
Round Table Discussion

**Potential Implications of Hospital Autonomy on
Human Resources Management. A Thai Case Study**

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Abstract

Management of human resources in health is a major challenge to health systems development in Thailand. This includes planning for, production, deployment and utilization of health personnel. Although a number of measures have been instituted to meet this challenge, considerable gaps still remain. Recently, hospital autonomy was introduced with a major emphasis to improve efficiency in the delivery of health services by the public sector. The term autonomy carries a number of connotations such as good governance, contractual relationships between public hospitals and the government, market exposure. It also means different things in different contexts. Different conclusions with regard to improving system efficiency have been derived from the experiences of several countries adopting hospital autonomy. Yet, there are a number of reports devoted to discussing the implications of hospital autonomy on the management of human resources in health. Using Thailand as a case study, this paper aims to explore the potential implications of integrated health system intervention. Within the Thai context, it is argued in this paper that autonomy of a network of public providers, rather than autonomy of individual hospitals, should be encouraged if management of health manpower is to be optimized. Other issues related to autonomy are also discussed in varying detail.

Key words: Hospital autonomy, human resources management, decentralization, hospital reform.

Introduction

The public sector in Thailand has been the major player in the country's health service system from the introduction of modern health services. It is undeniable that the public sector has a crucial role in meeting the health needs of the population, especially the underprivileged and disadvantaged. Given Thailand's economic crisis and experience with rapid fluctuations of the private sector over the last fifteen years, the government services delivery system has been a force for stability in the country. However, health services operating under the conventional civil service system are not without problems. There are situations illustrating the weaknesses of a health services delivery system being managed under a highly centralized bureaucracy. For example, staff working in the public sector lack motivation to deal with the large volume of work due to the fixed salary system and rigid manpower management rules and regulations. In addition, efficiency in the use of resources has not been ensured. Finally, systems to ensure transparency and accountability of the public sector resources still need to be improved.

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accountability, but also allow for better governance. In many countries, such changes in public hospitals have been called either “privatization” or “corporatization”. In the Thai context, it is best to refer to these changes as a process of creating autonomous public hospitals. This nomenclature is in line with the current effort of civil service reform, which is trying to make delivery of certain public services more autonomous and free from conventional bureaucratic red tape, rules and regulations, and Thailand’s historical organization culture.

In this respect, creating autonomous hospitals should be taken as a form of decentralization. Hospital Autonomy (HA) is essentially a form of decentralization addressing the division of economic and administrative power/responsibility between the central (in this case, the Ministry of Public Health [MOPH]) and sub-national units of government. Like decentralization, HA is an attempt to achieve the following objectives:

- Improve communication and reduce administrative complexity, thereby improving government’s responsiveness to local needs;
- Enhance effectiveness and efficiency of management by allowing greater discretion;
- Increase accountability to the public;
- Improve resource mobilization for national and local development policies, and improve local knowledge of development priorities;
- Achieve political objectives such as self-reliance, self-determination, and democratization, and,
- Increase the role of the local community in ensuring good governance.

Human resources for health (HRH) is one of the most important and most expensive health resources. It is the HRH that determines the utilization of other health resources. So human resource management (HRM) has been regarded to be the most crucial component for the successful arrangement of health care. HRM is concerned with mobilization, motivation, and capacity development of health personnel in order to achieve health goals. There are several challenges in HRM⁽¹⁾, namely, low motivation, ineffective staff utilization, low staff productivity, outdated and inappropriate skills/knowledge and overall maldistribution of HRH.

Strategies to improve HRM have been offered, i.e., development of management infrastructure, provision of HRH information and research, clarification of all HRM elements and management training for managers⁽²⁾. In principle, HA is quite involved with HRM. This raises some questions related to the HRM challenges. Will HA be a solution for those challenges? Will HA lead to some adverse or undesirable outcomes in terms of HRM, such as worsening of maldistribution or a poorer cadre mix? What should or should not be done in order to avoid the undesirable outcomes?

To our knowledge, the above questions have been rarely addressed in sufficient details by existing publications on HA or health sector reform. As a result, this article is focusing on the potential implications of HA on HRM. It starts with a definition of HA in the Thai context. Then main features of the HA in close relation to HRM will be presented. The potential implications for HRM are discussed. Finally, the “should” and “should not” issues are addressed.

Current Health Services System in Thailand

The health services system (HSS) in Thailand consists of public and private providers with the public sector dominating the market, especially in rural areas. Under the MOPH, public providers form a hierarchy of health care facilities starting from health centers at subdistrict level, community hospitals at district level, provincial and regional hospitals in urban cities of each province and in Bangkok. Their services constitute approximately 70% of all health care services in the country. The rest are shared by public hospitals under other ministries and private providers. The Provincial Health Office in each province except Bangkok is responsible for planning, coordinating, regulating and administering health services provided under the MOPH.

Financing of public health facilities is made through general taxation. Social Security Scheme, Civil Service Benefit Scheme, Workmen's Compensation Fund, Low Income Card Scheme, Voluntary Health Card Scheme, user charges and private insurance. Allocation of government budget to the provinces is based on input-oriented historical-based itemized budget process.

Public universities are the major sources for educating and training highly qualified health personnel, e.g., doctors, dentists, pharmacists and nurses. MOPH also plays a substantial role in producing nurses and non-bachelor degree qualified health workers. Medical education is influenced by medical schools, Medical Council, medical professional groups, and the MOPH. The Medical Council is responsible for licensing of doctors.

Major challenges of HRH development are deployment of highly qualified health professionals to rural areas and efficient management of human resources. In 1995, the ratio of doctors concentration (as measures by doctor-to-population ratio) in the Northeast, the poorest region, as compared to Greater Bangkok, the richest, was 11. The ratios for nurses, pharmacists and dentists were 6, 15 and 9, respectively⁽³⁾. Evidence from a time-motion study in Thailand revealed that only 25-30 percent of health workers time at rural health centers was spent on health services, compared to 15-22 percent of their time on record keeping and reporting, which was seldom used for management⁽⁴⁾.

Definition of an Autonomous Hospital

An autonomous hospital is an institution that is:

- Constituted under the Public Organization Act (POA) and operating under State supervision;
- Primarily responsible for curative care provision, but providing preventive and promotive health services, and financed by State subsidies;
- Responsible to the Ministry of Public Health (MOPH) and meeting basic minimum standards for its technical and administrative functions;
- Financed through a system of vertical block grants and/or transfers from the MOPH and locally generated revenue (in that order of importance);
- Able to retain surplus resources and openly and transparently accountable for all hospital resources, regardless of source; and,
- Governed by a Board of Directors (BOD) and run by a Chief Executive Officer (CEO).

The word “autonomy” refers to the extent of decentralized decision making in six main areas: (1) strategic management; (2) procurement; (3) financial management; (4) human resources management; (5) administration; and (6) clinical governance.

The Thai definition of HA moves public hospitals one step away from a “fully public” towards a “fully private” model. Autonomous public hospitals will be “public organizations” with the role to serve the community. The “governance” aspect of autonomous hospitals shows greater movement towards the fully private model, while the financing aspect calls for support by a performance-based block grant and so is closer to the fully public model as show in Table 1. Shaded areas of Table 1 indicate the scope of autonomy in the Thai context. In this regard, the government will not be abdicating its responsibility for providing health services to the Thai populations. Autonomous hospitals will continue to operate as part of a health system which is based on social equity principles, i.e. user charges will be set based on ability to pay, and service use is based on people’s need.

Table 1 Spectrum of Forms of HA by Component

Degree/ Component	Fully Public → Fully Private			
	Fully government	Government corporate	Non-profit institution	For-profit institution
Type	Fully government	Government corporate	Non-profit institution	For-profit institution
Governance	MOH	Board of trustees/Directors from Government	Board of Trustees/Directors (from local * community, government representatives, non-profit or private sector)	Board of Directors (from private sector)
Management	Government employees	Contract or service agreement	Wage contract or profit sharing	Private employees
Capital financing	Full government subsidy	Partial government subsidy	Lease or lending of government assets	Sale of government assets
Recurrent financing	Full government subsidy (indirect or direct)	Revolving funds (retention of locally generated funds)	Regulated user charges retained with government subsidy and insurance	Cost plus pricing (profit) and insurance

Source: Modification of Newbrander, W. (February 1993). “Policy Options for Financing

Health Services in Pakistan: HA Financing Issues” Health Financing and Sustainability Project Technical Report.

The scope of autonomization in Thailand will not only be confined to public hospitals but will also involve a network of public health facilities at provincial or

regional levels. A Provincial Health Board (PHB) will be set up to oversee essential functions and monitor performance of public health facilities under the network through financial and regulatory measures. It will coordinate among individual providers within the network and between the network and the central ministry. By so doing, it is hoped that coherence of the whole system could be maintained along with the progress in system efficiency.

With a concern for overall system efficiency, it is recommended that the central MOPH should be reoriented towards 4 major roles: health policy development, health personnel development, allocation of capital expenditures, and guidance for the development of the public and private sectors.

Human Resources Management

In essence, HA will lead to major changes in terms of HRM. Firstly, staff recruitment and positioning will be left to the discretion of hospital management under a framework set at the national level. The framework is required in order to safeguard against excessive pooling of HRH by particular hospitals. Secondly, contractual relationships between hospitals and staff will replace civil servant status arrangements. This means staff employment will be based on clearly defined expectations and payment systems. Renewal of contracts will be based on annual performance evaluations which might result in lengthening, shortening or terminating of contracts. Staff remuneration would be based on performance rather than qualifications and position alone. Doctors and paramedics will be paid at a level high enough to contribute on a full time basis and to preclude moonlighting. Fringe benefits will also be tied with performance instead of being considered as a welfare contribution from the government. The discipline oriented approach of the current system will be replaced with the patient centered approach in designing capacity building of staff. Finally, an autonomous hospital will have full responsibility to discipline its own staff. However, channels for filing complaints from staff, due to perceived unfair treatment, will be set up.

If the above changes take place, roles and functions of responsible agencies have to be clearly defined. Table 2 summarizes the areas for HRM development, degree of urgency for actions and responsible agencies. Up to this point, it should be clear that implementation of HA could not be left to the discretion and responsibilities of any single agency. Concerted efforts from all responsible agencies are needed. Even the community will have to be mobilized to help shape the reform.

Table 2 Suggested degree of urgency and responsible agencies for HRM development under HA.

Areas of HRM development	Degree of urgency	Responsible agencies	
		Key	Supportive
Development of management infrastructure			
personnel management	++	Hospitals	MOPH, CSC
management training	++++	Hospitals	MOPH, CSC
supervision	++++	Hospitals	MOPH
HRH research and development capabilities(policy analysis, task analysis, incentive development, productivity measurements, technique of developing performance profiles)	++++	Research institutes	MOPH,CSC, Hospitals, International development agencies
HRH information and researches to measure productivity, utilization, motivation, distribution etc.	++++	Hospitals, MOPH, Research institutes	International development agencies
Clarification of all HRM elements to achieve the objectives of HRM : employment, retention, support, development	++	Hospitals	MOPH
Management training for managers	++++	Hospitals	Training institutes, MOPH

Note: CSC = Civil Service Commission, MOPH= Ministry of Public Health

HRM is concerned with deployment of personnel, utilization, HRH planning, and training & education. The current centralised bureaucratic system of health services administration has been blamed for HRM problems. Whether decentralization under HA reform will bring solutions or invite new problems is the concern of this report.

The following discussions on the potential impact of Thai HA on HRM will focus on these areas.

Deployment of highly qualified personnel

Uncontrolled rapid growth of private hospitals in Thailand created an internal brain drain that resulted in a reduction of the proportion of doctors in the public sector especially in rural areas⁽⁵⁾. This should be regarded as an important warning sign for future development through HA, a half way departure from budgetary organization toward privatization. Without sufficient monitoring and an intervening mechanism at the central level, autonomized hospitals in better-off areas could mobilize personnel from worse-off areas in order to fulfill their local needs.

Under the current situation, there is already an exceptional case of a district hospital which manages to mobilize specialists in various fields, on both a part time and full time basis, to provide specialized care equivalent to that of a provincial hospital. 10 out of 18 permanent doctors at this hospital are employed on a contract even though it is a public hospital. All of them are specialists in various fields. This is due to the failure of the referral system and an exceptional management capacity and boldness of the Director of this district hospital. On the one hand, this story exemplifies the strength of an exceptional case of autonomy in mobilizing resources to meet local needs. On the other hand, it raises the concern for the overall efficiency of the provincial network of health care providers in this province. If this scenario will be extended to a wider scope under future HA reform, it is quite obvious that excessive pooling of highly qualified personnel in urban areas could occur. This will certainly lead to further deficiencies in rural areas.

An efficient referral system is thus a major contributing factor to HRM regardless of the degree of decentralization. This could be more readily achieved if the scope of autonomization is confined to the provincial or regional level rather than to individual hospitals. Another proposed preventive measure to lessen the maldistribution of highly qualified personnel is to freeze the number of the personnel in urban areas for 5-6 years. This proposal is based on the assumption that HA will improve productivity hence minimize demand for staff. In addition, alleviation of the rural deficiency will decrease workload of the urban referral hospitals.

If HA leads to improvement of the working environment at rural health facilities, retention of highly qualified personnel could be improved. Since high turn over rate of personnel is a major contributing factor for maldistribution, the improvement will subsequently improve the problem. The improvement of the working environment could be achieved by preferential allocation of resources to rural areas and increased flexibility of using government subsidies to create incentives and to finance personnel development activities. In effect, there was an argument supporting this conclusion. Chunharas proposed that paying attention to create a more flexible and efficient system of HRM in the civil service might help to improve the shortage of HRH in the rural areas⁽⁶⁾. Evidence from corporatization of the National Heart Institute in Malaysia also supports this notion. By provision of opportunities for more specialized training in various world-renowned centers and improvement in working environments and payment scales, the National Heart Institute succeeded in not only retaining health personnel but also in increasing number of staff by 30%⁽⁷⁾.

Utilization

In principle, introducing monetary and other tangible incentives tied with performance appraisal could be a strong motivation for increased productivity. The merit system and transparency in staff recruitment and promotion could enhance retention. Systematic organization of in-service training to update or to introduce new skills for all levels of staff in accordance with the strategic plan of a hospital could improve staff capacity relevant to hospital needs.

Nevertheless, experiences in New Zealand, the UK, and elsewhere show that HA may but does not automatically, enhance hospital performance⁽⁸⁻⁹⁾. The problem may be that proposed reforms were not fully implemented, due to political and administrative constraints. Micromanagement at the hospital level could also be a factor in determining success or failure. According to a study on autonomy in a number of developing countries in Africa and Asia⁽¹⁰⁾, significant improvement in hospital performance happened in one of five autonomous hospitals in India. This is despite the fact that the amount of autonomy enjoyed by the CEOs was relatively unchanged over time. The authors also asserted that it was difficult, in the studies in Kenya and Zimbabwe, to separate the performance of the autonomous hospitals in these two countries from the performance of their leaders.

This thus calls for an appropriate selection process of, and capacity building for, the CEOs. In certain circumstances where choices of CEOs are limited, capacity building will be the key input to enhance the contribution of the CEOs.

Full implementation of HA means not only changes at the local hospital level but also at regional and central level. Taking New Zealand as an example, separate mechanisms were established to oversee privatized hospitals under the Crown Health Enterprises (CHE)⁽¹¹⁾. Regional Health Authorities (RHA) were set up to purchase services from the CHE under contract basis. A Contract Surveillance Unit was established by the MOH to oversee the contracts issued by the RHAs with the CHEs. This was to ensure that value for money was obtained and that all contracting was open and competitive. In addition, an arm of Treasury called the Crown Company Monitoring and Advisory Unit (CCMAU) was employed to ensure financial return on the Crown assets which were used in the provision of medical services by CHEs. Highly quantitative and mostly financial measures of success have been used by the CCMAU to compare performance among CHEs.

Despite these sophisticated mechanisms to monitor the CHEs, the Auditor General's Report in 1997 revealed a mess in the CHEs finances⁽¹¹⁾. This could be viewed as an indirect indicator of overall hospital performance including personnel productivity. Many underlying influences on this fiscal situation were pointed out⁽¹²⁾. Overexpectations of the efficiencies to be achieved made it difficult to match levels of funding with the required service levels. Poor data and analysis have often led to the unrealistic costing of services within the budgetary process of government. Insufficient transparency in the budgetary processes and early mistakes in contracting within the purchasing organizations have made it difficult for the purchasers to allay the suspicions of Ministers that money the government wanted to spend on particular services was being channelled elsewhere. Slow implementation of capitation on primary medical services was mainly due to resistance from entrenched providers.

In short, the New Zealand reform could serve as an example of a drastic or “Big Bang” approach to change a highly complicated health care system characterized by the market failure. Under this approach, key players, particularly the purchasers and consumers, do not have enough time to prepare and adjust themselves. While the providers, in the environment of poor accountability but more freedom, used political and other pressures such as the media to extract gains⁽¹²⁾.

In countries like Thailand, which still suffers from a substantial degree of maldistribution of highly qualified personnel, central control of the distribution of personnel in order to ensure equitable distribution could ultimately compromise the efficient use of these personnel at individual hospitals. In this case, there seems to be a need to trade-off between efficiency and equity. And it may not be a clear cut solution for the trade-off. Joint planning between administrators at the central, regional or provincial levels and individual hospitals should be encouraged. Better information on the number of personnel, cadre mix and productivity at all levels of facilities are needed for evidence-based rational planning.

Switching hospital staff from an entrenched civil servant status to a contract hospital employee basis is not an easy under taking. Conversely, it could lead to considerable conflicts between managers and staff or between prime movers and followers. Without appropriate handling, a conflict could potentially compromise or even ruin the reform. There was a case study in Thailand where an attempt was made to introduce a mix of part time and full time employees into a medical school in order to improve performance. A forum was set up for open debate and to share concerns among all relevant stakeholders. At the end of the day, despite earlier cabinet approval, this proposal was aborted through lobbying by the opponent group. Conflict avoidance and resolution should, thus, be a crucial issue in implementing HA reform. In order to achieve this requirement, managers should be trained to handle conflicts and communications systems should be improved.

HRH Planning

HRH planning deals primarily with both numbers and quality of HRH. It has to support and be fully integrated with the planning of health sector reform. It must recognize the diverse interests involved and formulated through a participatory transparent process, involving all relevant parties, including consumers.

At present HRH planning in Thailand is characterized by fragmentation of positions, concepts and practices among interest groups without any involvement of the community. As was clearly highlighted by Chunharas, there were only a few occasions where the manpower plan in Thailand was carried out without a precontemplated decision in mind⁽⁶⁾. This situation could become even worse if HA leads to fragmented autonomous hospitals by focusing on the autonomy of individual hospitals.

On the contrary, if HA leads to a more coherent network of health facilities, it will be more likely to maintain continuous dialogue among the concerned parties on a variety of issues. This helps improve HRH planning. In addition, HA could bring in stakeholders from the community and other sectors. This will result in many forums where these stakeholders can participate in HRH planning, a situation which has never happened before. With HA heading in this direction, issues related to HRH planning can be

discussed among members of the Provincial Health Board (PHB), the Board of Directors (BOD) and central bodies comprising of all relevant parties.

At the national level, as a result of HA reform, roles and functions of the MOPH will be finally changed. The MOPH mission will be focused on planning and coordinating. Consequently, with the creation of various participatory forums the planning efforts will be less likely to end up in a vacuum.

The final point to make on the implications of HA on HRH planning is the estimation of demand for health personnel. If HA could lead to maximization of personnel performance, the estimation will result in an estimate closer to the real needs. This calls for accurate performance appraisals.

Training and education

Among the core activities of HRM are training and education. Training frequently refers to on the job training or short course training. While education usually refers to more formal and long term training.

At present, non-academic public hospitals in Thailand serve as training sites for health personnel both at undergraduate and postgraduate levels. Cost is not a concern for the provision of training services. In the future, HA might change the attitudes and practices of hospital managers towards more cost consciousness. As a consequence, autonomous public hospitals might ask for specific payments in order to undertake training functions. They could even decline to perform this function if financial incentives are not strong enough. This raises the concern of cost escalation in organizing health personnel education in the future. Regulatory measures as well as financing mechanisms are thus needed. A rational approach to contracting autonomous hospitals to provide training services should be based on the costing of such services as well as on the more objective measurements of outputs and outcomes. This calls for relevant research and improvement of information systems to support HA reform.

Taking a look at post-graduate training, according to some critiques, current vertical training programs for health personnel in Thailand have been characterized by redundancy⁽²⁾. A number of contributing factors could be described as follows: 1) lack of rational and systematic assessments of the needs for training at all levels; 2) fragmentation and low accountability of responsible agencies in organizing training programs; and 3) low concern for associated costs by all relevant parties. Before the economic crisis, it was a common practice to organize “training courses” which used a lot of money for study tours abroad for mid- and high-level health administrators. Returns from such huge investments remain questionable.

If more fruitful and cost-effective practices in health personnel training are to replace the current practices, those contributing factors have to be modified accordingly. Managers of health facilities at all levels should be trained to carry out training need assessments. Collaboration and coordination between academic institutes, MOPH, and health facilities should be encouraged. In Hong Kong, the Hospital Authority plays a pivotal role in designing, organizing and delivery of training courses⁽¹³⁾. Systematic needs assessments and evaluation of learning achievements and impacts on performance of personnel and hospitals are employed to guide the process.

Conclusions

HA, a form of decentralization in HSS, is a growing trend throughout the world. It is a fascinating approach toward more system efficiency. One of the key features in this regard is the improvement of HRM. However, there is no guarantee that HA will automatically and consistently lead to improved system efficiency. Expected outcomes of HA reform depend on the extent, features and processes of the reform. This paper attempted to shed some light on the potential implications of HA on HRM using Thailand as a case study. It drew on experiences from other countries where HA or corporatization process are far more advanced.

If HA will lead to the betterment of HRM in terms of deployment, utilization, planning, and training & education, the scope of autonomy should include a network of providers rather than individual hospitals. Communities and all other relevant stakeholders should be mobilized to actively take part in the HA process. The central ministry (MOPH) should redefine its roles and functions. Capacity building for HRH planning should be strengthened at all administrative levels. MOPH should coordinate the efforts to ensure continuous learning and capacity development of health personnel. Systems to provide relevant and timely information for HRH planning, deployment, utilization and training and education are needed.

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Discussion

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The Thailand Case Study on “The Implications of Hospital Autonomy (HA) on Human Resources Management” provides an excellent illustration of one of the most difficult challenges that policymakers face when trying to improve the performance of health systems through organizational reforms – the human dimension of the reform.

A central theme of recent health care reforms has been a re-definition of the role of the state and private providers in the health sector. Since the beginning of written history, the pendulum has swung back and forth between minimalist approaches to state involvement in the health sector and varying degrees of a greater role by governments.

For the past 50 years, proponents of public sector involvement in health care have argued their case on both philosophical and technical grounds. In most societies, care for the sick and disabled is considered an expression of humanitarian and philosophical aspirations. But one does not have to resort to moral principles or arguments about the welfare state to warrant collective intervention in health. Economic theory provides ample justifications for such an engagement on both theoretical and practical grounds to secure both efficiency⁽¹⁾ and equity⁽²⁾ objectives.

During the 1980s and 1990s, the pendulum began to swing back in the opposite direction. As in the case of the rise in state involvement in the health care, the recent cooling towards state involvement in health care and enthusiasm for private solutions has been motivated by both ideological and technical arguments.

The political imperative that has accompanied liberalization in many former socialist states and the economic shocks in East Asia and Latin America has contributed

to a global sense of urgency to reform inefficient and bloated bureaucracies and to establish smaller governments with greater accountability⁽³⁾. It would be too easy to blame ideology and economic crisis for the recent surge in attempts to reform health care systems by exposing public services to competitive market forces, downsizing the public sector, and increasing private sector participation⁽⁴⁾.

In reality, the welfare state approach failed to address many of the health needs of populations across the world⁽⁵⁾. Hence the dilemma that policymakers face throughout the world – although state involvement in the health sector is clearly needed, it is typically fraught with public sector production failure⁽⁶⁾. Governments everywhere are, therefore, reassessing when, where, how, and to what degree to intervene or to leave things to the market forces created by demand from patients. The reforms in hospital autonomy in Thailand and elsewhere is part of this trend.

The range of possible actions that can be taken by governments to improve efficiency or equity — from least to most intrusive — is extensive. These include⁽⁷⁾:

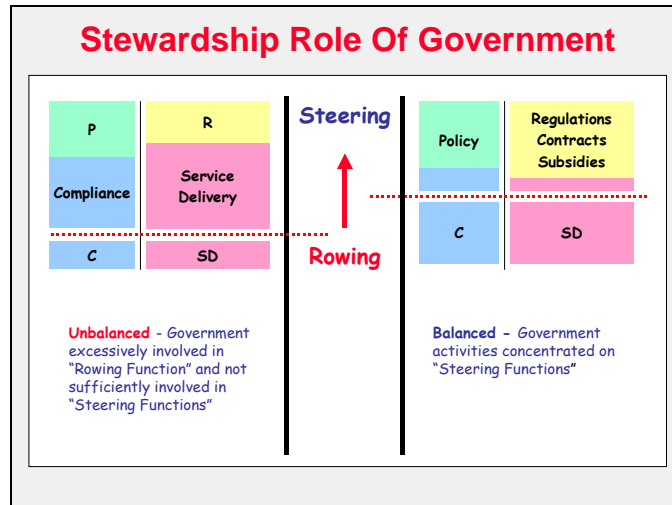
- providing information to encourage behavior changes needed to improve health outcomes;
- developing and enforcing policies and regulations to influence public and private activities;
- issuing mandates or purchasing services from public and private providers;
- providing subsidies to directly or indirectly pay for services; and,
- producing (in-house) preventive and curative services.

In many countries, for reasons of both ideological views and weak public capacity to deal with information asymmetry, contracting, and regulatory problems, governments often try to do too much – especially in terms of in-house service production – with too few resources and little capability.

Parallel to such public production, the same well-intending governments often fail to:

- develop effective policies and make available information about personal hygiene, healthy life-styles, and appropriate use of health care;
- regulate and contract with available private sector providers;
- ensure that adequate financing arrangements are available for the whole population; and,
- secure access to public goods with large externalities for the whole population.

Using a framework based on recent developments in organizational economics, it argues a strong case for greater private participation in providing health services (*rowing*). At the same time, it advocates a more focussed “stewardship function of governments in securing equity, efficiency, and quality objectives through more effective policy making (*steering*), regulating, contracting, and ensuring that adequate financing arrangements are available for the whole population (see Figure 1) ⁽⁸⁾.



Hiring, firing, and management of staff is clearly a “rowing” activity that in most cases can be delegated to service delivery organizations. The countries that have been most successful at introducing reforms in the autonomy of the hospital sector paid attention to human resource development, building this into the design of their reform strategies⁽⁹⁾. As in the Thailand case study, such strategies include recruitment of experienced directors from outside the health sector, training of sector managers, and development of performance management systems for staff. Such reforms in human resources were a major feature of the successful hospital reforms in Hong Kong and Singapore.

But giving hospitals and other sub-sectors of the health care delivery system full control over all aspects of human development is clearly not a realistic strategy. There are a number of critical human resources “steering” activities that require strategic regional and national approaches and cannot be delegated to individual service delivery organizations. Policymakers still need to have a firm grip on the “tiller” of activities such as education strategies, curriculum development, skills mix, and geographic distribution of staff, etc. The Thailand case study is an excellent example of how one country has tried to find an appropriate balance between “steering” and “rowing” in human development policies in the hospital sector.

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Our research in three countries is consistent with Dr. Suriyawongpaisal's opinion that human resources for health (HRH) issues are crucial to understanding the performance of hospital autonomy (HA) policy. In Zambia, the 'delinkage' of health workers from the civil service is proving a major stumbling block to the implementation

^a All the discussants are involved in research on hospital autonomy based at LSHTM and are members of the Health Economics and Financing Programme which is funded by the UK Department for International Development (DFID). Three current studies are referred to in the article: 'Autonomous hospitals in Zambia and the equity implications of the market for hospital services' which is funded by DFID and the Swedish International Development Agency (SIDA); 'Prospects for autonomy of public hospitals in Uganda' funded by SIDA; and 'Performance evaluation of public hospitals under a new entrepreneurial reform' funded by the International Clearing House for Health Sector Reform Initiatives (ICHSRI).

of the policy. Existing rights such as security of tenure and pension entitlements are not relinquished easily, and the costs of buying them out may prove prohibitively expensive to the Ministry of Health. Although Boards have been appointed and a measure of autonomy has been ceded to hospital level, this issue is widely perceived as having stalled the autonomy process⁽¹⁾. Similarly, in Uganda where hospital autonomy is not policy but hospitals have been transferred from central to district control, hospital workers are concerned that the change implies loss of career structures, training opportunities and the danger of partial decision making resulting from ethnic rivalries⁽²⁾. In Colombia, the issue is somewhat different. There is a divide between those hospital workers who have permanent appointments, tenure in their posts and a range of non-monetary employment benefits such as health insurance and pension rights, and those on short term contracts with none of those attributes. This divide pre-dated the reforms which created hospital autonomy, but it is thought that the numbers of short term employees in hospitals may rise in response to the pressures of reform⁽³⁾. All this suggests that hospital autonomy and decentralisation are associated with more casual employment which may improve the flexibility with which hospitals can respond to various challenges but also seems to imply costs to the workforce with wider implications which need to be taken into account.

Dr. Suriyawongpaisal begins his article by classifying HA as a type of decentralisation. We think this classification only partially captures what HA is about, and that it is more useful to think of HA as having two dimensions – one is the *locus* of control (which accords with the decentralisation idea). The other, which is often but not necessarily present, is changes in the *nature* of control. HA usually involves a changing basis on which decisions within the hospital should be made and is nearly always accompanied by the separation of finance and provision and the use, or intention to use contracts between purchasers and providers. This means that hospitals will not be controlled via the approval or rejection of plans and budgets, which are usually related to inputs, but by the ability to negotiate contracts for the delivery of services (outputs). This has profound implications which are not captured by the classification of HA as decentralisation, and which seem to us very relevant to the concerns of the paper under discussion.

First, it means that there is an inevitable trade off between being able to plan according to a blue print which allocates roles to hospitals at different levels of the system; and allowing the evolution of hospital roles according to the success of hospitals in attracting contracts. Inevitably, successful hospitals will be able to attract more than an appropriate share of staff as defined by previous planning norms. This should not be a serious problem if contracts are awarded according to a definition of performance which gives adequate weight to public health interests (which ensures access to services of the poor and a prioritisation of services according to effectiveness in reducing disease rather than solely in meeting patient preferences). This very much depends on the nature and motivations of ‘purchasers’. Private insurers will negotiate contracts which prioritise the demands of their enrollees – usually for highly specialised care. If the public health sector at district or any other level are purchasers, the idea is that they should negotiate contracts with the needs of the population in mind – and if they can get a better price-quality deal for a particular service from a hospital which was not supposed to offer it under the old blueprint, that should not constitute a problem. Of course this is simplistic.

Although the public sector is often the largest purchaser of care and therefore has great potential for shaping the range of services which are delivered, its obligation to provide care which is accessible to all may constrain its options when there is little choice of hospital. Furthermore, a degree of inertia in public sector contracting may mean that the real competition takes place around smaller contracts for the provision of specialised care for private payers. Finally, the capacity of public purchasers to use the contracting process effectively may be limited. However, trying to retain centralised controls will undermine hospital autonomy in both dimensions. Recognising the trade-off between autonomy and planning suggests the need to balance the public health goals on the financing side, and the possible advantages of allowing rewards to follow performance.

The importance of an efficient referral system as a solution to some of the possible problems raises further issues. What does hospital autonomy mean for the referral system? Have the incentives been changed by the change in the rationale for financing flows? In the UK, incentives seem to favour primary care doctors not referring, and the prospect of 'supplier reduced demand' ⁽⁴⁾. Much depends on prices and the functioning of other rules governing financial flows.

The question of whether or not hospital performance will improve following the introduction of greater autonomy is one which is bound to continue to be subject to debate. We have been involved in a study which is trying to provide some preliminary evidence in Colombia⁽³⁾. The study is tracking trends in hospital utilisation indicators in 5 public hospitals as hospital autonomy is introduced. In 4 of the 5 hospitals, the evidence suggests that efficiency may be improving – but the evidence is not unambiguous. There have been changes in case mix, and the process of implementing the health sector reform programme has not been smooth, making it difficult to demonstrate a clear cause-and-effect relationship. These kinds of uncertainties are never likely to be wholly absent from any health reform evaluation.

Finally, it is suggested that hospitals may not want to carry out their training functions after reform. Clearly, there have to be separate contracts with hospitals if these services are to be secured under new rules. As long standing debate in the UK attests ⁽⁵⁾, getting the prices right is crucial, yet it is difficult to identify the real costs of medical training. The incentive to carry out the activity must be sufficient, but at the same time ensure unfair cross-subsidisation of services does not occur.

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I would like to congratulate Dr. Paibul Suriyawongpaisal, Secretary General of the National Health Foundation of Thailand, on his lucid exploratory paper. Hospital Autonomy, and indeed the autonomy of various public sector health systems, is often seen as an efficiency producing measure and is advocated in many health sector reforms. Our reform proposals in Ghana are aimed at achieving substantial autonomy especially for the two Teaching Hospitals (*with about 2000 beds that absorb some 15-20% of recurrent budget resources and something like 48% of doctors in the country⁽¹⁻²⁾*) as well as creating higher managerial responsibilities for other units identified as “Budget and Management Centers” (BMCs)^b.

I think the key question raised for all of us by Dr. Suriyawongpaisal’s article is whether autonomy creation is a “risk-free” measure. Secondly, whether autonomy will or can achieve the efficiencies it is touted to resolve and thirdly, what the appropriate conditions will be under which the main objectives of Hospital Autonomy may be achieved?

In many developing countries, especially in sub-Saharan Africa, policy situations are further complicated by the very low level of resources for the public health sector, in some cases a severe shortage of trained clinical personnel (even in countries with a smaller private sector than Thailand has), and finally the lack of a critical mass of managers to reasonably ensure an acceptable level of success. The public sectors have often evolved into long standing entrenched bureaucracies, and the time span proposed for implementing such changes and other reforms are probably too short to enable effective change to occur.

However, for many of the efficiency reforms in health to survive, Public Service/Civil Service reform must happen concurrently with, or prior to, health sector reform actions. The “Civil and Public Services” will continue to manage and regulate reformed institutions. Systems that are not attuned to results oriented efficiency measures may undermine the decisions of autonomous institutions they are required to facilitate.

I agree with the analysis of the weaknesses of “centralized bureaucracies” in the introduction and the examples given that are entirely similar to the situation in my own country, Ghana, where fixed remuneration, centralized HR management and opaque and long winding processes and procedures have immobilized management innovation and have frustrated even the most self motivated health workers.

Ghana, since 1989, has attempted to introduce hospital autonomy with a variety of legislation (*PNDC Law 209: The Hospital Boards Law 1989 and more recently Act. 525 Health Service and Teaching Hospitals Act*)⁽³⁾ that try to move hospitals towards a more “corporatized” system of management. Since 1985, when cost recovery, revolving drug fund systems and new hospital fees were introduced in the country, and 1991, when all

^b BMCs include individually managed units such as all Hospitals, District Offices, Research Station, etc.

hospitals were allowed to retain 100% of their revenues, increased autonomy has existed (in terms of utilizing internally generated funds). Autonomy has however been limited with the regular government budgets (constituting over 80% of resources in most cases) which were still flexible to use for other purposes. In the case of human resources management, this remains strictly centralized despite development of a policy contrary to that stance⁽⁴⁾.

Every process of decentralization must involve significant elements of autonomy and hospital autonomy is indeed in effect substantive decentralization of authority to achieve the objectives described in the paper. Moreover, I think one major objective described, of “..... thereby improving government’s responsiveness to local needs.....” should really rather focus on local (Hospital Management’s) responsiveness to the community and other interest groups.

Ghana’s reform initiatives (and I believe those in other African States), whilst involving decentralization and increased autonomy, tended to neglect to resolve the structural and strategic changes in human resources that the reforms might entail (or they may not have been thought about) in the same way as financial, capital and logistics arrangements are thoroughly set out. Human Resources consume 50 to 70 percent of recurrent expenditures of most institutions, and the handling of personnel will significantly influence the efficient utilization of the remaining 30-50 percent. Efficiency improvement strategies that neglect this resource cannot be seen to enable efficiency in a holistic way.

Will HA be a solution to some of the HR challenges in hospitals? Will HA lead to adverse or undesirable outcomes, e.g., worsening cadre mix and maldistribution? The answer is possibly yes on all counts, however, we can carefully address these concerns by planning for the implementation of HA and in developing research questions to answer these needs. My concern has been that whilst we concentrate on changes necessary in the targeted institutions, we often neglect to focus on the changing role of the (former) central authority and determine in detail what new roles it should play in linkages with the newly autonomous hospitals, how these changes will be phased in, and what structural and procedural changes will be necessary at this level to facilitate the autonomy of hospitals (e.g., are new structures necessary?). Are there new ways/roles for existing civil service units to function? How will the style and format of budgets and other financial arrangements (including remuneration budget) change?

Green⁽⁵⁾ describes a generally poor record on human resource planning in developing countries (at various times or in combinations) influenced by [a] too few trained and available staff, [b] too many trained and unemployable staff, [c] distributional difficulties, [d] inappropriate use of personnel, [e] unproductive &/or demoralized staff. These are compounded by the influence of professional interests and attitudes on policy making and the lack of data and information for HR planning. How will these concerns be resolved to support autonomous hospitals?

Hospital Autonomy, as mentioned earlier, stands a chance of exacerbating the existing maldistribution of staff. Urban and densely populated locations as well as richer localities are better equipped to raise the additional moneys needed to recruit doctors and specialists. They are also in a better position to procure the attractive services and equipment which further encourages clients to by-pass the basic primary care hospitals and contributes to further depriving these lesser facilities of much needed revenue.

Larger urban based hospitals tend to have popular and more politically connected specialists who usually have substantial influence in professional associations. The resistance of specialists to even out the differences among various hospitals can often create results that may increase the inequities in public health services delivery.

One would like to see the definition of an autonomous hospital to include a statement of increased accountability to the community and also to the national health interests by achieving national service coverage targets. Their submissions to the national health information system are also important in assisting and facilitating national planning and resource allocation. Anecdotal comments suggest that Thatcher-era health reforms in the United Kingdom may have caused the inability of the NHS/DHSS to notice, until rather late, a shortage of nurses and some other health professionals countrywide due to reduced national coordination roles.

It is useful, in a discussion of the various forms of HA, to discuss the advantages and disadvantages of the various types and conditions under which each type of autonomy might be the best option and also, what systems and capacities (or criteria) may need to be put in place, both at local and national levels for efficiency to be achieved. One may also believe that in some situations, the mode of autonomy may need to be implemented as a planned and phased process, possibly initiated with a “fully government” option. As capacity is developed and as national political, economic and health systems evolve and lessons are learnt, the process should be gradually re-engineered towards the “fully private” model (but with strong community involvement).

Another concern in autonomy proposals has been the relationship that such public sector hospitals have with other health facilities in the public health system such as health centers, community preventive health and diseases control institutions, smaller hospitals, or indeed private hospitals that may refer clients. It might be important to develop these linkages comprehensively and test various options, in order to enhance the global efficiency with which health services are delivered and utilized.

We have been concerned, since cost recovery and retention of fees occurred in Ghana, that hospitals have tended to welcome clients who should really use primary care services, because of the revenue generated by a high patient base. In such situations, practices from the Central level may tend to subsidize expensive secondary care and further increase demands for higher subsidies because of the number of clients seen. Thus hospital autonomy needs to be seen in a wider context of health systems reform.

How can we manage preferential allocation of resources to rural areas? In efficiency terms, they often have smaller population densities, utilization levels may be rather low compared to hospitals in urban areas and they recover less revenue. However, we need to review and understand better the criteria used to measure the performance of health facilities, recognizing the different challenges and needs of rural facilities and setting different financial benchmarks for measuring efficiency (e.g; per capita expenditures on health/human resources in a sparsely populated rural area may need to be higher than in a densely populated area).

Human Resource Management: It is clear that a contractual relationship between autonomous hospitals and staff will need to exist to avoid the problems that previous public sector personnel employment systems have had to cope with. This review of employment conditions remains a common cause for contention between management and trade unions and professionals associations. Relatively stable employment conditions

and tenure are replaced by rather less reassuring circumstances. Benefits and rewards have been accumulated from years of sedate work conditions under Civil Service rules and systems. A threat to these can be a major problem with health worker unions (several newspaper reports from Zambia, for example, show the struggle with similar management shifts). The challenge will be how to introduce a more responsive HR system which is not seen as threatening to workers or resulting in the continuation of inefficient systems inherited from the old Public Service systems where performance is not rewarded.

Can doctors and paramedics be paid salaries that will preclude moonlighting? How can systems for remuneration be reorganized to ensure that adequate morale and efficient use of resources exists? Examples of arrangements being examined in Ghana include allowing internally integrated private practice and private units for specialists in these hospitals⁽⁶⁾ and also working out a system of procuring “overtime” or “extra-duty” services from other service providers. These options may enhance the incomes of staff and contain the staffing level of hospitals whilst reducing the temptation to moonlight. It may be very difficult to preclude moonlighting altogether.

I wish to also comment on the issue of decentralized disciplinary systems. This is essential to the control of staff (in addition to hiring and firing authority). Fair-play for staff should be a necessary aspect of the disciplinary process. However, how far should an appeal system go? A balance is necessary between evolving a system which encourages effective bureaucracy and quick and transparent responses to staff complaints. Final channels for appeal must be retained within the autonomous hospital structures (at least not beyond the Board) to ensure that management is not bogged down. Of course, this cannot preclude existing legal processes governing labour in each country.

From Dr. Suriyawongpaisal’s paper and the foregoing discussion, hospital autonomy and HR reform is a complex process involving many organizations and stakeholders. A major consultative and consensus process is required to clarify the many issues raised by the paper when implementing these reforms. Such changes will often involve various government Ministries and Departments, the health regulatory bodies, as well as professional associations.

Retention of staff in rural environments: Improvements in the “working environment” alone unfortunately cannot change retention of health workers and encourage the movement of highly qualified persons. In Ghana, it seems the social and economic environments seem to be a greater indicator of the likelihood of staff retention in rural areas than the work environment and proposals to encourage rural incentives have focused on ameliorating these factors⁽⁴⁾. In this context these include, assuring adequate schooling for children, access to tertiary health care, motor-able access roads, employment for spouses, communication-telephone services, etc.

It is again shown in the paper that even in rich developed countries, autonomy if not properly managed, may not result in efficiency. It is difficult to separate resulting efficiency from the leadership provided by managers as reported for Zimbabwe and Kenya (and indeed experienced for Ghana) and one of the key elements of hospital autonomy should not only be the authority to hire and fire health professionals but the authority their boards will have to dispose of non-performing Chief Executive Officers (CEOs) when even careful selection and grooming fails.

Dr. Suriyawongpaisal notes the difficulties New Zealand faces with the elaborate monitoring mechanisms it utilized. I think the lesson here is that a reform process is often a venture into the unknown for central level policy makers and managers, hospital CEOs and service providers, as well as for government financial mechanisms, etc. With all decentralization, difficulties will emerge. Can we anticipate these difficulties and treat them as learning opportunities that can be aimed towards improvements in the new systems being evolved? Are these opportunities to conduct research and evolve sustainable autonomy?

Training and Education: Using hospitals for training often involves additional administrative costs as well as increased use of consumables and services. On the other hand, training can provide hospitals with more staff (albeit on an interim basis). Autonomy can easily change these relationships and the training function should be part of the definition of the functions of autonomous hospitals and financial incentives should be provided for carrying out this important function (maybe even allowing hospitals to compete for the honour).

Hospital autonomy is an important aspect of most reforms aimed at efficient utilization of resources. In Ghana, hospitals absorb about 70 percent of recurrent resources. Planning and implementing of reforms must include central management systems, linkages to other care systems including referrals and the private sector. Whilst all these may not be feasible to undertake at the same time, it is important that they constitute part of the strategic framework right from the start. We must integrate human resources requirements and demands of the various levels of health care into reform proposals and evolve steps to rationalize expected untoward effects.

What are likely to be the key elements in the success of such an autonomy venture? Dr. Suriyawongpaisal describes a variety of these in the text from which I conclude;

- Leadership is often taken as an intangible element but is always critical in a reform process. Dr. Suriyawongpaisal makes a strong case for this in his paper with the examples from the UK and New Zealand. Leaders at both the central level and in the autonomous hospitals are essential for the likelihood of the success of the initial reform processes;
- Reorientation and reform of the “central level” is essential to prevent backsliding with decentralization and autonomy under pressure from interest groups representing professionals;
- The linkages between autonomous hospitals and various components of the entire health system must be thought through and provided for including issues of training and referral;
- HR systems must be a paramount concern and should take into account the effect of the changes on health workers security and the management of personnel. Some central information and coordination remains important to avoid losing the national picture;
- Improved administrative systems centrally and locally with enhanced transparent processes, will be indicators for staff confidence in resulting changes; and,
- Public and community information and education on the reforms will help to increase critical appraisal of autonomous hospitals and encourage community involvement in management.

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I. Introduction

To improve the performance of the public service, the Cabinet has endorsed the Public Reform Master Plan (1997-2001), and has approved the Public Sector Management Reform Plan to oversee and monitor implementation of the Master Plan. The underlying purpose of the Management Reform Plan is to implement the 'new public sector management' concept which is aimed at improving the effectiveness and efficiency of the public sector through the establishment of organizations of optimal size that are characterized by flexibility and transparency and that operate through result-based management as well as responsiveness to the needs of the citizens.

One of the major reform measures proposed is the establishment of an 'Autonomous Public Organization'. This new form of government agency, the concept of which has been well received by the government and the various departments, is aimed at effecting more efficient utilization of financial and human resources through the integration of public and private sector management approaches. The outstanding characteristics of private sector management, such as customer orientation and management freedom, are integrated with such features of public sector management as equity and morality. The aim is to install an appropriate combination of the two management approaches into the structure, management and work system of the autonomous public organization.

II. Implications of Hospital Autonomy on Human Resource Management

Dr. Paibul's paper has presented a thoughtful study of the problems and difficulties currently encountered in the management of health services in Thailand, and

has suggested that the planned transformation of hospitals into autonomous entities may not be effective in solving many of the problems, and may even further exacerbate them. His arguments point to the need for careful and well-thought-out measures to ensure that the changes underway in the public health sector are positive and result in improvements in the management and provision of health care for the people of Thailand.

Whether or not the final model for public health organizations is autonomy for individual hospitals, or autonomous regional networks or other groupings, will depend to a great extent upon the effectiveness of that model in addressing the issues of appropriate distribution of human resources in terms of numbers, balance, skills and utilization. The experiences of other countries in their attempts to improve health care services are useful in this matter.

In this transformation, the approach to managing health-related human resources is the crucial issue, since it is the human resources that determine the effectiveness of the other resources. Effective human resource management is thus the essential component for a successful autonomous public organization.

As Dr. Paibul points out, an autonomous public organization has greater management freedom. Under the Public Organization ACT, the chief executive officer has full authority over the human resource management of the public organization. However, the availability of flexibility and autonomy in management may not be enough to ensure the desired quality of performance and results. The management and working system calls for transparency and accountability. It will be important to recruit professionals who are not only competent, but also ethical and highly principled. Equally important, performance assessment procedures need to be established to evaluate the CEO, with a removal mechanism available in cases where the performance of the executive is found lacking.

A strong management board, comprised of knowledgeable and impartial members free from political influence, should be installed to ensure the proper oversight in hospital administration. The mechanisms for monitoring and evaluating should not be limited to evaluation and monitoring of the input, for example, the costs of operation, but should also be capable of assessing the effectiveness and efficiency of performance. In this connection, it is desirable for performance evaluation to be undertaken by an external agency. It would thus seem appropriate to establish a Health Management Assessment Agency to monitor the performance of the autonomous hospital or group, to ensure that the public receives quality service, and that the administration is conducted transparently, with those in authority being fully accountable.

Dr. Paibul also mentions the status of autonomous hospital staff as another critical issue to be considered. Once a public hospital is transformed into an autonomous hospital its officials become employees of the organization. Because loss of the status of 'government official' is deemed by most civil servants as a loss of prestige and security, the status change is a dilemma in moving towards organizational transformation. In this connection, the law has provided alternatives for staffing in the newly transformed public organization. Civil servants who are willing to accept the new status can become employees of the new organization after the verification of their qualifications by the director of that particular public organization. Civil servants reluctant to change their status can seek Cabinet approval to maintain their civil servant status for a three-year period. At the end of the provisional period, they have to choose either to continue on

the job with employee status or maintain their status as government officials, but have to find a position available in a government department. Hopefully, such a transitional approach will prevent unwanted negative impact on morale.

The paper has discussed several implications of hospital autonomy on human resource management. Conceptually, the critical issues have been clarified. Now it is necessary to further discuss and rationalize the implementation procedures. Transforming a government agency into a public organization means not only the establishment of the new form of government agency, but also the implementation of new perspectives of public management and inculcation of new ways of thinking about the Thai public service system as a whole.

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Dr. Paibul highlights critical issues and raises important questions about how human resources may best be mobilized in public hospital reforms. It is that, strategically, the approach in addressing the issues must be total, including structure, systems, people and culture.

Fundamentally, however, there are two vital elements regarding all public hospital reforms: (1) the process must involve drastic changes in behavior and attitudes; and (2) the organization must build the capacity to continuously adapt to changing circumstances. These elements are vital to the success of reform-be it hospital autonomy, corporatization or privatization.

Hospital Reforms are About People

People are at the heart of all reforms. Their behavior and attitudes are levers of change. To achieve successful reforms, there must be total focus on people, on enhancing individual and collective performance. Policies and procedures on system and structural changes must not be as the cart before the horse. Effective human resources management must be the horse. Effective leadership must be the driver.

Unfortunately, many hospital reform initiatives have focused too much on infrastructure and system changes. They are given stronger emphasis probably because they tend to more easily show visible changes. Through them, it is also easier to imply progress and achievements. While infrastructure and systems are important and necessary components, they are no substitutes for the human component which directly shapes and affects how healthcare could and will be provided.

Hospital autonomy should aim at developing knowledgeable and competent staff. This means empowerment and freedom from unwarranted bureaucratic or organizational constraints to make independent decisions. It also means that all systems, structures and processes, including board and management functions and necessary policies and procedures, are directed at helping and assuring effective individual performance so as to achieve quality care and outcome for the patient.

Competent Individuals Make Strong Organizations

Strong, competent and independent individuals may arouse fear that the system or organization will no longer be manageable. Trying to allay such fear could stimulate the institution of unwarranted controls through new systems, policies and procedures. The good intentions of the original reforms could be easily forgotten. The outcome is merely the replacement of one control system by another. Patient care quality and health outcome remain relatively unaffected.

Individual strength and competence engender performance. They are not a threat to an organization. It is hard to conceive of a weak or failed organization to have comprised strong and competent staff. Only strong and successful organizations have strong, competent and performing staff. Only when the individual parts are strong can the whole be strong.

Culture and Leadership are Critical Links to Success

Hence, a system that allows staff to exercise individual talents and skills for the optimal benefit of the patient should mean a strong and performing organization. But this requires that the organization has a clearly articulated vision of what it is to accomplish as a whole. It also requires effective reform leadership, to foster the proper culture and values, including systems thinking and perspective, at the very onset. How can all these be done successfully? The answer is not easy to come by, for it depends and requires sensitive thinking, critical analysis and a true concern for people and for the system as a whole on the part of the reform leadership. To come up with the right answer is by far the biggest challenge of all human resources management strategies and reform initiatives.

At the core of human resources management, however, must be the creation and promotion of the necessary organizational culture and values to motivate staff to always keep the patients' welfare in mind and to always strive to provide cost-effective treatment and care for the patient. Staff at front-line operating units must be empowered to decide and to work individually and together to do what is best for the patient and entrusted to decide what is best for the system as a whole.

Individual Performance Matters Most

Hospital Autonomy should ultimately be about improved quality and health outcome. But only people can provide quality care. Systems and infrastructures can only help to make that happen. The organization, guided by effective leadership, must build the capacity to continuously enhance individual performance. Competent staff performance builds successful organizations. The success of reform hinges on it.

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Improving Human Resources Management through Hospital Autonomy: the Right Tool for the Job?

As in Thailand, the government health sectors of many countries are plagued by low staff productivity and imbalances in the distribution of staff between rural and urban areas. The challenge is to design and implement appropriate policies to respond to these

problems and thereby improve the efficiency and equity of health service provision. “Hospital Autonomy” is a short-hand term summarizing a continuum of different measures taken by governments to decentralize authority for decision-making to health facility managers, management boards or networks⁽¹⁾. Decentralizing authority for certain decisions related to the selection, recruitment, payment, and deployment of staff would *appear* to be a necessary feature of reforms, but international experience does not yield clear evidence on the effects of such policies. So the questions facing Thailand’s Ministry of Public Health are:²

- Is the Hospital Autonomy policy, as currently defined, the right response to the Human Resources Management (HRM) and broader health system problems which it has identified?
- If not, how might the policy be modified, and/or what additional measures are needed to ensure that reforms will do more good than harm?

Table 1 summarizes two of the main Human Resources Management problems in Thailand’s public health system, possible ways to address those problems, and relevant features of the autonomy policy. Are the autonomy policies appropriate to the problems? In theory, the shift from civil service salaries to performance-related contracts should enable managers to induce better performance from staff. As the author points out, however, this is a very risky strategy, both politically and financially. For example, when the Government of Zambia attempted to shift the employment status of the entire public sector health workforce from civil servants to contracted employees of autonomous “health boards”, the two labor unions representing the workers sued the government because the status of the workers’ termination benefits (e.g. pensions) was not addressed clearly⁽²⁾. The reaction against the sudden ‘de-linkage’ of staff from the civil service became the core of resistance to the overall process of health reform. Similarly in Hong Kong, after the initial plans were made public to create an independent Hospital Authority to manage public hospitals outside of the civil service, 10,000 hospital staff petitioned against the reforms and specifically identified their opposition to removing staff from the civil service. Unlike Zambia, however, when the reforms were actually introduced in 1991, the change from civil service to contractual status was left to a voluntary decision of each health worker, and has proceeded gradually. As of 1998, about 25% of the staff of the Hospital Authority were still on civil servant status⁽³⁾.

Table 1 Summary of HRM Issues and Related Autonomy Policies in Thailand.

Problem	Possible Solutions	Relevant Autonomy Policy
poor staff productivity	financial and professional incentives, training, and improved management	performance-related contracts between hospital and staff; hospital authority to discipline staff
unequal distribution of skilled personnel; difficulties recruiting and retaining staff in rural health facilities	central or regional planning for fair distribution of staff; improve work environment in rural facilities, including financial and professional incentives	creation of autonomous 'network' rather than individual facilities; authority of hospitals to allocate their resources, including for staff incentives

As noted by the author, granting autonomy to individual facilities is unlikely to improve the distribution of skilled health workers and may make things worse (since better-off hospitals will be able to capitalize on their advantages to an even greater extent). Although there is not a body of evidence that demonstrates clearly effective policies to recruit and retain staff in rural areas, some mix of planning and incentives would seem to be needed. Both may be facilitated by autonomy granted at the provincial network level. However, many policies to redress rural/urban differences in service availability, such as changes in the pattern of resource allocation to favor rural providers or the creation of career paths that encourage rural service, do not *require* the creation of autonomous units within the public service. Moreover, without such policies, autonomy is unlikely to yield beneficial results.

Many countries are implementing "hospital autonomy", yet these policies (whatever their precise configuration) rarely meet the ambitious objectives set for them and often have undesirable unintended consequences⁽⁴⁻⁵⁾. The few relative "successes" that have been documented appear to depend heavily on selecting the right people to put in charge of autonomous facilities or networks⁽⁴⁾. This is an unsatisfying conclusion, as it suggests that the effects of this reform are sensitive to the personal characteristics of a few key individuals, which raises obvious questions about institutional sustainability.

Proceeding with a rapid implementation of Thailand's autonomy strategy on a nationwide basis would mean taking a big risk for an unproven policy. Although Thailand, like other countries, needs to address the problems associated with civil service constraints on health system performance, the limited international evidence suggests that the government should proceed gradually. This could be done through a pilot or phased implementation, accompanied by in-depth evaluations of process and effects to identify the systems and capacities that need to be in place to enable reforms to have their intended effects.

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The following comments on the article "Potential implications of Hospital Autonomy on Human Resources Management: a Thai case study" draw from my experience in the Latin American and Caribbean Countries, which, in turn, derives from my institutional responsibilities as the Head of the Program of Human Resources Development in Health of the Pan American Health Organization/World Health Organization. I also shared the article with a few colleagues at our Headquarters and Country levels, to benefit from their points of view on the matters raised.

We strongly agree with the author's views regarding the crucial importance of health personnel to achieve the paramount public health goals of equity, quality of health care and the overall social response to the health needs of the population. Not just for the high burden in the budget (60 to 70 percent both in hospital and in ambulatory services) but, most important, because of the inevitable direct correlation between their technical capacity, motivation, understanding of and commitment with public health goals and the social relevance and quality of the services they provide.

We also regard hospital autonomy as one of several modalities of decentralization that are being implemented throughout our region. It is important, however, not to see this organizational arrangement as a separate fashion from the decentralization of other forms of central, regional and local health structures, all of which are taking place at the same time and respond to the same stated objectives. Those objectives are, in general, the same outlined in the third paragraph of the paper under discussion. It would be difficult to find a public health specialist or an educated politician who would not agree fully with those objectives. The question is whether or not they are attainable considering the prevailing organizational culture in the public service and the required processes of planning, deployment and training of the human resources that such considerable reform

of the financing, organizing and delivering of health services calls for. Here is where the difficulties arise and they have a lot to do with the genesis of the health sector reform processes currently underway in most of the countries of the world.

The health and the economy agendas. Throughout decades re-organization of the health systems and services in most countries have taken place as new demands and changing public health conditions have called for. The agendas for those changes have emerged within the health sector, thus allowing the necessary time and the orderly steps to design and implement the policy and organizational arrangements. Included are those necessary to ensure planning for, training and deployment of qualified staff to guarantee that the appropriate technical and administrative competencies would be available at the right time and the consultations with qualified professionals, associations, unions and community leaders, in the right places. Unfortunately, this is not the case in the current wave of reforms, which are being “pushed” at the same time in all countries with one distinctive common characteristic: they do not emerge from the health sector. Rather, they operate in a broader context of State reform and globalization of the world economy, in which the macro-economic priorities and agenda prevail.

The horse behind the cart. For those reasons, the decentralization processes in all its forms, including hospital autonomy and their cousins managed care, management commitments (*compromisos de gestión* in the Spanish Language) are being rushed with disregard to the serious implications that such strategies may have in the attainment of the efficiency, efficacy and equity objectives being sought. The following tendencies demonstrate the above statement:

- In general, the meaning and the implications of the decentralization process are not well understood or not known at all by most health staff, including health managers, at all levels of the health system. The perception that decentralization is just the transfer of current responsibilities, activities and tasks from the central to the peripheral levels still persists. Therefore, a clear and commonly agreed redefinition of roles throughout the health system, necessary to re-make all the organizational structures as well as the necessary norms, procedures and staff development actions to support and make decentralization effective, are absent in many cases.
- In consequence, there is a tendency to reproduce in decentralized hospitals and other regional and local services the structure, norms, procedures and practices of the highly centralized and very formalized public service under which they have previously operated.

In order to correct this situation it is necessary to re-think the whole process while taking some immediate remedial actions. Among others:

- Crash training programs held to improve and share the understanding of decentralization as well as to upgrade the managerial capabilities at all levels.
- To design and implement managerial models for hospital administration that conceptually and operationally integrate health services development with human resource development. This implies the principle that the management of human resources, as critical factor as it is for the success of the hospital social responsibilities, is a primary responsibility of the hospital director.
- To develop the technical competencies within the hospital structure required to support decision making on issues regarding staff recruitment, selection,

training, individual and team performance appraisal and incentives, compensation policies and labor relations.

- To design and implement appropriate (not necessarily complex) information systems to support the above strategies and activities.
- The mechanism for transfer of human resources from central authorities to regional or hospital levels requires careful consideration and planning. This would best be done quickly once it is undertaken. However, this cannot be done properly if the above mentioned actions have not been implemented before hand.