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Review article

Does autonomy for public hospitals in developing countries increase performance? Evidence-based case studies[☆]

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ABSTRACT

Objectives: Governments in middle and low income countries have sought ways for the past decades to make their public hospitals more performing. The objectives of this assessment are to: (a) synthesize the experience of eleven countries at granting autonomy to their public hospitals and the obstacles encountered; (b) deduce which autonomy policies have or have not been effective documenting successes and failures; and (c) propose evidence-based recommendations to policy makers.
Data sources: Data for five countries are derived from the author's participation in the autonomy process augmented by current updates provided by national colleagues. Data for the other six countries are derived from publications available in the literature.
Principal findings: Policies granting autonomy to public hospitals have had limited success. In all cases Boards of Directors have been created. Governance of autonomized hospitals by Boards however is obstructed by the resistance of central level entities to have their authority diminished. The Ministry of Finance tends to maintain control over revenues and expenditures. The Public Service Commission resists abdicating its role to hire, promote, transfer and dismiss government employees. The Ministry of Health attempts to keep its authority to appoint hospital staff, procure medical supplies and equipment; it may do so directly or indirectly by selecting and appointing Board members. Management information systems continue to collect activity measures to be aggregated at the national level for statistical purposes and do not provide financial and clinical data useful for decision making by the Boards and by senior management.
Conclusion: Decentralizing decision making to the operational level has had limited success. Stakeholders at the central level devise strategies to maintain their power. Two main obstacles are delegating authority over human resources and finances that are sine qua non conditions for governing and increasing the performance of public hospitals.

1. Hospitals as budgetary versus autonomous units

Table 1 contrasts a public hospital in its most common form as a central government managed budgetary unit against an autonomous health services providing entity.

2. Large scale reforms of public hospitals

Four countries have attempted to grant autonomy simultaneously to most or all of their public hospitals: Iran, Tunisia, Lebanon and Pakistan.

2.1. Iran

The Government of Iran initiated a process of decentralizing its public hospitals in the 1990s. Parliament rescinded the 1995 structural reform in 1996. The Ministry of Health and Medical Education (MOHME) granted autonomy to 54 public university owned hospitals in 2006. The reform included establishing a Board of Trustees chaired by the Chancellor of the medical university (Doshmangir et al., 2015; Jafari et al., 2011) and was to meet every

[☆] Granting autonomy to make public hospitals should make them more performing and improve service delivery. Does the evidence support this hypothesis? What are the reasons that most autonomy experiments have failed and why some have been successful?

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Table 1
Public hospitals as budgetary entities versus autonomous units.

Functional Areas	Hospital as a Budgetary Entity	Hospital as an Autonomous Entity
Legal Structure	Government owned and managed	Autonomy granted through Presidential or Ministerial decrees or by law approved by Parliament. Government remains the owner of the hospital.
Governance	National Standard Operating Procedures to govern government institutions apply	Establishment of a Board of Directors accountable to Government.
Management Structure	Hospital Director appointed by central level.	Chief Executive Officer appointed by and accountable to the Board.
Financial Management	Government provides a line item budget and is responsible for deficits. Accounts audited internally only.	Hospital receives a subsidy from Government for uncompensated care. The hospital generates revenue from patient fees, sale of supplies and pharmaceuticals. External audits are mandatory
Procurement	Government procures goods and services and is responsible for physical improvements.	Hospital purchases medical supplies and pharmaceuticals. Investments in high tech equipment and civil works are proposed by the Board for approval by central government.
Human Resources Management	Number and type of staff defined nationally. Central government decides hiring, terminating, promoting and transferring staff.	Staffing approved by Board but subject to national guidelines. The CEO authorized to recruit permanent and contractual staff and to promote and transfer staff.
Information Management	Data collected for monthly and annual statistical reports by the Department of Statistics. Data are not used to improve hospital performance.	Hospitals define own needs to monitor and evaluate financial and clinical performance. Actions are taken as a result of measuring results.

Adapted from Harding and Preker (1999).

three months.

The large scale organizational reform was unsuccessful and obstacles cited include (Markazi-Moghaddam, 2014a,b; Leila et al., 2015):

- Appointing the Chancellor of the medical university with which the hospitals are affiliated to chair the Board of Trustees and the presence of two faculty members tilted the balance to benefit the medical university's objectives;
- The centralized structure of Iran's health sector affected negatively the autonomy policy as central control thwarted the hospital's decision making on managing its financial and human resources;
- Policyformulation did not include the views from major stakeholders such as the insurance industry and private corporations;
- Doubts existed about the effective support of MOHME who feared the erosion of its authority;
- Irregular board meetings at most hospitals and with few members present; and
- Shortage of full-time physicians: physicians can work in the public and private sectors when employed by a public hospital whereas they would have to work full-time in an autonomous hospital which would reduce their income.

Research on the failure of implementing the Board of Trustees policy concluded that “insufficient budget was the most influential factor that posed numerous challenges to the implementation of the hospital board of trustees’ policy in Iran” (Doshmangir et al., 2015).

2.2. Tunisia

The Ministry of Public Health (MOPH) initiated in 1991 a process to change how the 23 university hospitals were to be managed (Achouri, 2011, 2016) creating a legal entity “Etablissements Publics de Santé” or EPS administered by a Board of Directors with the President and its members appointed by the Minister of Health and managed by a Hospital Director proposed by the Minister of Health. Each ESP would have an advisory “medical committee” comprised of the chiefs of clinical departments.

Implementation of the reform was obstructed by key constituencies. The actions of the Board of Directors were constrained by mandatory adherence to existing laws and regulations; the Chair was selected from the higher levels of the MOPH. Board membership did not include enough physicians; and the Hospital Director was not a Board member to avoid any disagreement between the Board of Directors and the MOPH that appointed the Hospital Director thereby circumventing eventual Board rejection of the MOPH candidate. The “medical committee” never agreed to be merely an advisory body and started making decisions corresponding to the Board of Directors.

The hospital autonomy policy did not have the desired effect.

(i) MOPH continued to manage hospital personnel who remained civil servants and to decide on investments especially high-tech equipment;
(ii) The relationship between the central level and the EPS evolved into an incessant demand by the EPS for more human and material resources;
(iii) Decisions affecting hospital operations were made by the central level without consulting the Board of Directors; and
(iv) The medical committees made requests directly to the central level bypassing the Board of Directors.

2.3. Lebanon

The private sector is dominant in Lebanon's hospital sector. The 28 public hospitals account for 18 percent of hospital beds and are semi-autonomous. The 1996 Law on Public Hospital Autonomy was inspired by the Tunisian laws and mandated that public hospitals were to enjoy financial and managerial autonomy subject to supervision by the MOPH. Autonomous hospitals have the right to create their own revenue by charging patients to replace gradually transfers from MOPH. Reducing transfers was a major objective for making public hospitals financially autonomous (Eid, 2001).

All public hospitals are governed by a Board of Directors and membership ranges from 12 members in the largest hospital to six members in the smallest facility. Board members are remunerated receiving a stipend of about US$120 per meeting. Their strategic oversight role frequently strays into making operational decisions creating conflicts between governance and management. Board members, Board Presidents and Hospital Directors are appointed by the Council of Ministers upon recommendation of MOPH. The