HealthManagement
Promoting Management and Leadership

Volume 9, Issue 3 /2007 - Study

Hospital Governance: Exploring the European Scene

Authors:

Kristof Eeckloo, *LLM,*

(corresponding author)Doctoral researcher

Luc Delesie, *CE, MS, PhD, Professor*

Arthur Vleugels, *MD, PhD,*

DirectorCentre for Health Services and Nursing Research

Faculty of Medicine, K.U.Leuven,

Kapucijnenvoer 35B-3000 Leuven, Belgium

Ph: 0032/16/33.70.21

Fax: 0032/16/33.69.70

Email: kristof.eeckloo@med.kuleuven.be

This second part of the results of the study (see (E-)Hospital 2/2007) deals with Hospital Boards and general conclusions.

Hospital Board

The survey included a large set of questions on specific governing bodies. One of these bodies is the Hospital Board. The composition, role and functioning of this Board has been the focus within most traditional studies on hospital governance. Within this study the aim was to compare the main characteristics of these Hospital Boards and link them with elements of the larger governance configurations in which they are embedded.

Substantial differences between the various countries were found. One aspect, 'Board Size', is shown in Figure 4. As the figure shows, a middlesized Board in Ireland counts 14 members, whereas in Portugal and Greece, a middle-sized Board counts only 5 members. Other countries with relatively large boards are Spain, Belgium and the United Kingdom. These differences in board size can be a first indication of differences in the tasks of the boards. One might expect that large boards are dealing more with long-term policy, whereas small boards have more operational tasks. The results of the survey confirm this only in part. In the Netherlands for instance, hospital boards are relatively small (median value 7), but answers to several questions of the survey tell us that these Boards have predominantly a supervisory and long-term policy function. In Belgium, on the other hand, boards are relatively large (median value 12), but many hospital boards in Belgium are also actively involved in operational decisionmaking.

The results in Table 2 give a further picture of the profile of the different boards. The table includes the expertise or backgrounds that are represented at board level. Those individuals who have an executive function inside the hospital (e.g. Chief Executive Officer) are listed in the top part of the table. Individuals with an "external background" are listed in the bottom part of the table. The table reveals a clear "insider dominance" in Greece and Portugal, and an "outsider dominance" in The Netherlands and Switzerland. In Ireland, Belgium and France hospital boards typically include both insiders and outsiders.

One side remark: in times where "health service integration" is an often-acclaimed policy objective, it is notable that this is hardly reflected in the composition of the Hospital Board. Board members with a background in community healthcare are only common in Ireland, and to a certain extent in France and The Netherlands.

Figure 5, finally, is rather surprising. It shows the CEO's assessment of the impact of the hospital board on the overall performance of the

hospital. As the graph shows, about half of the CEOs of France, Switzerland, Spain, The Netherlands and Portugal state that the board of their hospitals has only a poor or fair impact on the performance of the hospital. High impact boards can be found especially in Greece, but also in the U.K. and Ireland.

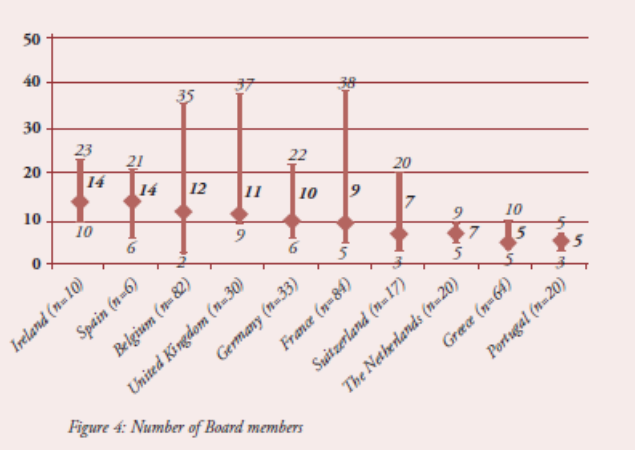

Figure 4: Number of Board members

BACKGROUND/EXPERTISE — *More than 25% of hospitals* — *More than 50% of hospitals*

n=363 %	EI	ES	BE	UK	DE	FR	CH	NL	GR	PT
CEO (65%)	30%	83%	73%	90%	41%	54%	29%	20%	78%	90%
CMO (48%)			46%	90%	22%	37%	6%	5%	76%	85%
CNO (42%)			23%	90%	22%	40%			73%	85%
Medical, non top manag. (29%)	50%		13%	13%	9%	59%	6%		41%	10%
Liberal profession (33%)	80%		51%	7%	38%	19%	59%	70%	17%	10%
Local government (32%)	30%	50%	24%	10%	22%	7%	29%	20%	6%	
Nat. or reg. government (24%)	30%	67%	6%	10%	9%	51%	18%	5%		5%
Community health care (16%)	40%		11%	7%	16%	34%	24%	25%		
Religious(14%)	70%		40%	3%	19%	4%				
Other hospital (12%)	30%		27%	3%	6%	8%	18%	5%		5%
For profit company (12%)	30%		15%	3%	9%	1%	47%	40%	3%	

Table 2: Background/expertise represented at Board level

Checks and Balances

The concept of “Checks and Balances” takes a prominent place within the governance literature. It refers to all kinds of relationships, functions and procedures that are built into the decision-making process. These should allow the managers of an organisation to take balanced decisions, which are based on a proper consideration of the interests of the different internal and external stakeholders. Or negatively phrased: they aim at reducing the likelihood of “inappropriate” or “opportunistic” behaviour of executive managers.

The previous paragraphs gave already some examples of such Checks and Balances. A functional hospital board for instance, with a balanced representation of backgrounds, which can monitor and guide the executive management, is a classic example of checks and balances. Openness to the public is another example; as the decision-making process becomes more transparent, more external parties become empowered to assess, influence and sanction or support the decisions as well as the decision- makers themselves.

The autonomy profile of a hospital is also a determining factor of Checks and Balances, since low autonomy rates imply that the decision-making process within the hospital will be highly influenced by decisions of the government or other third parties. This too diminishes the discretionary power of the executive management.

One of the purposes of the study was to analyse and synthesize these Checks and Balances across the different countries. The hypothesis was that within each of the participating countries, certain types of Checks and Balances would be more important than others. In other words: the research question was whether any “effect of substitution” could be found between the different Checks and Balances. For instance: is a higher degree of autonomy compensated or “substituted” by more openness to the public?

To test this research question, we identified 14 aspects of Checks and Balances within the survey (see Table 3). Some of them are quite complex aggregate variables (e.g. distribution of tasks over different governing bodies); others are simple yesno variables (e.g. whether or not an audit committee has been installed). However, all of the variables have in common that they measure the degree of delineation of the discretionary power of the executive management.

Overall, we found many complementary associations between the different variables of Checks and Balances, which means that when a hospital scores high for a certain variable, the odds are high that it scores high for the other as well. An example of two variables that are complementary can already be deduced from Figure 3 (see *Hospital* 2/2007): the extent to which information sources are open to hospital MD’s is positively associated with the extent to which information sources are open to the public (Kendall +0.34083, $p < 0.001$).

TABLE 3: ASPECTS OF CHECKS AND BALANCES

1. Distribution of tasks/activities over different governing bodies
2. Information sources open to the public (meeting reports, budget specifications, financial statements, activity data, external assessment reports)
3. Information sources open to hospital MD's
4. Hospital autonomy, in the field of management
5. Formal role hospital employees in decision-making process of governing bodies (e.g. advisory procedures, specific committees)
6. Formal role citizens/community representatives in decision-making process of governing bodies
7. Formal role physicians in decision-making process of governing bodies
8. Audit committee
9. Remuneration committee
10. Nomination committee
11. Physicians of hospital assembled in one or more formal collective bodies
12. Range of different 'outsider' backgrounds/expertise represented in the governing bodies of the hospital
13. Range of different 'insider' backgrounds/expertise represented in the governing bodies of the hospital
14. Systematic use of integrated organisational policy instrument (e.g. Balanced Scorecard, EFQM)

Another important complementary association was found between the extent to which information sources are open to hospital physicians and the extent to which hospital physicians have a formal role in the decision-making process of the hospital (Kendall +0.15790, $p < 0.001$). This confirms the general rule that information is indispensable for an effective management participation of physicians.

Yet, we also found some indications of substitution. An important finding for instance is that a high degree of hospital autonomy (i.e. low "external Checks and Balances") is positively associated with a large distribution of tasks/activities over different internal governing bodies (Kendall +0.15832, $p < 0.001$).

In addition, a high degree of hospital autonomy was also positively associated with the use of integrated policy instruments, such as the Balanced Scorecard or the EFQM-model (Kendall +0.11117, $p < 0.05$). Both findings seem to indicate that in hospitals with high autonomy, there is a stronger need for internal techniques to guide and balance the decision-making process of the hospital management.

Further Analysis

In-depth analyses on the data are currently taking place. Rather than making general observations and identifying general trends, the analyses aim to reveal and explain specific patterns of hospital governance and to offer the tools to translate them into practical knowledge. To make this possible, new methods of data-mining and knowledge discovery (including Multi-Dimensional Scaling) are applied, which are designed specifically to discover and display patterns and relationships within large databases. The methods are all based on computer algorithms calculating iteratively (step by step, data per data) the "best" visualisation for the selected variables in one single visualisation or virtual reality model.

Conclusion

The preliminary results confirm that governance practices in hospitals, based on the descriptions of the generic structures, processes and relations, maintain a direct correlation with the larger characteristics of the healthcare systems to which they belong. Despite the different levels of freedom for hospitals, certain systematics emerge even between different health systems. Comparing these to the Checks and Balances reveals the options available to European hospitals.

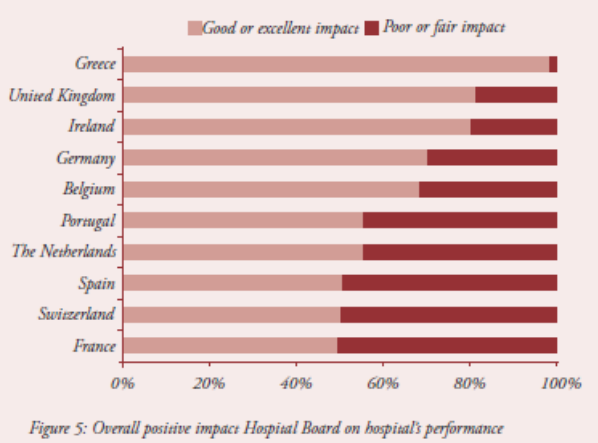

Figure 5: Overall positive impact Hospital Board on hospital's performance

Published on : Sat, 26 May 2007