

Hospital Autonomy in Ghana: The Experience of Korle Bu and Komfo Anokye Teaching Hospitals

Ramesh Govindaraj
Harvard School of Public Health

and

A.A.D. Obuobi
N.K.A. Enyimayew
P. Antwi
S. Ofosu-Amaah
School of Public Health
University of Ghana

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Glossary

CAG	Controller and Accountant General
DDM	Data for Decision-Making
EN	Enrolled Nurse
GMTHS	Ghana Medium Term Health Strategy
GOG	Government of Ghana
HHRAA	Health and Human Resource Analysis for Africa
KATH	Komfo Anokye Teaching Hospital
KBU	Korle Bu Teaching Hospital
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
PNDC	Provisional National Defense Council
PPME	Policy, Planning, Monitoring and Evaluation Unit, MOH.
PWD	Public Works Department
SMS	School of Medical Sciences
SRN	State Registered Nurse
UGMS	University of Ghana Medical School, Accra
USAID	United States Agency for International Development
UST	University of Science and Technology, Kumasi

Exchange Rates (US\$ 1 to Cedis)

1987	1988	1989	1990	1991	1992	1993
153.7	202.7	270.0	326.3	367.8	437.1	649.1

Source: International Financial Statistics, IMF.

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Executive Summary

Since the 1980s, public-sector teaching hospitals around the world have come under intense scrutiny in policy circles due to the complexity of these institutions, the heavy burden they impose on public funds, and the perceived difficulties in ensuring their efficient and effective functioning under centralized government control. One policy alternative that has found favor with policy makers in many countries is the grant of greater autonomy to these public-sector hospitals in running their operations. However, despite the implementation of “autonomy” in a number of public-sector hospitals around the world, very little research has been directed towards evaluating the experiences of these hospitals. Accordingly, as part of the overall strategy of the USAID to conduct policy relevant research into matters of importance to African policy makers and USAID missions in Africa, Harvard University was commissioned to conduct five case-studies on hospital autonomy. Ghana was identified as one of the sites for this cross-national, comparative, study.

Ghana, with an area of 238,537 square kilometers and a population of about 16.5 million (1994 estimate), lies along the west coast of Africa. For administrative purposes, the country is divided into ten regions, and one hundred and ten administrative districts. There are “four main categories of health care delivery systems in Ghana - the public, private-for-profit, private-not-for-profit, and traditional systems. Ghana was one of the first African countries to attempt giving greater autonomy to public sector hospitals. Since the 1970s, the government has gradually moved towards greater decentralization of the health system, creating a new Ghana Health Service (GHS), and providing management teams in hospitals at various levels greater flexibility in allocating resources according to their own priorities, within the overall context of the national policy. As part of this general reform of its health sector, the two teaching hospitals in Ghana, namely, the Korle Bu Hospital (KBU), and the Komfo Anokye Teaching Hospital (KATH), have also been encouraged by the Government of Ghana to become “self-governing”.

By far the most significant reasons underlying the grant of autonomy to teaching hospitals in Ghana are financial, the two teaching hospitals account for a disproportionate share of the Ghanaian MOH expenditures. Other reasons also cited by stakeholders include: separating the policy formulation function of the MOH from health services delivery; freeing the hospitals from the constraints of civil service regulations; increasing management efficiency; improving the quality of care; and improving the overall public image of the teaching hospitals.

In 1988, a legal framework, the Provisional National Defence Council (PNDC) Law 209, was developed by the Ministry of Health in Ghana as a key step towards providing full autonomy to the two teaching hospitals. Subsequently, several measures proposed by Law 209 were implemented at the two hospitals, beginning with the inauguration of the “autonomous” Teaching Hospital Boards in August, 1990. Encouraged by the initial “success” of the autonomy initiative, the Ghanaian government even proposed January 1, 1996 as a possible date for conferring on KBU and KATH the status of ‘fully autonomous’ institutions.

KBU, with nearly 1600 beds, functions as the teaching hospital for the University of Ghana Medical School, Accra, and has a staff component of more than one hundred and fifty doctors. KATH, with just over 750 beds, is the second largest hospital in this country. In 1975, in pursuance of an MOH policy to establish a second medical school in Ghana, Komfo Anokye was converted into a teaching hospital, and the medical school of the University of Science and Technology, Kumasi was provided an attachment to the hospital. As teaching hospitals, Korle Bu and Komfo Anokye Hospitals have three primary goals: the provision of high-quality medical care, teaching (including the training of students in medicine, nursing, pharmacy, and a variety of other para-clinical and technical disciplines), and research.

The main goals of the study in Ghana were: a) to provide a description and analysis of the experience of KBU and KATH in their move towards autonomy; and b) to draw on the Ghanaian experience to derive broader lessons about the viability, and the pros and cons, of hospital autonomy, in general. The study primarily entailed a qualitative analysis of the hospital autonomy experience in Ghana, supported by simple quantitative assessments. The four evaluative criteria used in assessing hospital autonomy in Ghana were: **efficiency**, **equity**, **public accountability**, and **quality of care**. The research methodology employed included secondary data collection and analysis, interviews, and conducting of field surveys.

For the purposes of the study, we found it necessary to propose a new conceptual framework, which was intended to guide our assessment of the autonomy effort in Ghana, assist us in organizing the presentation of our data and results, and help focus our discussion on how the Ghanaian government’s initiative can be steered towards a successful realization of its objectives. In our model, autonomy is conceptualized as a continuum from fully centralized decision-making to a fully decentralized system for each of four management functions, namely: **governance**, **general management**, **financial management**, and **human resource management**. For both hospitals, each of these management functions, as well as the legal basis for hospital autonomy in Ghana, has been assessed, using the four evaluative criteria.

Our study reports several interesting findings, of which the more important are as follows. First, Law 209 does spell out a framework for autonomy, albeit somewhat

broadly. Also, much of the relevant legislation is enabling. The Law makes important concessions to public-sector hospitals, which, ostensibly, are quite radical within the context of the existing organisational arrangement. However, the law has also placed such strategic and fundamental restrictions on the Board that, in effect, all key decision-making powers and overall control are still retained at the ministerial and cabinet levels. Also the Law does not lay down a timetable for the implementation of autonomy, set priorities in the implementation process, or provide systematic operational guidelines on the implementation of the phases of autonomy.

Second, while as a concept there is broad and enthusiastic support for the autonomy initiative, autonomy means different things to different people, and the expectations, among key stakeholders, of autonomy are quite different. In other words, there is no common vision of autonomy. In fact, the support of the various stakeholders for autonomy is for different, often conflicting, reasons.

Third, there is a tendency among stakeholders to focus almost exclusively on the perceived benefits of autonomy, neglecting, in the process, some of its potential pitfalls. Indeed, whatever opposition there is to autonomy is mainly because of autonomy's perceived negative impact on equity, and due to concerns about the administrative capacities at the hospitals.

Finally, the experiment to give hospital autonomy to teaching hospitals in Ghana has not yielded many of the hoped-for benefits in terms of efficiency, quality of care, and public accountability - although there have been some isolated successes. Clearly, the establishment of hospital Boards, while necessary, is not a sufficient step in the autonomy process. To some extent, the existing situation in KBU and KATH might be explained, simply, by the relatively short duration of "autonomy" enjoyed by the two hospitals, or the instability that often accompanies systemic reform. However, the evidence would suggest that problems are far more deep-rooted.

There are different perspectives on the reasons for the failure to achieve fuller autonomy. The hospital authorities refer to the inability or unwillingness of the MOH to allow them to function as fully autonomous institutions. The Ministry of Health authorities, on the other hand point to the provisions of Law 209 and argue that the hospital authorities have failed to take initiative in implementing them. Without the necessary consensus the move towards fuller autonomy is stalled. The ambiguities surrounding the autonomy initiative, and the absence of any clear sense of direction and purpose - either at the MOH or in the hospitals, have only compounded this problem. But the two Hospital Boards have not been able to use the autonomy provided to them.

However incomplete and circumscribed the autonomy - to bring about improvements at the hospitals. An inability to successfully transplant private sector structures and incentives to the two hospitals, institutional conflicts and inertia, limited decision-

making and management capacities, the absence of a comprehensive and sustainable financial plan, and inadequate information systems have all contributed to the failure to achieve significant change.

We emphasize in our report that if hospital autonomy in Ghana is to have a chance, some of the steps that must be taken are:

- A comprehensive conceptual model of hospital autonomy should be developed, adequately discussed among key stakeholders, and adopted;
- A series of national consensus building meetings must be initiated with the goal of exposing the hospital autonomy concept, as well as the specific initiatives designed to provide autonomy to hospitals, to constructive criticism and debate;
- Law 209 should be revised, based on the discussions among stakeholders, and the new legal instrument should be backed up by specific guidelines, provided to the hospitals, on how to proceed with the implementation of autonomy;
- External and internal organizational arrangements to support autonomy should be designed. In particular, the relationship between hospital Boards, the proposed Ghana Health Service (GHS), the Ministry of Health, and the two medical schools should be clarified and formalized;
- The costs of running the various operations of the hospitals must be assessed, and alternative funding mechanisms devised to enable a system-wide financing of health care services in Ghana, including the teaching hospitals;
- Management training should be provided, so that a cadre of managerial staff equipped to handle all the key management functions at the hospitals is developed; and
- The autonomy initiative should be gradually and methodically phased in, providing the hospitals ample time to prepare for autonomy, develop clear mission statements, and introduce strategic management in their institutions.

We also argue in the report that the failure to progress to full autonomy and realize its stated objectives does not, by itself, demonstrate the non-viability of the autonomy concept. The success of the Ghana Education Service, an autonomous institution created by the Ministry of Education, would suggest that at least part of the problem with hospital autonomy in Ghana is a lack of a similar vision and initiative among policy makers in the health field. While the results of this study do not allow us to either unequivocally validate, or categorically reject, the hypothesis that autonomy -- implemented systematically and in full -- can lead to improvements along the four dimensions considered in this study, it is certainly clear that for autonomy to succeed, it needs to be given a fair chance.

The primary rationale for hospital autonomy in the public sector, as discussed in the report, is that, by creating organizational arrangements that mimic the private sector and encourage competition, one can induce increased efficiency, greater public accountability, and improved quality of care at these facilities. This does mean, however, that the hospitals must be converted into private institutions. We believe that any efficiency gains resulting from such a policy initiative are more than likely to be off-set by losses in equity.

Finally, one needs to consider the intriguing possibility that many of the changes along the four dimensions considered in this study to evaluate autonomy might be achievable without the grant of autonomy to the hospitals. Maybe what is required, simply, is better management and incentive structures within the existing structure! If this contention is true, then the failure to bring about changes in the functioning of the two study hospitals might reflect more of a management problem, than an autonomy issue. Unfortunately, however, the findings of this study do not allow us to either substantiate or reject this claim.

1. Introduction

Since the 1980s, public-sector teaching hospitals around the world have come under intense scrutiny in policy circles due to the complexity of these institutions, the heavy burden they impose on public funds, and the perceived difficulties in ensuring their efficient and effective functioning under centralized government control. One policy alternative that has found favor with policy makers in many countries is a decentralization of these public-sector hospitals, accompanied by the grant of greater autonomy to the hospitals in running their operations.

However, despite the implementation of “autonomy” in a number of public-sector hospitals around the world, there has been relatively little research undertaken on assessing what hospital autonomy entails, either in general, or in the context of individual countries and hospitals; how to systematically move the autonomy process from the conceptual to the implementation phase; whether and how autonomy can enhance the productivity and efficiency of hospitals; and the institutional and other arrangements required for autonomy. Accordingly, as part of the overall strategy of the US Agency for International Development (USAID) to conduct policy relevant research into matters of importance to African and USAID policy makers, Harvard University was commissioned to conduct a set of cross-national, comparative case-studies on hospital autonomy. During the early planning stages, Ghana was identified as one of the sites for the study on hospital autonomy by a joint Technical Advisory Group organized by Harvard University’s Data for Decision Making (DDM) and USAID’s Health and Human Resource Analysis for Africa (HHRAA) project.

Ghana was one of the first African countries to attempt giving greater autonomy to public sector hospitals. Since the 1970s, the two teaching hospitals in Ghana, namely, the Korle Bu Hospital (KBU), and the Komfo Anokye Teaching Hospital (KATH), have been encouraged by the Government of Ghana to become “self-governing”. In 1988, a legal framework, the Provisional National Defence Council (PNDC) Law 209, was developed by the Ministry of Health in Ghana as a first step towards providing full autonomy to the two hospitals. Subsequently, several measures proposed by Law 209 were implemented at the two hospitals, beginning with the inauguration of the “autonomous” Teaching Hospital Boards in August, 1990. Encouraged by the initial “success” of the autonomy initiative, the Ghanaian government even proposed January 1, 1996 as a possible date for conferring on the two hospitals the status of ‘fully autonomous’ institutions.

But, despite the Ghanaian government's demonstrated desire to grant autonomy to its teaching hospitals, the autonomy initiative in Ghana has suffered several setbacks. Indeed, the full implementation of Law 209 might well have been delayed indefinitely, for a variety of reasons discussed in this report. In that sense, the two hospitals do not enjoy full autonomy (even within the framework of Law 209), and, indeed, many of the hospital managers interviewed as part of this study questioned the MOH claim that the two hospitals were "autonomous" entities.

A fundamental question that we had to confront in undertaking this study, therefore, was whether it was fair to evaluate hospital autonomy, based on its limited implementation in Ghana. We felt that the effort was justified, for several reasons. First, the study was evaluating not only the partial implementation of autonomy in Ghana, but also the move towards full autonomy as defined by Law 209. Thus, the study focussed on the performance of the hospital, following the inauguration of the Hospital Boards, in the hope that the shortcomings of the autonomy process could be identified. Second, even though the two teaching hospitals might not have full autonomy, they do enjoy considerably greater latitude in running their affairs than other public-sector hospitals in Ghana. Furthermore, it is an open question as to whether public-sector hospitals can (or should) ever achieve the level of autonomy that might potentially exist, for example, in the private sector. Third, the fact that the autonomy process has stalled in Ghana might, in fact, reflect general problems in implementing autonomy in any setting (e.g., generic institutional and political bottlenecks), or contradictions inherent in the autonomy initiative (e.g., balancing public sector goals with a blind emulation of the private sector). In other words, the autonomy process may be directly and inextricably linked with the outcomes of autonomy. Without a detailed evaluation of autonomy in a specific setting, these issues may well be overlooked.

This study, therefore, sought to assess the successes and failures of autonomy, as it has been implemented in the Ghanaian teaching hospitals; understand the reasons for the successes/failures; gauge the preparedness of the two hospitals to fully implement Law 209; and provide policy guidance to the MOH and the teaching hospitals on appropriate ways to deal with the problems they face in the transition to full autonomy within the overall framework provided by Law 209.

1.1 Project Goals and Objectives

The primary goals of the research are: a) to provide a description and analysis of the experience of Korle Bu and Komfo Anokye hospitals in their move towards autonomy; and b) to draw on the Ghanaian experience to derive broader lessons about the viability, and the pros and cons, of the hospital autonomy concept. The specific objectives of the study are:

- To assist Ghanaian policy makers in evaluating their policy on hospital autonomy, and determine the feasibility of its full implementation in the teaching hospitals (and, similarly, in the regional Ghanaian hospitals).
- To assist top management of Korle Bu and Komfo Anokye Teaching Hospitals in designing effective strategies to successfully implement autonomy in their institutions.
- To provide lessons for the other African and non-African countries involved in the broader five-country comparative study on how to approach the issue of autonomy for government hospitals.
- To provide direction to international agencies and bilateral aid organisations in their support of similar initiatives in developing countries around the world.
- To serve as the basis for further research and teaching in this area.

This study was jointly undertaken by School of Public Health of the University of Ghana, senior management of the two study hospitals, and the Harvard School of Public Health. The investigators were assisted in the study by several officials of the Ministry of Health and the two teaching hospitals.

The rest of the report is structured as follows: Section II presents a conceptual framework for hospital autonomy and describes the methodology used in undertaking this study; Section III provides descriptive information on Ghana and the two study hospitals; Section IV gives an account of the formulation and implementation of hospital autonomy in Ghana; Section V evaluates the management structure and functioning of the hospitals following implementation of autonomy; Section VI discusses the vision and interpretation of hospital autonomy among key stakeholders; Section VII highlights various issues related to the implementation of autonomy in Ghana; and Section VIII outlines some broad conclusions and recommendations.

2. Framework and Methodology of Study

2.1 Hospital Autonomy: A Conceptual Framework

Autonomy has been defined in the dictionary as “the quality or state of being self-governing, especially, the right or power of self-government”, and “existing or capable of existing independently” (Websters Collegiate Dictionary, 1994). However, using such “absolute” criteria to define hospital autonomy might, in practice, leave us with a “null set”, as few hospitals in developing countries, particularly in the public sector, are either completely self-governing or totally independent - at least to the extent that they are all subject to regulatory constraints in one form or the other.

Indeed, in the real world, the term “full autonomy” may have little meaning, unless used within the context of specific criteria that have been determined, for example, through public legislation or executive order -- which is the context in which we use the term throughout this document. In other words, in practice, hospital autonomy may have to be defined in relative terms. Thus, for example, the term autonomous hospitals is used in the literature to refer to hospitals that are “at least partially self-governing, self-directing, and self-financing” (Hildebrand and Newbrander, 1993).

Hospital autonomy has been conceptualized in various ways in the literature. For example, one attempt to categorize hospital autonomy conceives of autonomy as a “two-level nested structure” of “type” and “degree” (Berman and Chawla, 1995). The first level (type) is represented by a two-by-two matrix, where the two axes are constituted by hospital “ownership” and “authority”, respectively. The second level (degree), refers to hospital management functions (e.g., general administration, finance, human resource management, etc.), and is represented by another two-by-two matrix nested within each cell of the first matrix - with management functions on one dimension, and the degree of autonomy on the other. Based on this conceptualization of autonomy, a hospital might enjoy any degree of autonomy along one, or various combinations, of the three characteristics: ownership, authority and function, with a considerable extent of overlap likely between degree and type of autonomy (see Table 1). The framework is a laudable attempt at capturing in one model the many complex dimensions of hospital autonomy. In particular, the framework aims to separate the issue of hospital ownership from the *de facto* authority enjoyed by the hospital managers in running the hospital.

Table 1
Berman and Chawla Hospital Autonomy Framework

Nesting Level 1					
<i>Ownership -->Authority</i>		<i>Government</i>	<i>Parastatal</i>	<i>Joint Sector: Private Corporation</i>	<i>Privately Owned</i>
<----- Ownership Continuum ----->					
Centrally Controlled	A u t h o r i t y C o n t r o l I n d e p e n d e n t	Base Case: Zero Autonomy			
High Supervision/ Control					
Low Supervision/ Control					
Independent Management					Full Autonomy

Table A.1
Approved Estimates for 1989-1993 (US\$) - Korle Bu

	<i>Pre-Autonomy</i>		<i>Post-Autonomy</i>		
	1989	1990	1991	1992	1993
Salary (1)	2,016,294.27	2,142,979.46			5,544,884.75
Traveling&Transport Expenditure (2)	38,377.37	25,765.68			
General Expenditure (3)	633,435.10	758,899.92			
Maintenance/Repairs /Renewals (4)	227,488.84	331,248.05			
Stores & Supplies (5)	570,049.12	592,959.58			
Total Items 2-5	1,469,350.43	1,708,873.22		1,377,352.68	1,598,932.02
Total Items 1-5	3,485,644.70	3,851,852.68			7,143,816.77
Salary/Total Items 1-5	58%	56%			78%

Source: Biostatistics Unit, Korle Bu

Notes: Expenditures in US\$ are in 1987 constant terms.

The framework, however, poses several problems in its application. Briefly, some of these are:

- The conceptualization requires subjective judgements on how to place a hospital within particular cells in each of the two levels of nesting. For example, it is not at all clear as to what might constitute “high supervision/control” as opposed to “low supervision/control” (in level 1), or what it means to be fully autonomous (in level 2).
- While zero autonomy and full autonomy (in level 1) might be relatively clear concepts, there is little guidance on what it means (in definitional terms) to be in one of the intermediate cells of the matrix.
- It is also difficult to compare equivalent degrees of progression along the two dimensions of the matrix in Nesting Level I. For example, is the progression from government to parastatal ownership to be equated with a change from a centrally controlled environment to one of high supervision?
- This weighting problem in Level I is further complicated by the third dimension (management functions) in Nesting Level II. This is because, along this third dimension, it is entirely conceivable for hospitals to be totally autonomous in terms of one function, while enjoying only limited autonomy in terms of another.
- Probably, the biggest problem with this two-level conceptualization of autonomy are the internal contradictions between the two levels. For example, if one were to visualize the second level of nesting within the top, left corner of Level I (government ownership/ central control), it is clear that there is no scope for hospitals to be anything but non-autonomous along each of the three management functions. A similar, but opposite, argument applies to the bottom, right corner of Level 1 (private ownership/independent management). More interestingly, if, for example, a government hospital with an independent management (bottom left cell of Level I), has full autonomy along each of the three management functions (in Level II), it is hard to understand why government ownership, *per se*, should cause it to be labeled less autonomous than a private hospital with similar characteristics. To put it differently, how do we compare the autonomy of hospitals in the different cells of the bottom row of Level I?
- While the framework is exhaustive in its attempts to capture the multiple dimensions of autonomy, this very feature makes it more difficult to use in evaluations at the field level.

Another, earlier, effort to categorize hospital autonomy considers only the ownership (i.e., fully public to fully private ownership), and management functions (i.e., governance, management, and financing) of hospitals, disregarding the additional

“authority” dimension considered by the Berman and Chawla framework (Hildebrand and Newbrander, 1993). This conceptualization does have the advantage of relative simplicity. However, in this framework, the authority that individual hospitals enjoy in decision-making is assumed to be synonymous with the ownership of the hospital, i.e., government ownership of the hospital is automatically assumed to imply a lower level of autonomy than private ownership. The problem is that counter-examples to this simplifying assumption - both theoretical and “real world” - are not hard to provide.

Also, based on the Hildebrand/Newbrander framework, *full* autonomy necessarily implies privatization. However, privatisation is not necessarily the most obvious, or even the most appropriate, endpoint of autonomy, since certain desirable aspects of public health care delivery (notably, ensuring equity) might be unachievable under privatisation. Moreover, privatization of public-sector hospitals in developing countries (teaching hospitals, in particular) is likely to be interpreted as an “abdication of social responsibility” on the part of the government (as the authors themselves acknowledge), and will probably be politically very risky.

Indeed, this issue has been of major concern to the Ghanaian government, which has been at pains to publicly clarify that its autonomy initiative does not imply a desire to privatize the teaching hospitals. Moreover, it is the tendency to equate autonomy with privatization that has complicated the implementation of the autonomy initiative in Ghana (and very likely in other countries), as will become clear during the course of the following discussions. Unfortunately for policy-makers, neither theory nor the accumulated empirical evidence offers much guidance on how far one needs to move on the public-private continuum to achieve an “optimal” balance (if one exists) between efficiency and equity considerations.

Accordingly, for the purposes of this report, we propose a new conceptual framework. This framework is intended to:

- guide our assessment of the autonomy effort in Ghana;
- assist us in organizing the presentation of our data and results; and
- help focus our discussion on how the Ghanaian government’s initiative can be steered towards a successful realization of its objectives.

In our framework, we define and characterize hospital autonomy along only two dimensions: the extent of centralization of decision-making, and management functions. We believe that these are the appropriate dimensions along which hospital autonomy should be discussed. In our opinion, the ownership characteristics of the hospital have little to do with how much autonomy a hospital has (or can have). An autonomous hospital can exist just as easily under government ownership, as under private ownership. It is the extent of de-centralized decision-making that occurs within the hospital, and the extent to such decision-making is feasible for each of the management functions, that are the relevant

considerations. Moreover, as explained above, autonomy, as it exists in the private sector, may be inappropriate for the public sector (although, as we shall argue later, for hospital autonomy to succeed, certain features of the private sector may need to be introduced in the public sector).

Our framework also eliminates the problem of defining, in general terms (as opposed to within the context of a law), what it means for a hospital to be “fully autonomous”. At the same time, it does not require us to assume that private hospitals - by virtue of their “privateness” - have greater autonomy; and, therefore, the implication that greater autonomy automatically means privatization. This framework also attempts to lessen the subjectivity involved in categorizing hospitals as “more” or “less” autonomous, by basing this decision on specific hospital characteristics and the powers that its managers possess in each functional area. Of course, we are still left with the problem of the relative weights to be assigned to autonomy with respect to each management function. For want of an immediate better alternative, we assume equal weights for each function. Last, but by no means the least, our framework is simple to understand and use.

Table 2 presents our conceptual model in the form of a 4X4 matrix, with the extent of centralization of decision-making at the hospital, and the management functions, representing the two axes of the matrix. In our model, autonomy is conceptualized as a continuum from fully centralized decision-making for each management function, to a fully decentralized system. In this continuum, we define four stages (A-D) for each of four functional areas.

The four management functions are: governance, general management, financial management, and human resource management. **Governance** refers to the function of defining the overall mission of the hospital, setting broad strategic goals, managing the hospital’s assets, and bearing ultimate responsibility for the hospital’s operational policies. **General management** refers to the responsibilities involved in the day-to-day running of the hospital and the discharge of the functions defined by the mission statement. **Financial management** refers to the generation of resources for the running of the hospital, and the proper planning, accounting, and allocation of these resources. **Human resource management** refers to the training and management of the various categories of hospital personnel. The defining characteristics of each of the four stages, mentioned above, are outlined in the corresponding cell of the matrix.

Table 2 also indicates the current location of the two Ghanaian hospitals along the continuum for each of the four management functions. The categorization of the Ghanaian hospitals presented in the table is based on the findings of this study. The framework is also helpful in giving readers an indication of the distance that needs to be traversed in order for the two hospitals to be “fully autonomous”, as defined by Law 209.

Table 2
Conceptual Framework for Hospital Autonomy

<i>Functional Area</i>	<i>Fully Centralized (Low Autonomy)</i>	----->		<i>Fully Decentralized (High Autonomy)</i>
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Governance	Direct control by owner: Government, Parastatal, or private	Governance through Board consisting of owner's appointees, primarily carrying out owner's orders	Governance through Board appointed by owner, but not subservient to owner	Independently constituted Board, making independent decisions
Management	Direct management by owner, who also sets the rules for management of the hospital	Management through Chief Administrator and other managers appointed by owner, who wields significant influence over management decisions	Limited powers decentralised to hospital management; owner still wields some influence over management decisions	Independent management operating under Board's directions, with significant independent decision-making capacity
Finance	Full funding by owner; owner has financial control	Owner funding plus funds through other sources; significant owner control	Owner subsidy plus funds through other sources, some owner influence but finances generally under Board's control/2	Self-financing; no owner subsidy; funds entirely under Board control; significant independent decision-making capacity for managers
Human Resource	Staff appointed by owner; completely under owner's regulatory control/3	Staff are employed by Board, but subject to owner's regulations	Staff employed by Board, and subject primarily to the Board's regulations; also influenced by owner's regulations	Staff employed by Board; all conditions and regulation set by Board.; managers have significant decision-making capacity

Notes:

1. Bold italics indicate the present situation in the two Ghanaian teaching hospitals. Thus, based on our framework, the two teaching hospitals are at the first or second stages of the four stages of transition to full autonomy, depending on the management function being considered. The "owner" of the two teaching hospitals in the case of Ghana is the Ghanaian Ministry of Health.
2. An example would be a government block subvention, whereby the government provides a grant to the hospital on the basis of a budget, but leaves the hospital Board to manage the funds.
3. In Ghana, the medical school staff, who are employed by a University Council, which may be regarded as a semi-autonomous Board under the Ministry of Education, constitute an exception. Also, some of the employees, such as medical housemen, are recently being appointed by the hospital Boards.

2.2 Pros and Cons of Hospital Autonomy

In all developed countries, and in many developing ones, hospital autonomy initiatives have been proposed as an integral part of a broader health sector reform process. The main themes underlying these reforms (McPake, 1996), that apply equally to the hospital autonomy policies, have been:

- encouragement of competition,
- achieving a 'split' between purchasers and providers of health services,
- restructuring public-sector institutions to (at least partially) mimic private organizations,
- cost recovery (not so much a feature of hospital autonomy in the developed countries),
- managerial and budgetary reform,
- decentralization and increased community involvement in health management, and
- re-allocation of public sector budgets towards an essential package.

While many of the autonomy initiatives are of relatively recent origin, and, therefore, have not been fully evaluated, a substantial literature does exist on the potential benefits and pitfalls of providing greater autonomy to public hospitals (see reviews by McPake, 1996; Berman and Chawla, 1995). While, *a priori*, one can only conjecture as to whether, on balance, the positives of providing increased autonomy outweigh the negatives, the popular consensus seems to be that greater hospital autonomy can lead to significant gains in efficiency, effectiveness, public accountability, and the quality of care. But, it is important to stress, at this juncture, that even if hospital autonomy does have the potential to do more good than harm (and this is by no means completely clear), this potential can only be realized if the enabling conditions are in place (i.e., adequate competition, potential for cost-recovery, etc.), and if the autonomy measures are implemented in full. Half-hearted attempts to implement autonomy in public hospitals are only likely to aggravate the situation.

We do not intend, here, to go into exhaustive details of the pros and cons of hospital autonomy. However, to set the tone for this study it is useful to briefly identify the benefits and drawbacks cited in the literature.

It has been suggested in the literature on hospital autonomy that hospital autonomy may lead to gains in both **technical and allocative efficiency**. Various reasons have been cited for these gains: the incentive structures and other reforms that usually accompany autonomy; the assumption of greater responsibility by autonomous hospitals; the greater freedom of autonomous hospitals to choose their optimal production function, the types and levels of inputs, throughputs, and outputs, and the overall strategic direction and development agenda. The flip side, of course, is that when autonomy is not associated with incentive structures, or the incentives are inadequate, any potential benefits of autonomy are unlikely to be fully realized. Furthermore, autonomy may lead to a loss of the benefits of economies of scale and scope; this would actually increase the *inefficiency* of the hospital.

Autonomy is also conjectured to increase **public accountability and consumer satisfaction**. The argument is that autonomous hospitals, vested with greater authority, can be expected to be better able to respond to local community needs. This, in turn, is expected to increase public support and acceptance, and greater community participation in hospital decision-making. Moreover, the delegation of authority, it is reasoned, “may be accompanied by a matching system of control and supervision to ensure the responsible use of authority”, thereby “leading to improvements in patient satisfaction” (Berman and Chawla, 1995). There is, of course, the very real possibility that greater hospital autonomy will not be translated into an increased concern and responsiveness to community needs. In fact, it is not implausible that freedom from central control will allow hospitals to place their self-interest above that of consumers. In fact, in all likelihood, the most important potential drawback of providing autonomy to public hospitals may be a compromise of **equity** in the financing as well as the delivery of health care (Berman and Chawla, 1995).

Finally, it has also been suggested that autonomy is likely to lead to improvements in the **quality of care** provided by hospitals. Greater autonomy, it is argued, when accompanied by appropriate incentives, consumer responsiveness, and public accountability, would lead to optimal employment of personnel, improvements in staff performance and attitude towards patients, increased availability of drugs and services, improved maintenance of facilities and equipment, etc. - all of which would contribute to improving the quality of care.

2.3 Study Methodology

This case-study primarily entailed a qualitative analysis of the hospital autonomy experience in Ghana. The broad findings of the qualitative evaluation were supported by simple quantitative assessments. The four evaluative criteria used in assessing the successes/failures of hospital autonomy in Ghana, based on the issues discussed in the previous section, are: **efficiency, equity, public accountability, and quality of care**.

In writing up the case-study, the following sources of information were utilized:

- Published information, and other secondary sources of data, e.g. hospital annual reports, minutes of hospital Board meetings, MOH reports, etc.
- Interviews with the key players in the health sector in Ghana (using open-ended questionnaires), including officials from the MOH and Ministry of Finance; hospital administrators, health professionals, para-professionals, and other technical staff at the two hospitals; representatives of professional associations; and officials at the Medical Schools at Accra and Kumasi (namely, the Ghana Medical School, Accra, and the School of Medical Sciences at the University of Science and Technology, Kumasi).

- A consumer survey, aimed at eliciting the views and opinions of patients utilizing the services offered by the two teaching hospitals.

At this juncture, it is necessary to mention some of the constraints faced by the study in relation to secondary data. Accessing data sometimes proved to be difficult, even in the case of information that should have been in the public domain. We also had some problems in ascertaining the accuracy of published data. Quite often, the national records and the records kept by the individual hospitals on the same activity did not tally with each other. In such cases, the study used the hospital records, since they provided greater disaggregation, and could be cross-checked for internal consistency. The interviews were also helpful in resolving some of the problems with the published data.

3. Background: Ghana and its Teaching Hospitals

3.1 Ghana's Health Sector

Ghana, with an area of 238,537 square kilometers and a population of about 16.5 million (1994 estimate), lies along the west coast of Africa. For administrative purposes, the country is divided into ten regions, and one hundred and ten administrative districts.

There are "four main categories of health care delivery systems in Ghana - the public, private-for-profit, private-not-for-profit, and traditional systems" (Ghana Medium Term Health Strategy [GMTHS], 1995). The public health system, centered around the MOH, has a hierarchical organizational structure from the central headquarters in Accra to the regions, districts, and sub-districts. Services are delivered through a network of facilities, with health centers and district hospitals providing primary health care services, regional hospitals providing secondary health care, and two teaching hospitals at the apex providing tertiary services (GMTHS, 1995). The two teaching hospitals also play a key role in teaching and research - offering facilities for the training of doctors and other health professionals, and for medical and public health research.

In terms of coverage, as well as expenditures on health, the public health system has a marginal lead over the other sectors, although the contributions of the mission sector and the for-profit providers are very significant. In terms of tertiary level services, however, the public sector is clearly dominant, and has a virtual monopoly over some services. This fact has important implications for the autonomy issue, as will be discussed later.

MOH expenditures on health, in real terms, have remained practically the same since 1987 - accounting for about 9% of the government's total budget, and 11% of the recurrent budget (GMTHS, 1995). The two teaching hospitals consume a major portion of these resources, accounting for 21% of the non-wage recurrent health expenditures, and 19% of the capital spending in 1994 (GMTHS, 1995). With wage costs included, the proportion of MOH resources spent on the two hospitals is likely to be in the range of 15-20%. However, these figures significantly underestimate the total cost of running these two hospitals, since a sizable part of the salaries of employees is paid for by other government departments, like the

Ministries of Education and the Public Works. Also, about one-fifth of the hospitals' expenditures are covered through user fees. Moreover, the teaching hospitals are the recipients of a majority share of external health funding. In short, the teaching hospitals account for a share of Ghanaian health expenditures, that is, according to MOH officials, quite disproportionate to the hospitals' contribution to the public health services in Ghana; and this spending has only gone up over the years.

In this context, it must be noted that the overall epidemiological picture of Ghana is that of "a developing country at the onset of health transition - a predominance of communicable diseases, undernutrition, and poor reproductive health", accompanied by the rapid emergence of non-communicable diseases as major public health problems (GMTHS, 1995). Ghana also has one of the highest population growth rates in the world (about 3% per annum), and a very high dependency ratio of almost 50%. The high growth rates in Ghana have been accompanied by rapid urbanization. The combination of these trends poses major challenges to the delivery of health services in the country (GMTHS, 1995).

As a result of the perceived health needs of Ghana and the heavy resource drain constituted by the teaching hospitals, therefore, the government has moved to re-prioritize its health commitments and reallocate its health spending, as part of a general reform of its health sector (GMTHS, 1995). Public funds are now to be spent more on "the universal coverage of good quality primary health services within the district health system". Also, an increase is proposed in the "cost sharing with the population" for more specialized services. Stronger linkages are proposed between private and public health service providers. Besides attempting to promote greater efficiency in the spending on services at all levels of care, the government has moved towards decentralization of the health system, creating a new Ghana Health Service (GHS), and providing management teams at various levels greater flexibility in allocating resources, according to their own priorities, within the context of general policy guidelines.

This is nowhere more apparent than in the management of the two tertiary care facilities, which are now to be provided an autonomous status within the Ghana health system, reporting directly to the Minister of Health. According to MOH estimates, over the next five years, the share of the two hospitals of the overall MOH budget will be reduced to less than 15% (GMTHS, 1995). The hospitals will be allowed greater latitude in allocating resources, as well as raising additional resources, but nudged towards greater efficiency in the use of their finances. The government is considering a revision upwards of its official fee schedules so as to augment the coffers of the teaching hospitals. Finally, the government is exploring, with obvious hope and enthusiasm, the possibility of introducing universal social insurance in Ghana (GMTHS, 1995). Most government officials, and many outside the government, seem to believe that social insurance will help solve the government's health financing problem, and that its introduction will release substantial resources from government revenue for preventive services.

3.2 Korle Bu Teaching Hospital

The Korle Bu Teaching Hospital, formerly known as the Gold Coast Hospital, was opened at its present site, in the south-western part of the city of Accra, on October 19, 1923 by the then Governor of the Gold Coast, Sir Gordon Guggisberg. At its inception, Korle Bu Hospital had less than 200 beds and treated up to 200 patients daily. At that time, Korle Bu was described as the finest hospital in Africa, on account of its impressive array of fine buildings and a cadre of competent staff, who provided excellent medical care to the population of Ghana, in general, and the city of Accra, in particular.

Korle Bu Hospital, from its inception, has been used for the training of practical nurses, nurse-anaesthetists, dispensers, midwives and other para medical staff. In 1946, a Nurses Training College was opened at Korle Bu to train a higher level of Staff Registered Nurses (SRNs) for the hospital, and for the entire country. Throughout the 1920s, there had been a running debate among the medical establishment about whether the hospital should also be training doctors and medical assistants. In April 1963, this debate was permanently settled by a decision taken by the government to make Korle Bu Hospital the teaching hospital for the University of Ghana Medical School, until a medical center could be built at Legon (the main campus of the University of Ghana). The medical center in Legon never materialized, and, subsequently, the medical school was attached to Korle Bu hospital.

From 1957 onwards, a rapid development and expansion of Korle Bu's original design - aimed at modernizing the hospital - has taken place. The expansion of the hospital resulted in an increase in the number of beds to 1526 by 1972. Several specialties and sub-specialties, befitting the status of Korle Bu as the apex tertiary care center in Ghana, were added to the traditional departments of Medicine, Surgery, Pediatrics and Obstetrics and Gynecology.

Today, the Korle Bu Teaching Hospital has nearly 1600 beds (1995 estimates). It functions as the teaching hospital for the Ghana Medical School, and has a staff component of more than one hundred and fifty doctors. Korle Bu Hospital serves as the ultimate referral institution for patients from all over the country. It is also a general hospital for the Greater Accra Municipality which has an estimated population of 2.14 million (1993 projection from 1984). The hospital belongs to, and is controlled by, the Ministry of Health, although moves have been afoot for the last few years to make it a fully autonomous institution within the Ministry of Health, under the provisions of Law 209.

As a teaching hospital, Korle Bu has three primary goals: the provision of high-quality medical care, teaching (including the training of students in medicine, nursing, pharmacy, and a variety of other para-clinical and technical disciplines), and research.

The hospital has specialised units in Surgery, Medicine, Paediatrics, Obstetrics and Gynaecology, Dentistry, Ophthalmology, Ear, Nose and Throat, Orthopaedics, Pathology and Communicable Diseases. Within the surgery department, the main divisions are the Units of General Surgery; Oral, Dental and Maxillo-facial Surgery; Cardio-Thoracic and Vascular Surgery; Neuro-Surgery; Uro-genital Surgery; and Casualty. Similarly, within the medicine department, the main divisions are the Units of General Medicine; Infectious Diseases; Cardiovascular Diseases; Emergency Medicine; Endocrine/Genetic Diseases; Kidney Diseases; Neurology; and Dermatology. The other large departments include Laboratory Services, the Blood Bank, Radiography, Physiotherapy, Occupational Health, and the Pharmacy department.

There are a number of other institutions, with links to the Ministry of Health, located at Korle Bu. These are:

- The Nurses Training School,
- The Public Health Nurses Training School,
- The Midwifery Training School,
- The School of Hygiene,
- The Disease Control Division of the MOH,
- The Health Education Unit of the MOH, and
- The Center for Health Statistics of the MOH

In addition, several other institutions, with their own administration and budgets, have links with Korle Bu hospital. These include:

- The University of Ghana Medical School,
- The Blood Bank,
- The Health Laboratory Services, and
- The Public Health Reference Laboratory

Furthermore, there are other governmental institutions - like the Public Works Department - that are located within Korle-Bu and provide general services to it, but do not come under the hospital's control at all.

The rapid expansion of Korle Bu hospital, and its assumption of a large number of diverse responsibilities, has created several problems for its efficient functioning. These problems (Source: Korle Bu Hospital 1923-1973) include:

- inefficiencies introduced by the spread-out of the clinical departments (e.g., in terms of administrative, coordination, and communication difficulties);

- inadequate maintenance of the buildings, installations, mechanical and electrical services, vehicles etc.;
- the presence of the University of Ghana Medical School on the Korle Bu compound which uses the clinical facilities provided by the hospital, and in turn offers the hospital the services of its senior staff - but without a clear delineation of the extent of the *quid pro quo*;
- the great increase in the number of patients seeking medical care, at levels of care (i.e., primary, secondary, and tertiary), although the hospital's primary mandate is to provide tertiary care;
- the increased and persistent demands by patients for the latest and best available treatment; and
- the soaring cost of running the hospital almost free to all patients.

As we shall see, these problems provided the stimulus for the formulation of the hospital autonomy policy in Ghana.

3.3 Komfo Anokye Teaching Hospital

The Komfo Anokye hospital is located on a hill overlooking the city of Kumasi in the Ashanti region, and is built on the former site of the African and European hospitals. The hospital was completed in 1954, and initially named the Kumasi Central hospital. This name was subsequently changed to Komfo Anokye, in honor of a legendary fetish priest of the Ashanti kingdom of the same name. On its completion, the hospital also took over the Nurses Training College (established in 1945) and the Midwifery Training School (built in 1950), that had previously been attached to the African and European hospitals.

The Komfo Anokye Teaching Hospital, with just over 750 beds (1995 figures), is the second largest hospital in this country. In 1975, in pursuance of an MOH policy to establish a second medical school in Ghana, Komfo Anokye was converted into a teaching hospital (and renamed Komfo Anokye Teaching Hospital). The medical school of the University of Science and Technology, Kumasi, was provided an attachment to the hospital, which was now required to provide the necessary teaching facilities for medical students and other auxiliaries, in addition to patient care. In addition, Komfo Anokye Teaching Hospital is also the referral hospital for the Northern and Upper Regions, Brong Ahafo, and sometimes the Western and Central Regions of Ghana.

The goals of Komfo Anokye, thus, are similar to those of Korle Bu: patient care, teaching, and research (in that order) are all considered central to the hospital's mandate. The hospital has specialized units in Medicine, Surgery, Obstetrics,

Gynecology, Pediatrics, Dentistry, Ophthalmology, Orthopaedics, Ear, Nose and Throat, Pathology and Communicable Diseases. The other major departments include Pharmacy, Radiography, Radiotherapy, Physiotherapy and Occupational Health.

Like Korle Bu, albeit on a smaller scale, Komfo Anokye is host to other institutions attached to the Ministry of Health, and also has links with several autonomous institutions. These include:

- The Nurses Training School
- The Midwifery Training School
- The Medical School of the University of Science and Technology, Kumasi
- The Blood Bank, and
- The Health Laboratory Services

Again, like Korle Bu, the Komfo Anokye hospital has a Public Works Department that provides the hospital support services, but is not under its direct control.

Many of the problems of Korle Bu noted above, are also evident in the functioning of KATH. It was for this reason that the autonomy initiative was initiated in the two teaching hospitals, as a first step towards its implementation in all Ghanaian public sector health facilities.

3.4 Informal Autonomy At Teaching Hospitals: A Historical Overview

Although many people associate the effort to provide greater autonomy to hospitals in Ghana with the promulgation of PNDC Law 209, the experience of the teaching hospitals (Korle Bu, in particular) with autonomy - albeit partial - predates the Law by several decades. In fact, even at its establishment in 1923, Korle Bu operated under an independent management committee.

According to a historical account of the Korle Bu Teaching Hospital given by Dr A. J. Hawe, a British expatriate doctor who worked at Korle Bu from the 1920's to the 1970's, the hospital at its inception was almost independent of the Medical Department (MOH) and was run as a separate unit. The revenue necessary to run the hospital came from a special vote and a special committee was responsible for this. Among members of this committee were the Colonial Secretary, the Director of Medical Services, and the then Resident Medical Officer of Korle Bu Dr A. J. R. O'Brien. According to Dr Hawe's account, it was not until Dr O'Brien's departure to a post in the colonial office in London in 1929, that the hospital lost its independence and was taken over as part of the Medical Department.

In 1968, the then military government set up another semi-autonomous Hospital Board to steer the affairs of Korle Bu through the promulgation of Legislative Instrument (LI) No 577. The Board officially assumed office in 1970. However, the Board soon ran into difficulties due to opposition from various quarters. Firstly, the Board was not able to attain financial autonomy as provided by LI 577. Secondly, the MOH refused to recognise the existence of the Board. Thirdly, there was resistance from the Ministry of Finance to providing the hospital's subvention in the form of block grants. These difficulties naturally hampered the work of the Board, and it came as no surprise when the Board was finally dissolved on August 24, 1973.

Komfo Anokye Hospital's past experience with autonomy dates back to the 1980's, when the then Commissioner for the Ashanti Region set up a Committee of Enquiry to investigate the hospital's operations. Even though its terms of reference did not specify the issue of autonomy, the committee, in its final report, recommended the establishment of an independent Board to run Komfo Anokye Hospital.

This recommendation must have convinced the then Commissioner for Health, a lawyer by training, about the need to institute Management Boards to run the two teaching hospitals in Ghana. His Ministry therefore took the initiative to draft Law 209 which provides the framework for the present move towards autonomy for teaching hospitals in Ghana.

4. The Formal Autonomy Process in Ghana

4.1 Motivations for Proposing Autonomy for Teaching Hospitals in Ghana

By far the most significant reason underlying the need to grant of autonomy to teaching hospitals in Ghana is financial. Even though other reasons are also cited for providing the hospitals with greater freedom to run their affairs (e.g., separating the policy formulation function of the MOH from health services delivery; increasing management efficiency and quality of care at the teaching hospitals; freeing the hospitals from the constraints of civil service regulations, etc.), these appear to be secondary to financial considerations.

For many years, the financial operations of most hospitals have been characterised by lapses and uncertainties such as:

- lack of financial goals and planning;
- uncertain sources of funding both in magnitude and timing;
- rising operational costs;
- poor financial operations, especially in respect of investments;
- poor accounting systems;
- lack of proper internal controls;
- lack of regular reviews of costs to aid decision making;
- inappropriate rate-setting and service charges; and
- paucity of operational research to help with the proper management of hospitals.

In the 1980's, in particular, hospitals in Ghana were faced with severe financial constraints and dwindling government funding. In most cases, the health institutions did not get what they budgeted for and could not guarantee regular service and quality of care. The deterioration reached its peak between 1982-1984, when available resources were not adequate to maintain the existing services. Hospital buildings, plants and equipment broke down and could not be replaced as the economy was in a bad shape. Essential drugs and other medical supplies were also scarce.

In order to improve health sector financing, the cash flow position of hospitals, as well as to improve the quality of care offered to patients, new higher rates of hospital fees were introduced by the Government in 1985. The objective of the increase in the user charges at all the health facilities in the country was to recover 15% of recurrent costs, without denying access to those unable to pay (MOH, 1985).

In the case of the two teaching hospitals, it was envisaged by the MOH that a more lasting and comprehensive solution had to be found to reduce their financial difficulties. Policy makers became increasingly convinced that the teaching hospitals would function better under an autonomous Board, than under the control of the Ministry of Health. It was widely believed that granting autonomy to a Board to run the teaching hospitals would improve cost recovery, enable flexible financial decision-making, ensure efficiency in overall operations, and also increase public accountability.

4.2 Legal Provisions for Autonomy in Ghana: Law 209

Hospital Administration (PNDC) Law 209 (Appendix 1) was passed in 1988, and spelt out, among its other provisions, the legal framework for establishing Teaching Hospital Boards; the functions of a Teaching Hospital Board; the membership of the Board; and the committees of the Board. For other unit hospitals, Law 209 provided for the establishment of Management Committees to administer these hospitals on behalf of the MOH. In addition, Law 209 provided that each of the ten regions in the country should have a Regional Hospital Board, which would constitute the higher management body responsible for formulating long-range policies, with the Hospital Management Committees taking charge of the day-to-day running of the unit hospitals.

Law 209 made some important concessions to publicly-owned hospitals. Some of the key functions of a Management Board included:

- Formulating policies, plans and strategies to make hospital self-financing;
- Formulating plans for improving standards of health services of the hospital;
- Ensuring implementation of policies and programmes by appropriate units of the hospital;
- Providing resources required for teaching and research;
- Appointing staff, and determining their remuneration and benefits;
- Recommending to the Minister of Health the scale of fees to be paid by patients.
- Acquiring or disposing of property, and entering into contractual agreements up to a certain stipulated amount.

On the face of it, these concessions appeared quite radical within the context of the existing organisational arrangement. However, the law also set an important limitation on the Board, namely, that the *“functions of a Teaching Hospital Board under this Law shall be exercised subject to such policy directives as the Secretary(Minister) may determine”*. In addition, the Chief administrator, and 5 of the 9 Board members were to be appointed by the government. Lastly, the Board would have no authority to change the levels of hospital fees.

While the last point may be interpreted as an important safeguard of the general public's interests, the overall result of the law has been to ensure that key decision-making powers (particularly in relation to financing), and overall control, is still retained at the ministerial and cabinet levels.

4.3 Implementation of the Autonomy Law

Implementation of autonomy in Ghana has involved:

- interpreting and implementing the provisions of Law 209;
- defining the functional framework for managing the teaching hospitals under autonomy vis-a-vis governance, legal status, general management, human resource management and financial management;
- negotiations by the hospitals with the MOH about the direction of the autonomy process involving legal, organizational, operational, financial, and personnel matters; and
- developing a general consensus about the mission, and role of teaching hospitals in autonomy and improving the capacity of the hospitals to operate independently.

In 1994, as a means to further the above process, the MOH - through the WHO - commissioned a consultant to review the mechanisms for greater autonomy in the management of the country's two teaching hospitals as envisaged by PNDC Law 209. In a report submitted in December 1994, the consultant, among other things, made suggestions about the organizational arrangements required for autonomy, the criteria for approving autonomy for the hospitals, and a time scale for making autonomy operational.

In 1995, as a follow-up to this initiative, a series of meetings were initiated between the MOH and the two hospitals to review the consultant's report, and provide assistance to the hospitals in adapting the relevant parts of the report for implementation. It would appear from the available evidence that the two hospitals have been attempting, since then, to implement many aspects of the report, albeit, in a disjointed manner. Although most hospital managers claim that these moves towards implementing autonomy are only preparatory, the evidence suggests that

autonomy - admittedly partial - has been underway in the two teaching hospitals since the inauguration of the respective Teaching Hospital Boards (We have therefore based all our evaluation on the situation at the hospitals prior to the inauguration of the Teaching Boards, and the period subsequent to the inauguration of the Boards.).

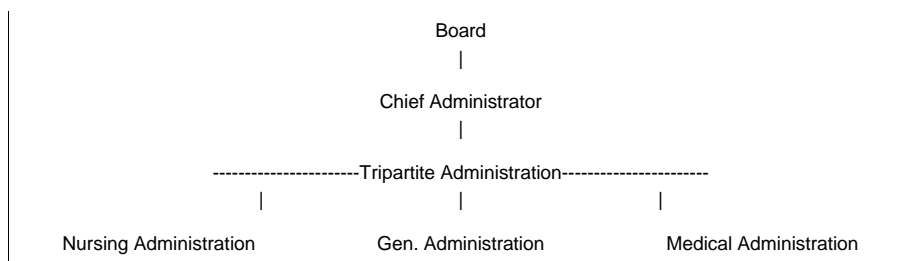
The major landmarks in the autonomy process, both in Korle Bu and KATH, have been:

- The establishment of the first Teaching Hospital Boards, inaugurated in August 1990.
- The inauguration of all the Statutory Committees of the Board.
- Selection interviews for medical internship jobs, held for the first time in 1994.
- The recommendation of the Ministry of Finance that an annual block subvention be granted to the hospitals, as of January 1, 1996. Informal approval for this measure has been given by the MOF, pending formal approval by Parliament.

5. Post-Autonomy Structure and Functioning of Teaching Hospitals: Description and Evaluation

The management of the two teaching hospitals, subsequent to autonomy, revolves around a Management Board, a full time Chief Administrator, and a tripartite administration. These levels of management at the hospitals have been prescribed by PNDC Law 209. Under Law 209, overall control over teaching hospital affairs is vested in a 9 member Management Board. These "independent" Boards are seen as a development of the 'Interim Management Committees', which had earlier been set up by the government at grassroots level (Weinberg, 1993). The hospital Boards involve specific representation of the public, either elected or appointed (McPake, 1996). The Chief Administrators are responsible for the day-to-day operations of the hospitals, and report to the Board. Below the Chief Administrator is a tripartite administration, as illustrated in Figure 1.

Figure 1
Illustration of the Tripartite Structure



The functioning of the two teaching hospitals, subsequent to the implementation of the hospital autonomy initiative, are now reviewed individually, and in detail. In keeping with the conceptual framework, the following description is organized according to the four defined management functional areas.

5.1 Korle Bu Hospital

5.1.1 Governance

According to Law 209, the purpose of the Korle Bu Board is to “improve and monitor the quality of care; appoint and evaluate the administrator and other hospital staff; assess periodically the adequacy of hospital resources; recommend fee levels; and provide, safeguard, and be the trustees of the facility and equipment of the hospital” (Weinberg, 1993; McPake, 1996). Thus, the Board is legally responsible for formulating policies and developing strategies to ensure that the teaching hospital functions effectively and efficiently within the overall health policy of government.

The Board at Korle Bu consists of a chairman and four persons appointed by the government, the Chief Administrator of the hospital, the Dean of the Ghana Medical School, and a representative each from the MOH and MOF. It is striking, as noted earlier, that the majority of the Board’s members are appointed by the government. In practice, this sets a severe limit on the Board’s capacity to function independently of the government. There is also a question about how representative the “autonomous” Korle Bu Board really is of the community it serves, and the broader issue, discussed later, of whether such representativeness is either necessary or desirable.

It was noted in a previous section that Law 209 sets important limits on the autonomy of the Board. In addition to these restrictions, a few others need to be highlighted. Besides not being able to unilaterally change the hospital’s fee schedule, the Board is also constrained in the extent to which virement between budget headings could take place, and is not free to develop its own procurement system (Weinberg, 1993). The Board is further restricted in its control over staffing and capital investment (McPake, 1996). These restrictions, quite understandably, are viewed by the Board as hampering its efforts to streamline the running of the hospital, and bring about greater efficiency in the hospital’s functioning.

In terms of the functioning of the Board, what stands out from a perusal of the minutes of past Board meetings, is the inordinate emphasis placed by the Board on routine operational issues, at the expense of questions of broad hospital policy and long-term strategy. To an extent, this problem might reflect a failure on the part of the hospital’s administration to adequately deal with management issues. But, the Board’s pre-occupation with administrative details might be more a symptom of the contradictions in Law 209 regarding the Board’s mandate and powers, the failure - so far - of the autonomous Board to develop a hospital mission statement that might provide it direction and focus, and the relative inexperience of Board members in directing the affairs of a complex institution, such as a teaching hospital.

5.1.2 General Management

According to Law 209, the Chief Administrator is responsible for the execution of the policies and decisions of the Board, and for the day-to-day administration of the Teaching Hospital. He/She is directly answerable to the Board. An issue that often emerged in discussions on autonomy, and has also affected the implementation of the autonomy policy in Ghana, is whether the Chief Administrator of the hospital should be a physician or a person with general management training. Passionate advocates of both positions exist within, and outside, the health system in Ghana.

In fact, in the past, this question assumed such seriousness, that at one point there was a move to legislate, through an amendment to Law 209, that the Chief Administrator at the teaching hospitals be a physician (and his title be changed to Medical Administrator). The amendment, however, was not implemented, and the current Chief Administrator at KBU, for example, is a non-physician. However, several stakeholders within the MOH and the hospitals are unhappy with this situation, and insist that only the return of a physician as Chief Administrator of KBU (as was formerly the case) would enable the autonomy initiative to work at the hospital.

As noted earlier, below the Chief Administrator, and reporting to him is a tripartite administration. The tripartite administration of the hospital involves a working partnership between the managers of the following departments:

- General Administration headed by a Principal Administrator
- Medical Administration headed by a Medical Administrator
- Nursing Administration headed by a Deputy Director of Nursing Services.

While no formal organogram has been developed for the “autonomous” Korle Bu hospital, all the departments of the hospital, except for the semi-autonomous ones, are expected to fit into this tripartite structure. This has created various problems in the administration of the hospital. Some departments in the hospital are uncomfortable at being forced to conform to this administrative structure, and reporting to one or other of the managers of the tripartite administration. For example, the placement of the pharmacy department under the medical administration at the hospital, according to the management of the pharmacy, deprives it of visibility in the hospital’s management structure, and also hampers its effective functioning. The pharmacy staff feels that managing the operations of the pharmacy requires specialized knowledge and expertise, that the medical administration might lack. They would, therefore, ideally, wish to be treated as a separate administrative entity. The pharmacy department also feels that it is subsidizing the rest of the hospital, at its own expense, since funds earned by the pharmacy are paid into the general hospital fund. An added problem at the teaching hospitals is that procurement of drugs occurs through the Government Central

Stores, which are not under the control of the hospital administration. Moreover, the central stores are headed by non-pharmacists, who often make un-informed decisions about procurement of drugs, which, in turn, affects the supply of drugs (in terms of price, quality, etc.) to the hospital pharmacy.

The presence at the hospital of various semi-autonomous departments and autonomous institutions, with their ambiguously defined administrative affiliations with KBU, adds its own problems to managing the hospital as an effective autonomous entity. In this context, the unsettled relationship between KBU and the University of Ghana Medical School (which uses the hospital's facilities in training its graduates, and, in return, provides specialist care at the hospital), and the Nursing School need particular mention. More will be said on this issue in relation to the management of human resources at the hospital.

Mention must be also made of the conflicts facing KBU regarding the type of care that it ought to provide. While the hospital was set up to primarily provide high-quality tertiary and quaternary level care, it has ended up meaning "all things to all people". The physical and financial accessibility to care at KBU, the failure of the MOH to set up an effective system of referrals (despite the setting up of polyclinics, which have obviously failed in their role as gatekeepers to KBU), and the paucity of reasonable alternative sources of care have all contributed to the crushing congestion at KBU. The public health system's inability to screen out patients who could benefit from care at lower level facilities, allowing hospitals like KBU to focus on more advanced care, has major implications for the efficiency with which the teaching hospitals can be run, the quality of care that they are able to provide, and, ultimately, for the extent of autonomy these institutions can really enjoy. This issue is, therefore, a matter of great immediate concern to the hospital management.

Finally, an issue that emerged from the interviews was the widespread feeling among hospital staff that the autonomy initiative was a mere "paper tiger", in the absence of a devolution of this autonomy among the departments of the hospital. The argument is that, for autonomy to succeed, the planning will have to come from the individual departments, who know their needs and resources better than the central administration. This devolution of autonomy would also be the appropriate mechanism to involve departmental staff in the hospital decision-making, and force them to take responsibility for their actions. This issue assumes particular significance in light of the fact that the current Board and Chief Administrators are perceived by many hospital personnel as outsiders, appointed by the government.

5.1.3 Financial Management

The Chief Administrator of the hospital is also the overall head of the personnel in charge of finances at the Korle Bu Hospital. As such, he/she is the ultimate spending officer. The Chief Administrator is assisted in his financial management functions by the Principal Hospital Administrator and the Chief Accountant.

The Chief Accountant coordinates the entire accounting system at Korle Bu on behalf of the Chief Administrator. He/she is a signatory to the hospital account, along with the Chief Administrator. The Chief Accountant, in turn, is assisted in his duties by four accountants who are the heads of department for the following sub-units:

- Revenue accounts
- Administration accounts
- Salaries accounts
- Costing and Reconciliation Accounts

In addition to these sub-units, there are special committees at the hospital in charge of Purchases, Tenders, and Therapeutics, respectively.

It is important to note that the Chief Accountant and all the accounting staff are employees of the Controller and Accountant General, and therefore owe their allegiance to the Ministry of Finance, rather than to the hospital or the MOH. We shall visit this issue again later in the context of the impact of varying primary staff allegiances on the efficient and effective functioning of an autonomous hospital administration.

The budgetary process at Korle Bu begins with the Principal Hospital Administrator receiving budgetary proposals from all user points in the hospital for collation early in each financial year, which begins in January. The departments submit their requests to the committee in charge of purchases that then submits them to the Principal Hospital Administrator. The proposals are due at the administration office, at the latest, by the end of March. The administrator normally reviews the proposals with user departments, sometimes requesting further justification for the proposals. On receiving returns from all the departments, the administrator goes to the Ministry of Health to defend the budget which is consequently taken to the Finance Committee of Parliament, and approved by Parliament.

Evidently, particularly in the last couple of years (after the setting up of the autonomous Boards), there has been a radical shift away from the formerly arbitrary projections of budget estimates (which involved such calculations as percentages over previous year's spending, etc.) by the departments. Now, each department is required to give a justification for its needs, based on a documented demand for specific products and services. Further, the Stores and Supplies Departments maintains a strict time-table for submission of returns from the departments. This has been a decidedly positive contribution of autonomy to the effective functioning of the hospital.

The Hospital's accounts are operated along two major components: the Central Vote from the Ministry of Health, and Internally Generated funds from hospital fees and other service charges. As has been emphasized, the primary considerations

motivating the decision to provide autonomy to the teaching hospitals in Ghana were financial. Thus, the MOH wanted to see the autonomous hospital less dependent on central funding, so that it could focus its attentions on funding more cost-effective health services. Further, it was the expectation of the MOH that autonomy, and the resultant efficiency, would increase the level of internally-generated revenues at the hospital.

However, the evidence from the first four years following the inauguration of the autonomous hospital Boards, would seem to belie such optimism. This fact, and several other findings related to the financial management of KBU under the autonomous Boards, emerge from the data presented in Tables 3-5.

Table 3 shows that, both in absolute and percentage terms, the level of subsidy provided by the MOH to KBU (both budgeted amounts and actual expenditures), while it declined in the initial years following the setting up of the autonomous Board, has shown an increasing trend in the last few years. In fact, the share of the MOH budget allocated to Korle Bu in 1994 (10.5%) was at the same level as in 1990, the year the Boards were inaugurated. In absolute terms, the spending by the hospitals has increased substantially. This occurred in spite of the fact that the money actually made available to the hospitals was less than the money initially

Table 3
MOH and Korle Bu Net Recurrent Budget Allocations ('000\$) 1989-1993

	<i>Pre-Board</i>		<i>Post-Board</i>		
	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
MOH Budget	60,031.00	55,212.01	57,882.15	58,366.98	74,668.00
Korle Bu Budget	3,484.37	n/a	3,609.74	4,094.96	6,172.78
MOH Actual	62,077.91	36,812.01	57,933.29	69,862.37	74,588.52
Korle Bu Actual	3,485.54	3,868.53	3,609.75	3,372.41	6,173.63
Korle Bu/MOH Actual %	5.8%	n/a	6.2%	4.8%	8.3%
Korle Bu/MOH Actual %	5.6%	10.5%	6.2%	4.8%	8.3%

Source: 1. MOH, Ghana, 2. Korle Bu Hospital.
Note: Numbers are in thousands of constant US dollars (1987=100).

budgeted for them by the MOH. This increasing trend in expenditures was confirmed by the finance personnel at the hospital, who also pointed out that, if the hospital was to "break even" in the future (it currently runs at a sizable deficit), even at current levels of operations, the share of the MOH funds allocated to the hospital would have to increase further. Under these circumstances, with currently available

resources, making any significant improvement in the quality of care, and/or adding facilities and services, would seem a herculean task.

Table 4 demonstrates that the hospital has been functioning at a considerable deficit, in real terms, since the inauguration of the hospital Board. This is the result of several parallel developments: a) the amount of money made available by the MOH for the recurrent expenditures of KBU (although not the share of MOH expenditures allocated to the hospital) fell, in real terms, between 1990 and 1992, although it increased in 1993, b) internally generated revenues (mainly hospital fees), while they increased in absolute terms, were not enough to make up for the declining MOH funding, and c) KBU expenditures have been increasing continuously

Table 4

Income and Expenditure Pattern ('000\$) 1990-1993 - Korle Bu

	<i>Pre-Board</i>		<i>Post-Board</i>		
	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
Hospital Budget Estimate	n/a	n/a	n/a	n/a	n/a
Approved Estimates	3484.37	n/a	3609.74	4094.96	6172.78
MOH Grant Spent	3485.55	3868.53	3609.75	3372.41	6173.63
Internally Generated Revenue	778.52	896.03	879.86	919.74	1456.08
Total Revenue	4264.07	4764.6	4489.61	4292.15	7629.71
Fees as % of total revenue	18.8%	18.8%	19.6%	21.4%	19.1%
Expenditure	n/a	4657.95	4795.11	6210.77	9389.48
Income minus expenditure	n/a	106.61	-305.50	-1918.62	-1759.77

Source:

1. Korle Bu Teaching Hospital 1992 Annual Report.
2. Korle Bu Hospital 1994 Financial Statements, prepared by S.S.K. Masiku, Chief Accountant.

Notes:

1. Excess expenditure over approved estimates represents increases in salaries and wages during the year.
2. Numbers are in thousands of constant US dollars (1987=100).

since 1990. It is particularly worrisome that the hospital's deficit has shown an increasing trend, although the deficit was brought down somewhat in 1993. Contributing, in no small measure, to this trend in KBU's deficits is the fact that the budgets put up for government approval by KBU are routinely cut. In fact, although

we could not get exact figures, our enquiries revealed that, sometimes, the monies approved are as little as 25-50% of the hospital's requests.

It is interesting to note that the share of revenues constituted by hospital fees has remained more or less constant at around 20% (19% - 21%), though the figure for 1994 (17.4%) is slightly lower. This would seem to suggest that, at current levels of user fees, it is probably unrealistic to expect that the collection of revenues through this source would go up significantly, even with increased efficiency.

Table 4, however, clearly shows that KBU continues to rely heavily on MOH support. This is often for reasons beyond the control of the hospital, e.g., the effect of general economic inflation, and the huge debts run up by the MOH itself. Still, the fact remains that the hospitals are heavily dependent on MOH funding. Actually, the government's support goes beyond the resources that it makes available to the hospital. In fact, the primary reason that the hospital is able to sustain the huge (and growing) deficit, and continue to obtain drugs and supplies from suppliers, is because of perceived or real government guarantees. The government has routinely been bailing KBU out through the use of funding that is not reflected in the hospital budget. Moreover, the government is perceived by hospital suppliers as a guarantor that the hospital will not renege on its payments. It is our contention (based on the available evidence) that, should the support provided to the hospital in the form of perceived or real government guarantees be removed, KBU would be unable to maintain its financial solvency. In other words, a completely autonomous KBU, at least in the near future, simply cannot function at its present level of operations, in the absence of MOH support. As noted earlier, the troubling reality is that the level of government support is only likely to go up, unless there is a radical rethinking on the role and responsibilities of KBU.

Table 5 below presents details of the collection of revenues by KBU through hospital fees. Again, an analysis of the pre and post autonomy revenue collection, through user fees, provides useful insights. The amounts collected by KBU, both in nominal and real terms, has been increasing steadily for each year after autonomy with the exception of 1991. Evidently, the dramatic increase in hospital fee collection in 1993 was facilitated by an improved, more efficient, system of revenue collection that was put in place. This might suggest that the autonomous Board has, indeed, been able to improve user fee collection. However, two cautionary notes are in order. Firstly, our interviews revealed that revenue collection through hospital fees has tended to level-off after 1993. And, secondly, it is important to note that the amounts collected (even in 1993), while not insignificant, are hardly enough to replace the support received from the MOH.

In fact, reading Tables 4 and 5 together makes it clear that even a doubling of the current levels of user fees (with the enormous implications this is likely to have for the accessibility of KBU's services to the poor), would not allow KBU to become

self-sufficient in its financing. This is a sobering thought, indeed, for advocates of autonomous public-sector hospitals in developing countries.

Turning now to the financial accounting at KBU, the system works as follows: all payments effected through the Controller and Accountant General's Department are subjected to thorough internal pre auditing. There is the use of imprest to effect payments. Amounts less than or up to ₵50,000 are controlled by the Chief Accountant and the Principal Hospital Administrator and paid in cash. Amounts more than ₵50,000 are always paid through checks. The Auditor General's Department is responsible for all investigations before vouchers are passed for payment by the Controller and General's Department. There are many problems, both institutional and otherwise, which have militated against the smooth implementation of this accounting system at Korle Bu Hospital, subsequent to

Table 5
Collection of Hospital Fees by Month 1989-1993 - Korle Bu

	<i>Pre-Board</i>				<i>Post-Board</i>					
	1989		1990		1991		1992		1993	
	cedis	\$	cedis	\$	cedis	\$	cedis	\$	cedis	\$
Jan	13,490,476.	51,148.88	23,591,485.	64,329.62	35,833,618.	81,092.17	33,303,797.	66,835.45	47,755,720.	76,547.76
Feb	13,490,274.	51,148.11	22,429,230.	61,160.36	29,378,348.	66,483.77	33,677,795.	67,586.00	51,539,675.	82,613.07
Mar	13,401,060.	50,809.86	26,082,439.	71,121.99	30,572,923.	69,187.12	37,242,725.	74,740.25	64,315,360.	103,091.2
Apr	14,320,086.	54,294.33	23,218,847.	63,313.50	25,578,590.	57,884.85	31,460,432.	63,136.11	65,489,450.	104,973.2
May	18,023,580.	68,336.06	27,248,417.	74,301.40	31,336,106.	70,914.22	34,615,730.	69,468.29	70,340,769.	112,749.3
June	18,318,700.	69,455.00	28,565,525.	77,892.91	31,897,925.	72,185.62	10,502,490.	21,076.84	65,596,630.	105,145.0
July	18,591,304.	70,488.57	29,583,200.	80,667.92	37,674,173.	85,257.39	41,904,950.	84,096.60	76,311,953.	122,320.6
Aug	19,730,441.	74,807.59	32,280,954.	88,024.19	36,294,228.	82,134.54	38,683,124.	77,630.91	88,290,001.	141,520.2
Sept	18,290,545.	69,348.25	30,417,062.	82,941.70	34,894,509.	78,966.95	45,046,697.	90,401.59	100,059,353	160,385.3
Oct	19,589,010.	74,271.35	25,487,498.	69,499.69	36,581,205.	82,783.98	61,632,665.	123,687.0	87,484,473.	140,229.0
Nov	19,777,374.	74,985.53	31,546,811.	86,022.32	32,101,248.	72,645.75	51,131,915.	102,613.6	99,113,223.	158,868.8
Dec	18,325,122.	69,479.35	28,257,881.	77,054.02	27,002,498.	61,107.18	39,126,205.	78,520.10	92,142,225.	147,694.9
Total	205,347,972	778,572.8	328,709,349	896,329.6	389,145,371	880,643.5	458,328,525	919,792.8	908,438,832	1,456,138.

Source: Biostatistics Unit Korle Bu.
1. Expenditures in cedis are in nominal terms.
2. Expenditures in US dollars are in 1987 constant dollars.

autonomy. Some of these are:

- *Slashing of budgets:* Budgets are almost always slashed by up to 60% every year. This makes implementation of budgetary proposals and plans very difficult, and the hospital is forced to give wide discretionary powers to the spending officers to adjust purchases and budgets. The perennial drastic cuts in proposals presented to the Ministry of Health forces the Korle Bu Hospital to operate well below capacity. Essential inputs are often lacking and this slows down work. Certain departments, i.e., Maintenance, Catering, and Laundry are particularly vulnerable.

- *Lack of incentive:* There is a general lack of adequate financial rewards for accounts personnel, who often have to work 24-hour shifts to keep up with the work load. The overtime put in by the staff is rarely compensated fully, if at all. Thus, the morale of the staff manning various revenue points at the hospital is not very high.
- *Duplication of effort:* There is a significant overlap in the duties of hospital personnel, especially in the laboratory departments. Also, with the University of Ghana Medical School taking over certain laboratory responsibilities, these departments owe double allegiance to the UGMS and the Korle Bu Administration. This often complicates budgeting and implementation procedures. The Hematology, Pathology, and Microbiology Departments are the most vulnerable. Similarly, the existence of other self-accounting units at KBU, like the Health Laboratory Service and the National Blood Transfusion Service, create difficulties in accounting, costing, payments and purchases. Sometimes, certain categories of expenditure or revenue cannot be placed under any specific account.
- *Inability to allocate joint costs, and price services based on actual costs:* The present accounting system is not equipped to handle the issue of joint costs. If the hospital is to become financially autonomous, it is important that the "real" costs of running the hospital be calculated, and the services priced accordingly. An important case in point (which is no means the only example), is the financial arrangement between KBU and UGMS. Korle Bu offers its facilities for the training of UGMS graduates, and in turn receives specialist services from consultants employed by the Medical School. This relationship has often been strained because of a mutual feeling that the relationship is unequal. In this situation, allocation of joint costs becomes a major issue that must be addressed, if the hospital is to be truly autonomous.
- *Overly centralized financial planning:* There is no system at Korle Bu to ensure that the financial plan of the hospital reflects the financial plans of the individual departments. This is primarily due to the lack of administrative manpower. An interim, short-term, measure of costing departmental inputs has been initiated, but even the finance personnel at the hospital acknowledge this to be less than ideal.
- *Non payment for services rendered by hospital:* The rate of non payment for services rendered by KBU is very high. There are many patients who claim to be indigent, and, thus, do not pay for their hospital care. There are also prisoners and refugees, who, by law, have to be given free treatment. Furthermore, all hospital staff, their spouses, and up to 3 children are entitled to free medical treatment. Reimbursement is rarely received from the government and other sources for such services.

- *Lack of control over key expenditures:* The hospital often has no control over some of its expenditures. For example, capital investment decisions are mostly made at the MOH, and the hospital rarely has a say in the use of these funds. In fact, sometimes, these decisions are influenced by the availability of a block grant from a foreign donor, rather than by investment decisions made by the hospital management. Also, the high salary component of the recurrent expenditures (Appendix 3.1), and the inability of the hospital to independently determine the size of its staff, places a severe financial burden on the administration that comes in the way of efficient planning.

5.1.4 Human Resource Management

Korle Bu Teaching Hospital has a staff strength of nearly 3,200 (1995 figures) made up of a complex mix of medical officers/specialists, nurses, midwives, pharmacists, physiotherapists, radiographers, technical officers, accounting officers, administrative staff, catering, laundry, engineering staff etc. A breakdown of personnel into five distinct categories is provided in Table 6. The staff strength shown in the table includes permanent (salaried) staff, as well as staff hired on daily wages.

The different categories of staff (and sub-units within these categories), shown in Table 6, are employed by a variety of ministries and institutions. These include:

- The Ministry of Health
- University of Ghana Medical School
- The Controller and Accountant General's Department for Accounting Staff
- The Ministry of Finance for Stores Personnel
- The Public Works Department for maintenance staff

In principle, all staff of the hospital are answerable to the Chief Administrator on all personnel matters. In practice, though, staff from other institutions seconded to KBU rely on their parent institutions for important personnel functions like leave, promotions, transfers etc. Many of these staff draw their salaries from their parent institutions (e.g. clinical consultants from UGMS or stores personnel from the MOF), and, furthermore, are bound by the rules and regulations of the parent organization (e.g. the Accounting staff from the CAG's office or the Public Works staff). They are also, for the most part, immune from being disciplined or fired by the Korle Bu administration. The implications of these circumstances for effective human resource management at KBU are obvious. Most of the senior administrators admit to being constantly frustrated in their efforts to introduce a rational management structure and ensure staff discipline at KBU - a basic requirement for

Table 6
Personnel Figures from 1990-1996 (Korle Bu)

	<i>Pre-Board</i>	<i>Post-Board</i>		
	1990	1993	1995	1996
Doctors	143		330	324
Para-medical	442		286	310
Nurses	816		1,317	1,316
General Administration	408		479	377
General Services	1,734		668	487
Total	3,543	3,200	3,188	2,892

Source: 1. Biritwum and Nyame, Ghana Medical Journal, Vol. 27-28, 1993/94.
 Biostatistics Unit, Korle Bu.

2.

an autonomous institution.

Table 6 shows that, while the overall staff strength at KBU has decreased subsequent to autonomy, most of the cuts have occurred in general services. These services are dominated by casual workers, who, being unorganized, are less protected from layoffs. Indeed, the large-scale laying off of these personnel is often achieved at the risk of a compromise of the quality of hospital services and patient care. It is interesting that, while general services have been pruned, the numbers of staff among the other categories of personnel has actually gone up.

5.1.5 Selected Hospital Statistics

The picture that has emerged so far is that, while KBU has been attempting to introduce changes in the management of the hospital in keeping with its "autonomous" status, it has been hindered at every stage by the considerable restrictions placed on its autonomy in each of the four management areas, i.e., governance, general management, financial management, and human resource management. Under these circumstances, it would seem almost unfair to expect the hospital to demonstrate significant improvements, either in its structure or functioning. It is, therefore, not surprising that a comparison of hospital statistics from the years preceding and subsequent to autonomy fails to show (with the odd exception) many changes. This can be seen from the data presented in Tables 7-10.

Table 7 and 8 present inpatient and outpatient statistics for KBU for the period 1988-1993. It is obvious from the data on inpatient attendance in Table 7, that

autonomy has not produced any declines in the numbers of patients attending the out-patient department. In fact, if anything, the number of attendances has gone up slightly. This assessment was supported by the hospital staff interviewed, and by the (admittedly cursory) observations of the investigators involved in this study. While some of this increase in OPD attendance may be attributed to a rise in Accra's population, the numbers clearly demonstrate the failure of the hospital to rationalize out-patient care. The attempts of the MOH and the hospital to encourage patients to visit polyclinics for primary and secondary level care, and have KBU deal with tertiary level cases has obviously not met with much success. It doesn't help matters that most polyclinics shut down by mid-afternoon, leaving KBU as the only alternative for care-seekers.

Table 8 shows slightly more encouraging results. While the total number of beds,

Table 7

Annual Outpatient Attendance 1988-1993 ('000) - Korle Bu

	<i>Pre-Board</i>			<i>Post-Board</i>		
	<i>1988</i>	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
Korle Bu	379,202	407,625	482,986	495,102	468,219	519,203

Source: Biostatistics Unit Korle Bu

and the number of inpatient admissions have gone up since autonomy, the average bed turnover has increased and the average lengths of stay have shown declines (though the figures for 1994 and 1995 must be interpreted with caution in view of the doctors' strike and the renovations being undertaken at the hospital). However, any optimism must be tempered by the fact that we do not have the outcome figures to gauge what the implications of these changes were for the discharged patients. The case fatality rate (deaths/admissions), which is a very crude measure, does show a sizable decline, but it is hazardous, at best, to make any claims about quality of care and hospital performance from these figures. Moreover, interviews with hospital staff revealed that many patients were being kept in the wards for much longer periods than would be considered acceptable by international standards.

The occupancy rate, which has hovered around the 75% mark, would suggest a less than optimal level of operations (although the distribution of bed occupancy rates varies considerably from one department to another). Even conceding the need to have free beds for emergencies, this would seem to suggest conservative admission practice (Biritwum and Nyame, 1993/94). This becomes even more relevant given that the hospital, as an autonomous entity, has been trying to raise its collection of

Table 8
Bed State Statistics 1989-1995 - Korle Bu

	<i>Pre-Board</i>		<i>Post-Board</i>				
	1989	1990	1991	1992	1993	1994	1995
Total beds	1,448	1,490	1,560	1,560	1,603	1,602	1,319
% occupied	75	75.1	75.2	75	74.7	63.2	71.3
Bed turnover	26.6	27.3	22.9	23.63	31.1	23.0	48.0
Avg. length of Stay	10	10	11	10.5	8.8	5.0	3.8
Total Admissions	44,281	46,837	33,580	42,500	49,072	28,645	47,230
Total deaths	2,458	2,476	4,015	4,015	2,722	1,879	3,217

Source: Biostatistics Unit Korle Bu

Notes:

1. There was a general doctors strike at the hospital in 1994, which influenced outpatient attendance, admissions, etc.
2. The number of beds at KBU have been reduced temporarily in 1995 because of the renovations being carried out in the main surgical block. The full complement of beds is expected to be restored after completion of the renovation. The renovations have also affected other bed state statistics.

hospital fees.

Table 9 and 10 below present data on the most frequent causes of inpatient admissions and outpatient treatment. Two points must be made in relation to these tables. First, while data, such as "top ten" diseases, need to be interpreted with caution, and it is difficult to draw any firm conclusions from this kind of information, it does seem that diseases that should be more appropriately treated at lower level facilities are disproportionately represented here. For example, it would seem quite unnecessary for cases of intestinal worms, upper respiratory tract infections, or diarrheal diseases (unless these cases involved complications) to be treated at the apex institution in the country. Secondly, the representation of various diseases has remained more or less the same in the period before and after autonomy, although individual distributions and the order of diseases might have changed. Thus, it seems fair to say that autonomy has not resulted in significant changes in the case-mix at the hospital.

5.2 Komfo Anokye Hospital

5.2.1. Governance

The Komfo Anokye Teaching Hospital, like KBU, is managed by a Management Board, which was inaugurated in August, 1990. The membership of the Board, as dictated by Law 209, includes 6 members appointed by the government, and 3 ex-officio members.

Currently, the Board holds regular monthly meetings, throughout the year, to deliberate on policy matters and strategies directed at ensuring the smooth running of the hospital. According to sources interviewed for this research, the existence of the Board at KATH has brought the hospital the following advantages:

Table 9**Top 10 Diseases of Inpatients 1989-1993-Korle Bu**

	<i>Pre-Board</i>				<i>Post-Board</i>					
	<i>1989</i>		<i>1990</i>		<i>1991</i>		<i>1992</i>		<i>1993</i>	
	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>
1	Abortion	26.7	Abortion	19.7	Malaria	25.4	CVA	16.8	CVA	22.1
2	Cardio-Vascular Accident (CVA)	14.3	Hernia	12.9	CVA	11.8	Pneumo-coccal Pneumonia	13.3	Fracture of the lower limb	12.2
3	Diabetes Mellitus	13.2	Pregnancy & related complications	12.6	Septic- aemia Newborn	11	Congestive heart failure	10.7	Congestive heart failure	11.2
4	Hernia	8.9	CVA	12.5	Cellulitis and Abscess	9.7	Other & unspecified anaemias	9.4	Other & unspecified anaemias	10.5
5	Pregnancy & related	7.9	Fracture of lower limb	11.2	Diabetes Mellitus	9.7	Diabetes Mellitus	9.1	Hypertension	8.3
6	Pneumo-coccal Pneumonia	6.6	Appendicitis	8.2	Other & unspecified anaemias	9.4	Abortion	8.7	Pneumo-coccal Pneumonia	7.6
7	Congestive heart failure	6.3	Other & unspecified anaemias	7.6	Hyper-tension	9.1	Appendicitis	8.62	Meningitis	7.4
8	Malaria	5.5	Diabetes Mellitus	6.3	Meningitis	8.1	Hernia	8.57	Hernia	7.2
9	Other & unspecified anaemias	5.4	Hyper-tension	4.5	Hereditary hemolytic anaemia	7.1	Meningitis	8	Appendicitis	7
10	Hyper-tension	5.1	Congestive heart failure	4.5	Fracture of the lower limb	6.9	Fracture of the lower limb	6.8	Chronic liver disease	6.5
Total		100*		100*		100*		100*		100*

Source: Biostatistics Unit Korle Bu

Notes: Percentages are calculated based on the top 10 diseases in each year

- the Board acts as a vital link between the hospital and the MOH. In this sense, it acts as a "shock absorber" in handling emergencies that confront the hospital from time to time.
- the Board provides the hospital with a certain vision, stemming from the Board members' understanding of the problems confronting the hospital.

Table 10

Top 10 Diseases of Outpatients 1989-1993 - Korle Bu

	<i>Pre-Board</i>				<i>Post-Board</i>					
	<i>1989</i>		<i>1990</i>		<i>1991</i>		<i>1992</i>		<i>1993</i>	
	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>	<i>Disease Type</i>	<i>%</i>
1	Malaria	33.9	Malaria	36.7	Malaria	39.2	Malaria	48.8	Malaria	26.6
2	Diabetes	22.1	Diabetes	15.3	Upper Resp. Tract Infections	18.3	Upper Resp. Tract Infections	17.5	Upper Resp. Tract Infections	14.6
3	Upper Resp. Tract Infections	9.3	Hernia	10.1	Diarrhoeal Diseases	14	Pneumonia	11.4	Hyper-tension	13.2
4	Hernia	8.5	Upper Respiratory Infection	9.2	Hyper-tension	8	Diabetes	10.1	Diarrhoeal Diseases	10.9
5	Pneumonia	6.5	Diarrhoeal Diseases	8.8	Anaemia	5.9	Hyper-tension	7.6	Ear Infection	10.4
6	Diarrhoeal Diseases	5.8	Hyper-tension	6.1	Disease of Skin (Ulcers)	5.3	Disease of Skin (Ulcers)	4.5	Skin Diseases	8.5
7	Hyper-tension	5.6	Anaemia	5.9	Hernia	4.7			Gynecological Diseases	6.3
8	Anaemia	4.6	Disease of Skin (Ulcers)	4	Intestinal Worms	4.6			Pneumonia	3.8
9	Intestinal Worms	2.2	Pneumonia	3.9					Intestinal Worms	2.9
10	Disease of Skin Ulcers	1.5							Typhus Fever	2.8
Total		100*		100*		100*		100*		100*

Source: Biostatistics Unit Korle Bu

Notes: Percentages are calculated based on the top 10 diseases in each year

- the staff of the hospital show a better sense of motivation, knowing that the Board is likely to take decisions that would serve the best interests of the hospital as a whole.

However, the same sources also claim that "too-frequent" meetings by the Board has deprived the hospital's middle level management of the latitude to exercise initiative and take creative decisions to support the Board's vision. Also the frequency of the meetings increased the administrative support activities of the managers, at the expense of their other responsibilities.

Many of the constraints facing the Teaching Hospital Boards, referred to in the section on KBU, also affected the functioning of the KATH Board; and it was felt by KATH staff that these impeded the establishment of autonomy. For example, the KATH Board was not free to develop its own systems for procurement, but had to go through standard civil service systems. In this context, control of drug procurement was seen as particularly important at KATH, especially the

procurement of drugs essential for the functioning of a tertiary care hospital (Weinberg, 1993). Also, the Board is constrained to the degree to which it can vire funds, especially between budgets, but also between certain budget lines. In addition, some of the provisions of Law 209, such as the establishment of a medical staff committee, evidently, have not been fully implemented at KATH. This was seen as detrimental to the effective running of the Board, as there was “no formal route for the medical staff to put their opinion to the Board other than by lobbying the members of the Board” (Weinberg, 1993).

Like KBU, the domination of the Board by appointees of the MOH and the MOF was felt to go counter to the concept of an autonomous hospital. Moreover, the assumption of a position on the autonomous Board by central government employees, while it might offer certain advantages in terms of access to the government’s “ear”, has the potential for “role conflicts” brought about by these members’ potentially divergent responsibilities to each of the institutions they served (Weinberg, 1993). Some of the MOH staff interviewed also alluded to the problems created for integration of the teaching hospitals with other health system components, because of the provision of Law 209 that enables the Board to report directly to the Minister of Health, rather than the Director General of Health Services. The ministerial responsibility for the hospital Board was also perceived as being inadequately defined (Weinberg, 1993).

5.2.2 General Management

Like Korle Bu, the Chief Administrator of KATH reports to its Board and is responsible for executing the policies and decisions of the Board. However, unlike Korle Bu Teaching Hospital, where the position of Medical Administrator is separate from that of the Chief Administrator, the Chief Administrator of KATH also acts as the Medical Administrator because he is a clinical specialist. The Chief Administrator is assisted by a Principal Hospital Administrator and a Deputy Director of Nursing Services.

This general management structure has, to a large extent, muted the debate at KATH over whether the Chief Administrator must necessarily be a physician. However, in the past, senior specialists have been known to interfere in the appointment of Chief Administrators who were not doctors. In Ghana, one has to live with the reality that a non-physician is unlikely to have the full acceptance of specialists, and the social status of doctors is such that senior specialists are likely to wield considerable influence over senior civil servants and ministers (Weinberg, 1993).

Many of the other general management issues highlighted in the section on Korle Bu, such as, the lack of a formal organogram, the problems experienced by some departments in fitting into the existing management structure, the complications brought about by the existence of other autonomous institutions at the hospital, the failure of the hospital to devolve autonomy to its various units, and the issue of

whether the teaching hospitals should also be burdened by primary and secondary level cases, also apply to Komfo Anokye hospital.

5.2.3 Financial Management

The financial administration of the Komfo Anokye hospital revolves around the Accounts Department, which has four major divisions, namely, salaries, cash office, revenues and costing/pre-audit. The Accounts Department is headed by a Principal Accountant who is responsible to the Chief Administrator. The objective of the Accounts Department is to advise the Chief Administrator and the Board on financial matters and other related issues. Like KBU, the staff in the accounting office owes primary allegiance to the Ministry of Finance.

Also like KBU, two sets of accounts are operated by the Komfo Anokye hospital, based on the source of the funds, i.e., a) Central Government Accounts/Treasury System: With this account, funds are provided to KATH by the Central Government, through the Kumasi Metropolitan Assembly. The funds allocated to the hospital every year are based on budgetary estimates that are submitted to the Ministry of Finance for approval, through the Ministry of Health; and b) Hospital Fees: To ensure continuous provision of health care needs to patients who attend the hospital, minimal fees are charged to supplement funds provided by the government for the running of the hospital. Revenue and expenditure returns are prepared every month to reflect total fees collected and expenditure made from such fees, which are also submitted to the Ministry of Health.

The financial accounting system at KATH is quite similar to that at KBU, and, accordingly, suffers from many of the same problems, although not necessarily to the same degree. However, though we could not obtain documentation to confirm or disprove it, there is a widely shared view among the staff at both teaching hospitals that the physical distance separating KATH from the MOH allows the hospital a somewhat greater latitude in operating its finances. In order to demonstrate KATH's financial performance subsequent to autonomy, information similar to KBU is now presented for the Komfo Anokye hospital (Tables 11-13).

Table 11 shows that the share of the MOH recurrent budget actually allocated to KATH has tended to vary between 3-5%, while the budgeted amounts varied from 3-6%. Like KBU, while the level of MOH subsidies to the hospital, in percentage though not in absolute terms, dropped in the year immediately following autonomy, these figures have shown a rising trend in subsequent years. In fact, our information suggests that, since 1994, the share of MOH expenditures constituted by KATH had increased to, and possibly exceeded, the pre-autonomy levels. In other words, the dependence of KATH on the MOH, as in the KBU case, has only grown since autonomy. Again, as in the case of KBU, this has occurred in spite of the fact that the KATH actually spent less than the amount budgeted for it by the MOH (often due to restrictions imposed on it by the MOH in terms of the virement of funds from one activity head to another).

Table 12 demonstrates that, like KBU, the collection of hospital fees by KATH is in the range of 20% of its total revenue, varying from a low of 17% in 1991 to a high of 23% in 1992. In percent terms, thus, autonomy does not seem to have had a significant impact on the collection of hospital fees. In fact, the consistency in the share of total revenues constituted by user fees across hospitals would seem to suggest that, under existing circumstances, this is the limit of the potential of user fees to generate revenues. In real US\$ terms, though, the amount of revenue generated annually from this source has been in the range of US\$ 375,000 to US\$ 990,000, and has shown an increasing trend.

Table 12 also reveals the dichotomy between the amount budgeted for KATH by the MOH, and the amount ultimately approved by the MOH. Thus, the hospital typically receives only about 70-75% of the money that is annually budgeted for it by the MOH. This phenomenon, to a significant extent, has led to cutbacks in the services offered by the hospital, compromises in the services it does offer, and delays in the updating of the hospital's facilities and equipment. The MOH, in its defense, has pointed to the fact that the hospital's own initial budget estimate is much lower than the amounts approved by the MOH (which, according to the MOH, reflects the poor financial management capacity at the hospital). However, hospital

Table 11
MOH and KATH Net Recurrent Budget Allocations ('000\$) 1989-93

	<i>Pre-Board</i>		<i>Post-Board</i>		
	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
MOH Budget	60,030.51	55,212.01	57,882.15	58,366.98	74668
Kath Budget	2,040.79	1,919.58	1,888.81	2,945.44	4,432.35
MOH Actual	62,077.91	36,812.01	57,933.29	69,862.37	74,588.52
Kath Actual	2040.79	1886.92	1825.77	2059.52	3280.66
Kath/MOH Budget %	3.4%	3.5%	3.3%	5.1%	5.9%
Kath/MOH Actual %	3.3%	5.1%	3.2%	3.0%	4.4%

Source: 1. MOH, Ghana, 2. KATH, Kumasi
Numbers are in thousands of constant US dollars (1987=100)

Notes:

management counters this charge by pointing to the huge rate of inflation in the country, which make it difficult to estimate hospital needs accurately, so far in advance of the disbursement of the monies.

Two other points need to be made with regard to the data from this table. Firstly, the deficits of the hospital have been growing continuously, since the assumption of office by the hospital Board. The changes introduced since autonomy, thus, have, if

Table 12**Income and Expenditure Pattern ('000\$) 1989-1993 - KATH**

	<i>Pre-Board</i>		<i>Post-Board</i>		1993
	1989	1990	1991	1992	
Hospital Budget Estimate	1,927.57	1,451.61	1,896.59	1,898.11	4,676.82
Approved Estimates	2,040.79	1,919.58	1,888.81	2,945.44	4,432.35
MOH Grant Spent	2,040.79	1,886.92	1,825.77	2,059.52	3,280.66
Internally Generated Revenue	483.49	436.29	378.74	622.60	988.05
Total Revenue	2,524.28	2,323.21	2,204.51	2,682.12	4,268.71
Fees as % of Total Revenue	19%	18.8%	17.2%	23.2%	21%
Expenditure	n/a	n/a	2,098.24	3,242.41	4,919.31
Income minus Expenditure	n/a	n/a	106.20	-560.29	-650.60

Source:

1. KATH Hospital Financial Statement, Annual Financial Report, and Financial Statements (Hospital Fees) for the year ended 31st December 1993
2. KATH 1995 Financial Statements - 31st December, 1994. Prepared by H. Baah-Adade, Principal Accountant.

Notes: Numbers are in thousands of constant US\$ (1987=100)

anything, increased the hospital's expenditures, without a comparable rise in its revenues. Secondly, it is quite striking that the actual expenditures have often exceeded not just the revenues, but the budgeted amounts. While the MOH has held this up as an example of the Board's failure to deliver the goods, the hospital staff have tried to explain this discrepancy as resulting from increases in salary levels and the general inflation rate, which complicates budget forecasting.

Table 13 below presents data on the collection of hospital fees between 1989-1993. The findings, in comparing the pre-autonomy and post-autonomy periods, are broadly similar to those for KBU- with KATH doing marginally better than KBU in terms of percentage annual increases in hospital revenues. Thus, at least in terms of total hospital fees generated, autonomy has yielded positive results.

5.2.4 Human Resource Management

The number of staff according to 1995 estimates was 1569. This was made up of the following category of health professionals and para-professionals: doctors, paramedical staff, staff registered nurses, emergency nurses/emergency nurse midwives, general administrative staff, and general services staff. A breakdown, similar to that of KBU, is presented below.

The staff size at KATH, from our information, has also not changed much between the pre and post autonomy years. This has been attributed by some to the inability of the hospital Board to alter manpower planning figures made centrally (Weinberg, 1993). Further, at KATH, as at Korle Bu, many among the staff owe primary allegiance to their parent employer institutions, such as the Controller and Accountant General's Department, the UST, and the Ministry of Finance. This, as noted above, has important implications for the autonomy process.

5.2.5 Selected Hospital Statistics

In this section, we present hospital statistics for KATH in the same format as the

Table 13

Collection of Hospital Fees by Month 1989-1993 - KATH

	Pre-Board				Post-Board					
	1989		1990		1991		1992		1993	
	cedis	\$	cedis	\$	cedis	\$	cedis	\$	cedis	\$
Jan	11,763,405	44,600.72	11,357,558	30,969.96	14,652,548	33,159.00	19,893,549	39,923.20	35,153,840	56,348.17
Feb	10,833,668	41,075.64	11,930,249	32,531.58	12,695,506	28,730.18	20,679,291	41,500.06	36,661,790	58,765.27
Mar	10,806,900	40,974.15	14,247,016	38,848.98	13,220,296	29,917.79	22,670,805	45,496.72	47,022,570	75,372.59
Apr	9,962,842	37,773.92	13,014,395	35,487.85	11,520,050	26,070.10	18,527,661	37,182.08	48,451,345	77,662.78
May	10,525,175	39,906.00	14,246,129	38,846.56	13,121,228	29,693.59	18,929,420	37,988.35	49,634,830	79,559.79
June	9,904,414	37,552.39	14,552,029	39,680.69	13,520,100	30,596.25	7,588,610	15,229.14	41,597,210	66,676.27
July	11,289,975	42,805.72	13,780,209	37,576.08	19,567,460	44,281.54	20,688,835	41,519.22	43,237,230	69,305.06
Aug	11,800,995	44,743.24	15,445,324	42,116.54	12,481,028	28,244.81	32,528,745	65,280.04	51,650,885	82,791.33
Sept	9,369,400	35,523.90	12,954,156	35,323.59	14,606,447	33,054.67	36,888,420	74,029.22	49,501,055	79,345.36
Oct	11,474,849	43,506.67	12,544,491	34,206.51	14,497,810	32,808.83	36,870,190	73,992.64	47,152,735	75,581.23
Nov	10,542,789	39,972.78	13,869,952	37,820.79	14,546,410	32,918.81	38,792,740	77,850.89	78,568,129	125,937.04
Dec	9,246,130	35,056.52	12,059,221	32,833.27	12,931,290	29,263.76	36,180,390	72,608.32	87,779,115	140,701.35
Total	127,520,838	483,492.8	160,001,729	436,292.4	167,350,173	378,739.3	310,237,656	622,599.9	616,410,734	988,046.25

Source: Biostatistics Unit, KATH.

1. Expenditures in cedis are in nominal terms.

2. Expenditures in US dollars are in 1987 constant terms.

data for Korle Bu. It is noteworthy that, while there are differences between the two teaching hospitals with regard to specific indicators, the overall patterns are fairly similar.

Table 15 shows that the outpatient attendance has remained more or less constant over the years before and after the grant of autonomy. Thus, KATH has been as unsuccessful as KBU in stemming the tide of patients seeking care at its outpatient facilities. Table 16 shows that, in terms of bed strength, inpatient admissions, and case-fatality rates, autonomy has brought about practically no change at KATH, unlike KBU. Also, unlike KBU, the bed turnover and average lengths of stay have actually worsened slightly since autonomy, although the difference is probably not

statistically significant. The bed occupancy figures at KATH are in particularly sharp contrast to those at KBU. KATH has been operating at near full-capacity, and has tended to exceed capacity occasionally. In some ways, KATH's situation is almost as undesirable as KBU's, because a greater than 100% occupancy implies that patients are either having to share beds, or are being accommodated on the floor of the hospital.

Table 14**Personnel Figures from 1989-1993 (KATH)**

	<i>Pre-Board</i>		<i>Post-Board</i>			
	1990	1991	1992	1993	1994	1995
Doctors	111	116	131	154	168	176
Para-medical	662	663	652	620	595	556
Nurses	753	790	783	779	792	757
General Administration	35	33	32	31	28	28
General Services	71	69	68	70	66	52
Total	1632	1671	1666	1654	1649	1569

Source: Central Administration, KATH.

Table 17 and 18 present the most common causes of outpatient visits and inpatient admissions at KATH. The findings reported here are broadly similar to those at Korle Bu, and are to be interpreted similarly.

Table 15**Annual Outpatient Attendance 1988-1993 ('000), KATH**

	<i>Pre-Board</i>		<i>Post-Board</i>			
	1988	1989	1990	1991	1992	1993
KATH	285,406	302,826	288,288	305,800	304,580	308,861

Source: Biostatistics Unit, KATH.

Table 16**Bed State Statistics 1989-1995 - KATH**

	<i>Pre-Board</i>		<i>Post-Board</i>				
	1989	1990	1991	1992	1993	1994	1995
Total Beds	720	751	727	748	727	748	755
% Occupied	102.7	99.12	96.36	97.82	106	85.34	99.59
Bed Turnover	50	49	47	44	44	32	43
Avg. Length of Stay	7	7	7	8	8	9	8
Total Admissions	38,057	37,584	36,813	34,317	37,861	25,702	35,232
Total Deaths	2,012	2,101	2,030	2,052	2,182	1,681	2,170

Source: Biostatistics Unit, KATH.

Table 17
Top 10 Diseases of Inpatients 1992-94 - KATH

	1992		1993		1994	
	<i>Disease Type</i>	%	<i>Disease Type</i>	%	<i>Disease Type</i>	%
1	Maternity Cases	57.1	Maternity Cases	58.5	Maternity Cases	52.1
2	Anaemia	21.6	Anaemia	9	Accidents	12.9
3	Pneumonia	7.1	Malaria	8.2	Malaria	9.5
4	Malaria	5.4	Accidents	7.9	Anaemia	9.3
5	Gynecological Disorders	2.5	Pneumonia	5.1	Pneumonia	5.6
6	Measles	1.5	Gynecological Disorders	3.8	Gynecological Disorders	3.5
7	Diarrhoeal Disorders	1.4	Cerebro Vascular Diseases	2.6	Cerebro Vascular Diseases	2
8	Abdominal Hernia	1.2	Diarrhoeal Disorders	1.7	AIDS	1.7
9	Cerebro Vascular Diseases	1.2	Abdominal Hernia	1.7	Diarrhoeal Disorders	1.7
10	Other form of heart disease	1	Other form of heart disease	1.4	Measles	1.6
Total		100*		100*		100*

Source: Biostatistics Unit KATH.

Notes: Percentages are calculated based on the top 10 diseases in each year

Table 18**Top 10 Diseases of Outpatients 1992-94, - KATH**

	1992		1993		1994	
	<i>Disease Type</i>	%	<i>Disease Type</i>	%	<i>Disease Type</i>	%
1	Malaria	41.4	Malaria	47.9	Malaria	49.7
2	Upper Resp. Tract Infections.	11.4	Upper Resp. Tract Infections.	13.3	Upper Resp. Tract Infections.	13.2
3	Disease of Oral Cavity	9.3	Disease of Oral Cavity	10.2	Diarrhoeal Diseases	8.1
4	Accidents	7.5	Diarrhoeal Diseases	8.2	Disease of Oral Cavity	6.9
5	Ear Infections	6.5	Accidents	5.2	Acute Eye Infections	5.6
6	Diarrhoeal Diseases	6.2	Ear Infections	3.98	Ear Infections	4.6
7	Pregnancy Complications	5.5	Acute Eye Infections	3.96	Accidents	4.4
8	Hypertension	4.7	Intestinal Worms	3	Intestinal Worms	3.2
9	Gynecological Disorders	4	Gynecological Disorders	2.2	Skin Disease	2.22
10	Measles	3.6	Skin Disease	2	Gynecological Disorders	2.17
Total		100*		100*		100*

Source: Biostatistics Unit KATH.

Notes: Percentages are calculated based on the top 10 diseases in each year

6. Interpretations of Hospital Autonomy in Ghana: One Vision or Many?

6.1 Understanding of Key Players of Autonomy for Teaching Hospitals

One aspect of the research was to conduct interviews with key players and stakeholders in health care/hospital care provision in Ghana to seek their views on autonomy for the two teaching hospitals. The purpose of this exercise was to assess whether, despite the existence of a single document (Law 209) outlining the goals of autonomy and setting out its boundaries, there was a shared common understanding/interpretation of hospital autonomy, its perceived benefits, and its implications, among the key stakeholders. The stakeholders included: government officials, Board members, hospital administrators, hospital departmental heads, medical schools representatives, health professionals, representatives of labour unions, etc. This section of the report presents a discussion of the outcomes of these interviews.

6.1.1 Views of Policy Makers - The Ministry of Health

In a Government of Ghana (GOG) official document, Medium Term Health Strategy: Towards vision 2020 (Sept. 1995), reference is made to the management of teaching hospitals. Without referring to Law 209, the document says "Teaching hospitals will be managed as self-governing institutions. The objective will be to ensure that managers have the autonomy to allocate resources as efficiently as possible and, at the same time, to ensure that hospital authorities are held accountable for performance of their institutions and the way resources are used". The document stresses that this form of autonomy does not mean that the hospitals are being privatized. On the contrary, they will continue to be owned by the public and, being in receipt of government funds, will operate within national policies and strategies, and their conduct and performance will be subject to regulation.

This official position is shared by many of the top policy makers interviewed at the MOH. They consider the provision of Law 209 to be adequate, and clear enough to be correctly interpreted by the hospitals - although, in the future, the Law may need to be revised to accommodate full autonomy. They also feel that, subject to the

provisions of the Law, the Board and top management of the hospital should carry the responsibility for determining the managerial processes for implementing autonomy. They feel that the delay in the implementation of autonomy has been primarily due to the weakness in management capacities at the teaching hospitals. Thus, they feel, that the Boards have not been able to seize the initiative in implementing autonomy, maybe because "they are afraid to take the blame for failure". Also, according to some MOH officials, the administration at the hospitals is more interested in the "perceived payoffs of autonomy", than in facing the responsibilities that come with it.

The policy makers in the MOH are firmly in support of autonomy, because, as noted earlier, they see autonomy for the teaching hospitals as the route to ending the enormous subsidies being provided to them by the government. They would also like the policy making function (to be retained by the MOH) separated from the provision of care (to be assumed by the Ghana Health Service and the independent teaching hospitals). Autonomy, they feel, would also remove the constraints that the hospitals currently face from having to subscribe to civil service regulations.

The policy makers point out that only the initial steps in the autonomy process have been taken through the formation of the autonomous Boards, the grant to the Boards of responsibility for managing the hospital staff, and the grant of funding in the form of a block grant. This, according to MOH officials, is a deliberate government strategy, as they do not want to see the past experience with parastatals, who arbitrarily raised the salaries of employees to unsustainable levels (which were also much higher than the civil service salaries, and therefore, much resented by the service), repeated at the teaching hospitals. They are also worried that the costs of running the hospital might escalate with full autonomy, and that, if the fee schedules are not controlled, this would result in a dramatic rise in hospital fees.

Ultimately, however, they see autonomy leading to an end to (or at least a substantial reduction in) the dependence of the teaching hospitals on the MOH (though not of the regulatory control exercised by the MOH over the hospitals). This, they see happening, through:

- the initiation of a National Social Insurance program in about 3 years, which will enable these two hospitals to charge commercial rates;
- the setting up by the hospitals of research projects that will attract external funding; and
- payment of fees by medical school students.

Revenues generated through increases in hospital fees, they insist, would be merely secondary to the above mentioned sources of funding.

6.1.2 Views from Ministry of Finance

The Ministry of Finance defines autonomy in the limited sense of giving a subvention to the teaching hospitals. According to the MOF, the advantages of the subvention over the existing system are:

- Funds will be given as a cheque to the institution, i.e., the money will actually be in the hands and control of the institution, whereas previously the hospitals only had Financial Encumbrances which represented a mere intention of the Controller and Accountant Generals Department to pay for goods and services up to the amounts indicated; and
- The institutions will have more room to shift money budgeted under one sub-item to another, and can therefore target their spending to their changing needs.

The Ministry of Finance has recommended that money for Hospital Expenditure Items 2-5 (Travel/transport, General Expenditure, Maintenance/Repairs/Renewals, Supplies/Stores - see Appendix 3) be given as a quarterly subvention to the two teaching hospitals from January 1, 1996 on a trial basis. The MOF will retain control over salaries (Item 1), and release it on a monthly basis, on receipt of expenditure returns of the previous month; however, salaries may also be given as a subvention in the future.

The MOF is one of the few public sector institutions in Ghana which does not look upon autonomy for the teaching hospitals with any great favour. This is because, according to the MOF, its primary condition for giving subventions had not yet been met. This condition was that the Controller and Accountant General assess and report on the capacity of teaching hospitals to provide effective financial management. There is a lingering doubt in the Ministry of Finance that financial leeway will lead to greater efficiency in the hospitals. This is because: firstly, there is a high level of mismanagement; and secondly, the hospitals do not seem to have people with the requisite managerial competence and professional stature to run an institution as complex as a teaching hospital. However, the appointment of qualified accountants to head the finance departments of these hospitals in 1994, has encouraged the Ministry to believe that the teaching hospitals will at least be able to account properly for GOG Funds released to them.

The MOF insists that, even under the new management at the teaching hospitals, the hospitals' budget will be regarded by it as part of the Ministry of Health total budget. The budget of the hospitals, according to the MOF, should reflect only those plans of the Hospital Board approved by the MOH, and should not be at variance with MOH policy.

6.1.3 Views from Korle-Bu Teaching Hospital

Top Hospital Administrators

The top administrators (Chief Administrator, Principal Hospital Administrator, Principal Accountant) at Korle Bu perceive autonomy as freedom from MOH controls, and the grant of the required powers to the hospital to manage its own affairs. They feel that the MOH should restrict itself to formulating policy. This view of autonomy, of course, is considerably broader, and more far-reaching, than that of the MOH, and would move the hospitals much further away from the MOH than is considered acceptable by most MOH officials.

The hospital administrators are generally strongly in favour of autonomy as they see it as leading to freedom from the financial and administrative yoke of the MOH. Overall, the administrators are confident that, with autonomy, they will be able to be financially self-sufficient, provided the current government controls are relaxed and reasonable government funding is provided. They feel that substantial benefits (e.g. better salaries, better work environment, more efficient operations) would accrue to the hospital, and its staff, if it were to become fully autonomous.

The administrators of Korle Bu think that the MOH should, as a matter of urgency, offer guidelines to assist the hospital to become self-financing entities. They worry about the limitations placed by Law 209 on the Board's ability to change the level of hospital fees, or initiate other entrepreneurial methods of raising revenues, such as selling of technical services by the hospital, and signing independent procurement contracts with private pharmaceutical and hospital supply companies. They are doubtful, under the current autonomy policy, about generating significant additional revenues, besides hospital fees, to cover the operations of the hospital. The administrators are also concerned about the inadequate levels of government financing. From the point of view of the administrators, the hospital budgets are always slashed by up to 60% every year by the Ministry of Finance. This makes implementation of budgetary proposals and plans very difficult and they wonder whether, under full autonomy, the hospitals would be provided with more realistic central government funding which could then be supplemented by internally generated funds.

Besides financial considerations, the other areas of concern for the administrators relate to governance, general management and personnel management issues. These include:

- Administrative mechanisms for recruiting and remunerating staff;
- The Boards role in determining staffing levels;
- Allegiance of hospital staff to the Board;

- The role of the Medical School at Korle-Bu; and
- Mechanisms for providing management training, and for restructuring management systems, at the hospital.

The Administrators are of the view that without resolving these key issues affecting the hospital, autonomy would be stalled. Furthermore, they strongly feel, that radical improvements in technical and allocative efficiency, public accountability, and service improvement are unlikely in the current policy and management environment.

Views of Departmental Heads/Clinical Specialists/Doctors

Departmental heads who were interviewed are in the employment of the University of Ghana Medical School (UGMS), but head the various clinical department of KBU hospital. They also generally define autonomy as the ability of the hospital to carry out its mission without interference or hindrance from the MOH.

Most departmental heads are strongly in favour of autonomy. But, while they are in agreement about the need for autonomy for Korle-Bu, they differ in their vision of the administrative setup for a fully autonomous KBU. A significant minority would like to see the UGMS take over the running of Korle-Bu, because, they argue, all the key departments are headed by UGMS specialists, who while they are employed by the University of Ghana, provide the bulk of clinical care to patients at Korle Bu. This, they think, would ensure more direct involvement of doctors in the management of the hospital, and ensure greater loyalty on the part of the Medical School Staff to the hospital. This suggestion, for obvious reasons, is vigorously opposed by the hospital's current management. Many departmental heads, though, oppose the suggestion, because they feel that KBU is way too large and unwieldy to be taken over by the Medical School. Further, the heads of department also see KBU primarily as a teaching and research centre, with patient care being secondary; unlike the administration, which perceives patient care as being the primary mandate of the hospital.

Most of the departmental heads interviewed hold the view that the hospital Management Board should have the power to make all the key employment decisions, such as being responsible for appointing the entire staff at Korle-Bu (including UGMS staff - although there is some disagreement on whether the hospital should hire senior doctors from UGMS as employees, or merely provide them consultant status), and also to decide on staff output levels/targets, remuneration, and disciplinary measures. They are, however, divided in their opinion regarding the qualifications of the individual chosen to become Chief Administrator/Chief Executive of the hospital. Whilst some of them think that the Chief Administrator should be a full time professional lay manager, others are of the view that the Chief Administrator/Chief Executive should be an experienced, well-

respected, physician. They also think that autonomy *within* the hospital should aim at giving the various large departments (which are sometimes bigger than entire district hospitals) the freedom to operate with at least as much autonomy as currently allowed to district hospitals, with the Board co-ordinating the departments' functions overall.

The departmental heads worry about the lack of financial autonomy which they consider to be the most crucial factor in granting autonomy to the teaching hospital. They do not see how, under the present tight financial constraints, Korle-Bu can achieve even partial financial autonomy. Since the hospital cannot presently charge "economic" fees to cover its running costs, they are of the view that financial autonomy cannot be achieved, in reality.

The heads consider the Government and the MOH to be the main stumbling blocks to implementing autonomy at Korle-Bu. They are not persuaded that the government is completely serious about, or committed to, autonomy for the teaching hospitals, because, they argue, that this would entail a substantial loss of power and prestige for the MOH. They also feel that Law 209 is merely a legal provision to set up hospital Boards, not a framework for autonomy. They believe that before full autonomy could be achieved by the hospitals, the following additional pre-conditions must be met:

- A national-level dialogue and discussion on autonomy should be initiated by the MOH;
- A proper definition of financial autonomy should be given by the MOH;
- A National Social Insurance System should be designed to supplement the financial base of the hospital, and private insurance explored as an alternative;
- The government should provide adequate resources to the hospitals;
- Sound management structures should be designed for the hospital, with appropriate incentives, and managers with the required training identified and hired; and
- Effective, and participative, leadership should be provided by the top management of the hospital. This must be supported by effective administrative structures within individual departments.

Views of Nurses

Nurses are generally in favour of autonomy, which they feel will bring the nursing community substantial benefits. Their major concerns relate to human resource management issues involving, eg, continuity of employment, salary levels,

promotions, retirements etc. They would like to see a more professional approach to nurses human resource management.

They consider financial autonomy as a key to hospital autonomy, but believe that the hospital's ability to recover costs through user charges is limited, since many of the people who utilize the services at Korle-Bu cannot pay for hospital fees. This, they feel, affects the hospital's ability to raise substantial resources through hospital fees.

The nurses interviewed suggested internal organizational restructuring at Korle-Bu to make it more de-centralized, with the individual hospital departments being given greater autonomy. They are generally worried about the large size of Korle-Bu, and the rapid rate of expansion still taking place at the hospital. They would like to see the hospital function effectively as a tertiary institution. They believe that autonomy cannot take off in January 1996, as envisaged, because these key issues relating to autonomy have not yet been adequately addressed.

6.1.4 Views From Komfo Anokye Teaching Hospital

Top Hospital Administrators

The hospital administrators at KATH are in support of autonomy. However, they hold the view that autonomy has not been properly defined, since the management of the hospital is still unclear about which functions the Ministry would like to hold on to, and which it wants to delegate to the hospitals, under autonomy. The management expects the Ministry of Health to provide further guidelines relating to the key functions under autonomy, such as governance, general management, finance, human resource management etc, and how power sharing in these areas should be determined between the MOH and the hospital. They feel that the MOH was being unreasonable in suggesting that the two teaching hospitals develop their own autonomy plan, but, at the same time, expecting the plans of the two hospitals to coincide.

The administrators also expect the relationship between the School of Medical Science of the University of Science and Technology (SMS/UST) and the hospital to be properly defined under autonomy. The administrators feel that the Board should have complete control over human resource management functions, and these powers should also extend to the doctors hired from UST. They, further, feel that all hiring should be based on signed professional contracts between the hospital and its employees - with the contracts clear specifying the roles and responsibilities of the employees.

In short, even though they consider Law 209 as appropriate in spelling out the legal framework for achieving autonomy, they think it is inadequate because it does not provide for the detailed guidelines for the actual implementation of autonomy. In

view of this, they are not certain about the sort of organizational arrangements to put together, that would satisfy MOH requirements for achieving full autonomy.

They also identify a general lack of competencies and skills among most hospital managers - especially service managers such as doctors, nurses, pharmacists, and managers of support services - as a limiting factor in the implementation of autonomy. They would like to see a renewed understanding and practice of management within the hospital, through training and re-orientation. They would like to see autonomy programmed into phases which could then be implemented over a given period of time.

Concerning the membership of the Board, the administrators think that Board members should not be selected along political lines. Also, the administrators point to the frequent (monthly) meetings of the Board as evidence that it was becoming over-involved in the running of the hospital, leaving little room for administrators to show initiative in running the hospitals. In addition, they feel, the management staff spent an inappropriate amount of time and funds servicing the needs of the Board.

Views Of Heads Of Department

The specialists and doctors at Komfo Anokye Teaching Hospital almost unanimously welcome autonomy. Most of them consider financial autonomy to be the single most important element in hospital autonomy. They think that the key elements of financial autonomy should include:

- adequate subventions from the Central Government;
- sufficient freedom for income generation on the part of the hospital; and
- support from central government and external aid agencies with capital expenditure and key hospital investments.

However, many of the physicians are of the view that a public hospital, such as KATH, can never make a financial profit unless it is privatised.

On the composition of the Board, they think this should not be politicised - so that, in the future, people with knowledge about hospital governance and management would be represented on the Board. On the employment of staff for the hospital, they hold the view that the Board should hire and fire staff, but in consultation with the departmental heads.

On the relationship between the School of Medical Sciences (SMS/UST) and the Board, they would like to see a special relationship established under autonomy where the hospital administration would employ specialists of the School of Medical Sciences as consultants and pay them for services rendered to patients.

Finally, they think autonomy can only take off when:

- a sound administrative structure is put in place;
- an effective financing mechanism is designed to support autonomy; and
- more professional hospital administrators are recruited.

Views Of Nurses

Nurses view autonomy as a right conferred on the Hospital Board to make key decisions affecting the hospital without referring everything back to the MOH. Regarding financial autonomy, they expect the central government to cover the salaries of all the hospital employees, as also capital expenditure, whilst the hospital employs user charges to cover other expenditure.

Their major concerns relate to human resource management issues such as recruitment, promotion, retirement benefits salary levels and other matters, especially pertaining to nurses. They also feel that the relationship between the hospital and the nursing school should be better defined.

6.1.5 Community Views

Proponents of autonomy often argue that autonomy will lead to an improvement in the quality of care, and a greater responsiveness by providers to clients needs. As part of this study, a client survey was carried out to find out their views on the care they receive in the two teaching hospitals, and their understanding of autonomy. There were 333 adults respondents for the two hospitals, chosen by random sampling. 54 percent were female. Four out of five respondents had some form of formal education. Most clients were likely to be residents of the city in which the teaching hospital was located. Thus, a little over two thirds of respondents normally reside in the cities of Accra or Kumasi, respectively, another 25 percent came from the region in which the hospitals were located, and only 5 percent came from other parts of the country.

More patients used the hospitals as a primary care facility than as a referral institution. Only 42 percent of respondents said they had been referred. This supports the view of senior hospital managers that there is inappropriate use of the facility. Patients come to hospital for outpatient consultation, and for diagnostic services including radiology.

There was general satisfaction with the services currently provided. Four out of five respondents had something positive to say about the services. The most frequently mentioned were the caring and positive attitude of staff towards patients, and the availability of a wide range of services. But there were also some frustrations. Twenty percent of respondents had some difficulties during their contact with the

hospital and mentioned the following as the greatest frustrations: delay in receiving attention, high fee levels or unofficial collection of money, and the negative attitude of some staff.

Most importantly, clients do not think full autonomy will lead to improvements in the quality of care and public accountability. The most prevalent view (only 42 percent of respondents gave an opinion) was that autonomy would lead to higher fees without necessarily resulting in an improvement in the quality of care. Equal proportions of respondent expected this situation to occur whether the institution was under government ownership or under private ownership.

6.1.6 Other Reactions To Hospital Autonomy: The Trade Union Congress and the Committees for the Defence of the Revolution

Both of these organizations have resisted the idea of autonomous teaching hospitals, and have carried on a very public debate with the Chief Administrator of Korle Bu, through the local press; in fact, many of the same sentiments were expressed in their interviews with us. The debate over autonomy began when the Chief Administrator of the Korle Bu Teaching Hospital first announced that moves were in place to make the hospital independent, with effect from January 1996, through one of the national newspapers (Weekly Spectator, Nov 5, 1994).

As a part of this announcement, he spelt out the activities that would be undertaken to reflect Korle Bu's independence, which included:

- recruitment of its own doctors, nurses and other paramedical staff;
- deciding how much to pay them; and
- a determination by the hospital of the level of fees to be charged to patients for services rendered.

The Chief Administrator also indicated, in the announcement, the hospital's preference for experienced medical doctors over junior doctors and said junior doctors would be employed only after they had gained some experience. He announced that the hospital's powers to hire and fire and also mentioned the intention to revise hospital fees upwards to more realistic levels. He also said the hospital would recruit new personnel in the departments that are under staffed and lay off the excesses.

The Administrators comments in the Weekly Spectator drew a strong reaction from the Trade Union Congress (TUC) (Ghanaian Times, Nov 10, 1994). The TUC categorically said it opposed attempts to turn Korle Bu hospital into an independent body. It expressed shock and dismay at the attempt to make health delivery another privilege to be enjoyed by only the affluent in society who are also in a position to afford high medical fees. The TUC considered health a fundamental right, and

rejected any proposal to privatize health service delivery to an impoverished society. It, therefore, called on the government to abandon the plan in the “supreme interest of the people”.

The officials of the TUC interviewed also emphasized that, rather than firing personnel, the focus of the hospitals should be on training (and re-training) its staff. Of course, if despite the training, the personnel do not perform up to expectations, they should be disciplined. They also stressed the importance of “adequate dissemination of information” and “openness” in discussions with workers on the autonomy issue. The TUC was strongly supportive of a National Social Insurance scheme to finance health care in Ghana.

Like the TUC, the National Co-ordinating Committee of Health Services Association of CDRs (Committees for the Defence of the Revolution) also asserted that Korle Bu could not go private (Ghanaian Times, Nov. 24, 1994). Many reasons were cited to back this position. Firstly, they felt that the government should not shirk its responsibility for providing the basic health care needs of the country. Secondly, they considered Korle Bu to be a national hospital, as well as the ultimate referral centre for the country, and wanted it to remain so for the sake of the average Ghanaian. Thirdly, they noted that Korle Bu was patronised mostly by the people in the low income bracket, who they could not afford the luxury of going to the private hospitals whose bills were very prohibitive. Thus, any moves to privatize the hospital, they maintained, would prove detrimental to the poor.

6.2 Implications of Multiple Visions of Autonomy

What becomes clear from the discussion in the previous section is that while as a concept there is broad and enthusiastic support for the autonomy initiative:

- autonomy means different things to different people, and the expectations, among key stakeholders, of autonomy are quite different;
- the support of the various stakeholders for autonomy is for different, often conflicting, reasons; and
- whatever opposition there is to autonomy is mainly because of autonomy's perceived negative impact on equity, and due to concerns about the administrative capacities at the hospitals.
- there is a tendency among stakeholders to focus almost exclusively on the perceived benefits of autonomy, neglecting, in the process, some of its potential pitfalls.

Many, if not all, of the problems experienced in implementing hospital autonomy in Ghana can be understood, and explained, in the context of the failure of policy

makers to articulate a common vision of autonomy. To be fair to the policy makers in Ghana, though, it must be stressed that a major contributing factor to this failure has been the lack of a comprehensive conceptual model of autonomy, and of sufficient empirical experience elsewhere, that might serve as a guide.

To compound this problem, many of the stakeholders interviewed seemed to believe that autonomy is a panacea for all that is wrong with the functioning of the health system, in general, and the teaching hospitals, in particular. In itself, the fact that stakeholders view autonomy as serving their self-interest, and a solution to their respective problems, is not necessarily a problem. In fact, this sentiment could well assist the government in pushing the initiative forward. However, the fact that stakeholders have such a divergent conception of autonomy and what it implies, and their tendency to overstate the benefits of autonomy and underestimate the problems, are definite bottlenecks in the autonomy process. This has been rather clearly reflected in the implementation of the autonomy in the Ghanaian teaching hospitals. Thus, although the major stakeholders have embraced the autonomy concept, there is a growing uncertainty about how to move the process forward.

7. Discussion

7.1 Legal Provisions for Autonomy in Ghana

Our review of Law 209, and our discussions with the stakeholders about the legal basis for autonomy, leads us to the following conclusions. The Autonomy Law does, albeit somewhat broadly, spell out a framework for autonomy of teaching hospital in Ghana, and much of the relevant legislation is enabling. However, the Law does not lay down a timetable for the implementation of autonomy, set specific priorities in the implementation process, or provide “step-by-step” instructions on the implementation of specific phases. The Law also does not provide the specific operational guidelines for implementation required by the hospitals to plan their long-term strategy, day-to day operations, financial management, and management of human resources. Further, the Law does not assign specific institutional responsibilities for the implementation of its various facets.

As noted earlier in the report, the powers granted to the “autonomous” hospital Boards by the Law are heavily circumscribed, and many of these restrictions imposed by the Law are contradictory to, and in direct conflict with, common notions of autonomy. Some of the provisions of the Law, such as the freedom of hospital Boards to set its own terms and conditions, are contradicted in other instructions. It is not surprising, therefore, that the interpretation of the Law by the MOH and the two hospitals, as well as by individuals within these institutions, differs significantly. In fact the Law is perceived by some stakeholders as little more than the legal basis for setting up autonomous hospital Boards, rather than a comprehensive piece of legislation on setting up autonomous teaching hospitals.

Certain sections of the Law also do not reflect the current thinking, either among the policy makers, or the stakeholders at the hospital. In fact, there is a widespread feeling that the law needs to be updated, and possibly modified, to bring it in line with the existing views on hospital autonomy.

In terms of the comprehensiveness of Law 209, one may argue that a legal document can only provide so much detail. Even if this premise be accepted, it is surely the responsibility of the MOH, as the formulator of health policy, to put out a detailed policy document - clarifying, and expanding on, the various provisions of the Law. However, the MOH has been either unable or unwilling to take on this responsibility, and, by default, the onus of negotiating the difficult process of

transition to full autonomy has fallen on the hospital Boards and the hospital management. It is, perhaps, slightly more understandable that the Boards have also been tentative in approaching the autonomy issue, and have not been very successful in pushing the process forward. This has resulted in an impasse, with both sides trading blame for the lack of progress.

In view of this impasse, it is hardly surprising that the implementation of hospital autonomy in Ghana has failed to yield tangible results. In fact, under the existing circumstances, not only is it unrealistic to expect that full autonomy can be implemented this year - as envisioned by the MOH - but it seems increasingly the case that the autonomy initiative will be delayed by several years.

7.2 Governance

The first conclusion, vis-a-vis governance, that emerges from the study is that while establishment of hospital Boards is necessary, and is an important step in the autonomy process, it is by no means sufficient. In other words, the mere setting up of Boards is not the be-all and end-all of autonomy. It is important to ensure that the enabling conditions are provided for these Boards to function effectively, and as truly autonomous entities.

Clear and unambiguous guidelines on the role, functions, and powers of the Board, which do not contravene the basic principles of autonomy, and which do not have inherent contradictions, are critically important. At the same time, the responsibilities of the Boards must also be clearly specified, and Board members held publicly accountable for their decisions and actions - with a clear definition of the sanctions to be imposed for contravention of their duties. Furthermore, adequate independent financial resources and management capabilities, at all levels of the hospital, must be ensured. Also, it is important that all the staff employed by the hospital, be selected by the Boards, function under the Boards' umbrella, and owe total responsibility to the Board. Finally, the Boards must be allowed to function independently, without government interference, subject to the overall policy direction of the government. In the absence of such arrangements, the Boards will, very likely, end up either as just another organ of the government, or a body incapable of making effective decisions.

In many ways, this is the situation in Ghana. The powers of the Boards are so heavily circumscribed that they are autonomous only on paper. Moreover, the majority of the appointees to the Board are either from the government itself, or owe their appointments to the government, which raises questions about their ability to function as an autonomous body. Because of the political nature of the appointments to the hospital Boards, the Boards also do not enjoy the complete confidence and the full support of the staff at the two hospitals. Under these circumstances, it is not surprising that the presence of the Boards has not brought

about very many significant changes at the two teaching hospitals, either in their day-to-day functioning or in the overall performance.

Having noted the need for the Board to have full control over its financial and human resources, comment must be made on the suggestion of senior clinical staff that the hospitals be attached to the corresponding medical schools, and the Boards constituted by them. This suggestion was supported by many clinicians by pointing to teaching hospitals in other developing countries - Nigeria in particular - that are attached to, and run by, medical schools. While it is true that many teaching hospitals are attached to medical schools, it is worth remembering that most of these started off as part of the Medical Schools. The teaching hospitals in Ghana, particularly KBU, are so large and unwieldy, that it is very unlikely that the medical schools would be able to manage them effectively. Indeed, it is an open question as to whether the medical schools are managerially any better placed to run the hospitals than the hospitals' current administrations. Also, over the years, the teaching hospitals have become an integral component of general Ghanaian health system, and any radical change in this status is likely to meet with resistance and resentment. Moreover, the administrative staff at the medical schools seem far less enthusiastic than the clinical specialists about taking over the teaching hospitals.

Several other issues related to governance also need mention. One very important step in the autonomy process is that the goals and mandate, of the teaching hospital be absolutely clear. Without such a mission statement - establishing the purpose and goals of the hospital, and the strategies to achieve these goals - to provide it guidance, the Board is left quite rudderless. It is striking that neither teaching hospital in Ghana has developed a mission statement, despite the fact that the Boards have been in existence for the last 5-6 years. The lack of assistance and adequate support from the MOH in this process, and in clarifying the formal relationships between the various institutions based at the two hospitals, has also not helped matters.

In this vein, it is also important that there be no conflict between the various goals of the teaching hospitals. Thus, it is critical that priorities, shared by the entire staff, be established among the three goals of the hospitals - patient care, teaching, and research. Similarly, the MOH and the hospitals must decide whether the hospitals will function solely as tertiary-care, referral hospitals, or continue to be "all things to all people". In the case of the MOH and the two hospitals, as noted, considerable disagreement exists about which goals constitute the primary mandate of the hospital. This disagreement has had a significant negative impact on the operations of the hospitals, the relationships among the various staff, and the overall morale of the employees.

A variety of issues, relating to the role, composition, and representativeness of Boards in public sector hospitals, have been discussed in the literature (see, for

example, McPake, 1996). In previous sections, we had raised questions relating to the composition and representativeness of the Boards in the two Ghanaian hospitals, and the appropriateness of their current roles. We now discuss these issues further, within the framework of the general literature.

The Ghanaian government, with the aim of ensuring “adequate representativeness” in the composition of hospital Boards, has taken steps towards expanding Board membership to include people who are opinion leaders in other fields. It is difficult, at present, to make any valid comment about the effect of this increased diversity in the composition of the Boards on the functioning of the two hospitals, as the Boards have not been able to perform as fully autonomous bodies. It would certainly be unfair to link the failure of the hospitals to bring about major changes in their efficiency, quality of care, and public accountability, with the observed changes in governance.

However, in general, it is important to bear in mind that the composition of Boards poses tradeoffs, which decision-makers need to consider (McPake, 1996). While including a diversity of interest groups in the Board’s membership might serve “participative objectives”, it might compromise the effective functioning of the Board because of increased disagreements and conflict. Similarly, inclusion of private sector executives in hospital Boards (as has been suggested in Ghana) might contribute to the hospitals, through an influx of business skills (Weinberg, 1993), and contacts with other private organizations (Peck, 1993). But, these Board members might have less time available for hospital business, and might be unable to reconcile their for-profit orientation with the functioning of public sector hospitals (Ashburner, 1993). Having non-physicians participate in decision-making at hospitals, as Board members, might alter the power balance between clinicians and managers, and increase efficiency, as seems to be the case in the U.K. (Peck and Spurgeon, 1993). However, inclusion of too many non-physicians as Board members risks a loss of support of the senior clinical staff, with a resultant marginalization of the Board - as observed in the Ghanaian hospitals.

What is clear, however, is that if hospital Boards are to function autonomously, it is important that they not be dominated by government officials or appointees (as in the case of the KBU and KATH Boards). A possible compromise, which recognizes the potential contribution that government officials can make to the Board, is to have these officials participate as non-voting members (Weinberg, 1993).

On the issue of the appropriate role for Boards, we have noted above the widespread sentiment among managers at all levels of the two Ghanaian hospitals that the “too-frequent” meeting of the Boards, and their involvement in “micromanaging” the hospital (rather than on more strategic issues), was compromising the efficiency of the hospital managers. While there has been an argument in the literature that “assumptions separating management and strategic planning functions are simplistic” (Wall, 1993), there is something to be said for

the ability to delegate management authority and responsibility. Moreover, within the context of the management structure of the two study hospitals and the dictates of Law 209, the Boards were clearly intended to have more of a strategic rather than internal management function, which is more the responsibility of the hospital administrators. It should also be noted that a movement towards greater autonomy suggests a decentralization of decision-making at the hospital, and this requires the empowerment, as well as an increased devolution of management responsibilities, to middle and lower level managers at the hospital.

7.3 General Management

There has been considerable debate at MOH and in the teaching hospitals about the appropriate qualifications of the Chief Administrator of the hospital - in particular, the issue has been whether the person should be doctor or a professional manager. The arguments on both sides are well known. While proponents of a professional manager have argued that the Chief Administrator must possess good management skills, which are not a part of medical training, and that the job requires a full time commitment that doctors may not be able to provide; the supporters of doctors have countered by arguing that "doctors know more about the hospital than managers" (equating management of the hospitals with treating patients), and pointing out that senior specialists are unlikely to cede managerial responsibility to a manager who is not a doctor.

What is not disputed is that the Chief Administrator's position is a crucial one, and that the person assuming the position must be a leader with considerable charisma and wide support. Thus, at least in the short-run, it seems unlikely that a non-physician administrator will be able to take over the position, and manage the teaching hospitals effectively. This is particularly so because there are not many senior hospital managers in Ghana to fill this post. In the long run, though, an effort needs to be made to train a cadre of full-time hospital managers.

We have referred above to the fact that, in the 4-5 years since the formation of the Hospital Boards, not even a proper organogram has been developed at the hospitals. We have also noted the problems of trying to arbitrarily fit all the sub-units of the hospital into the existing tripartite administration. In addition, the responsibilities and powers of managers are not clearly delineated at any level of the hospitals, including top management. It is curious, for example, that while a tripartite administration has been set up, the relationships between the three top managers is not at all clear. Thus, in inter-administration conflicts, there are no formal mechanisms for a redressal of grievances and imposition of sanctions - with each unit of the tripartite system often guarding its own turf zealously. Nor is the degree of autonomy enjoyed by the individual managers within their respective administrative units clearly specified. Moreover, the fact that many of the staff in each of these three units owe their primary allegiance to other institutions militates against an effective co-ordination of management functions of each unit.

In general, the teaching hospitals suffer from poor decision and management structures, insufficient management and administrative capacities, and a dearth of adequate information systems. There is also considerable inertia and resistance to change on the part of key managers in both the MOH and the hospitals. The fact that most managers have total job security, and that neither their tenures, nor the incentives they are provided, are linked to their job performance is a major constraint in bringing about a change in operations at the hospitals. As argued above, this is one of the contradictions of implementing autonomy at most public sector institutions. Unless, structures are created that mimic the private sector, and impose job pressures on managers in the public sector that resemble those in the private sector, the probability of hospital autonomy succeeding in the public sector is likely to remain low. That the administration at the two hospitals have been able to bring about few observable changes in the functioning of the hospitals, along any of the four dimensions being considered by this study - efficiency, equity, public accountability, and quality of care - would seem to support this contention.

While we have discussed, so far, the individual performance of the two Ghanaian teaching hospitals (before and after autonomy), it is instructive to place these hospitals within an international context, and compare them to each other and to tertiary care facilities in other developing countries. In Table 19, we present data on basic hospital in-patient statistics for tertiary hospitals from several countries¹.

Table 19 shows that the inpatient service statistics vary a great deal from one country to another. However, there are some observable patterns. For example, regarding bed occupancy levels, it has been suggested that individual facilities have a level of services, usually between 85-90% occupancy, at which they are designed to perform most efficiently (Barnum and Kutzin, 1993). By this standard, most of the hospitals in the table are performing sub-optimally. In particular, KBU, with a low bed occupancy, is performing less efficiently than is desirable; although its performance is better than tertiary hospitals in many of the other countries. The effect of low occupancy is to spread the costs of personnel and other fixed costs over a smaller number of service units, and raise the average costs of services. Even if hospital inputs are being used with technical efficiency, low occupancy indicates economic inefficiency (Barnum and Kutzin, 1993).

KATH's performance is somewhat more ambiguous. It may also be functioning sub-optimally, judged only on its relatively high occupancy rates. High occupancy rates at KATH are likely to make scheduling of service activities, maintenance, and management of the hospital more difficult and costly (Barnum and Kutzin, 1993). High occupancy is also likely to lower the quality of services, as staff attention and laboratory services are divided among a greater number of admissions than the hospital was designed to handle. In addition, they are likely to reflect overcrowding at the hospital. On the other hand, KATH's modest lengths of stay, and high turnover rates, might suggest that it is performing reasonably efficiently. It is difficult, thus, to make any categorical statement regarding KATH's efficiency. Even

1/ The data presented in Tables 19-21 were obtained from a landmark comparative study of public-sector hospitals in developing countries, undertaken by the Population and Human Resources Division of the World Bank. All inter-hospital comparisons made in this study use the same standards used in the World Bank study.

Table 19
Hospital Statistics: International Comparison of Selected Tertiary Hospitals

	Occupancy Rate (%)	ALOS	Bed Turnover
Belize (1985)	31	3.0	37.3
China (1986)	95	13.3	26.1
Fiji (1987)	46	3.5	47.9
Indonesia (1985)	54	5.9	33.6
Jamaica (1986)	61	7.8	28.6
KATH (1991)	96	7.0	47.0
Korle Bu (1991)	75	11.0	22.9
Malawi (1988)	116	9.0	47.4
Papua N. Guinea (1988)	60	12.9	16.9
Rwanda (1984)	57	-	-
Zimbabwe (1987)	76	6.8	40.8

Source: 1. KATH and KBU Biostatistics Units, 2. Barnum and Kutzin, 1993.

the average cost figures do not provide any additional insights. In general, though, very high turnover rates at a tertiary care facility must always be viewed with some suspicion, as they might reflect the treatment of patients at these hospitals who do not require tertiary care, and thus demonstrate sectoral inefficiencies (Barnum and Kutzin, 1993).

Regarding the ALOS and the bed turnover, KBU seems to have an ALOS somewhere near the average of the countries represented in the table, while its bed turnover rates are considerably higher. However, KBU has substantially longer lengths of stay than the average, and a low bed turnover. While it is difficult to make inter-country comparisons of efficiency based on ALOS and bed turnover rates - because of differences in case-mix, severity of cases, and treatment practices - the performance of similar facilities *within* a country can be compared. Based on their ALOS and bed turnovers, KATH seemed to be performing more efficiently than KBU, in 1991, as there is no reason to suggest that the longer stays at KBU contributed to higher-quality care (Barnum and Kutzin, 1993).

However, it is also important to note that, while KBU has improved its performance in relation to ALOS (and, correspondingly, the bed turnover rates) over the years, KATH's performance has actually dropped. Thus, in 1993, the ALOS at the two hospitals looked very similar; and were higher than the international average. The bed turnover rates at KATH in 1993, however, were still higher than at KBU (and the international average), although KBU's rates were approaching the international average.

7.4 Financial Management

A near-unanimous conclusion of the stakeholders interviewed was that finance was the key to autonomy: that full autonomy was not possible without financial independence, and that Ghanaian hospitals could not be considered autonomous till they had full control over their finances. Also, most of the stakeholders interviewed were convinced that, while financial efficiency and discipline were important, the ultimate consideration was whether the hospitals could raise the resources required to cover the expenditures of the hospital from the available sources of revenue. As noted earlier, the MOH wishes to reduce the level of subsidy that it has been providing the teaching hospitals, which currently amounts to about 20% of all MOH expenditures. The MOH expects that the increased efficiency ushered in by autonomy will enable them to accomplish this. The teaching hospitals also feel that autonomy will enable them to run their operations with increased efficiency and effectiveness.

However, the financial information from previous years show that the hospitals' income from all sources (including government subventions and user charges) still falls significantly short of expenditures. Indeed, the evidence suggests that if the government were to withdraw its financial support, *or even to lower the level of its subsidies*, the teaching hospitals would be completely unable to carry on their operations. In fact, if the current trends are an indication, the government would have to spend more on the teaching hospitals to keep them going, quite the opposite of what has been proposed in the GMTHS. If the premise that hospital services constitute cost ineffective use of resources compared to primary care services is accepted, then the future does not auger well for the Ghanaian health care system. For the hospitals, too, there is no alternative, in the foreseeable future, but to rely on the government support. This automatically raises questions about the ability of the hospitals to achieve true autonomy. It is hardly likely that the government, if called upon to raise its support of the hospitals, would lower its involvement in the affairs of the teaching hospitals.

Herein lies a major general dilemma for the implementation of autonomy in public sector hospitals! We had noted earlier that the periodic bailing out of hospitals by the Ghanaian government, whenever the hospitals run up deficits, eliminates the competitive pressures that would force the hospitals to be efficient. However, since the hospitals are public sector institutions, and committed to public service, the government is forced to step in whenever they are in financial trouble. This is particularly the case because no viable alternative source of funding exists for the hospitals, thereby limiting the hospitals' options. This is an important concern that need to be jointly resolved by the MOH and the teaching hospitals.

Let us now turn now to some average recurrent cost estimates from the two Ghanaian teaching hospitals, and compare them with data from other developing countries (Tables 20-21).

Table 20 demonstrates that all the average recurrent costs of both teaching hospitals have been going up dramatically, in real terms, since the advent of autonomy. In fact, in the case of KATH, the cost estimates for 1993 are, sometimes, two to three times as much as in 1991. These substantial increases in average costs, which are not matched by comparable improvements in hospital performance statistics (presented earlier), would suggest, at the very least, that the efficiency of the hospitals has not been helped by autonomy.

While acknowledging the caveats of using average cost data to compare the performance of different hospitals (e.g., the need to ensure that the quality of services and case-mix at each facility are comparable; the need to measure the social opportunity costs of resources used, in addition to the amounts spent; etc. - see Barnum and Kutzin, 1993), it seems reasonable to compare the two Ghanaian teaching hospitals, as they are similar in their structure and functioning. The average costs of KBU have, over the years, been significantly higher than those of KATH. However, the increases in KATH's costs in recent years have been much more marked than that of KBU, with the result that KATH's costs have sometimes even exceeded those of KBU (e.g., the per bed costs in 1993). This might suggest that the financial inefficiencies at KATH in recent years have been even greater than at KBU.

Table 21 below presents comparative data on the average recurrent costs at tertiary care facilities in a number of countries. The caveats above apply to cross-country comparisons even more so than to within-country comparisons of hospitals. This is particularly so when comparisons for the different countries are being made for different years. Still, it is interesting to note that the average cost figures for the

Table 20

Hospital Recurrent Average Cost Estimates: Korle Bu and KATH (1988 US\$)

	<i>Korle Bu</i>			<i>KATH</i>		
	<i>1991</i>	<i>1992</i>	<i>1993</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
Per Inpatient Admission	148.37	151.84	198.80	59.22	98.17	135.00
Per OPD Visit	2.53	2.86	4.34	1.63	2.40	3.36
Per Bed	3,193.67	4,136.53	6,085.88	2,914.53	4,503.83	6,833.11
Per Inpatient Day	13.49	14.46	22.59	8.46	12.27	16.87
Per Patient Day	10.10	11.46	17.37	6.52	9.61	13.45

Source: KATH and KBU Biostatistics Units.

Notes:

1. "Patient day" was calculated using the assumption that 1 inpatient admission was equivalent to 4 OPD attendances (see Shepard, 1988)
2. Total hospital recurrent costs are divided by inpatient statistics (except for costs per patient day and per OPD visit) to get average cost estimates.
3. Calculations are in 1988 US\$ to enable comparisons with data provided by Barnum and Kutzin.

Ghanaian hospitals are, in general, lower than the costs in the other countries. This is in spite of the many obvious inefficiencies in the financial management of the Ghanaian teaching hospitals, discussed above. To some extent, differing costs at hospitals in different countries merely reflect differences in the per capita national income. It would seem, though, that even adjusting the data from Table 21 for national income, the Ghanaian hospitals still spend less than tertiary hospitals in many other countries. The significance and implications of this, however, are unclear in the absence of such data as the price and quantity of inputs in the various countries.

As discussed above, major questions remain on whether, and how, the Ghanaian teaching hospitals will be able to fully finance their operations, if they attempt to reduce their dependence on the MOH, and achieve even minimal autonomy. Kenneth Lee, the WHO consultant brought in by the MOH to assist them with the autonomy process, had suggested the following options:

- Direct GOG subvention through the Ministry of Health;
- User charges;
- Ministry of Education grants (for education and training);
- Contributions from statutory and philanthropic bodies;
- Commercial borrowings;
- Multilateral and bilateral aid;
- In-house income generation (including, setting up a commercial pharmacy to serve non-hospital clients, and the commercialisation of support services); and
- National Health Insurance.

It is unfortunate that not much effort has gone into setting up other mechanisms to raise resources for the hospitals. For example, the national social insurance system, that has been discussed for a number of years, has not yet been put in place. At the same time, it must be said that the government seems to be putting a tremendous amount of faith in the ability of social insurance to fund - possibly fully fund - the teaching hospitals. The evidence in other developing countries would suggest that social insurance is by no means a magic bullet, and can, at best, serve to augment existing sources of revenue. In this light, the government's discouragement of private insurance may also need to be re-evaluated.

User charges, of course, are an avenue for generating more resources for the hospitals. The complaint of the teaching hospitals has been that the government has not been forthcoming in revising the fee schedules to match inflation and the

Table 21**Hospital Recurrent Average Cost Estimates: KBU, KATH, and Selected Tertiary Care Hospitals in Selected Countries (1988 U.S. Dollars)**

	<i>Per Inpatient Admission</i>	<i>Per OPD Visit</i>	<i>Per Bed</i>	<i>Per Inpatient Day</i>	<i>Per Patient Day</i>
Belize (1985)	126.00	-	4,714.00	-	42.30
China (1986)	57.00	1.10	1,489.00	-	4.30
Indonesia (1985)	41.00	1.80	1,384.00	-	7.00
Jamaica (1986)	176.00	9.00	6,699.00	-	23.00
KATH (1991)	59.22	1.63	2,914.53	8.46	6.52
Korle Bu (1991)	148.37	2.53	3,193.67	13.49	10.10
Papua N. Guinea (1988)	364.00	5.30	5,822.00	-	26.70
Rwanda (1984)	-	1.90	4,366.00	-	7.60
Zimbabwe (1987)	109.00	1.90	4,366.00	-	17.90

Source:

1. KATH and KBU Biostatistics Units.
2. Barnum and Kutzin, 1993.

Note:

1. "Patient day" was calculated using the assumption that 1 inpatient admission was equivalent to 4 OPD attendances (see Shepard, 1988)
2. Total hospital recurrent costs are divided by inpatient statistics (except for costs per patient day and per OPD visit) to get average cost estimates.

resultant increases in the costs of hospital inputs. This is undoubtedly the case, and is a well-known problem in countries where the fees are not indexed to the inflation rate and the decision to change fee levels must go through a protracted political process (Barnum and Kutzin, 1993). But it is also true that the hospitals have not done a good job of realizing the full potential of user fees, even under the existing fee schedules. Revenue collection has been somewhat lax, though it has improved in recent years, and the exemptions granted to the fees are many and quite arbitrarily decided. Also, the administrative and technical skills and ability to implement more sophisticated collection of user charges, such as selective price discrimination, or capitation, are not currently available at the hospitals. Thus, the potential to raise resources through user charges may indeed be under-realized.

That having been said, it should also be pointed out that increases in user charges, particularly in the absence of adequate insurance schemes (and the absence of adequate financial administrative systems), have the potential to very adversely affect equity. Also, given the widespread perception in Ghana of health as a fundamental right, dramatic increases in user charges are very likely to be resisted vigorously by the general population (as is evident from our consumer survey) and by various interest groups (e.g., the TUC and the political parties). The government,

itself, is unlikely to be willing to take on this political risk. This is all the more so since the user charge collection at the teaching hospitals is now in the range of 20%, which places Ghana in the middle range of user fees collected in developing countries (Barnum and Kutzin, 1993), and exceeds the government's stated goal of raising 15% of hospital revenues through user charges (GMTHS). Moreover, user charges can ultimately only realize a limited amount of resources, and the evidence in Ghana suggests that they can never be a viable substitute for either government subsidies or some form of public insurance.

One important (and immediate) measure, that could partially alleviate the scarcity of resource is a more realistic budgeting at the hospitals, and the institution of effective financial management procedures and control. The management of the hospitals should make an effort to determine the actual costs of running the hospital, and the unit costs of specific services, so that the prices they charge their clients can reflect the actual spending by the hospitals on these services. In particular, the hospitals should make an attempt to calculate the real costs of undertaking each of their three main functions: teaching, research, and patient care. The way the two teaching hospitals are currently functioning suggests that the financial lines between these three primary functions are quite blurred. Calculation of actual costs in a complicated setting, such as teaching hospitals, is no easy task, as daunting problems are involved in allocating joint costs to each of these activities. However, if the hospitals are to attain greater autonomy, it is critical for them to have a clearer understanding of the relative contributions of these functions to the primary goals of the hospitals, the trade-offs involved in the discharge of these distinctive functions, and the implications of the emphasis provided to each function for the financial viability of the hospitals.

Needless to add, a crucial element in being able to undertake such complex responsibilities is the presence of a skilled and fully committed financial management staff. Efforts in this direction will be well worth the while of the hospitals. It is also important that the financial staff owe their full allegiance (and their jobs) to the hospitals, rather than to the Ministry of Finance, as is currently the case. Other measures that must be implemented are the provision of greater flexibility to the hospital financial staff to vire available funds between accounts, and greater control over capital investment decisions, which are currently being made outside the hospitals. We have already referred above to the other entrepreneurial measures available to the management in augmenting hospital resources

7.5 Human Resource Management

The many functions of the two teaching hospitals are currently the responsibility of staff from various institutions within the hospital premises, that do not come under the direct control of the hospital Boards. Moreover, because of institutional

constraints, this situation is unlikely to change in the near future. For example, the training of medical students and trainees is likely to continue to be the responsibility of the University of Ghana Medical School in Accra, and the University of Science and Technology at Kumasi, even if Korle Bu and Komfo Anokye hospitals become fully autonomous, as per Law 209. Similarly, the training of nurses will continue to be the responsibility of the respective Nursing Schools. Also, patient care at the teaching hospitals is currently being provided by doctors who are a part of the University of Ghana Medical School, obtain their compensation from the Medical School, and therefore owe their primary allegiance to the medical school. It is, therefore, a priority for the implementation of hospital autonomy to examine the inter-relationships between the staff from the independent institutions working at the hospitals, anticipate the changes/conflicts that might develop with the grant of full autonomy to the teaching hospitals, and take steps towards resolving these conflicts.

This assumes importance because the ability of the hospital Boards to “hire and fire” staff is widely considered to be as important to the autonomy process as financial independence. Accordingly, additional legal provisions may be required to bring the hospitals’ employees, who currently owe allegiance to a diversity of institutions, including the civil service, the MOH, the MOE, the PWD, etc., under the umbrella of the hospital Boards. In concert with this initiative, there is the need to make these employees directly responsible to the Boards, and to link their tenures and incentives to their on-the-job performance. Current employees of the hospitals unwilling to accept these terms may be offered the choice of being transferred to other government jobs, where they would retain their government servant status. This is critical if efficiency and accountability are to be ensured within the autonomous hospitals. Also, clear lines of authority and responsibility need to be ensured within the teaching hospitals, so that the entire responsibility for human resource management does not fall on the top administration.

Finally, regarding the concern of the MOH that providing full autonomy to the Boards would lead to arbitrary and heavy raises in the salaries of employees, measures may be considered that are similar to those in the private sector. Thus, the government might require the hospitals to raise, on their own, any additional resource they may require to pay for the salary increases. Also, wages may be linked, in some way, to the performance of the staff to as to induce greater effort and efficiency. But the wage increase argument cannot, and should not, be used to justify delays in the autonomy process.

8. Conclusion and Recommendations

The main conclusion of the study is that the experiment to give hospital autonomy to teaching hospitals in Ghana has not yielded many of the hoped-for benefits in terms of efficiency, quality of care, and public accountability - although there have been some isolated success, as has been noted. To some extent, this situation might be explained, simply, by the relatively short duration of "autonomy" enjoyed by the two hospitals, or the instability that often accompanies systemic reform. However, the evidence would suggest that problems are far more deep-rooted. Certainly, the inability or unwillingness of the MOH (for all the reasons discussed above) to allow the two hospitals to function as fully autonomous institutions (as becomes clear from the position of the hospitals in our conceptual framework) has contributed significantly to the failure of the autonomy process in Ghana. The ambiguities surrounding the autonomy initiative, and the absence of any clear sense of direction and purpose, have only compounded this problem. But, it is also important to emphasize that the two Hospital Boards have not been able to use the autonomy provided to them - however incomplete and circumscribed the autonomy - to bring about improvements at the hospitals.

We should point out, however, that the failed experiment with autonomy in Ghana does not, by itself, demonstrate the non-viability of the autonomy concept. To emphasize this point, it is instructive to examine an example of a successful separation of the policy making and service delivery function, within Ghana itself. We refer to the setting up of the Ghana Education Service, an autonomous institution created by the Ministry of Education, following the MOE's decision to limit its responsibilities to priority setting and policy formulation. Many of the same issues currently confronting the MOH and the hospitals were also faced by the Ministry of Education and the Education Service. But these problems were successfully resolved, and the arrangement has been working relatively successfully for the last few years. This would suggest that at least part of the problem is a lack of a similar vision and initiative among policy makers in the health field. While the results of this study do not allow us to either unequivocally validate, or categorically reject, the hypothesis that autonomy -- implemented systematically and in full -- can lead to improvements along the four dimensions considered in this study, it is certainly clear that for autonomy to succeed, it needs to be given a fair chance.

The evidence accumulated as a part of this study suggests that, while lip-service is being paid to autonomy by the MOH, there is a general lack of motivation and incentive, among MOH officials, to see the initiative through. After all, relinquishing

control of the hospitals does represent a considerable loss of power and prestige for the MOH. Even if this is not the problem, there can be little doubt that the approach taken by the MOH makes it very difficult for autonomy to succeed in Ghana.

The primary rationale for hospital autonomy in the public sector, as discussed, is that, by creating organizational arrangements that mimic the private sector and encourage competition, one can induce increased efficiency, greater public accountability, and improved quality of care at these facilities (McPake, 1996). Thus, for autonomy to succeed, it is important that the hospitals be exposed to competition, and the tenure of employees be linked to their performance (judged on some pre-determined criteria). Half-hearted attempts in this direction (such as the mere creation of Hospital Boards without all the necessary follow-up discussed above) are likely to cause more problems than they solve.

In this context, while the Ghanaian government has proclaimed that it wants the teaching hospitals to function as autonomous entities, the reality is that the independence of the hospitals has been severely circumscribed. This substantially limits the ability of the hospitals to function independent of the MOH, far less "mimic the private sector". In any case, independence is probably an unattainable goal for the hospitals, given their almost total financial dependence on MOH resources; indeed, the hospitals could never hope to sustain themselves without continued (and probably increasing) MOH support.

Further, the fact that the teaching hospitals are the only two institutions in Ghana, public or private, that can provide many "high-tech" services implies that, even if they were to become autonomous, there is little likelihood of they will face much competition in the provision of these services. In other words, the near monopoly situation of the hospitals, removes any incentive for them to be competitive, and, in effect, reduces the probability that their efficiency will increase significantly with autonomy. Moreover, the fact that the government can be relied upon to bail out the hospitals (as has been evidenced in the past), however inefficiently they might function, further dilutes any competitive stimulus to do better. Finally, the fact that a significant number of hospital employees do not owe primary alliance to the hospital, and, sometimes, even to the MOH, removes the threat to their jobs, that might serve as an incentive for them to function efficiently. In sum, as things now stand at the Ghanaian teaching hospitals, the conditions required for autonomy to succeed are virtually non-existent.

Having said this, it is incumbent upon us to sound a note of caution. While the introduction of certain private sector characteristics, as argued, is desirable for augmenting the efficiency and effectiveness of public hospitals, this does mean that the hospitals must be converted into private institutions. We have already argued that any efficiency gains resulting from such a policy initiative are more than likely to be off-set by losses in equity. Moreover, committed as public hospitals are (at least in theory) to public service and equity goals, requiring them to emulate, blindly or *in toto*, the private sector is likely to introduce a dichotomy in their

functioning that would impede, if not completely paralyze, their operations. This is a general dilemma facing many public sector institutions implementing similar reforms, and will almost certainly confront the Ghanaian government and the hospitals at some stage in the autonomy process. Unfortunately, there is a relative paucity of theoretical or empirical guidance on how to implement hospital autonomy so as to balance the efficiency and equity objectives of governments. This is a challenge that needs to be taken up as a priority by the academic community.

Finally, one needs to consider the intriguing possibility that many of the changes along the four dimensions considered in this study to evaluate autonomy might be achievable without the grant of autonomy to the hospitals. Maybe what is required, simply, is better management and incentive structures within the existing structure! If this contention is true, then the failure to bring about changes in the functioning of the two study hospitals might reflect more of a management problem, than an autonomy issue. Unfortunately, however, the findings of this study do not allow us to either substantiate or reject this claim.

In sum, if hospital autonomy in Ghana is to have a chance, some of the steps that must be taken are:

- A comprehensive conceptual model of hospital autonomy should be developed, adequately discussed among key stakeholders, and adopted;
- A series of national consensus building meetings must be initiated with the goal of exposing the hospital autonomy concept, as well as the specific initiatives designed to provide autonomy to hospitals, to constructive criticism and debate;
- Law 209 should be revised, based on the discussions among stakeholders, and the new legal instrument should be backed up by specific guidelines, provided to the hospitals, on how to proceed with the implementation of autonomy;
- External and internal organizational arrangements to support autonomy should be designed. In particular, the relationship between hospital Boards, the proposed Ghana Health Service (GHS), the Ministry of Health, and the two medical schools should be clarified and formalized;
- The costs of running the various operations of the hospitals must be assessed, and alternative funding mechanisms devised to enable a system-wide financing of health care services in Ghana, including the teaching hospitals;
- Management training should be provided, so that a cadre of managerial staff equipped to handle all the key management functions at the hospitals is developed; and
- The autonomy initiative should be gradually and methodically phased in, providing the hospitals ample time to prepare for autonomy, develop clear mission statements, and introduce strategic management in their institutions.

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Appendix 1: Hospitals Administrative Law, 1988, Part 1 Pertaining to Teaching Hospitals

1. (1) There shall be established for the purpose of the management and administration of each Teaching Hospital a body to be known as the Teaching Hospital Board.
(2) A Teaching Hospital Board shall have perpetual succession and a common seal and may sue and be sued in its corporate name.
(3) A Teaching Hospital Board, shall, subject to the provisions of this Law, have power to acquire and hold any movable or immovable property, to dispose of such property and to enter into any contract or other transaction.
2. Without prejudice to section 1 a Teaching Hospital Board shall: -
 - (a) formulate policies and develop plans and strategies to make the Teaching Hospital self-financing;
 - (b) formulate plans for the improvement of the standard of health services provided for patients at the Teaching Hospitals;
 - (c) ensure the implementation of the policies, plans and programmes by the appropriate units at the Teaching Hospitals;
 - (d) provide for the Teaching Hospitals such facilities, including adequate accommodation and equipment, as appear to the Board to be necessary for teaching and research;
 - (e) subject to such limitations as are provided in the Law, acquire and maintain all hospital equipment and all movable and immovable property of the Teaching Hospital;
 - (f) undertake periodic assessment of the manpower, physical and financial resources of the Teaching Hospital;
 - (g) recommend to the Secretary the scale of fees to be paid by patients;
 - (h) appoint staff and determine remuneration and benefits of such staff.

3. (1) The functions of the Teaching Hospital Board under this Law shall be exercised subject to such policy directives as the Secretary may determine.
(2) A Teaching Hospital Board shall not enter into a contract in respect of any movable or immovable property or work or services for the hospital the total value of which exceeds twenty million cedis in any one financial year, or such sum as the Secretary may from time to time determine.
4. (1) A Teaching Hospital Board shall consist of the following members:
 - (a) a chairman and four other persons including at least one woman appointed by the Council on the recommendation of the Secretary;
 - (b) a Chief Administrator appointed under section 6 of this Law;
 - (c) the Dean of the relevant Medical School;
 - (d) a representative of the Ministry of Health;
 - (e) a representative of the Ministry of Finance and Economic Planning.(2) A member of a Teaching Hospital Board other than an ex officio member shall hold office for a period of four years.
(3) Every member of a Teaching Hospital Board shall on the expiration of his term of office be eligible for re-appointment.
(4) A member of a Teaching Hospital Board may at any time resign his office by giving notice in writing addressed to the Council, but the Council may at any time remove a member of the Board from office if in the opinion of the Council it is in the national interest to do so.
(5) Where the office of a member other than an ex officio member of a Teaching Hospital Board becomes vacant, the Secretary shall recommend another person to be appointed by the Council to fill the vacancy.
(6) The members of a Teaching Hospital Board shall hold office on such terms and conditions, including the payment of such allowances or remuneration as the Council may on the recommendation of the Secretary determine.
5. (1) A Teaching Hospital Board shall meet at such times and places as the Chairman may determine, but shall meet at least once every month.
(2) The Chairman shall preside at all meetings of the Board and in his absence a member of the Board elected by the members present shall preside.

- (3) The quorum at any meeting of a Teaching Hospital Board shall be five.
 - (4) A Teaching Hospital Board may at any time co-opt any person to act as an advisor at any of its meeting but no person so co-opted shall be entitled to vote at any such meeting on any matter for decision before the Board.
 - (5) Any member of the Board of a Teaching Hospital who has an interest, direct or indirect, in any company or undertaking which has financial concern in any matter that is a subject for the consideration of the Board shall disclose in writing to the Board the nature of his interest and shall not participate in any discussion or decision of the Board relating to such matters.
 - (6) Any member of a Teaching Hospital Board who fails to disclose his interest under subsection (5) of this section shall be removed from the Board.
 - (7) Subject to the provisions of this Law a Teaching Hospital Board shall regulate its own procedures.
6.
 - (1) There shall be appointed by the Council on the advice of the Secretary a Chief Administrator for each Teaching Hospital who shall be responsible for the execution of the policies and decisions of the Board and for the day-to-day administration of the Teaching Hospital.
 - (2) The Chief Administrator shall hold office upon such terms and conditions as the Council acting on the advice of the Secretary shall determine.
 - (3) Where the Chief Administrator is temporarily incapacitated from the performance of his functions under this Law, the Board may authorize any senior employee of the Hospital to perform those functions for the duration of the incapacity.
 - (4) The Chief Administrator may, subject to the provisions of this Law, delegate to any senior employee of the Teaching Hospital any of his functions under this Law.
 7.
 - (1) A Teaching Hospital Board shall appoint an officer to be designated as the Hospital Secretary.
 - (2) The Hospital Secretary shall act as the Secretary to the Board and shall perform such other functions as may from time to time be assigned to him by the Board, or the Chief Administrator.
 8.
 - (1) The Board of a Teaching Hospital may from time to time engage such employees as may be necessary for the proper and efficient conduct of the business and functions of the Board.

-
- (2) The Board of a Teaching Hospital shall in consultation with the appropriate medical school, appoint the heads of units of the Teaching Hospital.
- (3) A Teaching Hospital Board may engage the services of such consultants and advisors as may be necessary for the proper and efficient discharge of its functions on such terms and conditions as the Board of such Teaching Hospital Board may determine.
9. (1) A Teaching Hospital Board may appoint such committees as it may determine to assist it in the discharge of its functions and may delegate any such committee any of its functions as it may think fit.
- (2) Without prejudice to subsection (1) of this section a Teaching Hospital Board shall for the discharge of its functions under section (2), appoint the following committees:
- (a) A Finance Committee
 - (b) A Technical and Planning Committee; and
 - (c) A Staff Development and Disciplinary Committee.
- (3) A Committee appointed under this section shall have a Chairman who shall be a member of the Board of the Teaching Hospital.
- (4) The members of any such Committee shall be appointed on such terms and conditions including the payment of such remuneration or allowances as the Board may determine.
10. (1) The Finance Committee shall:-
- (a) submit proposals for the hospital budget to the Board;
 - (b) advise the Board on fiscal matters and programme for the Teaching Hospital.
 - (c) monitor hospital revenue and expenditure and make recommendations to the Board;
 - (d) propose to the Board the scale of hospital fees;
 - (e) advise the Board on investment opportunities and methods of improving the funds of the Teaching Hospital Board;
 - (f) submit quarterly and annual reports on the finance of the TeachingHospital to the Board; and
 - (g) perform such other functions as the Board may determine.

11. The Technical and Planning Committee shall:-
 - (a) advise the Board on the quality of medical care and the standard of skill required of the technical staff of the Teaching Hospital;
 - (b) advise the Board on medical equipment and supplies requirements of the Teaching Hospital;
 - (c) propose manpower structure and research programmes to the Board; and
 - (d) advise the Board on any other technical matter.
12. The Staff Development and Disciplinary Committee shall:-
 - (a) advise the Board on measures to motivate staff and promote efficiency;
 - (b) deal with such disciplinary matters as may be referred to it by the Board;
 - (c) advise the Board on measures to create and maintain at the Teaching Hospital such conditions as are conducive to the attainment of a high level of discipline by the staff.
13. Without prejudice to subsection (2) of section 9 there shall be established in each Teaching Hospital a House Committee composed of the following:
 - (a) the Chief Administrator of the Teaching Hospital;
 - (b) the Hospital Secretary;
 - (c) the Matron of the Teaching Hospital;
 - (d) the engineer of the Teaching Hospital;
 - (e) the supplies officer of the Teaching Hospital;
 - (f) four persons being representatives of all the clinical staff of the Teaching Hospital; and
 - (g) three representatives of the Committee for the Defense of the Revolution (CDR) and the TUC of the Teaching Hospital.
14. The House Committee of the Teaching Hospital shall:-
 - (a) explain policies and directives of the Board to members of staff of the Hospital;
 - (b) develop measures to promote the co-ordination of the activities of the various units of the hospital;
 - (c) provide information to the Chief Administrator on difficulties if any encountered in the implementation of the decision of the Board.

Appendix 2: Hospital Autonomy Study

Client Survey Instrument

The objective of this questionnaire is to solicit the views of users of the hospital on autonomy and on the type and quality of services they have received..

Circle or fill in the appropriate answer.

1. Personal Data on Respondent

1.1 Sex:

Male Female

1.2 Age:

15-44 45-60 More than 60

1.3 Place of usual residence:

Accra City Greater Accra Region Other region

1.4 Occupation:

Civil/Public servant Self employed Housewife Employed

1.5 Educational level

None Primary Secondary/Tech University

2. How often do you use this hospital?

First time Occasionally Often

3. Why have you come to the hospital?

4. Were you referred?

Yes No

8.4 Drugs Available Unavailable
often often

8.5 Services (available range)
Inadequate Adequate

8.6 Maintenance of buildings Poor Good

8.7 Compound Well kept Untidy

8.8 Provision for patient comfort (e.g., enough seating in waiting area, clear directions, etc.)

Adequate Inadequate

9. What suggestions would you have for improving the services in the hospital

10. Should the general public be involved in the improvement of the hospital or not?

Yes No

11. If YES in what ways

12. If NO why?

13. Have you heard of autonomy for Korle Bu Teaching Hospital?

Yes No

14. What does it mean to you? (spontaneous)

Better services

Lower fees

Higher fees

Korle bu will become private

Better salaries for staff

No difference in current services

No government control

Other_____

Appendix 3: Statistics From Korle BU Andkath

Table A.1

Approved Estimates for 1989-1993 (US\$) - Korle Bu

	<i>Pre-Autonomy</i>		<i>Post-Autonomy</i>		
	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
Salary (1)	2,016,294.27	2,142,979.46			5,544,884.75
Traveling&Transport Expenditure (2)	38,377.37	25,765.68			
General Expenditure (3)	633,435.10	758,899.92			
Maintenance/Repairs /Renewals (4)	227,488.84	331,248.05			
Stores & Supplies (5)	570,049.12	592,959.58			
Total Items 2-5	1,469,350.43	1,708,873.22		1,377,352.68	1,598,932.02
Total Items 1-5	3,485,644.70	3,851,852.68			7,143,816.77
Salary/Total Items 1-5	58%	56%			78%

Source: Biostatistics Unit, Korle Bu
Expenditures in US\$ are in 1987 constant terms.

Notes:

Table A.2

Approved Estimates for 1989-1993 (US\$) - KATH

	<i>Pre-Autonomy</i>		<i>Post-Autonomy</i>		
	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
Salary (1)		1,489,622.57	1,202,111.40	1,245,981.80	
Traveling&Transport Expenditure (2)			44,708.21	50,383.77	
General Expenditure (3)			150,728.41	134,667.11	
Maintenance/Repairs /Renewals (4)			156,671.10	154,508.75	
Stores & Supplies (5)			314,709.47	473,975.88	
Total Items 2-5		675,285.27	666,817.19	813,535.51	
Total Items 1-5		2,164,907.83	1,868,928.59	2,059,517.31	
Salary/Total Items 1-5		69%	64%	60%	

Source: Biostatistics Unit, Korle Bu
Expenditures in US\$ are in 1987 constant terms.

Notes:

Appendix 4: List of Persons Interviewed

Ministry of Health

Dr. M. Adibo, Former Director of Medical Services
Dr. A. Asamoah-Baah, Director, PPME
Dr. A.R.O. Chinery, Former Deputy Director Medical Care
Mrs. V. Dako, Director, Admin. Support Services
Mr. G. Dakpala (Budget Div.), PPME
Dr. E.N. Mensah, Director, Institutional Care Division
Dr. J. D. Otoo, Director, Health Insurance Unit
Mr. P. Smithson, ODA Resident Economist

Korle Bu Teaching Hospital and University of Ghana Medical School, Accra

Prof. G.H. Addy, Head of Department of Medicine
Col. W.Y. Anoff, Chairman of the Board
Prof. J.O. Commey, Head of Department of Pediatrics
Mr. Essandoh, Principal Pharmacist
Mr. T. Mensah, Principal Hospital Administrator
Mrs. F. Nelson, Deputy Director of Nursing
Prof. P.K. Nyame, Former Medical Administrator
Dr. S.N. Otoo, Former Chief Administrator
Mr. K. Owusu, Chief Accountant
Dr. S.K. Owusu, Dean of UGMS
Cmdr.(Rtd.) K.K. Pumpuni, Chief Administrator
Prof. J.K. Quartey, Consultant Urologist and former Medical Administrator
Prof. J.B. Quartey-Papafio, Ag. Head of Department of Surgery
Mr. M. Rebeiro, Executive Secretary of UGMS
Prof. J.B. Wilson, Head of Department of Obstetrics and Gynecology

Komfo Anokye Teaching Hospital and UST Medical School, Kumasi

Dr. S.W.T. Adedeyoh, Head of Department of Obstetrics and Gynecology
Prof. H.A. Addy, Dean of UST Medical School
Mr. G.K. Adu, Principal Hospital Administrator
Prof. A.P. Asafo-Addjei, Chief Administrator
Mr. A. Asiedu-Offei, Principal Hospital Administrator
Mr. H. Baah-Adade, Principal Accountant
Mrs. E. Markin, Deputy Director for Nursing Services
Mr. R. Safo-Mensah, Principal Pharmacist
Mr. N. Siribue, Chairman of the Board

Ministry of Finance & Economic Planning

Mr. S.K. Anipa, Director In-Charge, Health Sector

Others

Representative of Ghana Medical Association
Officials of Health Workers Association (TUC)