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Qualitative analysis of Autonomization of teaching hospitals of Punjab: A case study of Jinnah Hospital Lahore

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Abstract

This study aims at evaluating the nature and extent of autonomy in the areas of hospital financial management and procurement. Autonomy in financial management refers to the freedom to generate resources for the running of the hospital, and the proper planning, accounting, and allocation of these resources; and autonomy in procurement refers to making all the decisions regarding purchase of drugs, medical and non-medical hospital supplies, and hospital equipment. The population of this study consists of all the medical and non-medical staff of Jinnah Hospital, Lahore (JHL). In this research design, JHL is selected as a single case and then multiple sub units of analysis are selected from the top level management of Jinnah Hospital Lahore to get information about the nature and extent of autonomy granted to hospital in the said areas. In this way, 14 top level medical and non-medical staff members of JHL were interviewed. The findings of this study show that autonomous hospital is not independent in making its decisions in the matters of financial management and procurement. Most of the decisions concerning financial management and procurement of the autonomous hospital are taken after the approval from the finance and health department.

Key Words: autonomous public hospital, health reforms, nature of autonomy, extent of autonomy, Jinnah Hospital Lahore, Punjab

1. Introduction

Granting autonomy to public hospitals means decentralizing them as per the philosophy of New Public Management (NPM). In decentralization process, the central authority shares or transfers some or all of its powers to a lower level entity with an aim to deliver services the most efficiently. Administrative decentralization has three forms including delegation, deconcentration, and devolution (Agranoff, 2004). In case of Autonomization of the teaching hospitals, devolution is used as a form of decentralization When governments devolve functions, they transfer authority for decision-making, finance, and management to quasi-autonomous units of local government with corporate status.(McPake, 1996).

In case of Pakistan, as a signatory to Millennium Development Goals (MDGs), there is an obligation on make serious efforts for improving the performance of the health sector particularly efficiency of the public hospitals. In this context, some additional funds were allocated to health sector to meet the challenges which were set under MDGs, i.e. provision of better health services in the developing countries (Islam, 2004). The major focus was on child health care, prevention and control of diseases, reproductive health, and nutrient deficiencies. The major portion of public expenditures is directed towards primary and secondary tiers. According to Hall & Taylor (2003) following are the primary objectives of (HS) reforms

1. Improving the level of health sector, both primary and secondary level
2. Enhancing the overall service delivery of health sector
3. Adopting latest tools and techniques for better health system

Some other important steps were also taken to improve health outcomes as a part of the medium term planning. These include consolidation of primary health care, training and re-training of medical and non-medical staff, provision of emergency health care facilities (Collins & Tarin, 2002). Health boards and village health committees

were also established along with the reorganization of district health offices to make them locally managed health care network in rural areas. The primary purpose behind all these (HS) reforms is to improve the hospital administration and their financial management and the proper regulation of the public sector.

Hospital Autonomy

In this study, some of the key dimensions are identified in the light of Chawla & Govindaraj (1996)'s methododlogical guidelines for hospital autonomy which are as follows:

A. Procurement refers to the purchase of drugs, medical and non-medical hospital supplies, and hospital equipment. Procurement management refers to the purchase of medical and non-medical supplies for the hospital as well as purchase of hospital equipment.

B. Financial management refers to the generation of resources for the running of the hospital, and the proper planning, accounting, and allocation of these resources.

The aim was to fulfill its goals and objectives by enhancing the health care delivery system. This phenomenon resulted in a health care system which would reduce inequity of accessing services, acceptability, and adaptability of new health tools; focuses on quality of outcome of clinical as well as preventive programs. Under this program the basic focus was on using scarce resources as effectively and efficiently as possible.

Objectives of study

Following are the research objectives of the study.

1. To describe the extent of hospital autonomy after the process of granting autonomy to the Jinnah hospital
2. To assess the nature and extent of autonomy granted to Jinnah Hospital in decision making regarding financial matters of the hospital (budgeting, expenditure, debt structure and capital raising)
3. To check whether the Jinnah hospital is independent in the area of hospital procurement (purchasing drugs, selecting suppliers and deciding terms and conditions with them

2. Literature Review

Public hospitals are a major part of health systems in the developing countries. This component is generally responsible for 50 to 80 percent of recurrent government health sector expenditure (Barnum & Kutzin, 1993), public hospitals consume about half of the total national health expenditure (Mills, 1996). These public hospitals utilize a large amount of scarce resources, and many lean towards low occupancy rates. Public service provision of health in government owned and managed hospitals, at least in the present arrangement, is not the most efficient way of using government resources, and an improvement in the present situation is likely to have a major positive impact.

Reforms of Granting autonomy to the teaching hospitals of the Punjab were launched and implemented with the financial support of the World Bank, and legal assistance of the technocrats within the provincial capital. Under 'The Punjab Medical and Health Institutions (PM&HI) Ordinance' promulgated on 23 May 1998 and uninterruptedly legislated by the legislature, some teaching hospitals with their attached medical colleges in the Punjab got autonomous status (Government of the Punjab, 1998). Zaidi(1994) analyses different studies to conclude that changes within the health sector of Pakistan are often determined by consequences outside the health sector. Govindraj and Chawla (1996) offered a conceptual model to evaluate the experience of hospital autonomy in Ghana, Kenya, India, Indonesia, and Zimbabwe. They conducted case studies in order to get deep insight of this newly placed reform of hospital autonomy. They worked primarily with fundamental objectives including the purpose and process of granting autonomy, level of autonomy, and impact of autonomy on the overall performance of respective hospitals. In the case of Pakistan, Abdullah and Shah (2007) conducted a study on experience of autonomy in Pakistan and the focus of their research was on the pattern of autonomy and control in public hospitals with reference to the Shekhupura Pilot Project (SPP), Pakistan.

There are several areas regarding nature and extent of autonomization of hospitals to explore including medical care, procurement, administration, financial management, human resource management, and strategic management. Govindraj and Chawla (1996) suggested a procedure to evaluate the nature, extent, process, and impact of autonomy

on the performance of the hospitals. The transfer of semi-autonomous authority to tertiary hospitals is a well-recognized element of health sector reform in a number of countries (McPake, 1996; Collins et al., 1999; Collins and Green, 1999). It can be concluded on the basis of the above literature reviewed that the nature and extent of autonomy can be judged by analyzing the level of autonomy in the areas of administration, financial management, and procurement.

Few research studies have been conducted on the nature, extent and process of autonomy initiative in the public teaching hospitals of Pakistan. However, some researchers e.g., Zaidi SA (1994), Collins CD et al (2002), Tarin (2003), Abdullah and Shaw (2007), and Saeed (2012) have made significant contributions in this regard.

Health system of Pakistan

Health sector of Pakistan has remained a neglected area with respect to its development since she came into existence. Its severity can be gauged from the meager funds allocated in each annual budget which could never exceed one percent of the Gross Domestic Product (GPD) in the economic history of Pakistan. There are four former administrative units of Pakistan including:

1. Punjab
2. Khyber-pakhtunkhawa
3. Sindh
4. Baluchistan and

Gilgit-Baltistan (GB) is the fifth one as it is governed by an independent Chief Minister (CM) and Governor; along with the Federally Administered Tribal Areas (FATA), the Northern Areas (NA), and the Azad and Jammu Kashmir (AJK) (Musarrat, Ali, & Azhar, 2012). Each province is divided into Divisions, comprising Districts. Each Tehsil (sub-District) is subdivided into a number of Union Councils. A Union Council is the lowest administrative unit in rural areas comprising 10 villages.In Each province, the Department of Health is responsible for the administration and planning of health care system. It has also a direct control over the activities and management of teaching hospitals, specialized hospitals and medical colleges. The provincial Secretary of Health leads all of its activities as an administrator and the Director General (DG) of Health at the provincial level is answerable to the Secretary. DG is responsible for the overall organization and management of the public health system all over the province. The health service delivery is conducted through this hierarchical system from top to bottom. At the Divisional level the services are provided under the Deputy Director (DD) and at the District level by the District Health Officer (DHO)(Ghaffar, Kazi, & Salman, 2000).

Global Experience of health sector reforms

At global level, several nations have had experiences with the autonomization of public hospitals. However, available data and analysis of these observations and experiences concludes that such experiments initially started and achieved successes in the developed countries (Chawla, et al., 1996). Furthermore, these deliberations on hospital autonomy are generally based on different autonomy-related concepts, and several variations in a country's political, economic, and cultural circumstances.

Since the early 1980s, public sector hospitals around the globe have come under intense pressure in policy circles due to the bureaucratic structure of these institutions, the heavy burden they impose on public funds, and the perceived complexities in ensuring their efficient and effective functioning under centralized government control (Lee & Goodman, 2002). One policy choice that has found certain favor with governments is the granting of greater autonomy to these public sector hospitals in performing their operations (Ssengooba & McPake, 2002).As a result, in many developed countries (e.g., Denmark, Holland, UK, USA, France, Singapore), and in many developing ones (e.g., Ghana, India, Uganda, Indonesia, Kenya), "hospital autonomy" initiatives have been presented as a key part of a broader health sector reform process. To check the effect of the reform, several evaluations were made by different research groups along the lines of efficiency, quality, choices, and equity of the new health care scheme.

Pakistan experience of Hospital Reforms

In Pakistan, public sector institutional culture especially of the large-sized units is very complex and demand not merely managerial performance but transformational leadership to perform the mainstream tasks and activities

(Abbas & Yaqoob, 2009). Leadership is observed as a major factor in the initiation and implementation of the transformations in the institutions (Saeed & Ahmad, 2012). This will guarantee the development of initiatives and capabilities for encouraging an institutional-environmental transformation, and supportable working interactions with participants across different echelons and groups. The developments prominent to autonomy over the years, are being viewed as a transitional period which were subsequently led into its 'second generation,' while the autonomy changes are not only revealed and accepted for their apparent importance but also maintained by all the stakeholders and carried out in its true sense (Ghaffar, et al., 2000).

''In all the eight 5-year plans the health sector was characterized by ad hoc mentality, lack of initiative, low priority, and guided by foreign health programs and funds'' (Saeed 2012, p.76). Attempts to improve the performance of public enterprises through NPM have produced mixed results at best in India and Pakistan. Hospitals could receive only partial degree of management autonomy. Although there is provision for establishing performance targets for hospitals, the government may simply not have the capacity to do so (Islam, 1993; Mallon, 1994).

Hospital Reforms in the Punjab, Pakistan

A series of (HS) reforms were introduced in the Punjab during the last decade of 20th century. The central idea in these reforms was to decentralize the health sector at national and provincial level. In this regard, the first initiative was taken through Second Family Health Project funded by World Bank in the broader perspective of the Social Action Program (Abdullah & Shaw, 2007). In the case of granting autonomy, the first major step was taken in the form of Sheikhupura Pilot Project (SPP). In the second turn, autonomy was granted to some selected public sector teaching hospitals in the Punjab though Punjab Medical and Health Institution Act 1998, Punjab Medical and Health Institution ordinance 2002, and PM&HI Act 2003 (Abdullah & Shaw, 2007). SPP, as termed by Collins et al. (2002), was perceived to inter-link the formation of semi-autonomous district hospitals with attempts at decentralization reforms of the health sector in all over the Punjab province.

The Punjab Medical & Health Institutions Act, 2003

Background

Governor of the Punjab issued PM&HI Ordinance, 1998 and later, the PM&HI Act,1998 was promulgated by the Punjab Assembly in 1998 by virtue of which decision was made that all teaching hospitals and attached medical colleges in Punjab be granted autonomous status in phases. ''In 1999, army government took over and stopped the reform'' (Saeed 2012, 148). Then army monitoring teams were established, and they conducted independent inquiries. The autonomy initiative was again re-launched through the Punjab Medical & Health Institutions Ord. 2002. The Punjab Medical and Health Institutions Bill 2003 have been passed by the Provincial Assembly of the Punjab on 30 May 2003. It was ratified by the Governor of the Punjab on 5 June 2003 and was published on 7 June 2003. The triangulation administrative network of Principal, Medical superintendent (MS) and Director Finance (DF) under Board of Governors (BOG) was set up, Board of Management (BOM) replaced the BOG.

3. RESEARCH METHODOLOGY

The study is focused on the healthcare sector with reference to the nature and extent of hospital autonomy in the following two areas.

1. Procurement
2. Financial management

This objective made this study an explanatory study. Qualitative research methodology is used in this study because the explanatory needs of a study are found to be best served using qualitative method of research (McNabb, 2008). To find the answers of the research questions, embedded case study design is followed as it helps in reliable and valid explanation of the variables under investigation (Yin, 2003)

Population of the study

The population of this study consists of all the administrative medical and non-medical staff Jinnah Hospital,

Lahore. The issue of performance management and quality of medical care of public sector hospitals has attracted the attention of health care reformers and managers for many years in developing countries (Barnum & Kutzin, 1993). Moreover, public sector is much more involved in the health sector reforms (Ssengooba et al., 2002; Preker & Harding, 2003). because of its proximity to policy making bodies and dependence on government for getting monetary and non-monetary resources. The public sector stakeholders in this regard use different ways to satisfy their interest at the expense of others and this phenomenon reaches its climax in case of developing countries, like Pakistan, where supply of resources is very limited as compared to the demands. It can be concluded on this basis that a public hospital in health sector could be a best place to study nature and extent of reform process.

Unit of Analysis

In this study, Jinnah Hospital Lahore is the unit of analysis. The factual data about the participation of medical and non-medical staff members of Jinnah Hospital autonomy process is not available from any official source of Jinnah Hospital, Lahore. Because of this reason I used snow ball sampling technique among the available non-probability sampling techniques. The 14 top level administrative medical and non-medical staff members of Jinnah Hospital, Lahore were interviewed. According to Yin (2003) 6 to 10 cases, with replication logic, in aggregate would provide compelling support to make any sound conclusions. The replication logic is similar to that used in multiple experiments. First 4 cases were used to establish some theoretical arguments and later ten cases were used to find whether initial findings were replicated in next cases or not. If all cases selected exhibit some similar patterns then it can be inferred that research findings are valid and highly reliable (Yin, 2003).

Instrument of Data Collection

Since the purpose of the study is to explain the concept of nature and extent of hospital autonomy granted to Jinnah Hospital, Lahore under PM &HI act 2003 as it is perceived by the respondents, so the data about the research questions is collected using semi-structured interviews because it is the most useful method of data collection for studies of explanatory nature (McNabb, 2008). Also it provides flexibility and openness to the researcher regarding the information to be collected. In order to have some guidelines for asking similar questions from all the respondents and also to fulfill the reliability and validity requirements, an interview guide was prepared keeping research questions and literature reviewed in view.

Data collection

The top level administrative medical and non-medical staff members of Jinnah Hospital, Lahore were included in the sample. They were assured confidentiality of information provided by them and that the data will be used for academic purpose only. After seeking prior appointments, the respondents were interviewed using interview guide. Information provided by a respondent was repeated in the presence of the interviewee in order to enhance the reliability of the data. The respondents were contacted again for short time to get some other relevant information at the time of data analysis. Each interview was transcribed after it was conducted to ensure that maximum information provided by the respondents is available for data analysis.

4. Data Analysis and Discussion

Data analysis and interpretation was broken down into series of steps that include:

Data Preparation

Data gathered with the help of in-depth semi-structured interviews was in the form of hand notes and audio taped data. The data transcription was started right from the beginning of the data collection. It was better to transcribe the data as soon as possible to capture detailed responses.

Data Exploration

During the exploration phase the transcriptions were read in order to extract important ideas and significant points that were noted down in the form of memos. Further, the most significant quotes were also identified during this step which could be used as evidence.

Data Reduction

Data reduction involves coding of data which can start as soon as the data is collected; hence the data reduction was carried out in parallel to data exploration to the possible extent. Data reduction is basically an analysis

strategy that helps to identify key themes, patterns, ideas, and concepts that may exist within the data collected (Hesse-Biber, & Leavy, 2006).The technique used to analyze and summarize the collected data was generating categories and developing themes. Similar patterns and themes were discovered in different transcriptions. Then the coherent and similar views were placed under the categories. All the major themes were coded under *"free nodes"* and then similar ideas were grouped together under "*tree nodes"* which represented the major categories. This procedure provided the hierarchy of categories and themes; thus making it easier to interpret and analyze the data.

Data Interpretation

Data was interpreted with the help of coding made in data reduction stage. The coding made it easy to recognize the differences and similarities among various items. The major ideas prevailing in the transcriptions were discussed under the major categories and the themes. Inferences and implications of the data were presented on the basis of the findings of this study. The statements supporting the themes were quoted to provide evidence to the inferences. The data is interpreted and analyzed with the help of categories and themes identified in the phase of data reduction.

1. Autonomy in Hospital financial management

The autonomy of the hospital in financial matters can be measured through analyzing its independence in setting its own recurrent and capital budgets; explicitly earmarked items of hospital spending; autonomy to raise capital from private or not for-profit sources including bonds, loans, donations, equity etc.; autonomy to raise capital from private or not for-profit sources including bonds, loans, donations, equity etc. after granting autonomy, the financial powers of the Board, Medical Superintendent, and Principal have limited scope. In all types of financial decisions approval is necessary from the finance and health department. Some of the observations from interviews are highlighted as follows.

> *Although the power to recommend the development scheme is available with the board, Medical Superintendent, and Principal but unfortunately these Development schemes shall be approved as prescribed by the Government*

A. Autonomy in setting its own recurrent and capital budget

The hospital prepares its annual budget and sends it to the health department for final approval. Even after autonomy the hospital are not authorized to decide its capital budget. Although some financial powers are delegated to the hospital administration through its Board, Medical Superintendent, Principal and Director Finance but final authority in financial matter is still the finance department of the government *(PM&HI Act 2003, schedule-V)*. In this way, hospital has limited powers as evident from the following excerpts from different respondents having similar views.

> *The hospital prepares the estimated recurrent budget within the ceiling provided by the health department…; and the capital budget is approved by the health department. Hospital can only prepare estimated budget for each unit or department and then send it to the government for final decision.*

The Accounts of the hospital are maintained according to the prescribed rules of the Government. The board can determine user charges and fees for admission, clinical and procedural services and facilities but with the prior approval of the Government.

> *The Director Finance shall prepare the Budgets within the limits set by the government. After the Budget is approved continuous monitoring shall be made on all the Receipts and expenditure. Reconciled quarterly statements shall be sent to the Government (PM&HI Act 2003, clause-18)*

Government keeps check on the hospital management through internal and external audits. For the external audit, the government hired external consultants in the public hospital in order to verify the financial transactions with the financial rules set the government. The government has kept its control through audit cell- a sub-unit working under the health department.

> *Government shall conduct Financial, Managerial, Medical / Clinical and other audits through a third party. The selection criteria including the composition of such Evaluation Party shall be notified by Government (PM&HI Act 2003, clause-19).*

B. Explicitly earmarked items of hospital spending

The budget in the autonomous institution is explicitly earmarked although some adjustments with the approval of board can be made. However, approval from the health department is necessary. In this regard, sometimes the summary is moved back without passing or rejecting it due to its political nature. Therefore, the board is virtually powerless in budget allocation.

> *The hospital retains the user fee in its separate accounts but later on 45% is transferred to the Government and remaining 55% is distributed amongst the hospital employees after deducting the expenditures; The Chief Minister often intervened and issued abrupt directives to gain political gains and his orders result in reduction of user fee or sometimes free services are asked to be provided.*

C. **Autonomy to raise capital from private or not for-profit sources**

Autonomy to raise capital from private or not for-profit sources including bonds, loans, donations, equity etc. is very limited. The hospital can take donations in shape of cash and kinds. If the donation is received in shape of cash then it is used for the purchase of specific machinery which is necessary for the patients care in case the budget for said items is not provided by the government. Similar views were also noted during the interviews conducted with the top level medical and non-medical staff of the Jinnah Hospital Lahore.

> *Hospital is allowed to receive donations from individuals as well as other groups; Bond and loans are not in the domain of hospital and can't be issued to collect money or generate finances to meet its future need; Hospital can't issue shares in the stock market;*

The hospital management was encouraged to mobilize resources, though many restrictions were put on raising revenue through fee collection (Halpern, Arnold, Stok, & Ersoy, 2003).

> *The health department issued the ceiling to the individual formation (each public hospital). After preparing its budget on the basis of midterm budgetary frame work, each formation then forwarded it to the health department and health department forward it to Finance Department, in this way final approval is made.*

2. Autonomy in Procurement

The hospital autonomy in procurement matters is measured in terms of autonomy regarding purchasing drugs, selecting suppliers and freedom in selecting the procedure of purchasing medical and non-medical supplies etc. Saeed (2012) highlighted in his study that procurement of drugs, medical and non-medical supplies for the hospital, as well as purchase of hospital equipment hospitals in most of the countries enjoy considerable autonomy. In the case of procurement of drugs, medical and non-medical supplies for the hospital, as well as purchase of hospital equipment hospitals in most of the countries enjoy considerable autonomy (Govindaraj & Chawla, 1996). But in case of Jinnah Hospital Lahore there are some different views regarding purchasing of the medical and non-medical supplies of the hospital. Most of the decisions of the board regarding purchasing medicine are influenced by the bureaucracy, because District Coordination Officer (DCO) is the head of the purchase committee. On practical terms, the Board is not autonomous in taking any decision regarding procurement, the real power lies with the health and finance department. Similar views are also observed during the interviews conducted with the top level medical and non-medical staff of the Jinnah Hospital Lahore.

> *The hospital even after autonomy is not independent to make the decisions regarding purchasing drugs, selecting suppliers and deciding terms and conditions;…the board always needs to follow the canons of financial rules, these can't be violated; The medical and non-medical supplies in the hospital are purchased in the light of Punjab Procumbent Rules - authority guidelines and according to other Government instructions from time to time.*
>
> *Purchase of machines / equipment; write off of irrecoverable value of stores or public money due to loss, and Purchase and replacement of motor vehicles including operational vehicles, jeeps, land cruisers are made according to the provisions of purchase and*

procurement procedure (PM&HI Act 2003, schedule-v, clause-14)

According to PM&HI Act (2003) all purchases of goods and services shall be made after receiving the demand from the concerned Department by the Purchase Section of the Institution by following the provisions of Purchase Manual issued by S&GAD, Government of the Punjab (PM&HI Act 2003 schedule-vii, clause-1). Hence Autonomous hospital could not make decisions independently in the areas of purchasing medical and non-medical supplies. Similar views were also observed during the information gathered from the top level medical and non- medical staff of the Jinnah Hospital Lahore. These observations are evident from the following excerpts.

> *All purchases shall be made from the manufacturers / suppliers pre-qualified by the Health Department and also registered with the Health Department. The purchases beyond Rs.1,50,000/- shall be made from the pre-qualified firms after open advertisement in the press as per policy of the Government.*

The hospital is bound to purchase the supplies from those firms which have been approved by the government i.e. Health department. So, hospital is not practicing autonomy even in its purchase matters. Government has not provided the real autonomy to the hospital as most of the matters regarding purchase and procurement are settled through health and finance department as it is also evident from the following government rules.

> *All purchases shall be made in accordance with the specifications of equipment, instruments, medicines and such other items as approved by the Departmental Standardization Committee (DSC) / Inter Departmental Standardization Committee (IDSC) constituted by the Government* (PM&HI Act 2003, schedule-vii, clause-14)

In case of purchasing new machine, the hospital needs to follow the instructions of the government in the form of some procurement rules. Similar observations were also made during interviewing with the top level medical and non-medical staff of the Jinnah Hospital Lahore. These views are highlighted from the following excerpts.

> *Purchase of machines / equipment is made according to the provisions of purchase and procurement procedure provided by the government and all the instruction regarding procurement, are in the form of Punjab Procurement Regularity Authority (PPRA)*

In case of small items of daily use having smaller monetary value, the Board, Medical Superintendent and the Principal can take decisions if the funds are available with the hospital. These views are evident from the following excerpts

> *Purchase of liveries, typewriters, Photostats, duplicating machines; Purchase and repair of bicycle and motorcycle; Purchase of periodical and newspapers; Purchase of books, maps etc*

Hospital can only make purchase and maintenance decisions in small item of daily use on the availability of the funds. But it has to get approval from the health department purchase heavy equipment and machinery. Similarly, all the purchases are to be made according to the prescribed procedures and rules provided by the health department and finance department.

Conclusion

Hospital autonomy is such a vital and dynamic issue that it has become a key concern for policy makers in health sector (Collins & Tarin, 2002). It has become a fundamental concern of the government to improve the health service delivery for the provision of better health care facilities to people. It has been alleged that the public sector is not cost- effective, lacking sense of responsibility, poor governance, and officials prefer personal interests over organizational interests (Puig-Junoy, 2000). Results of this study show that autonomous hospital is not independent in financial and procurement matters in the wake of active role of health and finance department. Hospital has no freedom even after constituting its own board of management to deal with the hospital matters. The Board can only recommend or send proposals to the health department. For all the regular revenues and ongoing expenses mostly the decisions are made by the health and finance department on the recommendations of the Board. Instead of giving more powers to the hospital in managing its affairs, the level of responsibility on the hospital administration has

further increased as a result of autonomy. Although the board, principal and medical superintendent have some powers with respect to sanctioning amount but its approval from the finance department is mandatory. The hospital cannot set its own capital budget without the approval of higher authority; it can only send the proposal for estimated budget. The hospitals are only autonomous within a predefined framework but in a true sense, hospital is not autonomous in running its affairs. After granting autonomy to the public sector teaching hospitals, it was assumed that they could run their affairs through their boards but this could not happen. The primary reason was that the very structure and composition of the Board was dominated by the health and finance department. Both the secretary health and finance are the members of the Board and they influence all the decisions regarding hospital affairs. The Boards constituted after the process of autonomy have only dummy role and these boards only recommend and send proposal to the health department for the final approval.

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