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Evaluating the Nature and Extent of Autonomy in Public Teaching Hospitals: A Case study of Jinnah Hospital Lahore

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Abstract

This study is aimed at evaluating the nature and the extent of Autonomy in Hospital Administration and Medical Care. Autonomy in administration means the freedom in deciding all the matters involved in the day-to-day running of the hospital and the discharge of the functions defined by the mission statement. Autonomy in Medical Care was meant to provide efficient services to patients at autonomous hospitals. The population of this study consists of top level administrative medical and non-medical staff of Jinnah Hospital, Lahore. In this research design, Jinnah Hospital Lahore is selected as a single case and then multiple sub units of analysis are selected from top management of Jinnah Hospital Lahore to get information about nature and extent of autonomy. In this way with the support and cooperation of respondents, 14 top level administrative medical and non-medical staff members of Jinnah Hospital Lahore were interviewed. This study shows that autonomous hospital is not independent in making its decisions due to the increased role of health and finance department. Most of the matters concerning hospital administration and developing medical care tools are managed with the final approval of health department.

Key Words: autonomous hospital, health reforms, nature of autonomy, extent of autonomy, public hospitals,

Introduction

Health plays a primary role in developing of the human capital of a nation. Better health enhances the efficiency and the productivity of the labour force. (Schultz, 1961). Governments are investing a major portion of its health sector budget in improving the service delivery of the hospitals (Strauss, 1986). Public sector hospitals are generally viewed as less efficient as compare to relatively more efficient and patient-friendly private hospitals. For this, several Health Sector (HS) reforms were introduced in the developing as well as developed countries during the last quarter of 20th century. These health sector interventions including 'granting autonomy' were first initiated by the developed nations and later on introduced among developing countries (Loevinsohn & Harding, 2005). For this, International Financial Institutions (IFIs) proposed different prescriptions including standards and accreditation for hospital quality assurance, private health insurance, and hospital autonomy (Saeed, 2012, p. 15).

Hospital autonomy

Hospitals were not considered as a part of core health policy till the first half of 20th century and the basic focus of health care managers was on Primary Health Care (PHC) service (Reerink & Sauerborn, 1996). In the second half of the 20th century, some HS reforms were announced in the public sector hospitals at global level (Walt & Gilson, 1994) including United States, United Kingdom, Singapore, Italy, Holland, France, Denmark, New Zealand, Philippines, Thailand, South Korea and Malaysia, Nigeria, Uganda, Tanzania Ghana, Kenya, India, Indonesia, and Zimbabwe. (Cassels, 2006).

In Pakistan, the autonomy reform was first initiated at two public hospitals at the federal level and later on, this reform was also introduced at provincial level hospitals on basis of its claimed successful experience in federal hospitals. Hospital autonomy was launched in the province of Punjab through an ordinance presumably under the influence of federal government and donors. Politicians and doctors actively took part in this reform of autonomy. In fact, Political leaders presented the idea of autonomy to make the public hospitals efficient and doctors supported this reform in the hope of getting freedom from the clutches of bureaucracy. This cooperation between political leaders and doctors having different goals resulted in the successful introduction of the reform of hospital autonomy (Saeed, 2012, p. 17). Granting autonomy to public hospitals among other reforms was considered as a solution for less effective and

expensive public hospitals. It was assumed that autonomous hospitals would be cost-effective, efficient and respond to patient needs flexibly (McPake, 1996).

Autonomy is the extent of devolved decision-making that takes place within the hospital (Chawla & Govindaraj, 1996). Saeed (2012) proposed a conceptualization where autonomy is either achiever-driven or granter-driven. In the first instance, the autonomous body would have actively pursued it making certain efforts, struggles and sacrifices and in the case of granter-driven autonomy, it is always for the benefit of the granter; it will be up to him to decide the extent and the nature of the autonomy. In sum, such type of autonomy will in most cases be to the disadvantage of the receiver. Hospital autonomy has been studied in several ways in the literature, but the recommended frames are either situation or country-specific. Researchers have defined autonomous hospitals as those institutions that are at least partially self-sufficient, self-financing and self-directing (Hildebrand and Newbrander, 1993). Chawla et al (1996) identified several important dimensions which are affected directly or indirectly as result of hospital autonomy reform including:

a. Financial management
b. Hospital administration
c. Procurement
d. Hospital Information Systems
e. Human Resources

There are several areas regarding the nature and the extent of autonomization of hospitals to be explored including medical care, procurement, administration, financial management, human resources management, and strategic management. In this study, some of the key dimensions regarding the nature and the extent of hospital autonomy are identified in the light of Chawla & Govindaraj (1996)'s methododlogical guidelines as follows:

1. Medical care refers to the patient care by the hospital medical and non-medical staff. In this regard the aim is to provide efficient services to patients at autonomous hospitals.
2. Administration refers to all the other responsibilities (i.e., other than financial, personnel and procurement management) involved in the day-to-day running of the hospital and the discharge of the functions defined by the mission statement(Chawla, Govindaraj, Berman, & Needleman, 1996).

The governance system of health sector of Pakistan with respect to hospitals is divided into three types. Firstly, private hospitals, these are financed and governed privately by the donors or their representatives. In these hospitals purely private practices are followed. They are further sub-divided into three categories; first, those being run purely on profit basis, second, being run on no-profit-no-loss basis and third which are run in the spirit of philanthropy or religion where expenses of the hospitals are met through alms, charity or private donations. Secondly, public hospitals, these are being governed, managed and financed purely by the government. Third type of hospitals are those public hospitals which have been granted autonomy and they are being independently governed by a board of directors/governors/management, managed partially by permanent and contractual employees, and financed partially by government and hospital's own funds. In healthcare sector in Punjab, around 13 hospitals were given autonomy in the last ten years or so (Saeed, 2012).

Objectives of the study

1. To describe the nature of hospital autonomy after the process of granting autonomy to the Jinnah hospital
2. To measure the extent to which Jinnah Hospital is autonomous in implementing its own-developed medical care tools
3. To check the level of autonomy granted to administration of Jinnah Hospital in employee selection, salaries & incentives, employee training and skills development

Literature Review

Decentralization in the health sector has attained a primary importance for both the policy makers as well as the end users. This phenomenon of transferring authorities and responsibilities from the central

to the provincial or state level is transferred from the developed European nations to the developing Asio-African countries. Health reformers have often proposed that granting autonomy to these public hospitals could provide solutions to many of their problems. Autonomy is a form of decentralization and inter-relates with other reform concepts including (McPake, 1996; Govindraj & Chawla, 1996; Cassels, 2006), the concept of the 'New Public Management(NPM),' or practices of public–private partnership (McPake, 1993; Chawla & George, 1996), and the scope for organizational change (Collins & Green, 1993; Bossert et al., 1998).

Global experience of health sector reforms

Hospital autonomy reforms were first introduced in the developed countries including Denmark, France, Holland, Italy, New Zealand, United Kingdom, Singapore, and United States (Kirkpatrick, Dent, & Jespersen, 2011) and later on, these reforms were also initiated at the level of developing countries including Ghana, India, Indonesia, Uganda Zambia, and Kenya (Govindaraj & Chawla, 1996).Hospitals in France prior to 1984 were managed in a traditional way. There was no system of long-term planning, and most of the key decisions were not attended to. The primary reason of hospital reforms in France during 1984 therefore was to minimize costs (Ritchie et al., 1992).

Ghana was the first among African nations to start granting greater autonomy to public sector hospitals. Since the 1970s, the two teaching hospitals in Ghana, namely, the Korle Bu Hospital (KBU), and the Komfo Anokye Teaching Hospital (KATH), were supported by the Government of Ghana to become self-governing (Govindaraj & Ofosu-Amaah, 1996). Similarly Zambia has attracted substantial attention for its determined program of health sector decentralization. The Health Sector Reform Program (HSRP), started in 1993, can be more specifically named as a program of administrative de-concentration and delegation. In the Zambian case, the Ministry of Health (MoH) has reset its role in policy making and regulatory functions (Hanson et al., 2002).

Pakistan experience of Hospital Reforms

Pakistan could not develop any independent health policy till 1990 though it incorporated health in all the 8 five-year plans. The need for hospital autonomy in Pakistan occurred when the government thought that there was an urgent need to restructure the health care delivery system. Hildebrand and Newbrander**,** (1993) produced a report for USAID which became the basis of hospital autonomy initiatives in Pakistan (Saeed, 2012).There are very few studies which are conducted on the autonomy reform in the public sector teaching hospitals of Pakistan. Yet, some notable efforts have been made by some research scholars e.g., Zaidi SA (1994), Collins CD et al (2002), Tarin EH (2003), Abdullah and Shaw (2007), and Saeed (2012).According to Tarin (2003) following are the postulates and key characteristics of the reorganization under which autonomy was granted to some teaching and other public sector hospitals under the "Punjab Medical and Health Institutions Ordinance 1998 (PM&HI)" by the government of the Punjab.

(a) To enhance the quality and efficiency, together with better provision and approachability of health related services
(b) To enhance the role of local decision making authorities and limit the functions of the central state
(c) To improve the economic conditions of the institutions

There was an Institution Management Committee (IMC) for every autonomous hospital whose chairperson was designated as Chief Executive (CE) and had members from the public and the private sectors. The College Principals were expecting that they would be promoted in the new set-up and appointed as CE. The CEs were being appointed for the autonomous institutions through open competition (Abdullah & Shaw, 2007).

The Punjab Medical & Health Institutions Act, 2003

Background

Governor of the Punjab province issued PM&HI Ordinance,1998 and later, 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, p. 148). Then army monitoring teams were established, and they conducted independent inquiries. The autonomy initiative was again re-launched through the PM&HI 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 approved by the governor of the Punjab on 5 June 2003, 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.

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. Autonomy in Hospital Administration
2. Autonomy in Hospital Medical Care

The purpose and objective of this study is to explain the nature and extent of autonomy granted to the Jinnah Hospital Lahore and to achieve this objective explanatory approach is adopted. Qualitative research methodology is used in this study as 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 and Unit of Analysis

The population of this study consists of all the administrative medical and non-medical staff Jinnah Hospital, Lahore and hospital 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 guideline 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 included in the sample. They were assured confidentiality of information provided by them and that the data will be used for academic purpose only. With prior appointment the respondents were interviewed using interview guide. Information provided by the respondent was repeated in the presence of interviewee in order to enhance the reliability of the data. The respondent contacted again for short time to get some other relevant information at the time of data analysis. Each interview was transcribed after conducting it to assure that maximum information provided by the respondents is available for data analysis.

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. In

order to capture the maximum detail of the responses, it was important to transcribe the data as soon as possible.

Data Exploration

During the exploration phase the transcriptions collected while gathering data 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 was interpreted and analyzed with the help of categories and themes identified in the phase of data reduction. The statements supporting the themes were also quoted in short form while analyzing the data.

1. Autonomy in Hospital Administration

The findings of the study after the interviews were conducted with the top level medical and nonmedical staff members of Jinnah Hospital, Lahore indicate that different staff members took different meanings of autonomy in hospital administration with respect to its nature and extent. The autonomy in hospital administration was seen in terms of autonomy in employee recruitment, hospital's own employee evaluation criteria, opportunities of employee training, hospital administration's discretion in awarding extra bonuses to employees and Hospital's own mechanism to improve its working environment (Castaño, Bitran, & Giedion, 2004).

A. Autonomy in employee recruitment

After the process of autonomy, recruitment of the staff up to grade 15 is made through Board of the hospital. The board can send recommendations for grade 16 and above to the health department. It can also create temporary posts in some cases.

> *The Board may appoint staff in the service of Institution, as may be necessary on the recommendations of the Special Selection Board of the hospital (*PM&HI Act 2003, clause 9)

It could not be inferred that the hospital after autonomy had become independent in employee recruitment as the Board cannot make permanent hiring; it can only send recommendations to the health department. Similar types of views were also observed while gathering data from the top level staff of the Jinnah Hospital Lahore. These views are evident from the following excerpts.

> *The teaching hospital could not get autonomy in the area of employees recruitment as most of the decisions regarding hiring and firing are done at the health and finance department level. The non-gazetted employees were hired by the hospital administrator even before granting autonomy to the hospital and similar practice of making recruitment for the lower staff can currently be observed in non-autonomous hospitals. So no major change had occurred after the so-called autonomy process.*

The board cannot hire the top level staff of the institution but only recommend some individuals to the health department for these posts including doctors, principal, medical superintendent etc. PM&HI Act 2003 gave details of this procedure.

> *The Government shall appoint a whole time Medical Superintendent of the Institution from a panel of three individuals recommended by the Board (*PM&HI Act 2003 clause 8)

The real powers of deciding the fate of the employees are with bureaucracy (in case of hospitals, Health & Finance departments) as it is evident from the structure of the Board. There are two powerful members in the Board each from health and finance department of secretary level having dominant role in decision making of the Board. In this way most of the hospital decisions regarding employee recruitment are finalized at the health department and the Board is not independent in deciding the hospital matters. it is also highlighted in the Saeed (2012)'s study. In the case of public teaching hospitals, all the types of decisions including HR, financial, purchases, infrastructural, developmental, structural were carried out by the Dept. of Health, Government of the Punjab.

> *In case of recruitment process, employees are recruited through proper advertisement but the board can only make temporary hiring and later on these posts were make permanent only through health department. The daily wages employees are recruited even without advertisement by the board or principal. In the same way, in the situations like strikes, emergency (dengue etc) appointments were even made by the medical superintendent and in some cases by the 'Nominated Committee' of the hospital in order to fulfill the urgent needs of the patients. But the approval of all these posts from the health department is necessary as a final authority.*

B. Hospital's own employee evaluation criteria

According to PM&HI Act 2003, the board has discretionary powers in awarding some extra bonus to best performing employees. During the interviews with the top level staff of the Jinnah Hospital Lahore, the researcher found similar views as evident from following statements:

> *The board of management and the principal of the autonomous medical institution have a power to sanction the one month basic salary as honoraria to any employees if his performance is extraordinary*

It is very important that employees should be motivated at any cost in order to give due consideration to the patient care. The extra bonuses, incentives, good working conditions and other monetary and non-monetary rewards play a key role in employee loyalty, motivation and commitment (Benabou & Tirole, 2003); which ultimately help in enhancing institutional efficiency and better performance. In granting hospital autonomy a board was constituted to also look after the similar type of issues and to keep the medical and non-medical staff motived for better patient care. Therefor the board can award some extra bonus to the good performers as it is evident from the following excerpts

> *Although hospital employees got their salaries as decided by the government yet the Board can award some additional monetary incentives and status to more responsible and efficient employees. Before granting autonomy there was no system of granting extra bonuses to employees for better performance in public hospitals and the promotions were only made on the basis of seniority, totally ignoring the performance dimension. As a result the doctors, nurses and other medical and non-medical staff of the public hospitals had low level of motivation and hence resulted in low level of patient care.*
>
> *Few months ago, the hospital had its own system to motivate employees in the form of employees of month, doctor of the month etc. Currently there is no system of bonuses at hospital; employees are given only salaries according to their pay scales*

The hospital can arrange and implement only small activities on temporary basis at the hospital level. The Board cannot become effective until it attained the powers of final approval. Therefore it cannot be said that the hospital after autonomy is autonomous in deciding its affairs through Board.

C. Opportunities of employee training

Organizational level training and support enhances organizational performance (Russell, Terborg, & Powers, 2006). The training facilities are provided to the employees in the short run as well as in the long run to increase the performance of the employees in the best interest of public health. The proper implementation of the employee training programs has produced the desired results (Bartel, 1994). The employees of the autonomous hospital are trained through several ways including seminars, workshops etc. These training activities are arranged by the health department. There is no significant impact on training due the reform of autonomy at the hospital level. Some similar observations were also seen during data collection from the Jinnah Hospital Lahore as highlighted below.

> *Some type of workshops and seminars are arranged by the health department…; Health department makes it compulsory for one representative from each hospital to attend annual budget related seminars and workshop…; Doctors are also offered some workshops and training programs by the health department.*

Hospital does not provide any training to its employees for their skills development and even employees do not take any interest in such activities. Similar observation is also made by Saeed (2012) during his study research on Services Hospital Lahore- an autonomous hospital i.e. employees working in such institutions are not properly trained. Since lot of postings are politically backed, so people selected are neither trained, nor bother to work and nor interested to train themselves.

It is inferred that the hospital developed programs for its employee training and development at the hospital level after the granting autonomy to it. Hence, the so-called autonomous hospitals have to rely on the health department for the training of its employees.

D. Hospital's own mechanism to improve its working environment

Every autonomous and non-autonomous hospital has some mechanism to improve its working environment to make the institution's services efficient and effective. Quality of working environment results in quality of patient care (West, 2001). The hospital exerts its efforts through different strategies to improve its working conditions. Mostly, medical superintendent as a hospital administrator issues regular directions on the instructions of health department for the efficient working environment of the hospital. The hospital often receives instructions from health authority to improve its working conditions (Cassels, 2006). Some of the observation from the data collected through interviews from the excerpts as follows:

> *The AC are installed in the wards, costly plant & equipment are purchased on the orders of the health department, competitive HR is recruited, proper cleanliness and security issues etc. are addressed. All of this work is done due to the political pressure from the current chief minister side.*

Although some efforts are made to improve the working environment of the hospital including provision of heavy generators to each hospital of the Punjab at district level on the instruction of health department. As these efforts were not limited to the autonomous hospitals only, therefore, it cannot be inferred that the autonomous hospital can independently develop its own mechanism for better working environment. Moreover, any instruction from the health or finance department is to be followed by the hospital administration.

Autonomy in Hospital Medical Care

Autonomy in hospital medical care was measured in term of autonomy in planning and implementing hospital's own developed medical-care tools, autonomy in developing schemes to protect the poor, autonomy in linking of services provision from other public hospitals independently. There are some cases when hospital develops some medical tools to deal with urgent needs without the prior approval from the health department but later on the approval is necessary.

A. Autonomy in planning and implementing hospital's own developed medical-care equipment

Hospital has its Board of Management which recommends all the medical and non-medical matters of the hospital to the health department. It has no powers to approve or reject any

proposal regarding purchasing new medical equipment for the hospital. Similar views are also highlighted from the following excerpts.

The power to approve or reject a medicine supplier lies with the health and finance department. The board nominates different teams for different tasks and on the recommendations of these committees, the final proposal is forwarded to the health department; Hospital can purchase some needed equipment and latest medical care equipment from local as well as international market with the approval of health department

The hospital only gives its input and sends requests to the health and finance department in planning and purchasing the future needed medical tools. In this way, hospital after autonomy could not decide about the supplier of medicine as district coordination officer is the chairperson of the purchase committee. Hence real autonomy is not granted to the hospitals.

B. Autonomy in developing schemes to protect the poor and services provision from other public hospitals

Public hospital tries to cater the medical needs of the public and provides them the health facilities at lower cost. For this purpose, medicines are provided free of cost but Jinnah Hospital Lahore which is autonomous public sector hospital did not provide this service to the poor patients. In this regards some observations were made during data gathering from the Jinnah Hospital Lahore's top level medical and non-medical staff members.

Sometimes if the budget is not available than medicine/ kits is to be arranged by the patient himself or any NGO within the hospital which also may support the patients; There is a welfare society which protects the poor patients;

The public sector autonomous hospital has the facility of Provision of services from other public hospitals for better patient care. In this regard, some of the observations from the following are also evident during the interviews with the top level staff of the hospital;

Yes, the hospital can refer the patient to other hospitals for better health services. For example when any facility is not available in the hospital then patients can be shifted to that hospital where required facility is available; In case, the services of the hospital in one unit or department, patients are referred to some other public sector hospital''

...Referral services are available in the hospital...;

The autonomous hospital could not develop any schemes to protect the poor patients and the facility of free medicine is also not available to the patients.

Conclusion

Governments are major players in the health sector in virtually all countries — developed and developing —the specific role played by the government differs from one country to another (Govindaraj, et al., 1996). Results of this study show that autonomous hospital could not develop its own efficient health-related services to the patients. Hospital had no role in the overall health policy and even in the hospital goals. Government has retained the right to make policies at national and local level. For this, the hospital could not adopt any new tools and techniques in its different units without the prior approval of health department. The similar practices are also observed at the Jinnah Hospital, Lahore while doing interviews with top level medical and non-medical staff of the hospital. The findings of this study indicate that hospital is not independent to make any health programs to provide better health services. Generally hospital administration adopts different tools and techniques for patient care. Although autonomy has granted yet all public hospitals come under health department and are supposed to function under the rules issued by the government or broadly speaking hospital autonomy act. After the grant of autonomy most of the issues related to hospital administration and adopting some medical care tools are discussed at the hospital level. The top level posts including post of medical superintendent, principal, director finance and doctors are only filled with the approval and orders of health and finance department. Therefore, hospital could not make independent decisions regarding the employee recruitment. Yet, in the area of awarding some extra bonuses to the efficient employees is under the control of the Board. It can appreciate and award any employees on the basis of good performance in the form of the employee of the month etc. But

these activities have little impact on the administrative and management system of the hospital. So in true sense, hospital is not autonomous in running its affairs.

The hospitals are only autonomous within a predefined framework. In the Health domain which is related to those decisions that are made at the level of the government or at the government-hospital interface, the hospital has only limited control. However, at hospital domain which is related to the day-to-day activities undertaken within the hospital, the hospital management usually exercises greater control through its board. The Hospitals were only the implementers.

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