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Hospital Governance:Exploring the European Scene

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In many European countries, governments, researchers and hospital leaders are attempting to find the right “fit” between the changing context of healthcare and the key configurations of the governing structures and processes within hospitals. Many of them are looking at examples from abroad to learn from the innovative solutions, the achievements and the mistakes of their European colleagues.

However, it is clear that no uniform scenario, or road map for governance reforms, applicable to all hospitals in all European healthcare systems, is available (nor would be useful). This is due to the very nature of hospitals themselves. Although they constitute more or less autonomous business entities, they are at the same time deeply embedded in, and influenced by, the healthcare system of which they are part. This means that innovative models from abroad will not be helpful, unless they are cautiously examined against the background of the wider configurations in which they are embedded.

This state of affairs provides ample arguments why comparative research is needed on hospital governance and its determinants within the national health care systems. The added value of such a research framework will only increase, as in the near future, there will be an urgent demand for empirical studies testing how the gradual changes in the configurations of hospital governance affect performance, both in terms of efficiency of the governing bodies and overall hospital outcomes. Without seriously taking into account the specificities of the context, the relevance of these empirical studies will not exceed the setting of th (nonexistant) “average” or “typical” hospital.

The Survey

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In 2004, The European Association of Hospital Managers joined with the European Hospital and Healthcare Federation (HOPE) and launched a pioneering research project on this subject.

Scientific support is provided by the Centre for Health Services and Nursing Research of the Catholic University of Leuven. HIGIS healthcare information provides the technical support.

The principal goal of the project is to foster a better understanding on how the characteristics of the national healthcare systems can explain differences in governance practices in European hospitals.

The study uses both primary and secondary data. The main source of the former is a comprehensive survey of individual CEOs, which was organised in the spring of 2005. The focus of this survey was on Western Europe. Individual CEOs were contacted through the intermediary of the national member organisations of HOPE and EAHM.

Survey Sample

Thanks to the efforts of the national associations and, of course, all participating CEOs, a large sample of 522 hospitals has been obtained. Figure 1 shows the sample distribution as regards legal form and hospital type.

Table 1 shows the total number of participating hospitals per country. “Positive outliers” are Greece and Belgium.

A “Hospital”. What’s in a Name?

As inclusion criterion, the questionnaire referred to the WHO-definition of a hospital, which states that a hospital is a residential establishment equipped with inpatient facilities for 24-hour medical and nursing care, diagnosis, treatment and rehabilitation of the sick and injured, usually for both medical and surgical conditions, and staffed with at least one physician.

It is clear that in practice, this definition covers a wide range of situations. As to the size, 50 of the participating hospitals count less than 100 beds, 163 between 100 and 300, 212 between 300 and 800, 50 between 800 and 1,200, and 40 hospitals count more than 1,200 beds. 86 participating hospitals are academic centres (teaching and research). 6 are so called “industrial” hospitals, which means that they are affiliated with a major employer.

An important observation is that less and less hospitals correspond to the archetype of a one-building, one-management and one-hierarchy organization. For instance, 237 of the 522 participating hospitals are spread over multiple sites or locations. Hence, the total data set includes 1,013 hospital sites. The autonomy status of these sites varies widely. The individual sites have their own management in 16% of the multiple site hospitals.

On the other side of the spectrum, 243 of the participating hospitals are themselves part of a larger group or network, which was defined as any type of formalised affiliation which has a considerable impact on the top decision-making process of the respondent’s organization. Figure 2 shows the profiles of the other members of such groups or networks. When asked to describe the daily practice of their membership of a group or network, the top answers were “shared vision or ideological policy” (129 respondents) and “continuity of care” (128 respondents). Only 38 respondents state that “price setting” is a central function of the group or network.

Transparency

One of the major themes of the survey was public accountability. A specific question contained a list of five information sources (meeting reports governing bodies, hospital budget specifications, annual financial statements, hospital activity data and external assessment reports) and asked the CEO to indicate which of these sources are open to the public. Overall, large differences were found between the different countries. As a general trend, hospitals from Northern-European countries show markedly higher openness scores than those of Southern-European countries. Figure 3 displays the results for one of the information sources: “annual financial statements of the hospital”. In about half of the countries, financial statements are open to the public in almost all hospitals. In Spain, Belgium, Germany and Greece, they are open to the public in half of the hospitals. As for France and Portugal, financial statements are open to the public in only a quarter of the hospitals.

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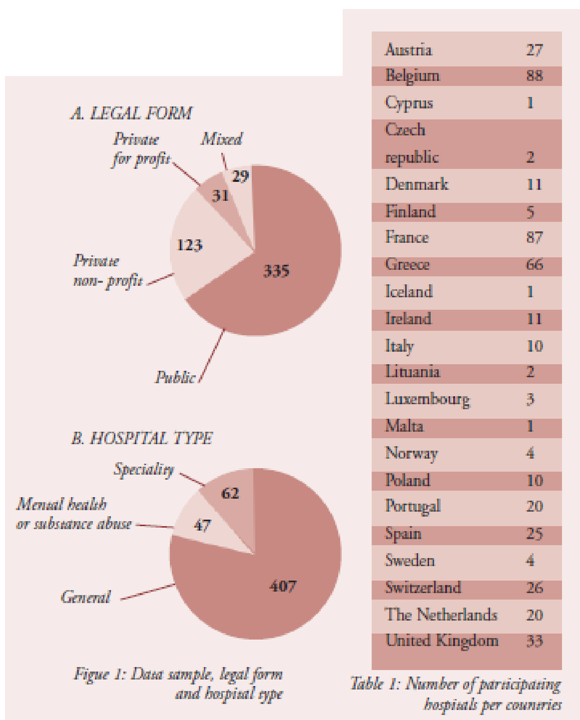

Figue 1: Data sample, legal form and hospital type

Country	Hospitals
Austria	27
Belgium	88
Cyprus	1
Czech republic	2
Denmark	11
Finland	5
France	87
Greece	66
Iceland	1
Ireland	11
Italy	10
Lituania	2
Luxembourg	3
Malta	1
Norway	4
Poland	10
Portugal	20
Spain	25
Sweden	4
Switzerland	26
The Netherlands	20
United Kingdom	33

Table 1: Number of participating hospitals per countries

The questionnaire also asked whether the same five information sources could be accessed freely by the physicians of the hospital. As regards the annual financial statements, it is interesting to note that in almost all countries, the figures are more or less the same as for openness to the public (see figure 3), except for Belgium and France. In contrast to the relatively low openness to the public, financial statements can be accessed by the physicians in nearly all hospitals in these two countries. This can be explained by the fact that hospitals are obliged by law to convey these statements to the physician representatives of the hospital (respectively Conseil Médicale/Medische Raad (BE) and Commission Médicale d'Etablissement (FR)).

Autonomy

An extensive part of the survey dealt with hospital autonomy. The underlying reasoning for this approach was that one cannot have a clear idea of the decision-making processes within a hospital, without insight into the content and the actual scope of the decision-making power at hospital level.

The survey used an instrument to measure hospital autonomy in six decision-making domains: setting outcome targets, strategic planning, management, procurement, capital and human resources. For each of these domains the CEO was asked to rate the level of decision-making autonomy vis-àvis the government (national or regional) or other third parties, on a four-point ordinal scale (from no autonomy to full autonomy).

Figure 2: Groups or networks

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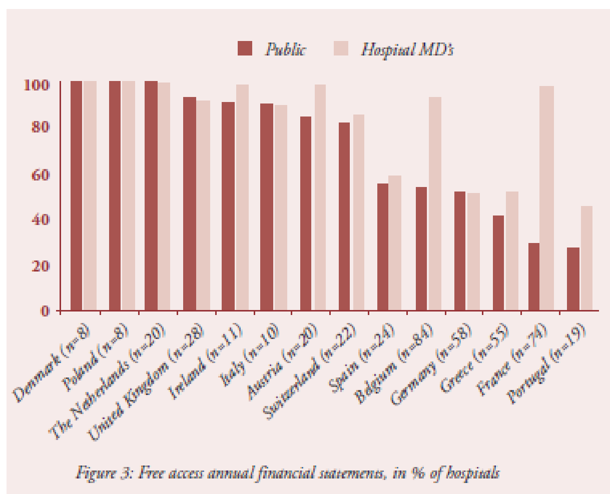

Figure 3: Free access annual financial statements, in % of hospitals

Each combination of the decision-making domain and level of autonomy was further defined. For example: high autonomy in the field of human resources was defined as “Staff appointed by hospital, with extensive discretionary power regarding staff number, qualifications and remuneration”. The use of this instrument has been very useful in explaining differences in governance practices (see also further). Clear patterns within the different countries were found.

At a general level, autonomy scores of public hospitals were significantly lower than those of private non-profit and private-for-profit hospitals, in all six domains (Wilcoxon $p < 0.05$). Between private non-profit and private- for-profit, no significant differences were found, except for human resources, where for-profit hospitals appear to have more autonomy than non-profit hospitals; and for procurement, where for-profit hospitals appear to have actually less autonomy than nonprofit hospitals. The latter can be explained by the fact that in for-profit hospitals procurement arrangements are often embedded in commercial contracts that exceed the level of an individual hospital.

As could be expected, the level of autonomy is also negatively associated with group or network affiliation. Hospitals that belong to a group or network have significantly lower autonomy scores (Wilcoxon $p < 0.05$). However, this is true for only four of the six domains: setting outcome targets, procurement, capital and human resources. This gives us more insight into the rationale of these groups or networks: it is mainly about benchmarking and what we could call “economies of scale”.

The second part of the results of the study dealing with the concept of the Administrative Council will be included in th next edition of Hospital (Hospital III/2007.

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