Islamic Republic of Afghanistan
Ministry of Public Health

Hospital Sector Strategy

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1- Background

The government of the Islamic Republic of Afghanistan with the help of international assistance has made great progress in improving the primary care sector of the health system. From an epidemiological and cost effectiveness perspective, this is as it should be. The first priority of any national health system should be to make the greatest impact on reducing morbidity and mortality with scarce resources. There reaches a point however, where attention needs to shift to the hospital sector that provides essential services beyond the limits of primary care. For the most severe illnesses and injuries, survival can only be possible through the use of hospital interventions.

In addition to being vital extension to care begun at the primary level, hospitals are the most visible segment of the health care system and receive the most intense scrutiny by the public.

Although central government supervision and support are often problematic due to security and logistical concerns, hospitals in the provinces have received the vast majority of international assistance. This assistance has been largely carried out through the mechanism of contracting with non-governmental organizations (NGOs). To a greater or lesser degree, these NGOs have had some success in raising the standard of care.

Hospitals in Kabul have generally not received financial or technical support and are losing “hearts and minds.” The dismal state of hospital services contributes significantly to the mounting public criticism of the central government’s inability to manage institutions and provide essential services.

Although Kabul hospitals suffer from severe resource shortages, organizational and structural problems are even more disabling. Unlike NGO run hospitals, National Hospitals have a total lack of control over resource allocation. Control and knowledge of resource costs and allocation is segregated from operational control at both the hospital level and at the Central Ministry. Lack of management capacity, institutional experience, and fundamental understanding of efficient function hampers any progress.

Fears of corruption and the draconian measures taken to control it have had devastating unintended consequences. Officials avoid using signatory authority for fear of unjust prosecution. Centralized procurement requirements have resulted in a totally opaque financial system that is immune from outside scrutiny or intervention.

The result is a system of hospitals unable to provide services at an acceptable level. The high numbers of Afghan Citizens who seek health care services in other countries is direct evidence of the sorry state of medical care. Anecdotal evidence suggests that anyone with significant illness or injury will go out of the country to obtain hospital care if they are able to come up with the needed funds. This willingness to pay dearly for hospital services and go through the personal and familial hardships of “medical tourism” speaks loudly of a crisis of care.

Implementation of Limited and Progressive Autonomy at National Hospitals is the most essential requirement for service improvement. Control over resource allocation decisions must be localized at the individual hospital level and corrupt and opaque centralized procurement and financial
Hospital Sector Strategy

systems must be sidestepped. Sector wide and individual hospital budgets and actual disbursements must be made available to MoPH and hospital officials and management. Decision making must be made on the basis of a functional budget system and the flow of management, utilization and financial information.

Hospitals are vital to the provision of health care services to the population of the Islamic Republic of Afghanistan. As focal points for essential Secondary Care and as providers of tertiary services, these high cost institutions need to be managed with great care. Potential for public good is high, but the risk of inefficient use of scarce resources is also high.

Because hospitals located outside of Kabul have either been contracted to NGOs, are located in areas where the lack of security prevents sustained support, or, are located in areas where the Central Government is unable to reach, this Hospital Sector Strategy is designed to be implemented on a geographically phased basis:

- National and Specialty Hospitals Serve the entire country;
- National and Specialty Hospitals may be in worse condition operationally than many peripheral hospitals;
- National and Specialty Hospitals are at the pinnacle of the Afghan Healthcare System and thus serve as a model for all other providers;
- National and Specialty Hospitals are in the greatest proximity and communication with the Ministry of Public Health.

Because of these factors, this Hospital Sector Strategy will focus on National and Specialty Hospitals during the first stage covered by this document.

Once the primary strategy of hospital autonomy has been successfully established in National and Specialty Hospitals, all other hospitals will be considered for conversion to this status.

It is important to note that the status of Afghanistan’s peripheral (i.e. outside of Kabul) hospitals will need to be considered on an individual basis. Some, like the Hospital Reform Project facilities should be converted to full autonomy as soon as National and Specialty Hospital autonomy has reached a state of initial stability. Although Hospital Reform Project facilities presently function under some limited aspects of autonomy, conversion to full and legal autonomy will provide significant benefits.

Other hospitals such as Regional, Provincial and District will need to be evaluated for conversion to autonomy on a case by case basis during the third stage of this strategy. Some hospitals contracted to NGO management will be running well and may be considered to be in a state of de facto autonomy. In this case it may be prudent to maintain their present status. Other hospitals that are less successfully operational or whose NGO contracts are no longer supported by donor funding should be considered for conversion to autonomous status.

This Hospital Sector Strategy presents vision for hospital autonomy as it should exist on a nationwide basis. It begins however with a specific strategy for the conversion of National and Specialty Hospitals. A companion document, Procedural Manual for the Progressive Implementation of
Hospital Autonomy expands on the steps outlined in the Hospital Sector Strategy and presents greater detail on the process to be followed.

2 - Structure of the Hospital Sector

Patient care is a complex process that is most efficiently and effectively accomplished by different levels of facilities providing appropriate levels of care. A basic principle is that care should be provided at the lowest level of facility that has the needed resources and medical personnel.

Terminology for health care services can be sometimes vague and confusing. In the interest of clarity and to assure that discussions of health services are consistent the following definitions will be used for the various levels of health care services:

**Primary Care** is the most basic level of service that is always carried out in the community, at a clinic, or on an outpatient basis at a hospital. Primary care includes basic curative services that provide treatment for non-complex illnesses and injuries. Preventive Services such as vaccinations and basic health and nutrition education are also part of primary care.

**Secondary Care** is care of a higher level of sophistication than primary care and is carried out on an inpatient basis at a hospital. Most hospital inpatient services are considered secondary care.

**Tertiary Care** is the highest level of care in terms of medical complexity and technical difficulty which is administered to patients with complex diseases who may require high-risk pharmacologic regimens, surgical procedures, or high-cost high-tech resources. Tertiary care services are only available at the highest level of hospital such as a university hospital or a National or Specialty Hospital as it requires sophisticated technology, multiple specialists and subspecialists, a diagnostic support group, and intensive care facilities. (note – most services provided at National and Specialty Hospitals are at the secondary level)

At this time, few Tertiary Services are being provided in Afghanistan’s hospitals. The long term benefit of Hospital Sector Strategy implementation will be the creation of stable management, finance and clinical support systems capable of supporting the provision of Tertiary Care Services at National and Specialty Hospitals. When high quality and high technical level services are reliably available, citizens of Afghanistan will no longer need to travel to other countries to receive sophisticated high quality medical care.

3 - Cost of Care and Cost Efficiency

As health care services become more complex and thorough, they become more costly. All national health systems, especially those with limited resources must assure that investments are made at
the level that is most efficient at providing the type of care needed by the population. Investments must also be made in a manner that reaches the greatest number of people for the least amount of money as long as the care provided saves lives and reduces suffering.

In general this means that the majority of funds available for health care should be used at the primary care level. In terms of both cost efficiency and in terms of achieving the greatest benefit, the largest share of health care resources should be used for primary care while a much smaller amount should be used for tertiary care. This can be graphically represented as an inverted pyramid with the largest section (primary care) at the top and the smallest section (tertiary care) at the bottom.

In many countries the proportion of funds used for primary care is lower that it should be and the amount used for secondary and tertiary care higher than appropriate. In the case of Afghanistan however, the reverse is true. A great amount of attention and investment of resources has been made in the primary care sector while few resources have been devoted to secondary and tertiary care.

![Appropriate Use of Healthcare Resources (Funding and HR)](image)

**Figure 2 Investments Should be Higher at Lower Levels of Care**

This is particularly true in the case of Kabul where the National and Specialty Hospitals are located. It is important to remember that these hospitals provide more than advanced care; they are the sole source of secondary care for the majority of the city’s population.

It is critical that the essential life-saving nature of secondary care is recognized and that improvements are made in this sector. The curative capacity of the primary care sector is very limited and many avoidable deaths occur when hospitals are underfunded or in poor condition. A prime example of this is complicated childbirth and cesarean section. Primary care obstetrical services are not able to provide these essential services.

Although there is a great demand for “tertiary care services” on the part of the public and on the part of political leaders, expectations in this area must be controlled. In general, true tertiary care is extremely expensive and rarely needed. Most “medical tourism” (the seeking of healthcare services out of the country) is for secondary care. This behavior of travelling abroad to seek medical care will be greatly reduced if basic good quality inpatient services (secondary care) become widely available.

If too much early attention is placed on the development of true tertiary care (such as open heart surgery), the resulting transfer of resources away from primary and secondary care would be devastating to the health of the population. In financial terms, the cost of treating tertiary care patients in Afghanistan will fail to pay for itself as the cost will be huge and the money saved from prevented medical tourism will be small.
4 - The Ministry of Public Health Hospital System

Four core clinical functions exist in each of the first three levels of hospitals: medicine, surgery, pediatrics, and obstetrics/gynecology. Mental health and dental health are predominantly provided as outpatient services at various levels. Mental health services, for instance, are provided as an outpatient service at the district and provincial hospitals and on an inpatient basis at the regional level, if required.

The Essential Package of Hospital Services (EPHS) developed by the Hospital Management Task Force (HMTF) has three purposes:

1. Identify a standardized package of hospital services at the first three levels of hospital;
2. Provide a guide for the MoPH, private sector, nongovernmental organizations (NGOs), and donors on how the hospital sector should be staffed, equipped, and provided with materials and drugs;
3. Promote a health referral system that integrates the primary care Basic Package of Health Services (BPHS) with hospitals.

The EPHS defines, for the first time, all the necessary elements of services, staff, facilities, equipment, and drugs for District Hospitals (also included in BPHS), Provincial Hospitals, and Regional Hospitals in Afghanistan. The EPHS identifies, with tables, the following elements for each level of covered hospital so that the inputs or resources needed at each level may be easily compared:

- Diagnostic and treatment services for various conditions;
- Diagnostic tests;
- Staffing;
- Equipment and supplies;
- Essential drugs

The MoPH Hospital System is composed of four levels of facility; District Hospitals, Provincial Hospitals, Regional Hospitals, and National and Specialty Hospitals.

4.1 - District Hospitals: The district hospital brings professional inpatient and emergency services closer to the population in rural areas. Its priority role in supplementing health centers aims at reducing the maternal mortality rate (MMR), infant mortality rate (IMR), and under-5 mortality (USM). The District hospital is mainly an emergency hospital where patients are assessed, diagnosed, stabilized, and either treated or referred back to a lower level or referred to a higher level of health facility. Provision of 24-hour comprehensive emergency obstetric care service is a crucial aspect of a District hospital. District hospitals are typically staffed by junior general medical officers.

4.2 - Provincial Hospitals: The provincial hospital is the referral hospital for the provincial health system. It offers the same clinical services as a district hospital as well as adding a few more sophisticated services for diagnosing and treating various conditions and is usually staffed by
specialist doctors. In most cases, the provincial hospital is the last referral point for patients referred from the districts. In some instances, the provincial hospitals can refer patients to higher levels of care—to a regional hospital or to a National or Specialty Hospital in Kabul. The provincial hospital brings professional inpatient and emergency services closer to the population in rural areas.

4.3 - Regional Hospitals: The regional hospital is primarily a referral hospital with a number of specialties for assessing, diagnosing, stabilizing and treating, or referring back to a lower-level hospital. The regional hospital provides professional inpatient and emergency services at a higher level than is available at district or provincial hospitals.

4.4 - National and Specialty Hospitals: Hospitals at the fourth level (National and Specialty Hospitals) are intended to be referral centers for tertiary and secondary inpatient care and are located primarily in Kabul. They provide education and training for health workers and act as both referral hospitals for provincial and regional hospitals and as providers of all levels of inpatient care to residents in the capital city. National and Specialty Hospitals are required to conform to EPHS as a minimum level of care in each service area provided by the hospital. Advanced inpatient care (tertiary level) will be further covered by standards and protocols currently under development.

In addition to the MoPH Hospital System, other governmental hospitals are run by the Ministry of Education (medical school facilities), the Afghanistan National Army, and the Police. As these are the responsibility of other ministries they are not covered by this document.

Private Hospitals and Public/Private Partnership Hospitals are under the authority of the MoPH. As such they are covered by this document in a limited manner. With independent management structures these facilities are not subject to the MoPH restructuring efforts. They are however subject to MoPH regulation and quality supervision. As such they are covered under specific areas such as Licensing and Accreditation and Certificate of Need.

5 - Problems and Constraints

Hospitals are extremely complex structures which are challenging to run in even the best of circumstances. In the context of Afghanistan, the task of running hospitals that provide acceptable quality and quantity of services has proven beyond the means and resources of the Central Government.

The structure of the system in which hospitals must try to function has proven inadequate to the task of managing and maintaining the provision of health services. A human and financial resource poor Ministry of Public Health, despite the best efforts of its dedicated leadership and staff cannot provide the support that complex institutions require.

This problem of inadequate resources compounds an already sub-optimal system. World-wide experience has conclusively demonstrated that even in the best of circumstances a centrally managed and controlled hospital system is poorly suited to the needs of modern healthcare. The organizational complexity of hospitals, the diversity of services that must be provided and the constantly changing influx of people needing care requires a very high level of managerial and operational flexibility. It is literally the case that flexibility and the ability to respond rapidly to ever changing internal and external conditions make the difference between life and death.
Using drugs and medical supplies as but one example, it is clear to see that the absence of a life saving medication often means that a patient suffers or dies. In even a highly functioning centralized system time is wasted in replenishing missing drugs because restocking requests must be made to a remote central authority.

The key point is that even if the government of Afghanistan attains a level of wealth where vital supplies are no longer in short supply, the inefficiencies of central command and control will remain. In examining the problems and constraints facing Afghanistan’s Hospital Sector, it is very important to consider the nature of the system in addition to the shortages of resources and specific dysfunction. For this reason, the solution to be proposed in a Hospital Sector Strategy must seek to improve not only immediate concerns but to include structural changes that improve long term prospects.

6 - The Repeated Destruction of Management Systems and Capacity

The healthcare system of the Islamic Republic of Afghanistan, particularly the hospital sector, has gone through several devastating systemic shocks that have caused profound dysfunction. The Hospital Sector has been particularly vulnerable to these repeat assaults on structure, operations and management capacity because of the size and complexity of the institutions involved.

Over the past thirty years, there have been four traumatic occasions when government was radically altered and where management expertise and institutional memory were effectively eliminated. Each time a new system of government was established with a new cast of health sector leadership, a protracted period of on the job learning was necessary where a new group of ministry and hospital officials struggled to understand and gain control over the health system.

During these upheavals, hospitals continued to provide some level of care for the sick and injured, but in terms of operations, fell into lower and lower levels of dysfunction and increasingly inappropriate staff behaviors. At each point of traumatic transition, accepted behaviors of job performance and clinical quality declined with the new lows soon becoming the accepted norm. As new physicians, nurses, technicians and managers who lack prior experience entered the system, dysfunctional behaviors were learned and perpetuated.

Due to the protracted length of trauma and decline, few of the currently working physicians, managers or staff has ever experienced the level of quality that existed in Kabul’s hospitals prior to 1978.

When organizations (such as the MoPH or hospitals) fall to lower levels of quality or allow inappropriate behaviors to become established, poor performance soon becomes the “normal” way of doing business. Once established, such behaviors become extremely difficult to change.
A clear understanding of this repeated assault on capacity, institutional memory and worker behavior is essential in the effort to reform the healthcare system and bring about service quality improvements. Afghanistan is likely unique in this phenomena of Punctuated Equilibrium Systemic Decline.

Whereas most hospital and healthcare systems have experienced parallel growth and development processes in health facilities and central management capacity, one of the most insidious effects of war and strife in Afghanistan has been the repeated destruction of institutions. The loss of leadership staff and the disappearance of institutional memory effectively took MoPH and hospital management capacity to zero on a repeated basis. Meanwhile, hospitals continued to function as best as they could during these periodic upheavals. In essence, leadership and institutional regulation and control (Ministry and hospital management level) capacity started over from a zero baseline on several occasions. Each time this happened, new, lower quality operational patterns and behaviors became the established norm.

7 - Structural Disconnect Between Finance and Operations

The greatest single systemic problem in the Ministry of Public Health is the complete disconnect between operations and finance.

It is fairly common in non-reformed highly centralized national health systems for the operations side of the ministry and the managers of hospitals to be unable to significantly control or redirect the use of resources. In the most poorly developed centralized systems, hospital directors and those in the ministry with the responsibility of managing institutional operations are given annual budgets for consumables, investments and human resources but they are not given the power to change proportions or deployment. Despite this lack of control however, higher level directives and priorities are communicated through financial figures. In other words, the budget information that hospitals are given clearly spell out the resource limitations to be faced during the coming year and thus allow managers to plan activities accordingly.

In the unique situation of Afghanistan however, even this basic level of knowledge is withheld from those responsible for operations. Managers responsible for the National and Specialty Hospitals are asked to make decisions and to make requests for future allocations without any information on either the cost of inputs or the total (or even line-item) amount of resource that are available.

Each year hospital managers are required to prepare “budgets” that are largely fantasy. Each National and Specialty Hospital is required to make these projections and plans without essential information. Critically,

- The amount of funding that will be available is unknown;
- There is a complete absence of historical expenditure information (in other words, managers do not know what was spent during the prior year);
- There is a complete absence of cost data (the cost of services provided by the hospital is unknown)
There is a complete lack of price information (the prices for needed human resources, equipment, drugs or supplies are unknown).

Budgeting and financial management under these conditions is impossible.

Managers are asked to make improvements in operations and implement new procedures without the ability to redistribute resources. Lack of basic information also prevents leaders from making cost benefit estimates or from effectively considering opportunity costs.

This functional disconnect even extends to such financially driven activities as central human resources management. Central HR managers make personnel deployment decisions based on raw numbers and categories of workers without knowing funding totals for either the entire system or for individual hospitals. When upper level orders for reductions in staff are issued, gross numbers of non-categorized staff are given rather than budgetary goals. Not only does this make rational decisions on staffing of individual hospitals impossible, it also defeats efforts to control overall system wide costs.

8 - Human and Material Resource Problems

In order to improve services at National and Specialty Hospitals, critical limiting factors must be recognized and corrective actions must be planned accordingly.

- National and Specialty Hospitals are severely underfunded, under supplied, and lack the resources to make major changes;
- Donor support of this sector is very limited and unlikely to grow to levels needed to make major sector wide changes;
- Management capacity is insufficient to manage institutions as large and complex as the National and Specialty Hospitals;
- Central MoPH financial and management resources are insufficient to provide the support necessary for major structural improvements or adequate monitoring and supervision;
- Leadership and hospital staff are severely underpaid. Salary levels are below what is necessary for basic needs. Faced with very real and unrelenting shortages in income, staff members are placed in a state of untenable moral hazard. Illegal under the table demands for payments from patients or other forms of economic wrongdoing are the inevitable result.
- Infrastructure and material assets are in a state of major disrepair and continue to decline. A significant increase in repair and maintenance funding will be necessary to maintain even present levels of building and equipment function; Medical/technical skill levels are insufficient to implement widespread improvements in hospital care.
9 - Hospital Policies

The Hospital Policy for Afghanistan’s Health System was approved by the MoPH Executive Board in February 2004. This document specifies the services and structures of District, Provincial and Regional Hospitals. In addition, the Policy specifies:

a) Hospitals, as part of a unified national health system, will provide necessary curative and emergency services, which complement the Basic Package of Health Services that includes disability care, offered at basic and comprehensive health centers.

b) Hospitals must be rationally distributed so their services are accessible on an equitable basis for the entire population.

c) The MOH will carefully plan the number of hospitals, their location, hospital beds, and types of hospital beds to ensure that the resources committed to hospitals result in the maximum impact on the population’s health status. Because Afghanistan does not have unlimited resources to finance hospitals, so health planning, resource allocation and financial management of hospitals will be undertaken by MOH for the entire hospital sector as a means for maximizing the impact and effectiveness of hospitals on the country’s health status.

d) Provision of hospital care must be based on need for hospital care and not on ability to pay.

e) Hospitals must be managed in an efficient manner that adheres to basic clinical and managerial standards that ensure the provision of quality care to all patients, including patients with disabilities.

f) The proportion of the government’s annual operational budget for hospitals will not exceed 40% of the total health budget.

g) To ensure budgetary accountability and transparency, the MOH will develop the appropriate financial systems and develop proper mechanisms, such as empowering financial management of hospitals to their board of directors.

h) Equitable cost-sharing strategies which are appropriate for Afghanistan will be developed to help make the operation of hospitals more financially sustainable.

i) Hospitals also have a role within the health system to provide supervision of lower level health facilities, a place for professional training of physicians, nurses, midwives and other health providers as well as supporting necessary national medical and health systems research.

jj) Private hospitals are permitted and are part of the health system and must comply with all standards for providing good quality care, be accredited and adhere to all MOH policies.

In 2009 the MoPH developed the Policy for National and Specialty Hospitals that specifically addressed Afghanistan’s pinnacle Secondary and Tertiary Hospitals located in Kabul (although future classification of a hospital located outside of Kabul as a National or Specialty Hospital is allowed). This document calls for these hospitals to become autonomous organizations governed by boards of directors. The Policy also calls for hospitals to become accredited once such as system is developed.

National and Specialty Hospitals are to serve as the ultimate level in a national referral system and are to provide tertiary level services when internal capacity has reached that point.

National and Specialty Hospitals are subject to the requirements of EPHS as a minimum and to exceed these levels when possible. Specialty Hospitals are only required to meet or exceed EPHS in those medical technical areas provided.
10 - Vision for Afghanistan’s Hospitals

All Hospitals in Afghanistan, whether Public, Private or Charity shall strive to provide inpatient and outpatient services that achieve the maximum possible reduction in morbidity and mortality. As long as needs are great and wealth is small, decisions affecting the use of all human and material resources will be based on sound public health priorities and cost effectiveness.

While reducing maternal and child mortality will remain the highest priority and equity for the poor will always be sought, hospitals will dedicate themselves to the ideal that suffering and premature death must be reduced for all human beings.

Hospitals require urgent and sustained improvement and the implementation of essential operational systems. Although present operating levels are very low, capacity to absorb and implement improved systems is extremely limited. Improvement programs must therefore be tailored to this reality. All implemented procedures and systems must achieve easily perceived benefits while moving staff to ever increasing levels of performance.

Because of the widespread need for improvement, the large numbers of facilities and staff involved and the scarcity of implementation and training funding, implemented procedures and systems must be simple enough to be put in place with a minimum amount of outside technical support. Further, there is considerable benefit to “learning by doing.”

11- Core principle:

In viewing the content of this Hospital Sector Strategy three principles will need to be diligently followed:

- Reality is what it is: understanding and acknowledgement is essential;
- Problems are many and human capabilities are limited: some problems will need to be “let go” for the present;
- Whatever is done must be within the existing capabilities of human and material resources.

A core principle to be followed in all hospital improvement programs must be: Simple systems implemented on a phased basis with incremental and continual increases in complexity and effectiveness, and, the building of capacity through the implementation of manageable systems.

In other words, all improvement processes chosen for implementation must be doable by present staff with a minimum of training and must provide successful experience with on-the-job learning. Visible benefits must result from early and continued success. Staff abilities should be challenged and stretched but never exceeded. Overly complex or ambitious systems and procedures will fail to produce noticeable benefits while instilling a sense of failure or futility in hospital staff.
Transparency Based Decentralization is fundamental to all Hospital Sector improvement efforts. All financial and procurement transactions will be carried out in front of multiple witnesses which shall include persons without a financial interest in the transaction and the end users/Recipients of the procured items.

Central control of finances and resources has failed because it is unresponsive to the day-to-day needs of complex organizations such as hospitals and prevents the efficient and effective provision of patient care services. It has also failed because the central control of financial assets carried out “behind closed doors” has resulted in an apparent massive disappearance of resources.

Financial and procurement control and functions shall be moved to the hospitals themselves in order to allow rapid response to the ever changing needs of complex patient care. Resource utilization decisions must be made by those responsible for service provision.

Further, the potential for corruption in the performance of financial and procurement functions shall be greatly reduced by the institution of Sunshine Directive safeguards (see Section 7 Autonomy). The core idea behind this safeguard is that multiple witnesses to the management of funds and the decision making process will discourage persons involved from diverting or stealing funds.

A core philosophy behind this safeguard is the belief that most people are honest and most healthcare workers want to provide good services to people who are sick and dying. It is acknowledged that some amount of theft will occur as no system is foolproof, but the majority of funds will be used for their intended purposes because of the basic good will of healthcare workers and the great difficulty of hiding illegal transactions in a transparent system.

12 - Strategic Goal

Successful implementation of modest improvements will provided the motivation that is essential to move staff towards increased productivity.

13 - Implementation Risk Analysis

The move to autonomy for National and Specialty Hospitals represents a major change in the hospital system and a complete rethinking of the basic rules under which hospitals operate. As with any major structural change there is the potential for problems to develop. It is certain that a number of challenges will arise during the transition period but with careful adherence to the Progressive Hospital Autonomy Procedural Manual and the maintenance of good will and cooperation between all involved parties these challenges will be overcome.

A critical idea that must be followed in order to assure the ultimate success of this or any other major change activity is that risks and problems must be not only anticipated and prevented
whenever possible, but when problems do occur, the hospitals must immediately develop and implement recovery measures.

To be clear, problems will occur and things will go wrong. This is inevitable in any major program. The difference between success and failure is not simply the avoidance of problems but how committed the hospital is to detection of errors, taking responsibility for problems and implementing recovery measures. Hospitals and their guiding ministries (MoPH, MoF) must adopt the attitude and perspective that problems are to be solved and that help should be given to those making errors. Things that go wrong should be seen as learning opportunities rather than occasions to place blame or punish wrongdoers.

In order to best prepare to overcome challenges it is helpful to examine the areas where potential problems are most likely to occur and those possible risks that pose the greatest threat to success in this process. Potential risks fall into three major areas:

1. Financial
2. Operational
3. Political
4. Hospital management capacity Risk

Risks in each of these areas have elements that are within the control of the hospitals themselves and elements that are outside of the hospitals influence. It is therefore important to understand both the nature of the risk and the source of threats in order to plan for prevention and recovery.

**13.1. Financial Risk**

Problems with corruption have been a major concern in Afghanistan’s Public Sector. While the actual extent and breadth of corruption his difficult to determine, perception and fear that it is massive and omnipresent has resulted in the implementation of control measures that are often harmful and in fact make situations worse. This is particularly evident in the areas of procurement of goods and services. The result has been the development of overly centralized procurement rules and structures that perform poorly in terms of operational support and that are opaque to the point where goods and moneys are unaccounted.

A perceived risk of autonomy is that by moving financial management and procurement to the hospitals and out of central control, corruption will increase. While this is possible, it is not likely and is highly controllable. Corruption can only exist where wrongdoing can be done out of sight. If hospitals implement *Sunshine Directives* in financial management and in procurement, instances of theft or misuse of funds will not only be rare, but they will be quickly uncovered. As this system depends on financial transactions to be carried out in front of multiple witnesses and for several layers of managers and end users to be aware of procurement decisions and activities, problems that do develop should become quickly evident.

A greater risk than intentional corruption and theft will likely be loss or misuse of funds due to errors and poorly implemented procedures. There is very little experience managing money in hospitals. It is therefore highly likely that mistakes will occur. It is extremely important that when errors are found efforts are aimed at fixing procedures and teaching those involved how to avoid the error in
the future. A huge mistake would be to assume that instances of missing or misused money is due to corruption when it is far more likely to be the result of human error or improperly implemented systems.

This risk of unjust prosecution for financial errors is very real and must be avoided at all costs. Tragedies in this area will be avoidable if hospitals and guiding ministries are committed to the belief that financial problems are more likely to be caused by error rather than theft. It is therefore critical that when problems are discovered efforts are aimed at determining the source of the error and implementing a recovery plan to teach better practices and fix broken systems.

13. 2. Operational Risk

The greatest risk in terms of hospital operations and patient care delivery is that improvements will fail to materialize quickly or sufficiently. As recent experience in a National Hospital receiving a substantial investment in donor funds and outside technical assistance has demonstrated, failure to win over hospital physicians and staff to the new program will have devastating consequences. Risk of failure in this regard will be great if hospital leadership and the MoPH do not completely involve physicians and staff in the implementation of autonomy, develop implementation strategies and systems in collaboration with these key persons and develop an active and ongoing partnership where commitment is built and valued between all parties.

In the case of the National Hospital that is not achieving expected improvements, the relationships that are so important to making progress deteriorated into us versus them struggles, blaming, and in some cases outright obstruction. As an example, senior physicians have offered training programs and have been expected to follow new hospital procedures. Resistance to these efforts has been substantial. It is not only that programs have been brought in from the outside and presented to these senior physicians, but also these programs do not address the key structural problems that prevent good practices from occurring.

To mitigate this risk, it is critical that hospital leadership, physicians and staff work together to implement autonomy and that solutions are developed jointly to the structural problems that make quality patient care almost impossible. For example, it is clear that salaries paid by the civil service are not adequate. Even if physicians wanted to practice exclusively in the hospitals they are unable to do so and still feed their families. Conversion to autonomy will allow hospitals to pay higher salaries but this alone will likely be insufficient. Other solutions will be required to address this complex issue and these solutions can only be developed through a collaborative process where physicians feel that they are in a true partnership with the hospital.

13.3. Political Risk

The political system of the Islamic Republic of Afghanistan is in a state of flux and is highly unpredictable. As result of multiple factors, the Parliament will pose a considerable risk to the functioning of the health care system as a whole and to the newly autonomous hospitals. Although members of Parliament likely want good things for the people of Afghanistan, a lack of knowledge about the functioning of health care delivery as well as poor understanding of finance and administration means that even the best of intentions can result in very damaging legislation.
Mitigation of this very considerable risk must come in two areas. The fist of these is education and lobbying of members of Parliament by health experts from the public and private sectors. Only a concerted effort by health care professionals as well as financial and economics experts can increase the knowledge and understanding of Parliament members in complex health and hospital issues.

The second area where risk can be minimized is for the MoPH, the MoF, and the MoJ to make maximum use of regulation to control the functioning of the health and hospital sector. Although regulations (which are created and enforced by the ministries) are subject to limits posed by legislation (laws created and/or approved by the Parliament), most operational issues can be addressed in this manner.

Whenever possible, the functioning of hospitals and particularly the implementation of autonomy should be done through regulation and avoid any involvement of Parliament. As more issues are controlled through regulation, the risk of negative outcomes because of ill informed decisions by members of Parliament who lack the technical knowledge to make sound decisions is decreased substantially.

13. 4. Hospital management capacity Risk

The low capacity at the hospitals itself would stands as a challenge for implementation of the hospital sector strategy. Currently there is some evidence that the efforts for improving the quality of care at hospitals has vanished as result of the low management capacity of hospital team. Poor coordination, un clarity on rules and responsibilities, un transparent financial and procurement system and low knowledge of data and information are the common problems at the hospitals.

Knowing the reality of current situation at the hospitals this point has been taken into consideration based on learning by doing principle. While proficient technical back up is recommended for implementation of hospital autonomy this would be an useful approach to enable the hospital management team to run the hospitals on an effective manner. Also gradual adaptation of hospital autonomy would avail the opportunity to simultaneously practice and enhance the learning skills of hospital management teams.

14 - Strategy Components

The first step in solving any problem is an honest acknowledgement of the extent of the problem and an understanding of its complexity. Next, a realistic vision of steps that can be taken given existing resources to improve the situation is needed. The goal of the Hospital Sector Strategy is to provide such vision.

All problems cannot and will not be solved at once. Even if huge investments of additional funds would be made, the extent of problems faced would make improvements slow and difficult.

It is essential that problems are tackled in a manageable manner and that initiatives are within the technical competence of existing staff. This Sector Strategy outlines basic initiatives for improving
the hospital sector. Each section outlines the state of operations that are desired then lists realistic steps for gradual and continuous improvement.

In some areas progress may be faster than outlined. In other areas challenges will prove more difficult and a plan for slower progress or a different approach will be necessary.

14 – 1: Autonomy hospitals shall be granted increasing levels of autonomy with the end goal of becoming state owned fully autonomous institutions.

14 – 2: Tassadyha Daulatee Ghairy Muntafay In accordance with the laws of Afghanistan, autonomous hospitals will be chartered as Non-profit State Owned Enterprises. This legal restructuring (to be carried out first in National and Specialty Hospitals and eventually in other government hospitals as appropriate) will place these facilities under the Law for State Owned Enterprises and thus confer the organizational structure of a fully autonomous entity with full control over human and material resources. Hospital Charters will include a binding clause specifying that the move to full autonomy will be carried out on a phased basis as hospital capacity allows.

14 – 3: Budget Based Management hospitals will eventually have complete control over all resources including those generated by user fees and those coming from the National Budget. The use of financial resources will be based on prioritized needs planned, managed and monitored through an active budgetary process. As capacity for financial management increases, the budgetary process will involve additional management levels eventually reaching the department and service level.

14 – 4: User Fees will be collected for appropriate services at National and Specialty Hospitals. The user fee system will start on a simple basis with the collection of a modest simple fee for all outpatient services. As capacity is increased to collect, manage and utilize funds, additional fees for diagnostic services and select hotel services will be implemented. Eventually a complex user fee schedule will be developed and implemented for tertiary and select secondary care services. Certain protected services such as cesarean sections shall forever remain free to all patients.

14 – 5: Independent Governance starting with community boards and progressing to fully engaged boards of directors, legal operational control of hospitals shall move from the Central MoPH and become vested in legally constituted Boards of Directors responsible to the citizens of Afghanistan. The MoPH will assume a stewardship role rather than retain direct management control.

14 – 6: Financial and Managerial Transparency will be practiced in the management, procurement and use of all tangible resources including financial resources. Complete transparency shall be achieved through implementation of the Sunshine Principle which will discourage corruption and lead to the investigation of possible financial misconduct.

14 – 7: Information Gathering and Utilization will be used in the management of all hospitals, the control of all finances, and the improvement of clinical practices. Data collection and utilization will be started on a limited basis with the initial system being within the capacity of existing hospital staff and resources. As success is gained in information use, increasingly complex indicators will be introduced. The eventual goal is the implementation of a comprehensive Hospital Information System (HIS) at all facilities.
14- 8: **Prioritized Resource Utilization** hospitals will use Rational Prioritization methods to plan and implement the procurement and utilization of all material and (eventually) human resources. This approach is based on the principle of achieving the greatest possible reduction of morbidity and mortality with available resources. Rational Prioritization will be conducted using the Prioritization Matrix System which is based on cost efficiency and public health benefit.

14 – 9: **Hospital Drug and Therapeutics Committees (DTCs)** the creation of DTCs will be required in the Charter for each Non-Profit State Owned Enterprise Hospital. Each DTC will work to improve the use of medications within the hospital through the examination of practices within the facility and through the adoption of best practices acquired from other Afghan and International hospitals and through the MoPH.

14 – 10: **Continuing Medical Education (CME)** will be required of all medical staff of NPSOE Hospitals. The MoPH shall collaborate with the medical colleges and the Ministry of Higher Education to develop an obligatory program of physician and nurse continuing education. Until such a national program is developed, NPSOE Hospital Charters shall require that all physician and nursing staff are provided with educational materials such as printed handouts or bound documents selected by the hospital’s DTC to cover improved medication use practices.

13 – 11: ** Licensing and Accreditation** all hospitals in the public and private sectors will be licensed for operation and may not open or continue to remain open without a valid hospital license. Hospital Licensing will be the responsibility of the MoPH. An Accreditation System based on Tiered Standards will be created and function under an autonomous body made up of government and private sector representatives. After gaining an initial license to open and operate issued by the MoPH, continuation of the license will be contingent on achieving and maintaining accreditation. At the present time, only private hospitals will be required to obtain a license to open and operate. Public hospitals shall eventually be required to obtain a license once they have achieved autonomous status. All hospitals shall be required to seek and maintain accreditation once the accreditation system is functional.

14 – 12: **Hospital Access and Population Coverage Plan/Certificate of Need** large sections of Kabul are without adequate hospital coverage while the central core of the city has a high concentration of facilities. Based on an assessment of population distribution, new hospitals (government or private) must be located in areas currently underserved by existing facilities and not located in the central area of the city. Before any new hospital (public or private) is built, a Certificate of Need must be issued by the MoPH. Any entity, whether for-profit private, charity private, or the MoPH itself that wishes to open a new hospital must submit a detailed proposal showing 1) the exact physical location of the proposed facility, 2) a map of all existing hospitals within a 3 kilometer radius of the proposed facility, 3) a listing of all specialty and general hospital services provided by existing hospitals within the 3 kilometer radius, 4) a listing of the number of beds and type and ratio of specialty and general services that will be offered by the new hospital, and 5) an assessment of actual need for these services at the proposed location. The MoPH will evaluate the proposal and if appropriate issue a Certificate of Need authorizing the proposing organization to begin construction.

14 – 13: **A Fully Functioning National Referral System** that assures that patients from across Afghanistan are cared for in the appropriate level of facility ranging from rural primary care centers
up through District, Provincial and Regional Hospitals and culminating with the National and Specialty Hospitals.

14 – 14: Improved Human Resource Management is essential to the provision of quality hospital services. One of the most critical elements of HR management is assuring that adequate trained staff are present and working in hospitals twenty four hours per day, 365 days per year. Staff present at the facility must have appropriate technical skills and must be assigned clear duties. Sufficient numbers of staff must be present to meet the needs of patient care at all times.

14 – 15: Secondary and Tertiary Services will be provided at National and Specialty Hospitals as soon as clinical and financial systems become strong enough to support them. The eventual long-term goal is for the provision of high quality and high technical level services so that citizens of Afghanistan will no longer need to travel to other countries to receive sophisticated high quality medical care. It is important to understand that most hospital services obtained by Afghan citizens in other countries are at the Secondary Level. Priority must be given to improving the most common levels of inpatient care. When high quality secondary care services are widely available in Afghanistan, few people will travel to other countries for hospitalization.

14 – 16: Public/Private Partnerships (PPP) will be sought for the improvement of health care service delivery in a manner that minimizes the cost to the MoPH and that provides a sound business or charity service opportunity for private partners from the NGO (charity) and the for-profit sectors. As the resources of the MoPH are extremely limited and insufficient for existing public commitments, the participation of the MoPH in any PPP should be the way that maximize benefit of government resources (land, buildings, equipment) in order to improve the health of the people. In light of the scarcity of government funding, PPPs must not become a subsidy to the private sector. In any potential PPP, the private partner shall be responsible for proposing the scope and technical specifications for the use of the government resource and the MoPH will be responsible for evaluating the bids and technical proposals and for awarding contracts and/or leases. In the case of a highly sought resource where multiple private partners express interest in a resource then a formal bidding process will be implemented. In the case of a resource where potential qualified private partners are limited (such as in the case of Jamhuriat Hospital) then sole source non-competitive proposals will be sought and evaluated on their individual merit.

15. Objectives:

15 – 1: Autonomy

- Hospital Autonomy will be introduced on a phased basis as outlined in the Procedural Manual;
- All hospitals in Afghanistan will eventually become fully autonomous;
- National and Specialty Hospitals will be the first to become autonomous on a phased basis;
- Hospital Reform Project Hospitals will begin the transition to autonomy on a phased basis (as appropriate according operational status) after the first group of National and Specialty Hospitals has begun the conversion to autonomous status;
• Other Regional, Provincial and District Hospitals operating under the authority of the MoPH will be converted to autonomous status as appropriate according to experience gained in National, Specialty and Hospital Reform Project facilities.

15 – 2: Tassadyha Daulatee Ghairy Muntafay

• The purpose of hospital autonomy is to create state owned non-profit organizations where operational authority is located within the institution itself and where the management staff of the organization can respond rapidly and effectively to daily as well as unplanned needs of the institution;

• State owned non-profit enterprises must be chartered according to the laws of Afghanistan; as such, the organizational structure of these autonomous hospitals shall be in a legal form known as Tassadyha Daulatee Ghairy Muntafay

15 – 3: Budget Based Management

• Hospitals will be managed on the basis of full financial knowledge. In the immediate term, all financial information such as actual budget allocation, the MoPH and the MoF will provide budget utilization and complete historical expenditure records to hospitals.

• Fully functional accounting systems will exist in all hospitals

• Hospital Management Teams will be skilled in financial management

15 -4: User Fees

• User Fees will be collected by hospitals to supplement their annual budget allocations. User Fees will initially be collected for outpatient services at National and Specialty Hospitals.

• Additional fees will be collected for other services as hospital capacity for collection, accounting, and financial management become capable.

• User Fees will eventually include a complex fee schedule for diagnostic and curative services when cost data becomes sufficiently available.

15 – 5: Independent Governance

• Community Boards will be developed in autonomous hospitals as an initial step in conversion to Tassadyha Daulatee Ghairy Muntafay. These community Boards will be involved in establishing and maintaining transparency for all finance related activities.

• Full-fledged Boards of Directors will assume control of all governance activities in fully autonomous hospitals.

15 – 6: Financial and Managerial Transparency

• The Hospital Management Team carries out planning and utilization of the hospital budget. Department directors participate in the budget development process and are informed of utilization activities. Community Boards actively review activities and progress.
• Management and utilization of all funds generated by or given to the hospital are carried out under the *Sunshine Directive*.

• All procurement activities are carried out in accordance with the *Sunshine Directive*.

15 – 7: Information Gathering and Utilization

• Regular and reliable utilization data will be collected by hospitals. Hospital Management Teams will base resource allocation decisions on the basis of financial and utilization data.

15 – 8: Prioritized Resource Utilization

• All procurement decisions are made on the basis of rational prioritization that is conducted using the Prioritization Matrix System.

15 – 9: Hospital Drug and Therapeutics Committees (DTCs)

• Hospital Drug and Therapeutics Committees will be formed in all autonomous hospitals and will actively guide the procurement, storage, dispensing and utilization of all drugs administered.

• On a monthly basis, DTCs will randomly select and review medical records of 10% of all patients treated at the hospital to determine that the all drugs prescribed at the hospital are in compliance with DTC utilization guidelines.

15 – 10: Continuing Medical Education

• A system of Continuing Medical Education is essential to the provision of diagnostic and curative services at an acceptable level of quality. A National System of obligatory CME must be established for all physicians and nurses as soon as possible.

• All autonomous hospitals must institute an in-house CME program that will be obligatory for all medical staff.

• As a first step, CME programs will be based on the protocols and procedures developed or selected by the hospital’s DTC.

15 – 11: Licensing and Accreditation

• All private hospitals are licensed to operate.

• All hospitals (government, private, PPP) are accredited according to the requirements of the Accreditation Organization.

15 – 12: Hospital Access and Population Coverage Plan/Certificate of Need

• A *Certificate of Need* (CON) is issued by the MoPH before any new hospital is built.

• All new hospitals will be located in areas that are in need of medical services and not be located in close geographic proximity to existing hospitals where an adequate volume of care is available for the local population.
• Medical Specialty Services will be distributed according to the needs of local populations. Particular emphasis will be given to assure that secondary level obstetrics and pediatrics services are available in all areas with sufficient population.

15 – 13: A Fully Functioning National Referral System

• The National Referral System Policy has been approved by the MoPH Executive Board
• The MoPH has sought input from all hospitals under its control for information on present referral practices.
• The MoPH has developed a grid showing all hospitals and indicating which hospitals will refer to which higher level or specialty hospital.
• Regional committees consisting of representatives of all local hospitals will gather to develop agreements for referrals in compliance with the National Referral System Policy

15 – 14: Improved Human Resource Management

• All Hospitals have functioning Shift Systems in place and operational to assure staff coverage that is adequate at all times.
• Hospitals select their own staff according to needs levels determined by the Hospital Management Team.
• After full autonomy is granted to the hospital, staff will become employees of the hospital itself for the purposes of selection, evaluation, promotion and dismissal. Salaries for individual staff members will be determined by the hospital in compliance with MoPH guidelines.
• Staff Pensions will remain the responsibilities of the Government of Afghanistan and will be provided through the Civil Service Ministry.

15 – 15: Secondary and Tertiary Services

• Priority will be given to the provision of high quality hospital inpatient services (Secondary Care).
• Tertiary Services will be developed when adequate support services are fully functioning and when national resources are sufficient.

15 – 16: Public/Private Partnerships (PPP)

• Public Private Partnerships are developed by the MoPH in collaboration with private partners to provide improved health services to the population.
• PPPs are developed using the government property or resources on a way that the benefit of these resources can be maximized for improving health of the people.
• PPPs are financed by the private partner and do not use resources that are needed by government facilities.

**16: Implementation**

The following dates are targets for implementation. It is understood that unforeseen events may result in adjustments to the actual implementation schedule.

**16 – 1: Autonomy/Tassadyha Daulatee Ghairy Muntafay**

• National and Specialty Hospitals will be the first to become autonomous on a phased basis; Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals will be the first three hospitals to be re-chartered as autonomous starting in Jun. 2011.

• Other National and Specialty Hospitals will be convert to autonomy starting in Jun. 2012.

• Hospital Reform Project Hospitals will begin the transition to autonomy starting in Oct 2011.

• Other Regional, Provincial and District Hospitals operating under the authority of the MoPH will be converted to autonomous status as appropriate according to experience gained in National, Specialty and Hospital Reform Project facilities.

**16 – 2: Budget Based Management**

• Full and complete copies of all records of historical expenditures will be turned over to the Hospital Management Teams of National and Specialty Hospitals by Oct. of 2011.

• National and Specialty Hospitals will be managed on the basis of full financial knowledge by Sep. of 2012. In the immediate term, all financial information such as actual budget allocation, the MoPH and the MoF will provide budget utilization and complete historical expenditure records to hospitals.

• Fully functional accounting systems will be developed in National and Specialty Hospitals starting in Jun 2011 and completed by Sep of 2012.

• National and Specialty Hospital Management Teams will be trained in financial management starting in Sep of 2011.

• Hospital Reform Project Hospitals will finish implementing Budget Based Management by Dec. of 2012.

• All other hospitals under MoPH control will begin the process of implementing Budget Based Management systems in next three years.

**16 – 3: User Fees**

• User Fees will initially be collected for outpatient services at National and Specialty Hospitals. Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health
Hospitals will begin collecting User Fees in Jun 2011. Other National and Specialty Hospitals will begin collecting User Fees for outpatient services beginning in Dec 2011. Hospital Reform Project Hospitals shall begin collection fees for outpatient services in Dec 2011.

- Additional fees will be collected for other services as hospital capacity for collection, accounting, and financial management become capable. Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals should begin collecting additional fees in Feb 2012. Other National and Specialty Hospitals shall begin expanded User Fee collection in Jul. 2012. Hospital Reform Project hospitals shall begin expanded User Fee collection in Jul. 2012.

- User Fees will eventually include a complex fee schedule for diagnostic and curative services when cost data becomes sufficiently available. (anticipated for May 2012 in National and Specialty Hospitals)

16 – 4: Independent Governance

- Community Boards will be established at Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals in May 2011. Community Boards will be established in the remaining National and Specialty Hospitals in Dec 2011.

- Full-fledged Boards of Directors will be established at Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals in Apr 2012. Boards of Directors will be established in the remaining National and Specialty Hospitals and in Hospital Reform Project Hospitals in Apr 2013

16 – 5: Financial and Managerial Transparency

- Community Boards are full participants in assuring financial management transparency at Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals in Jun 2011. Community Boards are full participants in assuring financial management transparency in the remaining National and Specialty Hospitals in Dec 2011.

- Sunshine Directive procedures are in place in all National and Specialty and Hospital Reform Project Hospitals in May 2012.

- Sunshine Directive procedures have been implemented in all hospitals under MoPH control by December of 2015

16 – 6: Information Gathering and Utilization

- Regular utilization data collection is implemented in National and Specialty Hospitals by Jul of 2011. Utilization data is collected on a regular basis in all hospitals under the control of the MoPH by January of 2012.

16 – 7: Prioritized Resource Utilization
• All procurement decisions are made on the basis of rational prioritization that is conducted using the Prioritization Matrix System in National and Specialty Hospitals by Sep of 2011 and in all hospitals under the control of the MoPH by May of 2012.

• A Procurement Review Committee made up of Department Heads will be formed in National and Specialty Hospitals by Aug of 2011 and in all hospitals under the control of the MoPH by May of 2012. This committee will be responsible for reviewing all procurements of medicines, supplies, equipment and services on a bi-annual basis.

16 – 8: Hospital Drug and Therapeutics Committees (DTCs)

• Hospital Drug and Therapeutics Committees will be established at Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals in Jun 2011. DTCs will be established in the remaining National and Specialty Hospitals and at Hospital Reform Project Hospitals in Dec 2011. DTCs will be established in all hospitals under the control of the MoPH by May of 2012.

• Monthly reviews of medical records of 10% of all patients treated at the hospital will begin at Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals in Jul 2011. DTC reviews of medical records will begin in the remaining National and Specialty Hospitals and at Hospital Reform Project Hospitals in Feb 2012. DTC review of medical records will begin in all hospitals under the control of the MoPH by February of 2012.

16 – 9: Continuing Medical Education

• A CME program based on DTC protocols and procedures will be established at Wasir Akbar Khan, Malali Maternity and Indira Gandhi institute for Child Health Hospitals in Jul 2011. CME programs will be established in the remaining National and Specialty Hospitals and at Hospital Reform Project Hospitals in Feb 2012. A national CME program that is obligatory for all physicians and nurses will be established by the MoPH by January of 2013.

16 – 10: Licensing and Accreditation

• The MoPH will establish a functioning system of Private Hospital Licensing by Sep. of 2011.

• All Private hospitals will be registered with the MoPH by Oct. of 2011 if they are to be eligible for “Grandfather” licensing status.

• Private hospitals not licensed by January of 2012 will be closed.

• A functional Accreditation Organization will be established by February of 2012.

• All hospitals must be inspected for accreditation by November of 2013.
16 – 11: Hospital Access and Population Coverage Plan/Certificate of Need

- The MoPH has established a Department under the General Directorate of Curative Medicine that is responsible for reviewing all applications for new hospitals and for issuing CONs for all approved hospitals by Jun of 2011.

16 – 12: A Fully Functioning National Referral System

- The National Referral System Policy has been approved by the MoPH Executive Board by Aug 2011.
- The MoPH has sought input from all hospitals under its control for information on present referral practices by December 2011.
- The MoPH has developed a grid showing all hospitals and indicating which hospitals will refer to which higher level or specialty hospital by March 2012.
- Regional committees consisting of representatives of all local hospitals will gather to develop agreements for referrals in compliance with the National Referral System Policy by June 2012.


- All National and Specialty Hospitals as well as all Hospital Reform Project Hospitals will have functional Shift Systems implemented by Jul of 2011. All other hospitals under the control of the MoPH will have Shift Systems implemented by Dec 2011.
- Implementation of personnel management will follow the time schedule for the implementation of autonomy with National and Specialty Hospitals followed by Hospital Reform Project Hospitals and lastly by all other hospitals.
- Personnel management functions will shift to the hospitals on a phased basis. Partially autonomous hospitals will initially review the performance of staff and make staffing requests to the MoPH. This will be followed by the selection and refusal of personnel proposed by the MoPH.
- As soon as complete hospital budget allocations (including funds for staff salaries) are issued to the hospitals on an annual basis, all other human resource management functions will be assumed by the individual hospitals.

16 – 14: Secondary and Tertiary Services

- The National Institute of Public Health will conduct a survey of people leaving Afghanistan to seek medical care in other countries. The aim of this survey will be to determine the types of services being sought and the proportion of medical tourists seeking care at the primary, secondary and tertiary levels by Sep 2011.
- A list of services for priority improvement will be developed based on the results of this survey.
• All hospitals (autonomous and non-autonomous) will be required to concentrate improvement efforts of these services.

16-15: Public/Private Partnerships (PPP)

• The MoPH will review the PPP Policy by Jun 2011 and assure that it states clearly that PPPs will use of the government property or resources on a way that the benefit of these resources can be maximized for improving health of the people.

• Existing PPP agreements will be reviewed at the end of their term to see that they comply with the above requirements.

17 - Monitoring and Evaluation

Implementation of Hospital Sector Strategy components will be monitored and evaluated by the MoPH as part of its Stewardship role. The following indicators will be used to determine if systems have been successfully implemented in hospitals. These indicators will apply to all level hospitals on the basis of the schedule of implementation outlined in the previous section.

17 – 1: Autonomy/Tassadyha Daulatee Ghairy Muntafay

• Autonomous hospitals are functioning under the legal charter of Tassadyha Daulatee Ghairy Muntafay.

• Autonomous hospitals receive yearly budget allocations from the MoF and are able to use that budget according to their self-determined needs.

• Autonomous hospitals control and manage human, financial, capital and material resources independently

• The MoPH no longer controls hospital operations but does monitor and review activities as part of the Stewardship process.

17 – 2: Budget Based Management

• Hospitals have ready access to all financial documents and data. Copies of all documents and data are located in the hospitals.

• Hospitals make all resource allocation decisions based on full financial information.

• Fully functional accounting systems exist where all income and expenditures are fully recorded and monitored. Results and summaries are provided to Hospital Management Teams on a weekly basis.

• Hospital Management Teams understand the principles of financial management and are able to demonstrate proficiency in reading and using all finance and accounting documents and data.
17 – 3: User Fees

- User Fees are collected for outpatient services.
- Additional fees are collected for other services.
- Complex fee schedules for diagnostic and curative services based on actual cost data exist.

17 – 4: Independent Governance

- A partially autonomous hospital has established a Community Board which is fully involved in monitoring finance and procurement activities.
- A fully autonomous hospital has established a Board of Directors which functions as the ultimate authority for operations and management. The Board of Directors has delegated day-to-day management authority and responsibility to the Hospital Management Team.

17 – 5: Financial and Managerial Transparency

- Hospitals are functioning under Sunshine Directive procedures. There are no substantiated instances of theft or inappropriate diversion of resources found during annual reviews of hospital finances by the MoPH and the MoF.

17 – 6: Information Gathering and Utilization

- Utilization data reports are available and used at all meetings of the Hospital Management Team. Summary data reports are presented at all meetings of Community Boards and Boards of Directors.

17 – 7: Prioritized Resource Utilization

- Bi-annual reviews of all drug, supply, equipment and service procurements conducted by the hospital’s Procurement Review Committee show that at least 80% of all items purchased conform to the principles of the Prioritization Matrix System.

17 – 8: Hospital Drug and Therapeutics Committees (DTCs)

- The Hospital has a functioning DTC that meets at least on a monthly basis
- At least 80% of drugs prescribed at the hospital (whether provided by the hospital or purchased by the patient at an outside pharmacy) comply with DTC protocols and procedures.

17 – 9: Continuing Medical Education

- Personnel files for all physicians and nurses contain written evidence that the staff member participated in CME at least once per year.

17 – 10: Licensing and Accreditation

- 80% of all private hospitals have been registered by March of 2011
• All operating private hospitals are licensed after August 2011
• All operating hospitals are accredited after May of 2014

17 – 11: Hospital Access and Population Coverage Plan/Certificate of Need
• All new hospitals are issued a CON prior to construction

17 – 12: A Fully Functioning National Referral System
• The MoPH has developed a grid showing all hospitals and indicating which hospitals will refer to which higher level or specialty hospital.
• Regional committees consisting of representatives of all local hospitals will gather to develop agreements for referrals in compliance with the National Referral System Policy.
• Regional Referral agreements exist.

• All hospital departments are covered by adequate numbers of trained staff 24 hours per day, 7 days per week, 365 days per year. (indicator will be verified by compliance to Shift System guidelines for the individual hospital)
• Fully autonomous hospitals have complete hire, fire, evaluation and salary authority on all staff.
• Retiring hospital staff receive a government pension equivalent to other personnel of equal rank and seniority from other ministries.

17 – 14: Secondary and Tertiary Services
• The number of medical tourists seeking care at hospitals outside of Afghanistan has been reduced by 25%

17 – 15: Public/Private Partnerships (PPP)
• All PPP agreements will be reviewed to determine that the government contribution is limited to use of the government property or resources on a way that the benefit of these resources can be maximized for improving health of the people.