the patient leaves the hospital.

The Social Services Department, possibly working with welfare committees, will be asked to study those who cannot pay for health services and classify them as "free" patients. The social workers in this department must be highly trained individuals and must have an advanced degree of education.

Information Systems Manager

Management information will enable the Hospital Administrator, Deputies, and Departmental Managers to monitor the performance of the various aspects of the hospital and to respond appropriately and in a timely manner to problem situations. The hospital needs an efficient flow of information in order to enable it to function as an autonomous institution and to deliver effective services. The hospital deputies will assist in developing and implementing this system in order to assure that all information required by the management of the hospital is gathered, disseminated to the particular departments that require it, and used effectively to gain greater control over hospital operations.

Marketing Manager

The marketing of hospital services will become a critical function for autonomous hospitals. Marketing is one of the most important managerial roles in health services. Patients are the primary, sometimes the only, source of revenue, and the hospital must promote its services in order to attract paying patients. An immediate task for the Marketing Manager will be the establishment of contracts between local businesses and the hospital to provide medical care to employees.

FINANCE DEPARTMENT

The Finance Manager, who reports directly to the Deputy Director, Finance, will be responsible for ensuring the successful operation of the department. This person will oversee all phases of financial management of the hospital, including general accounting and bookkeeping, patient financial accounts, and financial reporting. Responsibilities will include handling a capital replacement fund for the repair of equipment, the purchase of new equipment, and the maintenance of the physical plant of the facility.

MEDICAL SERVICES DEPARTMENT

The hospital's medical staff has the greatest impact on the quality of care and utilization of services given at the institution. Under this function are: internal medicine, surgery, anesthesia, pediatrics, urology, orthopedics, ophthalmology, obstetrics/gynecology, dentistry, dermatology, emergency services; and other medical specialties offered by the hospital. Each of these departments will be headed by a physician specialist who reports to the Deputy Director, Medical Services. Each of these physicians will be responsible for both inpatient services and outpatient clinics (where applicable) under each medical specialty.

NURSING SERVICES DEPARTMENT

All nursing care will be the responsibility of the Deputy Director, Nursing. This person will be assisted by a Degree Nurse responsible for the management of the Nursing Department. Each specialty department such as pediatrics, intensive care, and surgery will require nurses trained in these areas. In addition, each inpatient wing needs a Head Nurse Supervisor.

It is vital that Nursing Services develop a written plan that assures coverage on a 24-hour-basis for all patients, with appropriately trained nurses on all shifts.

SUPPORT SERVICES DEPARTMENT

The following describes the functions of the department managers who report directly to the Deputy Director, Support Services. Under these functions are: (1) Technical/Diagnostic Services (radiology, laboratory, and pharmacy) and (2) Hotel Services (housekeeping, maintenance, kitchen, laundry, and hospital store). Each of these areas will be headed by a manager responsible for the successful operation of the department. It should be noted that if a skilled administrator cannot be found to fill the position of Deputy Director, Support Services, this

position may be combined with that of Deputy Director, Administration.

(1) TECHNICAL/DIAGNOSTIC SERVICES:

Senior Radiology Technician

The Senior Radiology Technician will be responsible for operating the Radiology Department and establishing radiology administrative procedures. This person will also work with the Medical Records Manager, Finance Manager, and the Deputies of Medical Services and Support Services to develop a method of ordering radiology services that will be medically appropriate, will record the results of tests on the patient's medical record, and will capture this information on the patient's bill for services.

Senior Laboratory Technician

The Senior Laboratory Technician will be responsible for operating the Laboratory Department and establishing laboratory administrative procedures.

Pharmacist

The pharmacist will be responsible for the operation of the hospital's Pharmacy and for establishing pharmacy administrative procedures. The Pharmacist will determine what drugs will be stocked and will develop an inventory management system to assure the supply and security of the pharmacy's inventory. An important factor in assuring patient satisfaction is the uninterrupted supply of appropriate drugs.

Another responsibility of the pharmacist will be to work with the Medical Records Manager, the Finance Manager, and the Deputy Directors of Medical and Support Services to develop a method of ordering drugs for inpatients that will be medically appropriate, will record the nature and quantity of these drugs in the patient's medical record, and will capture them on the patient's bill for services. For outpatients, the Pharmacist will work with the Finance Manager to develop a system where outpatients will pay for drugs at the time of delivery.

(2) HOTEL SERVICES:

Housekeeping Manager

The cleanliness of the hospital is vital for both the health of the patients and for their perception of quality service. Housekeeping staff have the primary function of keeping the hospital clean — not an easy task. Part of the problem is that a hospital is an active place, open 24 hours a day, every day of the year. Frequently, the high traffic areas need special attention; if they are not cleaned properly, they can give a negative image to the entire hospital. A clean hospital is perceived to be a well-organized and well-managed hospital.

Under autonomy, the Housekeeping Department will develop and implement plans and schedules to clean the hospital. The Housekeeping Manager will be responsible for developing a schedule for daily cleaning of the hospital. The Housekeeping Manager will train staff to follow the cleaning plan and will arrange additional training in techniques to clean such specialty areas as operating theaters, intensive care units, isolation rooms, and delivery rooms. Also, housekeeping personnel are needed to work in the laundry, kitchen, and dry waste disposal areas. Housekeeping personnel should be sufficient in number to clean the hospital twice daily.

Maintenance Manager

A department in the hospital that often is overlooked by patients and visitors is the Maintenance Department. There are essentially two aspects of the maintenance function of the hospital: (1) traditional maintenance, and (2) biomedical maintenance.

Traditional maintenance involves maintaining the building and machinery of the hospital. These functions may be improved if the Maintenance Department and the hospital have preventive maintenance programs to ensure that work will be done on a regular basis to keep the hospital's machinery and equipment from breaking down. The preventive programs include periodic inspections of the equipment, at which time inspectors should make minor adjustments to the apparatus. Record keeping is critical to adequate preventive maintenance programs; the purchase date of the item, major repair of the equipment, and inspection reports all must be recorded.

Biomedical maintenance involves the repair and scheduled testing, calibration, and upkeep of diagnostic and therapeutic devices used in patient care.

Kitchen Chief

The Dietary Department has a role in the therapeutic care of the patients, as well as in providing quality food menus for the patients and the staff. No department in the hospital reaches more patients and hospital staff than this department. If the food service is good and adequate, it receives only faint praise from patients and personnel. If the food service is inadequate, criticisms abound.

The Kitchen Chief will be responsible for the department and will have two supervisors, one for each shift. The Kitchen Chief will develop a reliable source for procuring food stuff, oversee the operation of the kitchen, develop a schedule for preparation of patient meals, and determine how meals will be served to patients. A qualified professional dietician will plan and direct the patient menus.

Laundry Manager

Without clean linen and staff uniforms, the hospital cannot operate properly. The Laundry Manager is responsible for developing a plan for the operation of the Laundry Department and the distribution of clean and the collection of soiled linens. The Laundry Manager will also develop a method for the control of linen inventories and determine the specialty services which are required, such as linen repair.

Stores Manager

A wide variety of materials are required for the operation of any hospital. These range from bandages to medical gasses to sterile supplies. The Hospital Stores department is usually under the direction of a Stores Manager. This manager has to determine what, when, and how much should be purchased for hospital inventories. The receipt of goods is the responsibility of the manager and the personnel in purchasing. These goods must then be maintained in the storeroom. The Stores Manager determines which supplies will be stocked, the quantities required, and how they will be procured, stored, and distributed.

In developing this inventory, the Stores Manager will also develop an inventory control system that accounts for the quantity, location, and condition of storeroom items. This system will include an efficient method for the ordering of supplies by the various departments of the hospital, the rapid delivery of the supplies to the department, and any accounting of all items consumed. The Stores Manager will also develop a plan for the operation of the Sterilization Department, determine what quality

control methods will be used, and how sterile items will be stored, cared for, and supplied to the areas where they are needed.

APPENDIX C

CALCULATIONS RELATED TO EXHIBIT 7 - Finance Section

APPENDIX C

Calculations Related to Exhibit 7 - Finance Section

Unit Costs

The following calculations were used to arrive at estimates of unit costs per inpatient day and outpatient visit in 1992 at the two institutions targeted in this study.

The total workload was 24,105 admissions and 381,690 outpatient visits. To determine the total workload for a facility whose output includes both inpatients and outpatients, four outpatient visits were assumed to equal one inpatient day of care with regard to resource consumption. This is consistent with the methodology used by Shepard and Carrin in Rwanda and cost studies in Papua New Guinea. Using the 4:1 ratio of outpatient visits to one inpatient day with regard to resource intensiveness, there were a total of 309,452 patient days of which 214,029 (this implies an average length of stay of 8.9 days) were attributed to inpatients and 95,423 to outpatient visits.

Dividing total costs by total patient days yields the average cost per patient day. On the basis of these assumptions, the average cost per patient day at PIMS, including both recurrent and capital costs, was estimated at 737 rupees. This breaks down to an estimated 567 rupees per day for recurrent costs and 170 rupees per day for capital costs. With four outpatient visits equaling one inpatient day in resource consumption, the average cost of an outpatient consultation at the two PIMS hospitals is 184 rupees (142 rupees are the recurrent costs and 42 rupees the associated capital costs.)

There are cost differences between the two hospitals, with Children's Hospital having a lower unit cost. Breaking down the costs, the unit costs of an inpatient day and an outpatient visit are 801 rupees and 200 rupees, respectively, at Islamabad Hospital and 562 rupees and 141 rupees at Children's Hospital. However, the higher costs estimated for Islamabad Hospital are due, in part, to the fact that certain costs, such as utilities and maintaining the site on which both hospitals are located, are attributed solely to the Islamabad Hospital. Thus, its total recurrent costs are overstated and those of Children's Hospital are understated.

BIBLIOGRAPHY

Abrar, Hasan. (1991). Constitutional Crisis and the Judiciary in Pakistan. Karachi: Asia Law House.

Aga Kahn University Hospital. (1989). Marketing Strategy Report.

Ahmed, Syed Harron. (1988). Health, Policy and Planning Perception. Karachi: Asia Law House.

Alderman, Harold, & Gertler, Paul. (1989). The Substitutability of Public and Private Health Care for the Treatment of Children in Pakistan. World Bank Living Standards Measurement Study Working Paper No. 57.

Ali, Hamid. (1991). General Financial Rules of the Central Government, Revised Edition Volumes I and II. Karachi: Ideal Publishers.

Ali, Hamid. (1984). The Federal Employees Benevolent Fund and Group Insurance Act of 1969. Revised Edition. Karachi: Ideal Publishers.

Altaf, Anjum. (1991). Financing Pakistan's Development in the 1990s: Financing Social Services. Lahore: University of Management Sciences.

Altaf, Samia. (1991, December). Proposal: Social Action Program for the Health Sector, Punjab Province, Pakistan. Submitted to Social Action Program Coordinator, Government of Punjab.

Andreano, Ralph, & Helminiak, Thomas. (1987). Report on Health Insurance in Pakistan: Observations and Situation Analysis. University of Wisconsin, Madison.

Ashir, Zohair. (1992). Trip Report: (September 13-19, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Becker, Gregory C. (1992). Facility Standards Manual. Committee for Standards Development, Cost Recovery for Health Project. Cairo, HFS Project, Abt Associates Inc.

Becker, Gregory C. (1992). Trip Report: (February 7-21, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Becker, Gregory C. (1992). Trip Report: (May 31-June 11, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Bennet, Sara. (1991, November). Draft 1: Evaluation of Recent Changes in the Financing of Health Services. WHO Study Group.

Berman, Harris. (1992). Trip Report: (January 29-February 14, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Bitran, Ricardo, et al. Zaire: Health Zones Financing Study. (1986, June- October). USAID/Kinshasa. Resources for Child Health (REACH) Project in collaboration with the Basic Rural Health (SANRU) Project.

Bovbjerg, Randall R. (1992). Trip Report: (April 29-May 9, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, The Urban Institute.

Brooks, Jr., & Roy, M. Institutional Development: PROSALUD. Monograph. Management Sciences for Health.

Central Zakat Administration. (1982, June). The Zakat Manual. Ministry of Finance, Government of Pakistan, Islamabad.

Central Zakat Administration. (1990). Zakat and Ushr Ordinance, 1980, (No.XVIII of 1980). (Corrected up to March 31, 1990). Ministry of Finance, Government of Pakistan, Islamabad.

Country Department I: Europe, the Middle East and North Africa Region. (1991). Towards a Social Action Program for Pakistan: Impediments to Progress and Options for Reform. (For Official Use Only.) The World Bank.

Country Profile: Pakistan. (1992, January). The World Bank, Compliments of POPTR Communications: Field Training.

Creating Resources for Health: A Strategy to Expand Development of Health Sectors in the ANE Region. (1990, January). Draft Number 5. Asia/Near East Bureau, USAID.

Cross, Glendon, & Setzer, James C. (1992, March). A Study of User Fees at Centre Pour le Developpement de la Sante (CDS) Facilities in Haiti . Abt Associates Inc.

"District and National Planning and Management Workshops Manual." (1983). The MEDEX Primary Health Care Services. University of Hawaii, Honolulu.

Ebel, Beth. (1991, July). Patterns of Government Expenditure in Developing Countries During the 1980s: The Impact on Social Services. Innocenti Occasional Papers, Economic Policy Series, No. 18.

Economic Policy Research Unit. (1989). The Financial Sector in Pakistan, With Particular Reference to Investment Finance Banks and Development Finance Institutions. USAID Mission to Pakistan, Islamabad.

Economist Intelligence Unit. (1991). Pakistan, Afghanistan: Country Profiles. Analysis of Economic and Political Trends Every Quarter. No. 2. London.

Economist Intelligence Unit. (1991). Pakistan, Afghanistan: Country Profiles. Analysis of Economic and Political Trends Every Quarter. No. 3. London.

Economist Intelligence Unit. (1991). Pakistan, Afghanistan: Country Profiles. Annual Survey of Political and Economic Background, 1990-91. London.

Employee Incentive System (PROSALUD). (1989). USAID/Bolivia: Management Sciences for Health. (October 1988 - March 1989).

Federal Bureau of Statistics. (1991, March). Statistical Pocket Book of Pakistan, 1991. Government of Pakistan, Statistics Division.

Financing Primary Health Care: Lessons from Bolivia. (1989, February). Management Sciences for Health.

Findings to Date: Policy Options for Financing Health Services in Pakistan. (1992, July). Health Financing and Sustainability Project.

Foreign Investment Advisory Service (FIAS). (1991, December). Foreign Investment Environment in Pakistan. (Draft). Washington, D.C.: The International Finance Corporation (IFC) and the Multilateral Investment Guarantee Agency (MIGA).

Forgy, Larry, & Manundu, Mutsembi. (1990, October). Preventive and Primary Health Care: Resource Gap Study. Kenya Ministry of Health, University of Nairobi. Health Financing and Sustainability Project. Abt Associates Inc.

Gareen, Michael, & Zaidi, Sarah. (1991, September). Estimates of Child Survival in Pakistan. Harvard School of Public Health, Report submitted to Basic Health Services Cell, Ministry of Health, Government of Pakistan and to the Office of Health, Population, and Nutrition, USAID Mission to Pakistan, Islamabad.

Gazette of Pakistan (Extra). (July 1, 1989). "New Import Policy: 1989-1990." Ministry of Commerce, Islamabad.

Gazette of Pakistan. (Extraordinary). (January 7, 1979; September 10, 1980; and October 31, 1982). Ministry of Commerce, Islamabad.

Government of Pakistan. (1988, April). Health Sector in Pakistan: A Health Financing and Expenditure Study. Ministry of Planning and Development. Final Report.

Government of Pakistan, Ministry of Health. (1991, February). Bio-Statistics Section, Health Division, Health Statistical Pocket Book 1990-91. Islamabad.

Government of Pakistan, Ministry of Health. (1991, March). Immediate Measures for Improvement of Health Services in Pakistan.

Government of Pakistan, Ministry of Health. (1991, March). Immediate Measures for Improvement of Health Services in Pakistan: Transparencies.

Government of Pakistan, Ministry of Law, Justice and Parliamentary Affairs. (1989, January). The Insurance Act, 1938 (IV of 1938). (As modified up to January 31, 1989).

Government of Pakistan, Ministry of Health and Social Welfare (Health Division) Notification. (August 20, 1991; February 26, 1983; January 13, 1983; January 13, 1983; December 20, 1982; November 14, 1982).

Government of Pakistan. (1992, June). Policy Options for Financing Health Services in Pakistan. Health Financing and Sustainability Project, Abt Associates Inc.

Health Care Financing Review. (1989 Annual Supplement). Health Care Financing Administration, U.S. Department of Health and Human Services.

Health Financing and Management in Belize: An Assessment for Policymakers. A Compendium of Technical Notes. (Revised 1991, September). Health Financing and Sustainability Project. Abt Associates Inc.

La Forgia, Gerard, & Levine, Ruth. Volume I: Summary Diagnosis. The Urban Institute.

La Forgia, Gerard, & Griffin, Charles. Volume II: Cost Recovery. The Urban Institute.

La Forgia, Gerard. Volume III. Social Security. The Urban Institute.

La Forgia, Gerard, Cross, Harry, & and Levine, Ruth. Volume IV: The Private Medical Sector. The Urban Institute.

Levine, Ruth, & La Forgia, Gerard. Volume V: Resource Allocation. The Urban Institute.

Rankin, James. Volume VI: Pharmaceuticals and Supplies Procurement. Management Sciences for Health.

Health, Population, and Nutrition Strategy Workshop: Strategy Priorities, Issues, and Discussion. (1989, May). Jakarta, Indonesia.

Health Sector in Pakistan: A Financing and Expenditure Study, Final Report. (1988, APN1). Institute of Health Economics and Technology Assessment. North Sidney, Australia.

Health Sector in Pakistan: A Financing and Expenditure Study, Volumes 1 and 2. (1988, April). Ministry of Planning and Development, Government of Pakistan.

Hildebrand, Stan Lee. (1991). Trip Report: (December 9-13, 1991). Phase Two: Study of Feasible Policy Options for Financing Health Services in Pakistan. Health Financing and Sustainability Project, Abt Associates Inc.

Hildebrand, Stan. (1992, June). Trip Report: (June 3-19, 1992). Policy Options for Financing Health Services in Pakistan. Health Financing and Sustainability Project, Abt Associates Inc.

Hildebrand, Stan. (1992, October). Trip Report: (September 30-October 16, 1992). Policy Options for Financing Health Services in Pakistan. Health Financing and Sustainability Project, Abt Associates Inc.

Hildebrand, Stan, & Becker, Gregory. (1992). Commissioning Plan for El Kantara Gharb Hospital. Arab Republic of Egypt, Cost Recovery for Health Project, Health Financing and Sustainability Project, Abt Associates, Inc.

Information Directory. (1992, January). Health Financing and Sustainability Project: Study of Feasible Policy Options for Financing Health Services in Pakistan. Abt Associates Inc.

Iqbal, Masud. (1990, May). Government Financing of the Health Sector. USAID, Islamabad.

Iqbal, Masud. (1991, February). Health Financing Issues and Policy Options: An Annotated Bibliography. USAID Contract #391-0496-0-00-1440-00.

Institute for Health Economics and Technology Assessment and United Computers (Private) Ltd. (1988, April). Final Report: Volume 1. Main Report: Health Sector in Pakistan: A Financing and Expenditure Study; and Volume 2: List of Annexes. (For official use only.)

Joint Commission on Accreditation of Healthcare Organizations (JCAHCO). (1992). Accreditation Manual for Hospitals, Vol. I.

Katz, Daniel, & Kahn, Robert. (1966). The Social Psychology of Organizations. New York: Wiley.

Karachi Chamber of Commerce & Industry. (1991). Annual Report 1990-1991.

Kingsdale, Jon M. (1992, February). Trip Report: Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Kingsdale, Jon M. (1992, April). Trip Report: (April 15-30, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Khan & Mirakhor, Abbas. (1990). Islamic Banking: Experiences in the Islamic Republic of Iran and in Pakistan. The International Monetary Fund.

LaForgia, Gerard, & Cross, Harry. (1991). Trip Report: Ecuador. (August 12-30, 1991). Health Financing and Sustainability Project, The Urban Institute.

Lahore Chamber of Commerce & Industry. (1990) Annual Report.

Lahore General Hospital and the Postgraduate Medical Institute, Lahore. (1992, February).

Langebrunner, John C. (1990, June). Draft Report for the U.S. Agency for International Development, Health Care Financing Study: Phase I. Baltimore, MD: U.S. Department of Health and Human Services.

LeBow, Robert H. (1992, April). Trip Report: (April 10-24, 1992). Government of Pakistan, USAID/Islamabad; Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

LeSar, John W., Haq, Sirajul, Duncan, Ann, Hussain, Tariq, & Newberry, David. (1990, September). Evaluation of the Northern Pakistan Primary Health Care Program, Phase I (1987-1991). Aga Khan Health Service. USAID Cooperative Agreement No. OTR-0530-A-00-7212-00.

Lippeveld, Theo, M.D., et al. (1991, April). Assessment Study on Health Information Systems in Pakistan. Submitted to the Ministry of Health of Pakistan and USAID/Islamabad.

Litvak, J. "User Fees Plus Quality Equal Improved Access to Health Care, Particularly for the Poor: Results of a French Experiment in Cameroon." (Forthcoming). Social Science and Medicine.

Lloyd, P.J. (1987). The Australian Model of Hospital Accreditation: A Discussion. Australian Health Review.

Makinen, Marty. (1993). The Health Financing Transition in Pakistan. HFS Project, Abt Associates Inc.

Makinen, Marty. (1992). Trip Report: (January 19-February 5, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Makinen, Marty. (1992). Trip Report: (April 9-18, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Makinen, Marty. (1992). Trip Report: (June 26-July 9, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Makinen, Marty. (1992) Trip Report: (November 13-24, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Makinen, Marty, & Ashir, Zohair. (1992). Report on the November 21, 1992 Workshop on Policy Options for Financing Health Services in Pakistan. HFS Project, Abt Associates Inc.

Making Ends Meet: Public-Private Partnerships Into the 1990s. (1989, November). Proceedings of the Privatization Council's Third National Conference, The Privatization Review, Vol. 4.

McMahon, B.J., & Winters, J. (1993). Models of Accreditation in Health Care. Health Bulletin.

Mian Burhan-Ud-Din, et.al. (1984, September). Report by the National Commission on the Administration of Hospitals and Medical Education Institutions. Pakistan Medical Commissioner: Islamabad.

Mubarik, M. Mohsin, M.D. (1992) Health Coverage in Pakistan: Evaluation for Future Strategy "Health for All". (Unpublished), Capital Development Authority (CDA): Islamabad.

Myers, Charles N. (1987). Thailand's Community Finance Experiments: Experience and Prospects in Health Care Financing. Asian Development Bank, Economic Development Institute, East-West Center.

Pakistan's Health Manpower and Training Plan Project, Volume I, Final Report. (1990, August). Asian Development Bank. Submitted by ACTS Inc.

Pakistan's Health Manpower and Training Plan Project - Executive Summary and Appendix III: Discussion of the Macro Environment and Overall Health System Resources. (1990, August). Asian Development Bank.

Pakistan's Health Sector Strategic Planning Workshop for Health Manpower and Training Plan Project (October 30-November 1, 1989). Asian Development Bank, Health Division.

Pakistan Medical Association (PMA). (1989, February). Proposals on National Health Policy. PMA National Headquarters, Garden Road, Karachi. Submitted to Government of Pakistan, February 15, 1989.

Pickering, E.N. (1975). The Mechanics of Accreditation. National Hospital and Health Care Project. (Australia).

Planning Commission, Government of Pakistan. (1991, May). Eighth Five-Year Plan (1993-98) Approach Paper.

Planning Commission (Programming Section), Government of Pakistan. (1991, October). Public Sector Development Program 1990-91: Summary Tables.

Planning Commission, Government of Pakistan. Annual Plan 1991- 92: Economic Framework and Public Sector Development Program. (1991, May).

Policy Planning Section/Social Action Program Secretariat (Planning and Development Division), Government of Pakistan. (1991, October). Preparation of Social Action Program: A Progress Report. Government-Donors Dialogue. (1991, October).

Population and Human Resources Division, Country Department I: Europe, Middle East and North Africa Region. (1991, April). Staff Appraisal Report: Pakistan Family Health Project, (For Official Use Only). The World Bank.

Population and Human Resources Division, Country Department I: Europe, Middle East, and North Africa Region. (1988, June). Pakistan: Population and Health Sector Report. (For Official Use Only). The World Bank.

PROSALUD: Self-Financing Primary Health Care ... and More. (October, 1989). Prepared for the American Public Health Association's 117th Annual Meeting. Management Sciences for Health.

Rapid Population Growth in Pakistan: Concerns and Consequences. (1988). Report No. 7522 - Pakistan, Country Operations Division, EMICO.

Report on the Affairs of the Pakistan Institute of Medical Sciences (PIMS). (1990, July). Final Draft.

Report by National Commission on Administration of Hospital and Medical Educational Institutions. (1982, March). Ministry of Health and Social Welfare, Government of Pakistan Notification No. F.20-14/81-MF-II.

Robert, James S., M.D., Coale, Jack G., & Redman, Robert. (1987, August). A History of the Joint Commission on Accreditation of Hospitals.

Sacca, Stephen J. (1990). A Step Closer to "Health for All by the Year 2000" - A Critical Analysis of the Potential for Replicating a Self-Financing Primary Health Care Delivery System Based on the PROSALUD Experience in Bolivia. Massachusetts Institute of Technology.

Sacca, Stephen J. (1991) Trip Report: (December 10-20, 1991). Phase Two: Study of Feasible Policy Options for Financing Health Services in Pakistan. Health Financing and Sustainability Project, Management Sciences for Health.

Sacca, Stephen J. (1992). Trip Report: (January 14-February 9, 1992). Policy Options for Financing Health Services in Pakistan. Health Financing and Sustainability Project, Management Sciences for Health.

Shafi, M. (1989). Handbook of Social Security Legislation. Karachi.

Sharif Al Mujahis. (1990). Muslim League Documents 1900-1947. Volume I, 1900-1908.

Sohair, Syed Tariq, Khan, Rashid Ahmed, Malik, Shaukat, & Khan, Nadeem Mustafa. (1990, July). Report on the Affairs of the Pakistan Institute of Medical Sciences Islamabad (PIMS). Prepared for the Ministry of Health, Pakistan.

Stevens, C.M. (1983, December). Alternatives for Financing Health Services in Pakistan. USAID/Islamabad.

Stover, Charles C. (1991, June). Developing the Management-Ownership Matrix. Health Financing and Sustainability Project, Management Sciences for Health.

Stover, Charles C. (1991). Social Health Insurance: Lessons From Other Countries (Summary of Visual Presentations). National Hospital Insurance Fund Planning Conference, Mombasa, Kenya, September 30-October 2, 1991.

Stover, Charles C. (1991). Strategic Issues for National Hospital Insurance Fund (Summary of Visual Presentations). National Hospital Insurance Fund Planning Conference, Mombasa, Kenya, October 2, 1991.

Stover, Charles. (1992). Trip Report: (January 21-February 9, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Stover, Charles. (1992). Trip Report: (April 4-17, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Stover, Charles C., Almario, Emelina S., & Mendoza, Bim S. (1991, November). Evaluation of an Experimental HMO Program for the Philippine Medical Care Commission Prepared for the 119th Annual Meeting of the American Public Health Association.

"A Survey of Health Care: Surgery Needed." (1991, July). The Economist.

Syed, Riaz Mustafa, M.D. (1991, February). Increase in Budget for Service Charges in Teaching Hospitals. Report submitted to the Secretary, Government of Punjab, Health Department, Lahore.

Tariq, Najib Choudhry. (1991). Import Policy Order, 1991-92 (As amended up to July 1, 1991). Sheikh Publishers: Lahore.

Tawfik, Youssef, M.D. (1992). End of Assignment Report On Drugs and Logistics Component: Objectives, Strategy, Achievements, and Recommended Action. Pakistan Child Survival Project.

"Thailand Country Paper". (1987) Health Care Financing. Asian Development Bank and Economic Development Institute.

Tibouti, Abdelmajid. (1991, May). Pakistan Health Sector: Problems and Potential Contributions to Human Development. United Nations Development Program, Pakistan Human Development Country Mission.

USAID Asia/Near East Bureau. (1990, January). Better Health for Families Through Public Private Cooperation: Health, Population and Nutrition Strategy for the 1990s. Second Draft. USAID.

Vian, Taryn, et al. Financial Management Information Systems in Four Zairian Health Zones. (1987, December). Final Report of a Study Sponsored by the Basic Rural Health Project (SANRU) and Resources for Child Health Project (REACH), Arlington, VA.

The World Bank. (1990, August). Report No. 8848-PAK: Pakistan, A Profile of Poverty.

The World Bank. (1992, January). Report No. 9826-PAK: Access of the Poor to Basic Health Services in Pakistan.

The World Bank. (1992, January-February). Pre-Appraisal Mission, Second Family Health Project: Punjab Province. Lahore.

The World Bank. (1992, February). Aide Memoire: Second Family Health Project Pre-Appraisal Mission. South Asia Region - Country Department III, Population and Human Resources Division. Islamabad.

The World Bank. (1992, February). Islamabad Capital Territory Family Health Project. Islamabad.

The World Bank. (1992, February). Pre-Appraisal Mission, Second Family Health Project: Balochistan Province. Quetta.

The World Bank. (1992, February). Report No. 10391-PAK. Pakistan Health Sector Study: Key Concerns and Solutions.

The World Bank. (1992, March). Report No. 10223-PAK. Pakistan: Current Economic Situation and Prospects. Country Department III, South Asia Region.

The World Bank. (1992, December). Report No. 11127-PAK. Staff Appraisal Report. Pakistan Second Family Health Project.

UNICEF. (1988). Situation Analysis of Children and Women in Pakistan.

Wong, Holly, & Makinen, Marty. (1988, October). Financial Review of the Complexe Medical-Social de la cite soleil. Abt Associates Inc.

World Health Organization. (1991, July). The Public/Private Mix in National Health Systems and the Role of Ministries of Health. Summary Report.

Yoder, Richard A. (1989). "Are People Willing and Able to Pay for Health Services?" Social Science and Medicine, Vol. 29, No. 1.

Yoder, Richard A. (1992, October). Trip Report: (October 6-22, 1992). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Yoder, Richard A. (1993, March). Trip Report: (January 27-February 19, 1993). Policy Options for Financing Health Services in Pakistan. HFS Project, Management Sciences for Health.

Yu, Seung-Hum. Health Systems of Korea. (1988) Research in Human Capital Development, Vol. 5.