



The Israel National Institute for Health Policy Research



GOVERNING HOSPITALS

INTERNATIONAL WORKSHOP REPORT

EDITOR: SHLOMO MOR-YOSEF

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Dear Colleagues,

Increasing market and regulatory pressures impose on hospitals all over the world important strategic challenges to the scope and quality of services rendered, cost control, equity and resource acquisition and allocation, financial stability, and many others. The following questions often rise: Are the current forms of hospital governance suitable to face these challenges? Should "philanthropic" hospitals, with a volunteer board, adopt a more active and critical form of governance typically found in the "corporate" model? Who should man the Board of Directors? Should legal and economic considerations prevail over professional and ethical ones? Should the hospital CEO be a doctor or a "professional" manager?

The comprehensive study on "Governing Public Hospitals in Europe" conducted by Richard Saltman, Antonio Duran, David Chinitz and others in the European Observatory on Health Systems served as an initiator to this workshop. In Israel we have 4 different major forms of hospital governance facing the same doubts and soul searching. In this workshop, the heads of Israel's health system, hospital directors and academicians deliberated these basic questions regarding hospital governance in great depth. This book comes to summarize the principle methods and various models for managing hospitals.

Prof. Shlomo Mor-Yosef

Chairman, Board of Directors

The Israel National Institute for

Health Policy Research

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ABSTRACTS



ISRAEL: DIFFERENT GOVERNANCE EXPERIENCE

Alik Aviram

Panelists represent the different modes of hospital governance prevailing in Israel: Governmental, Public (NGO), HMO owned and Private. Each will be asked to describe his own experience coping with issues raised in previous sessions of the workshops. Effort will be made to draw a common understanding as to how a hospital, in a certain setting, should be governed. The guests from abroad will be asked to comment on the Panelists' deliberations.

GOVERNING GENERAL HOSPITALS: THE ISRAELI CASE

David Chinitz and Avi Israeli

In the context of the European Observatory Project on Hospital Governance, specific questions about the Israeli context were answered. The questions addressed overall mission, strategic decision making, financial accountability and incentive schemes, internal structure, operational governance, and monitoring. Four hospital types were examined on these dimensions: private not for profit, government owned, health plan owned, and private. The main source of information was interviews with hospital directors, supplemented by hospital documentation, laws and statutes, and expert information. The draft was circulated to hospital directors for comment and revised accordingly. The four hospital types differ substantially in governance arrangements and autonomy. The picture of governance that emerges reflects overall trends in the Israeli health system and overall political economy, in which considerable central control co –exists with substantial flexibility, and even autonomy. This situation, with its advantages and disadvantages, poses major challenges for regulation of the system. While management of health organizations in Israel has become more sophisticated over the last decades, governance is still nascent concept.



THE CHANGING ROLE OF HOSPITALS IN THE MODERN HEALTHCARE SYSTEMS AND ITS EFFECT ON GOVERNANCE - THE SPANISH EXPERIENCE

Antonio Durán

Hospitals have moved massively in important areas from waiting for death places to organ-transplantation networks. After World War II most publicly owned hospitals were run as administrative arms of government(s), focused on delivering inpatients and outpatient acute medical care. Reforms in the late 1980's developed more flexible arrangements combining better service integration with increased institutional autonomy.

Hospitals are now expected to provide services across boundaries (chronic-, elderly-, "integrated care"). Quality assurance programs, patient rights charters and quantitative, standardized information on performance (efficiency, waiting times, etc.) are widespread. Policy makers and managers face a radically different set of expectations. New Public Management frameworks are perhaps not robust enough to answer the many question marks posed. "Governance" models are rather needed.

Evolving from a bureaucratic system funded by social insurance contributions, the tax-funded Spanish National Health System provides (almost) universal comprehensive coverage to all residents free at the point of use. Political transition to democracy in the 1970s devolved to regions (autonomous communities, ACs) powers to develop their own health policies. New public management schemes practices were developed, including health targets, framework-contracts, modern accounting tools, DRGs, etc.

In this context, Spain has explored hospital self-governance arrangements over two decades. It has done so however via ad-hoc, politically-driven, last-minute legislation, resulting in a confusing regulatory framework, with national and regional norms superseding each other. Various self-governing hospitals with different ownership status, legal nature, degrees of autonomy and accountability arrangements now coexist with traditionally-managed public hospitals.

The Spanish case includes two elements with applicability elsewhere. First, innovative features of hospital self-governance models have been eroded by

strong centralising forces at regional level. This shows that those models are not simple technical solutions but get embedded in powerful structures able to limit or enhance their capacity for change. In other words, context and politics matter.

Second, command and control, public administration or even private-sector management styles are not useful anymore. “Governance” implies that new tools are needed in response to new state-society relationships transforming social structures, policy processes, political systems and institutions.



SHOULD THE CEO OF A HOSPITAL BE A MD, OR NOT?

Avi Israeli

Mutual respect between managers and physicians is problematic to say the least. In recent decades there has been a trend, based on the assumption that physicians would benefit from having more managerial knowledge, to require physicians to study and even obtain degrees in management. After, or during, long years of medical studies, the addition of such requirements is not an insignificant burden. Aside from the obvious fact that increasing numbers of doctors are undergoing this process, little is known about its impact. Some say that for managing hospitals "professional" managers are needed and not necessarily physician managers.

To discuss these issues, this panel will focus especially on the position of Hospital Director. In Israel, even though in recent years the requirement that the holder of this position be a physician has been rescinded, traditions die hard and they remain physicians, some with added management training. Moreover, in Israel there exists a unique situation pertinent to our discussion. Medical Management is looked upon as any other clinical specialty. A MD can therefore acquire, through defined further studies and on the job training, an official board certificate.

Among the questions to be discussed are:

What should physicians learn when they study management, and what they do?

Does management training influence their performance, and how?

Can physicians achieve managerial skills and even excel in performance without special training? Perhaps by natural selection the best doctors with managerial skills will surface among the clinicians without training imposed from the outside.

What are the various stakeholder interests surrounding this issue?

Do we really need physician/managers, or should we rely on professional managers? Are hospitals really all that different when it comes to management?

Are the answers to these questions different or special when we speak of the role of Hospital Director?

CREATING EFFECTIVE HOSPITAL GOVERNANCE: THE FINE LINE BETWEEN STEERING AND MEDDLING

Paul F. Levy

Recent experience in the United States suggests that a failure of effective hospital governance carries great risk to the institution, its employees, and its patients. There has been a tendency to focus on such failure with regard to financial management, but the fiduciary responsibility of the governing body also carries through to the quality, safety, and efficacy of clinical care. Accordingly, many governing bodies of US hospital have been reevaluating their roles and responsibilities.

Using a major Boston teaching hospital and other US hospitals as examples, Mr. Levy will review possible strategies and approaches that can be used by governing bodies to fulfill their fiduciary roles. He will also address the age-old issue of how to separate governance responsibilities from management responsibilities.

His presentation will demonstrate how a well-functioning governing body can enable hospital leaders and management to harness the experience, wisdom, and judgment of members of the community to build a stronger hospital. He will also show, in contrast, how a governing body that does not function well can impede management's ability to do its job and can interfere with the smooth operation of a hospital and lead it to failure."



RE-DESIGNING PUBLIC HOSPITAL GOVERNANCE: HOW MUCH SEMI-AUTONOMY?

Richard B. Saltman

European health reform efforts over the last 20 years have included numerous efforts to re-structure how public hospitals are governed. Starting with the introduction of self-governing trusts in England in 1991, policymakers in a number of countries have sought to design more independent decision-making capacity into public hospitals. The goal has been to generate more innovative and entrepreneurial behavior, while simultaneously preserving the social advantages that accompany universal publicly operated institutions.

This presentation will briefly review key attempts to re-structure hospital governance, exploring their broad organizational dimensions and contrasting recent models with each other. The objective will be to set the stage for a more in-depth discussion of how to structure future hospital governance in Israel.

WHO ARE THE BENEFICIAL OWNERS OF HEALTH ORGANIZATIONS IN ISRAEL?

Omri Yadlin

In this lecture I identify two failures of the Israeli Health Law:

1. Israeli Law fails to provide a clear definition of the goal that public health organizations should strive to achieve – should such a health organization maximize the number of customers? Provide best treatment to current customers? Provide equal treatment to all citizens?
2. Israeli law is schizophrenic in its approach to health organizations: Although they are defined as “not for profit”, in reality they are forced to operate very similar to “for profit” organizations. This dissonance is the products of three factors: (a) they operate in a competitive environment; (b) they are allowed to provide private, non subsidized services; and (c) They are under budgeted by the government.

I suggest few potential remedies to these failures and point at the connection between the remedy we adopt and the governance model that accommodates such a remedy.



PRESENTATIONS



Governing Public Hospitals – An International Perspective

Richard B. Saltman
Emory University

European Observatory on Health Systems and Policies
www.healthobservatory.eu

Defining Hospital “Governance”

- Multi-dimensional and multi-faceted
- Incorporates:
 - *national*: policy, regulation (macro)
 - *institutional*: strategy (meso)
 - *internal/clinic*: management (micro)
- Complex interaction between multiple levels

20 Years of Reform Experience

Starting in early 1990s:

- England 1991
- Sweden 1993
- Estonia 1993
- Czech Republic 1994
- Spain 1996
- Norway 2002
- Portugal 2003

Different Names/Similar Concepts

- “self-governing trusts” (England)
- “foundation hospitals” (Spain, England, Estonia)
- “joint stock companies” (Estonia, Czech)
- “public stock corporations” (Sweden)
- “state enterprises” (Norway)
- “public enterprise entity hospitals” (Portugal)
- “consorcio” (Spain)
- “concesion administrativa” (Spain)
- “empresa publica sanitaria” (Spain)

Different Concepts/Similar Objectives

- “public competition” (Saltman/von Otter)
- “quasi-market” (LeGrand/Bartlett)
- “internal market” (Enthoven)

Similar Policy Objectives

- Public hospitals compete for public purchaser’s/patients’ custom
- Funding follows contract/patient choice
- Hospitals have *semi-autonomy* on meso and micro levels of governance
- Competition on quality, responsiveness, cost
- Financial efficiency essential to offer new services

- NO HOSPITAL IS PRIVATIZED



Conceptual Points about Hospital Semi-Autonomy

- Semi-autonomy is a good tracer variable for meso-level governance
- Semi-autonomy is typically a formal status
- No public hospital is fully autonomous
- Private hospitals (including for-profit), although more autonomous, still have to follow state regulation/expectations
- All hospitals (public and private) fit on a continuum of degrees of semi-autonomy

Key Dimensions of Semi-Autonomy for Public Hospitals I

- Set up separate hospital-level Board of Supervisors
- Board can hire staff on short-term contract under private law
- Board can open and close clinical services
- Board can pay financial incentives to staff tied to performance (up to ceiling)
- Hospital can keep budget surplus for next year
- Board can borrow new capital (to a set ceiling)

Key Dimensions of Semi-Autonomy for Public Hospitals II

- Politicians try to re-assert decision authority:
- England: "Foundation Hospitals" as 2nd try
 - Norway: Minister overrules closure
 - Portugal: Ministry encroaches
 - Spain: politicians sit on Board/veto power
- Partial Solution: New/protected legal status (Estonia;Czech)

Key Dimensions of Semi-Autonomy in Public Hospitals III

- Employee Unions unhappy:
 - seek to control/limit/prevent incentive pay (Norway; Spain)
 - go over CEO's head directly to Board
 - seek to go directly to politicians to reverse unfavorable Board decisions

What Public Hospital Remains Accountable to Political Authorities For

- Universal access to all public patients
- National quality standards of care
- Fiscal probity/solvency
- Patient satisfaction



How Successful?

- Estonia/Czech: patients, politicians, physicians all happy with semi-autonomous approach
- England/Norway: mixed reactions still
- Spain: somewhat (complex issue)

Some Initial Implications

- The more autonomy, the more the outcome changes
- Financial incentives to medical staff based on performance is key for improved outcomes
- Preventing political re-assertion of control is difficult

International Workshop on "Governing Public Hospitals"

Tel Aviv, 8- 9 March 2011

The changing role of hospitals in modern healthcare systems and its effect on governance – the Spanish experience

Dr. Antonio Durán

Main topics to be addressed

- Short overview of the Spanish health system;
- Description of hospital governance models
- Managers and Board of Directors:
 - Professional background and election process
 - Director General's position; terms & relationships
- Issues
 - Hospital financial customers
 - Levels of managerial flexibility (financial, policy)
 - Performance measures (hospital and Director)
- Pros and cons of the current system

"Governance":

- Structural transformation processes,
 - Political systems
 - Institutional frameworks
- in today's State-Society relationships;

(old ways to run the public sector and their tools -command and control, traditional management, etc.- just do not work anymore!)



Hospitals: an outdated offer

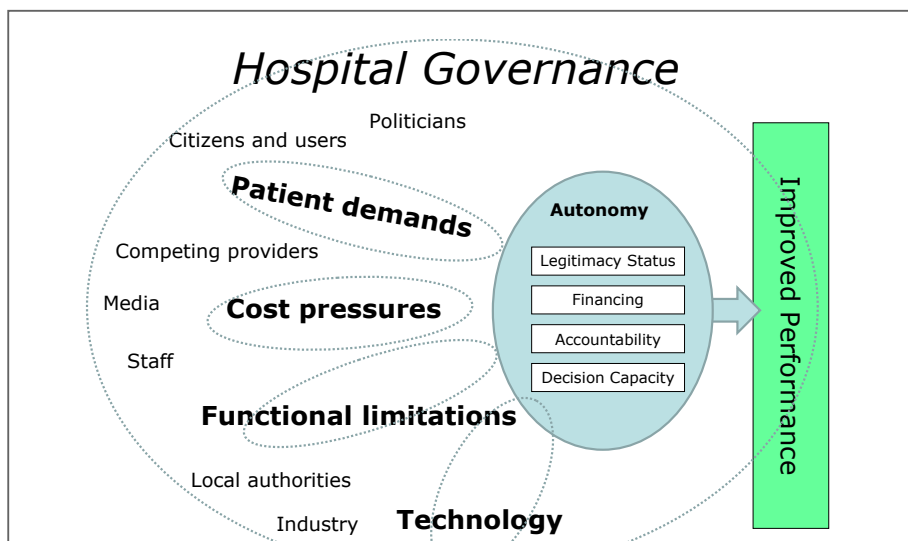
- *Silos* based on clinical disciplines ... but patients increasingly have *multiple problems*
- Designed for episodic treatment... *but many patients have chronic conditions*
- Designed for batch & queue operation... *but modern medicine requires flow and patients don't want their time treated as free*
- Often only fully work 5 days (that is <40 hours a week)... *when pace now requires 18/7 if not 24/7*

Edwards, N, 2008, Hospital Reconfiguration, Venice Summer School, European Observatory on Health Systems

Cost pressures, growing patient demand, technological innovation, and the functional limitations of physical structures in modern hospitals make *quick change* a must; hospital *autonomy includes* in that context the indispensable room for adaptation.

Hospital Governance: "a specific combination of strategic and operational decision-making".

We are particularly interested in the extent to which *autonomy (as an intermediate, performance-favoring variable)* is promoted.



Total population of 46,157,822 and GDP per capita of 30,565 US \$ at PPP

- 4th in the world in l.e. birth (3rd for females);
- 4th in life expectancy at age 65;
- Under average in EU infant mortality (sixth in average annual rate of decline since the 1970);
- Mortality for top causes since 1970 in Europe (CV diseases, cancer and respiratory diseases) among the lowest, and in steady decrease.

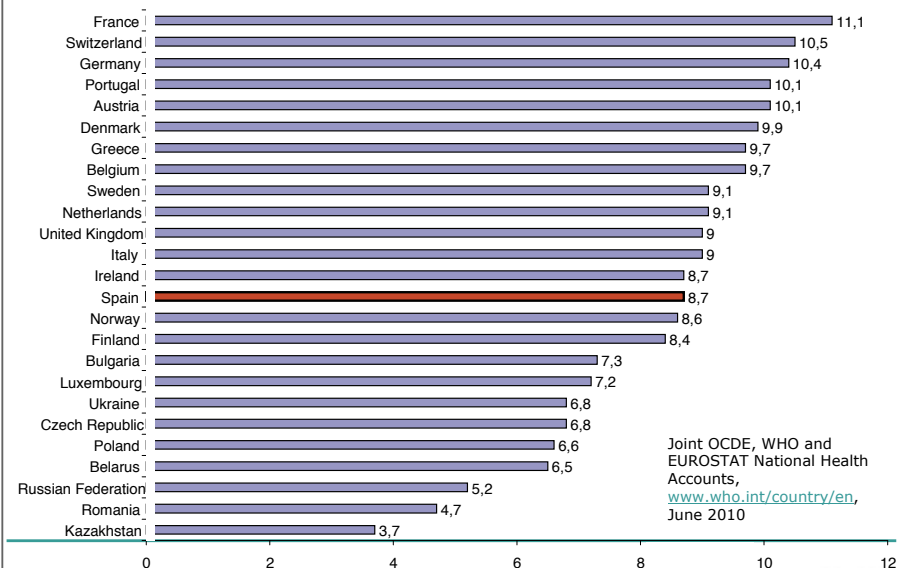
National Institute of Statistics. <http://www.ine.es> Consulted May, 2010; The Economist Intelligence Unit, March 2010, Spain Country Report p.17 <http://www.eiu.com>



- Coverage: virtually all citizens *and residents*;
- PHC provided by publicly salaried professionals (1 doctor & nurse for every 1,500 inhabitants);
- Public sector: 71.2% of available beds (40% owned) inc. 80% of the acute beds pool, 36% of psychiatric beds and 30% of long-term beds;
- High users' satisfaction and system legitimacy as per surveys (with specific exceptions).

García S, Abadía B, Durán A and Bernal E, 2010, Spain: Health system review.
Health Systems in Transition, 12 (4): 1-290

Health expenditure as % of GDP, selected European countries 2008



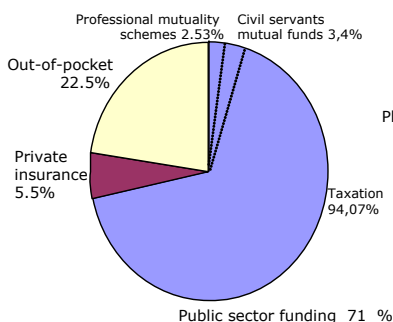
OECD, Per Capita Health Spending US\$, 1960-2007

	1960	1965	1970	1975	1980	1985	1990	2000	2007
Australia	99	127	219	463	696	998	1,310	1,730	3357
Austria	69	94	172	389	716	984	1,383	2,277	3763
Belgium	55	84	135	320	607	879	1,242	1,918	3595
Canada	109	155	264	457	773	1,244	1,811	1,783	3895
Denmark	70	125	226	363	618	807	1,051	2,574	3512
Finland	57	95	172	320	539	855	1,291	1,789	2840
France	75	124	215	409	736	1,083	1,528	2,369	3601
Germany	98	135	228	484	856	1,175	1,522	2,713	3588
Greece	16	27	61	107	192	282	400	905	2727
Iceland	53	88	146	307	611	889	1,379	2,149	3319
Ireland	37	52	102	246	477	572	748	1326	3424
Italy	51	83	162	296	600	814	1,296	1,855	2686
Japan	27	64	133	269	540	792	1,119	2,373	2696
Luxembourg	-	-	160	340	657	930	1,392	2,580	5686
Netherlands	74	106	222	441	742	931	1,286	2,041	3837
New Zealand	49	77	183	369	568	747	995	1,416	2454
Norway	95	-	141	322	573	846	1,193	2,283	4763
Portugal	-	-	48	166	265	398	554	845	2283
Spain	14	38	87	198	342	452	774	1,071	2671
Sweden	94	151	285	496	897	1,150	1,455	2,456	3323
Switzerland	96	141	281	541	886	1,224	1,640	3,564	4417
Turkey	-	-	-	39	67	66	133	118	651
United Kingdom	80	101	155	286	474	685	985	1303	2992
United States	143	204	346	592	1,064	1,711	2,601	4,187	7290
OECD average	70	104	180	343	604	855	1,212	1,984	3049,5*

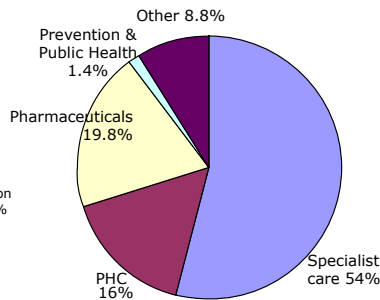
*Average for 2007 includes the 6 last members (Czech Republic, Hungary, Korea, Mexico, Poland and Slovakia).
 Source: Schieber G, Poulhier JP, Greenwald L, "US Health Expenditure Performance: International Comparison and Data Update" Health Care Financing Review 1992; "Health Spending, Delivery and Outcomes in OECD Countries," Health Affairs 1993, WHO World Health Report 2000, OECD Health Data: Statistics and Indicators for 30 countries, (http://www.irdes.fr/EcoSante/Download/OECDHealthData_FrequentlyRequestedData.xls)

2008; sources of funds & expenses

% of revenue by source



% of public funds spent



Source: García S, Abadía B, Durán A and Bernal E (2010) Spain: Health system review. *Health Systems in Transition*, 12 (4): 1-290



“Federal-like” system... without Federation

National Government +
2-Chamber Parliament

17 Autonomous Communities
2 Autonomous Cities



Parliaments elected by direct vote
Regional Governments

Regional Ministries of Health *coordinated* by
the Ministry of Health and Social Policy

1978 Constitution, Art 43

1986 National Health Law

2003, Cohesion and Quality Law

Public funds -mostly not ear-
marked budgets transfers;

Regions spend 89.81%

Central administration 3%;

Municipalities 1.25%

Regional governments:

Health authority plus

Regional Health Service

(30% of AACCs' total budgets).

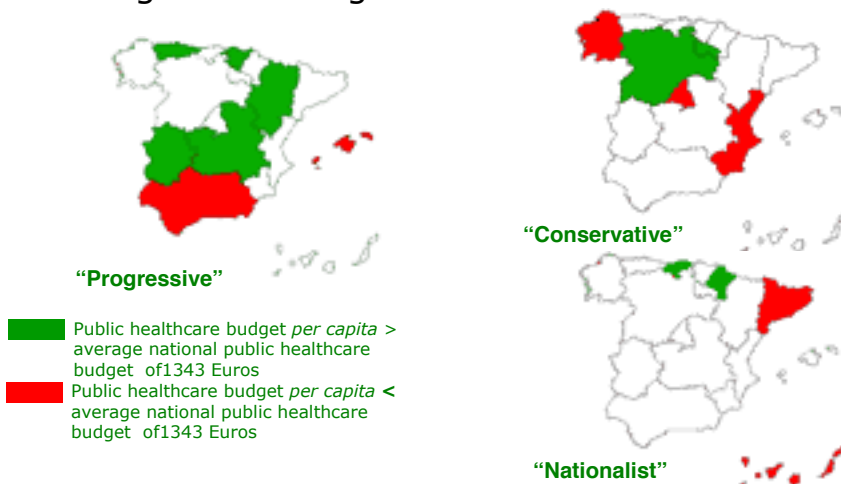
But problems with

(i) Geographical differences in health outcomes (3 years of L.E.B.) and in financing (40'73% *around the average* in public expenses per person in 2010);

(ii) Large unwarranted variability in access, quality, safety and efficiency;

(iii) Sustainability concerns (capital expenditure growth 2000–2008 >130%!)

Public healthcare budget *per capita* and political sign of the Regional Government 2010



Federación de Asociaciones para la Defensa de la Sanidad Pública (FADSP), 2010. *En* Diferencias notorias en el presupuesto per cápita entre CC.AA., según un estudio de la FADSP, Anónimo, 2010. <http://www.medicosypacientes.com/5 Enero 2009>



Spain, beds in acute care hospitals, psychiatric hospitals and long term institutions, 1980-2007

	1980	1985	1990	1995	2000	2003 ^(a)	2007*
Acute care hospital beds per 100000	398.4	350.9	333.4	303.6	284.0	301.5	301
Psychiatric hospital beds per 100000	114.4	91.7	70.6	60.2	52.2	36.7	37
Nursing & elderly home beds/ 100000	22.6	12.8	21.7	30.4	32.5	26.2	31

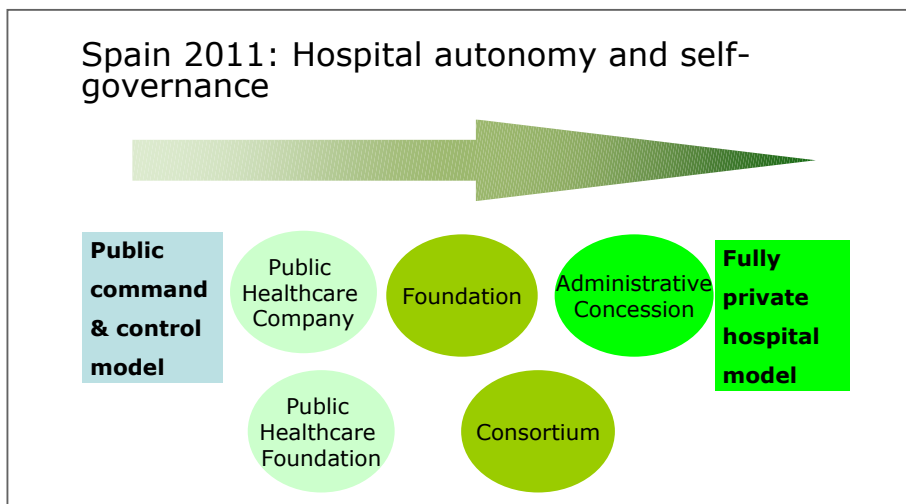
European Observatory on Health Policies and Systems, 2006, Hit, Spain. For 1980-2000, WHO/EURO HFADB. 2004 Spanish National Hospitals Catalogue" (Ministerio de Sanidad y Consumo, 2004a). Hospitals National Catalogue, 2007. Ministry of Health and Consumption,

Managers and Board of Directors: not necessarily doctors. Political appointees –removable any time.

Hospital Directors very conditioned by professional associations and trade unions, but still financial and policy room to maneuver ... in selected areas).

Financial "customers" mostly public. Reflection of NHS funding mix (mutual, private, etc) in Regions.

Increasing performance measures for the Director (but also for hospital, specially in Concessions)



Public Health Enterprise

- In Andalucía: Costa del Sol Marbella, Poniente, Alto Guadalquivir and Empresa de Emergencias Sanitarias; in Madrid: Fuenlabrada.

Public Health Foundation

-In Asturias: Oriente "Grande Covián"; in Baleares: Inca.

Foundation

- In Madrid: Alcorcón; in Baleares: Manacor; in Galicia: Barbanza, Virxe da Xunqueira, Verín and Salnés (status abolished July 2008)

Consortium

- In Cataluña: Maresme, Integral de Cataluña, Vic and Tarrasa; in Sevilla: Aljarafe -San Juan de Dios.

Administrative Concession

- In Valencia: Ribera Hospital in Alzira, Torrevieja; Marina Alta in Denia and Manises; in Madrid: Infanta Elena in Valdemoro.



Spain 2011: Hospital autonomy and self-governance

	Public Healthcare Company	Public Healthcare Foundation	Foundation	Consortium	Administrative Concession
Status/ Recognition	Regional law. Portfolio by regional dptment Stakeholders: non-statutory staff.	Secondary legisl. Portfolio by regional health department Stakeholders: statutory staff.	Second. legislation Some decisions on services portfolio. Stakeholders: non statutory staff.	Agreements with non profit org. Decide on portfolio Stakeholders: non-statutory staff	Contract with private company. Decide on portfolio. Non-statutory and statutory staff
Financing	Capital investment under public procurement law. Budget. Unable to retain surpluses.	Capital investment under public procurement law. Budget. Unable to retain surpluses.	Free to invest. High vol contracts, procurement law. Cash flow and pay providers. May retain surpluses for reinvestment.	Free to invest. High vol contracts, procurement law. Activity& capitation Payment/cashflow+ pay providers. Reinvest surpluses.	Free on sources of capital. Not subject to procurement law. Capitation. Can retain surpluses and annual profit capped.
Accountability	Board chaired by regional minister No patient involv. or reporting obligations.	Part of Board appointed by regional minister. No patient involv. or reporting obligations.	Board chaired by regional minister. No patient involv. Accounts registered annually.	Supervisory Board of participating organisations. Local people in the Board. Annual report.	Joint Committee and Commissioner. No patient involvement. Annual report.
Decision Capacity Vs Responsibility	High interference. Some freedom for clinical managers. Free internal monitoring.	High interference. Some freedom for clinical managers. Free internal monitoring.	High interference. Some freedom for clinical managers. Free internal monitoring.	Low interference. Some freedom for clinical managers. Free internal monitoring.	Low interference. Some freedom for clinical managers. Free internal monitoring.

1977/81	Creation of Ministry (Health and Social Security, then Consumer Affairs)
1986	General Health Law
1991	Comision for the Analysis and Evaluation of the NHS ("Comisión Abril")
1992	Law on Consortia
1993	Creation of Public Enterprise "Hospital Costa del Sol" in Marbella
1994	Law on "Foundations and Fiscal Incentives to Private Participation in Activities of General Interest"
1996	Royal Decree on "New Management Modalities in the INSALUD"
1997	Law on "New Management Modalities in the NHS. The "Parliamentary Agreement for Reforming and Modernising the NHS" fails
1998	Creation of Public Health Foundations. Fiscal, Administrative and Social Measures in the Addendum to the Budget Law.
1999	Valencia uses Law 15/1997 to create Administrative Concessions
2000	Royal Decree on New Management Modalities : "Self-governance models, Public Health Foundations, Consortiums and Foundations
2002	Abolition of INSALUD. Updating of Law on Foundations
2007	Law on Public Sector Contracts reducing autonomy of new schemes

Pros of the current system:

- Pluralism, flexibility and innovation;
- Not more expensive than the average schemes;
- Space for generating evidences.

Cons of the current system:

- Political polarization precluding transparency;
- Opportunity of "learning by doing" distorted.

Some provisional conclusions (1 of 2)

1. Autonomy, key dimension of *governance*
2. Neither politics nor management *per se* explain what is happening in areas of the Spanish health system/ within facilities

Some provisional conclusions (2 of 2)

3. Changes are occurring with ad-hoc and last-minute legislation, a fragmented regulatory framework and progress in several directions.
4. Still lacking stable regulation for key problems in building a very decentralized modern State *within a complex accountability context and with grossly insufficient information systems.*



Hospital governance Experience in England

Nigel Edwards

Evolution

- ▶ 1948 NHS created as a monolithic organisation
- ▶ 1990– NHS becomes a system / organisation hybrid
- ▶ 2010– NHS moves to system / market hybrid

Background

- ▶ Tax Funded
- ▶ Government acts as the payer
- ▶ Purchaser–provider split
- ▶ Local purchasers make contracts with providers
 - Capitation based budget based on estimation of needs
 - Purchasers are accountable via regional bodies to the Department of Health
 - Purchasers are non–competing public bodies
 - There are currently 150 going to 50 to 0 by 2014
- ▶ DRG payment for 2/3rds of hospital care
- ▶ Providers largely state owned but autonomous
 - There is a small independent sector
- ▶ Regulator determines minimum standards

Background

- ▶ Frequent reorganisation is an issue
- ▶ New system being developed in which:
- ▶ Groups of family doctors take over the purchasing function covering populations of – 600k
- ▶ An economic regulator will promote competition, set prices and protect essential services
- ▶ National standards for purchasing health care will be set out
- ▶ Government will cease to take day to day responsibility for providers
- ▶ UK has a relatively highly concentrated hospital system

A few other basic facts

- ▶ Access to secondary care is via GP referral
- ▶ Private healthcare is a relatively small market confined largely to outpatients & elective surgery – 10%

Hospitals

- ▶ UK has been unusual compared with much of Europe in the way central government:
 - Owned most hospitals
 - Exercised very detailed control
 - Over capital
 - Over operations
 - Management costs
 - Staff terms and conditions
 - Some aspects of performance
- ▶ Lack of autonomy stifles innovation
- ▶ Pay uniformity costs quality & money
- ▶ There are limits to the ability of performance management to drive improvement
- ▶ Centralisation of blame was a serious issue



Foundation Trusts

- ▶ Independent bodies
- ▶ Out of the direct reach of government
- ▶ Set their own strategy
- ▶ Have full profit and loss responsibility
- ▶ Can build and retain surpluses
- ▶ Can determine their own pay and conditions
- ▶ Covered by a commercial style insolvency regime

Trading activities

- ▶ Procurement freedom
- ▶ They can borrow commercially
- ▶ They can set up subsidiary businesses & enter into joint ventures
- ▶ Can acquire and dispose of assets (some limits apply)

Oversight

- ▶ To 2014-16
- ▶ Monitor's compliance regime
- ▶ Prudential borrowing
- ▶ More recently quality compliance regime

- ▶ From 2011-16
- ▶ Some oversight of particular 'designated' services
- ▶ Governance only

Flexibilities

- ▶ More in theory than practice
- ▶ Pay and conditions
- ▶ Standards and policies
- ▶ Regulation
- ▶ Public sector accounting rules
- ▶ Protected assets can not be disposed of

Governance

- ▶ Members
 - Staff
 - Public
 - Patients
- ▶ Some flexibility in defining these
 - Still some way to go in defining
- ▶ Governors elected by members 20–40
 - Turnout not very high and falling
- ▶ Some new powers of stewardship in the new B ill
- ▶ Appoint the Chair and Board and can remove them
- ▶ Chair appoints the chief executive

Management issues

- ▶ Chief Executives appointed against criteria set by the trust but there are a number of frameworks available
- ▶ Competency based
- ▶ Non-political
- ▶ Open ended
- ▶ However, it has been a high risk position
- ▶ Turnover has been high



Directors

- ▶ Medical Director
- ▶ Finance Director
- ▶ Nurse Director
- ▶ Others at their discretion
- ▶ Generally 5 Executives, 5 non-executives and a non-executive chair

Medical Chief Executives

- ▶ Not a great history of this
- ▶ There has been an attempt to professionalise management which
- ▶ Pay differentials
- ▶ Giving up medicine
- ▶ Going to the Dark side
- ▶ Risk-reward ratios
- ▶ Career paths and return to medicine

Medical directors

- ▶ Appointed
- ▶ Increasingly full time
- ▶ Try and keep some clinical work
- ▶ Well paid
- ▶ Hard to attract doctors with extensive private practice

Structures

- ▶ Initially flat structures but now a trend to a smaller number of business units
- ▶ Business directorates based around types of medicine:
 - Surgery
 - Medicine
 - Diagnostics
- ▶ Or types of activity
 - Emergency
 - Planned
- ▶ Or a hybrid
 - Specialist care
 - Diagnostics
 - Emergency

Accountabilities

- ▶ Directorates
- ▶ General led by a physician (part time)
- ▶ Appointed (not elected)
- ▶ Support from a senior manager & nurse
- ▶ Aim:
 - ▶ Get clinicians taking responsibility for the management of resources
 - ▶ Service line management developing
 - ▶ Fairly rigorous internal performance management system – but still some way to go
 - ▶ Accountability for performance still weak
 - ▶ Too many internal systems focusing on risk rather than opportunity

Reflections 1

- ▶ Culture change takes a very long time
- ▶ Entrepreneurial culture has not really developed
- ▶ Focus still on top down targets
- ▶ Flexibilities take time to learn
- ▶ Payers need the same sort of flexibility



Reflections 2

- ▶ Investing in management does seem to pay off
- ▶ But, there are risks
- ▶ Management needs a set of skills that are often missing, esp process design, performance management, giving feedback
- ▶ Doctors are missing these too

Reflections 3

- ▶ Autonomy works but requires
- ▶ Strong boards that are well led and have time available
- ▶ Skilled executives – not necessarily medical Chief Exec
- ▶ High quality information systems to support
- ▶ Costing, performance management & quality systems
- ▶ Management structures that delegate to clinical teams but holds them to account
- ▶ Skills and capacity in these teams
- ▶ Aligned objectives and performance management

- ▶ The big issue has always been that most professionals don't want to be managed and that we have increasingly complex and interconnected organisations that required co-ordination and can't do with management.

CREATING EFFECTIVE GOVERNANCE

Paul F. Levy

I was asked to bring lessons concerning effective hospital governance from the United States for consideration by hospital leaders in Israel. This is a risky task, in two respects. First, it is always difficult to overcome the cultural traditions and differences that exist between any two countries. Second, my message to my Israeli colleagues is that more supervision and accountability of hospital directors general is a good idea. It is hard to imagine a country in which that kind of message is less likely to be well received!

Nonetheless, it is the case that effective hospital governance – in the form of an expert and involved fiduciary Board of Directors – brings benefits to the chief executive officer as well as to the hospital and the community. That is the case because a properly constructed Board will provide expertise, advice, and assistance to the chief executive that will be especially useful during times of transition and stress in the health care environment. In addition, Board members can act as the eyes and ears for the chief executive in the community. In that role, they can provide feedback from segments of the community back to hospital management. They can also serve as advocates in the community for the strategic direction and role of the hospital. Finally, they can serve to “watch the back” of the chief executive, to protect him or her from political or commercial adversaries in the community. But, these functions will not be carried out properly if the Board comprises the wrong people or is not properly organized.

The most important official purposes of a governing body is to hire, evaluate, and (as necessary) fire the chief executive. A regular and rigorous performance review process must be put in place to carry out this task. There must also be a common understanding of the job description. Each year, the chief executive and the Board must come to agreement on that year’s priorities and the manner in which success or failure in meeting those priorities will be measured. Each year a formal review should take place. The chief executive should prepare a written self-appraisal. A review panel should take that document and conduct interviews with responsible members of the hospital community to validate the assertions made. That review panel should review its finding with the chief executive and then report on the entire process to the full Board of Directors.



The Board also has a role and responsibility with regard to setting the broad strategy direction for the hospital. While it is the management's job to offer such a strategic plan, the Board has an obligation to consider it and approve it. If approval is not forthcoming, the Board and the CEO must decide if they have a sufficiently common vision for the organization to continue to work together.

Finally, the Board has certain legal and regulatory responsibilities. In the United States, for example, the annual financial audit is prepared for and ultimately approved by the Board.

However, governance can go awry and can end up being destructive to an institution. Boards lose their effectiveness and purpose when they fail to understand the difference between governance and management; when people join the Board mainly to gain social standing in the community; and when Board members seek to gain special treatment for themselves, their families, or their private commercial interests.

How, then, do we organize things to create a high likelihood of good governance and avoid poor results? The answer lies in an explicit discussion of Board roles and responsibilities and in instituting formal processes and procedures that consider the structure and the people of the Board.

Each Board should have a set of by-laws in which the governing structure is clearly defined. Issues to be considered are the number and characteristics of Board members; their responsibilities; terms of office; the existence of standing committees; and quorum requirements. A regular feature should be an annual Board self-evaluation – of the Board as a whole, of each committee, and of each individual on the Board. Term limits are important to ensure that fresh blood is brought into the organization over time, balanced against the need for institutional memory and continuity. A process is likewise needed to decide on the election of the chair of the board and designation of committee chairs. These positions might have term limits that are different from the overall term limits.

One can imagine two broad types of committees for a hospital board. One set would relate to business practices: Audit, compliance, governance, nominating, finance. Another set would relate to substantive areas: Patient care, education, research, philanthropy.

INTERNATIONAL WORKSHOP

The membership of a Board should represent a diversity of backgrounds to bring the largest possible set of perspectives to bear in assisting the chief executive. It is not uncommon to include lawyers, finance people, real estate developers, venture capitalists, and information technology experts. It can also be helpful to have people with experience in community development, advocacy, and public outreach.

The membership of the Board should likewise comprise a diversity of personality types to ensure vibrant participation and discussion. But that very diversity suggests a need for clear rules of behavior in how people will conduct themselves during meetings.

I end with an example of excellent board involvement from Beth Israel Deaconess Medical Center. BIDMC is a major academic medical center (with 600 beds, 900 physicians, and 6000 full time equivalent staff members). The issue under consideration at the time was the scope and scale of the hospital's strategic commitment to the quality and safety of patient care. The senior management and clinical leadership had already made great strides in infection control and other quality improvements and had also made a significant commitment to transparency of clinical outcomes and disclosure of medical errors. Indeed, the staff's implementation of these strategies was well out in front of what the Board's expectations were. The same thing had taken place at our small (40-bed) community hospital affiliate, Beth Israel Deaconess Hospital~Needham.

Accordingly, we organized an intensive educational and decision-making retreat for the two Boards on these topics. After having heard from national experts on the subject, the Boards were asked to codify their hopes and aspirations - as representatives of the community - for the hospitals on this front. They did so in a way that was supportive of the initiatives of the administrative and clinical leadership, but that set a clear direction for the hospital to be in the forefront of the hospital quality and safety movement. Here is the summary of that meeting, as later set forth in a memorandum I sent to the staff of the BIDMC:

Dear BIDMC,

There are some things that we do that are meant to transform our hospital, to set us on a path to very high standards that, at first blush,



appear so audacious as to be unachievable. But if you never take the leap and set out the goals, you never know what you really can achieve.

Today, we announce such goals, in the hope that they will set the stage for such a transformation.

Several weeks ago, the Board of Directors of BIDMC and the Board of Trustees of BID~Needham met and had serious discussions about what their hopes were for our two hospitals. As the representatives of the community who have fiduciary responsibility for our two non-profit organizations, they decided on a pair of goals that represent their aspirations for us. Of course, the clinical and administrative leadership of the hospital were deeply involved in these discussions as well and provided the technical support for the decisions that were made.

The Boards decided that two overarching types of goals were important. The first relates to patient satisfaction. The second relates to safety and quality of care. Here is the vote that was taken by the BIDMC Board (and a virtually identical one was taken by the BID~Needham Board):

WHEREAS, the Board of Directors, Patient Care Assessment and Quality Committee ("PCAC"), and Patient Care Services Committee ("PCS Committee") of Beth Israel Deaconess Medical Center ("BIDMC") have determined that it is in the best interest of BIDMC to set ambitious and overarching goals related to healthcare quality and patient safety, and patient satisfaction.

NOW THEREFORE BE IT RESOLVED AS FOLLOWS:

To approve the following goals for BIDMC related to healthcare quality and patient safety, and patient satisfaction:

BIDMC will create a consistently excellent patient experience. We will measure ourselves based on national benchmarks and, by January 1, 2012, be in the top 2% of hospitals in the country, based on national survey responses to "willingness to recommend." For this goal, BIDMC will measure itself against a national dataset of all hospitals.

BIDMC will eliminate all preventable harm by January 1, 2012. We will accomplish this by continually monitoring all preventable and non-

preventable occurrences of harm, and continuously improving our systems to allow the greatest opportunity to reduce harm.

That Management will develop and implement action plans and programs to achieve these goals, to be reviewed and approved by the PCAC Committee, PCS Committee, and the Board, and will report to the Board, PCAC, and PCS Committee on at least a quarterly basis using defined metrics against which performance will be measured.

Daunting, eh? You bet. Here's more. We will be publicizing our progress towards these goals on our external website for the world to see. In other words, we will be holding ourselves accountable to the public for our actions and deeds. Our steps towards transparency have just been notched up a level.

These Board votes certainly do not mean that we are not already doing a good job now. Our Boards have immense respect and affection for all of the staff who work in our hospitals. They know you take really good care of patients and provide a warm and caring environment for patients and families. But the votes mean that our Board members who represent the community want us to do even better, out of a sense of public service and also out of a sense of pride that we can do better.

Hospital leadership

In a later session of our conference in Haifa, the question was posed as to whether it is necessary for a person to be a physician to be a director general of an Israeli hospital. In the United States, it is not at all uncommon for non-MDs to hold these positions, but to date this has not occurred in Israel.

Several of my fellow panelists suggested that the characteristics needed to be an effective hospital leader – including concern for patients (as distinct from hospital finances), analytic ability, and native intelligence – made it imperative that a physician be chosen for this position. I can't speak for the situation in Israel, but in the US, this kind of generalization and the conclusion drawn would be viewed as silly, insulting, and based on stereotypes that simply have no basis.



While we can acknowledge that physicians will certainly have better technical knowledge of medicine than non-physicians, it is not at all obvious that the skills and knowledge needed to run a hospital require much in the way of that knowledge. Indeed, the chief executive's job does not involve making clinical judgments about particular patients: Those are left to the attending physicians in charge of each case. Where hospital-wide clinical protocols are to be developed, likewise, that is the result of collaboration among physicians. Where choices must be made about the purchase of major medical equipment and construction of facilities, that must be the result of collaboration between medical personnel and business personnel. The job of the chief executive is to ensure that such decisions have proper analytical rigor, both in medical terms and financial terms. There is nothing inherent in the training of physicians that suggests they are more likely to successfully ensure that such discussions and decisions are made. It may actually be the case that experience from other industries would be useful to a chief executive and to the hospital he or she leads.

Creating Effective Governance

The fine line between steering and meddling
Paul F. Levy
International Workshop: Governing Hospitals
National Institute for Health Policy Research
Haifa, Israel -- March 8, 2011

“Official” purposes of governance

- Hire, evaluate, fire chief executive
- Determine broad strategy direction
- Carry out regulatory responsibilities

The real agenda for the CEO

- Engage smart people in offering their advice, experience, and skills
- Liaison with the community: Your eyes and ears
- To watch your back



A worrisome agenda for some board members

To manage, not govern
To gain social standing
To get special treatment

How to get the good and avoid the bad

Need an explicit focus on governance -- not an
after-thought
Structure
People
Terms

Structure

- By-laws and charters
- Committee of the whole, or an executive committee
- Other working committees
- Self-evaluation

Committees

- Business practices: Audit, compliance, governance, nominating, finance
- Substantive areas: Patient care, education, research, philanthropy

People

- Mix of desired skills
- Mix of personalities
- What do you want: “Do, give, and/or get”?
- Rules of behavior

Terms

Continuity vs fresh blood
Selection of chairman
Renewal process



Hospital Governance in Israel

David Chinitz and Avi Israeli
School of Public Health
Hebrew University-Hadassah

Outline

- Musings on Governance
- Intuitions about the Israeli context
- Typology of Cases
- Summary of Governance across cases
- Conclusions

Musings on Governance

- No term in Hebrew
- Governance is an elusive concept
- The accountability wish
- No matter how clear the governance arrangements are laid out
 - There will always be, and maybe should, be areas of “flexibility”
 - Especially in health
 - Especially in Israel

Intuitions about Israel

- Centralization
- “Improvisation”
- Lack of enforcement
- Pre-centralization (Saltman and de Roo 1989)
- Overall: two sectors
 - One strictly controlled
 - One more “fluid”

Overall Governance Frameworks

- National Health Ordinance
- Budget Fundamental Regulations: Rules Regarding Hospital/Health Corporations
- MOF plays big role along with MOH

Typology of Cases

- General hospitals
 - Public not for profit
 - Government owned
 - Health plan owned
 - Private for profit (Health Plan shareholder)



Summary of Governance Across Cases

- Role of Board of Directors
- Autonomy of Hospital Director
- Employment Relations
- Certificate of Need

Presence of Board of Directors

- Public not for profit: Board of Directors
- Government owned: No Board of Directors
- Health Plan owned: No Board of Directors
- Private for profit: Board of Directors

Autonomy of Director (ranking in parens')

- Public not for profit: Subject to approval of Board and MOH for expansion (3)
- Government: Subject to approval of MOH for expansion (2)
- Health Plan owned: Subject to approval of Health Plan and MOH (4)
- Private: Subject to approval of Board and MOH for expansion (1)



Employment Relations

- Public not for profit: National wage agreements, regulated private service
- Government owned: National wage agreements, civil service requirements, more (regulated) flexibility within health corporation
- Health plan owned: National wage agreements
- Private for profit: individual contracts

Certificate of Need

- All hospitals limited by MOH Certificate of Need approval, but sometimes facts seem to get created that can get around this

Summary of Findings


- Hospital governance in Israel is schizophrenic:
 - Strict rules on expansion
 - Strict rules on employment relations in the public/government sector
 - But
 - Flexibility for hospital trusts and especially private for profit



Conclusions

- Combination of centralization and flexibility
- Stopping short of overhauling governance on a national scale
- Perhaps reflects
 - Cultural attitudes towards formal rules
 - Wisdom
- Perhaps leads to
 - Efficiency
 - Inequity
 - Corruption
- Need to
 - Strengthen regulation and transparency






Who is best suited to manage a hospital,
M.D's or M.B.A's?


Avi Israeli

9/3/2011




A healthcare organization management is not just responsible for top financial performance, but also responsible for the quality of care it delivers to its patients

These dual performance goal present top managers with unique challenges that is not present in non healthcare organizations



The combination of dual performance goals and distinct professional backgrounds has given rise to debates about-

who is best suited to manage a healthcare organization?



Is it- the managerially educated executives, who understand the financial metrics of an organization and believe that their primary allegiance is to the organization even if it comes at the expense of the patient



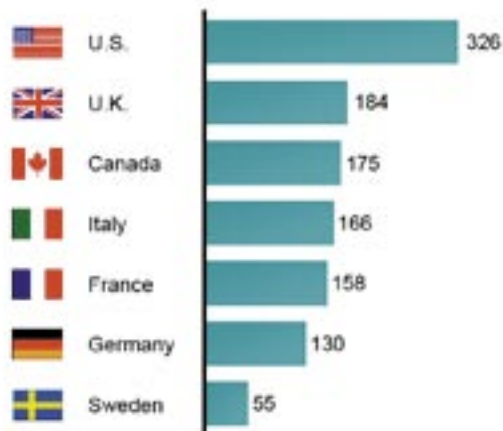
Or is it- the medically educated executives, who understand and are attuned to the requirements for quality patient care, and believe their primary allegiance is to their client/patient and less appreciate the financial impact of their decision

The McKinsey groups together with the LSE have conducted over 40 interviews and studied almost 1,200 hospitals in Canada, France, Germany, Italy, Sweden, the United Kingdom, and the United States

S. Dorgan, D. Layton, et al. Management in healthcare: why good practice really matters, McKinsey&Comp and LSE, 2010.

They interviewed almost 1,200 hospitals across 7 countries

Number of interviews

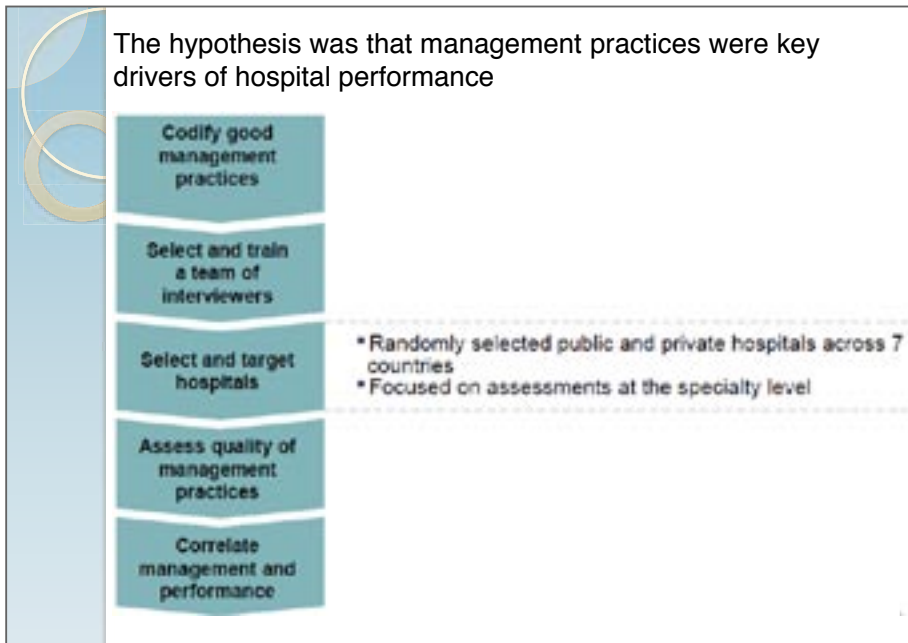
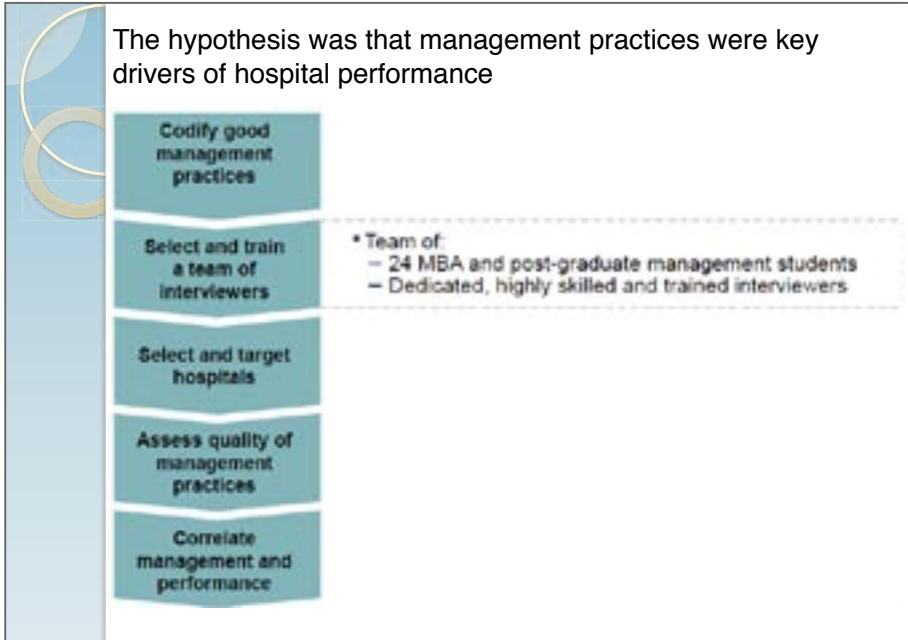


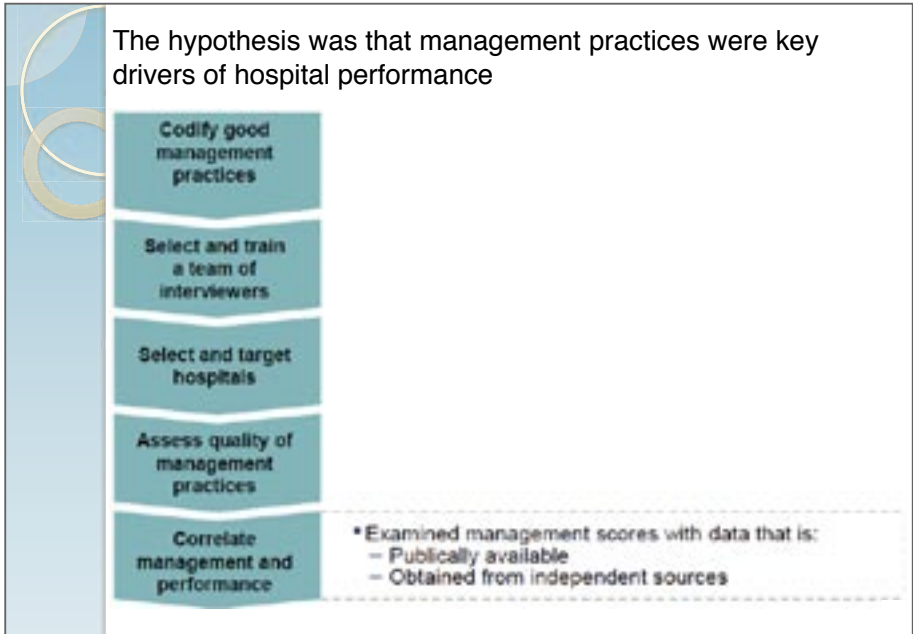
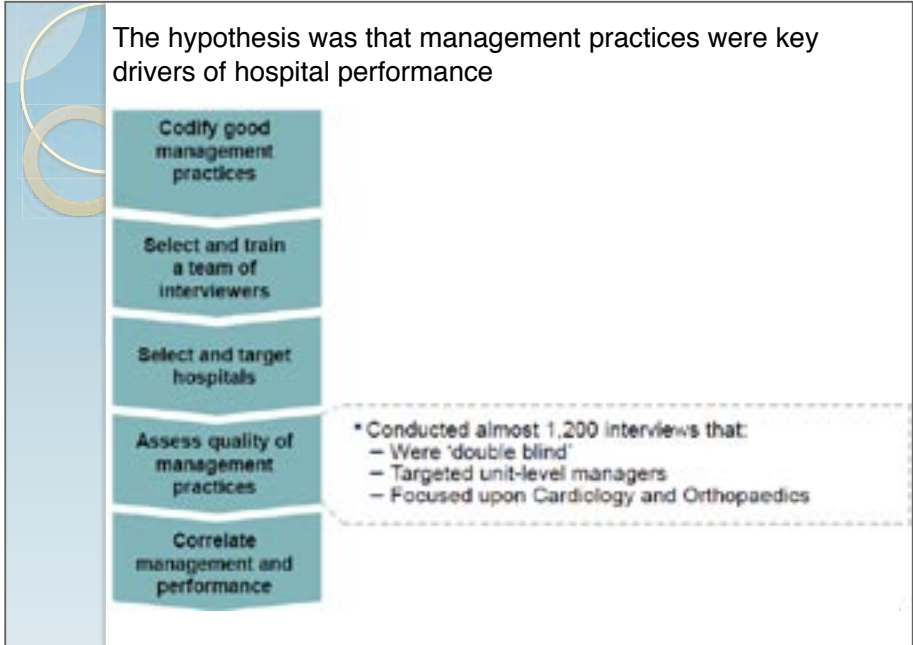
Healthcare management practice findings

- Management really matters**
 - Management practice is strongly related to:
 - Clinical outcomes
 - Patient satisfaction
 - Hospital financial performance
- There is large variation**
 - UK healthcare management practice:
 - Good UK average score Vs others
 - Large intra-country variation creates a real opportunity for improvement
- Improvement is possible**
 - 5 factors are associated with better management practice:
 - Share of clinically trained managers
 - Degree of competition
 - Hospital size
 - Managerial autonomy
 - Hospital ownership

The hypothesis was that management practices were key drivers of hospital performance

- Codify good management practices**
 - Based upon our *Management Matters in Industrials* work:
 - Defined 20 scoring dimensions focusing on:
 - Lean hospital operations
 - Performance management
 - Effective talent management
- Select and train a team of interviewers**
- Select and target hospitals**
- Assess quality of management practices**
- Correlate management and performance**







Healthcare management practice findings

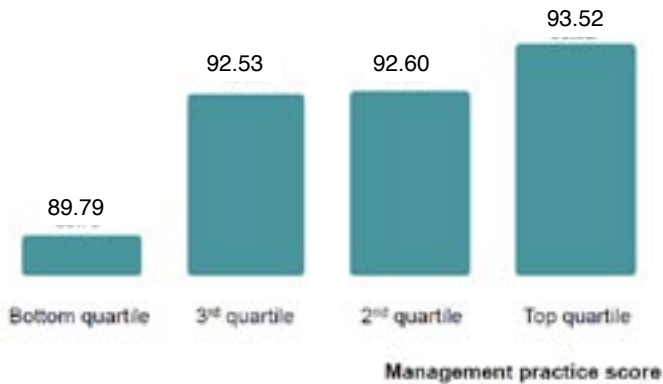
There is a strong relationship between specific hospital management practice scores and specific hospital health outcomes


The management practices assessed were those determining how well hospital operations, performance, and talent were managed

The results were that hospitals with higher management-practice scores had better clinical outcomes

Exhibit 4. Good management is correlated with adoption of clinical best practice

Clinical best practice index*






The hospitals with the best management practices (analyzed as if they made things rather than curing people) also ranked best on a standardized measure of medical success: death rates among emergency patients experiencing heart attacks. That score works across countries and cultures, and has unambiguous results.



Additional findings

- In the United States, there was a positive relationship between management score and financial performance
- In the United States, Germany, and Sweden, there was an association between higher management scores and the adoption of clinical best practices
- Hospitals which scored well in one area of management tended to score well in all of them



Therefore we can assume that improving management practices is definitely a way to raise both quality and productivity



Additional findings

There is a particularly strong relationship between management scores and the percentage of managers with clinical degrees

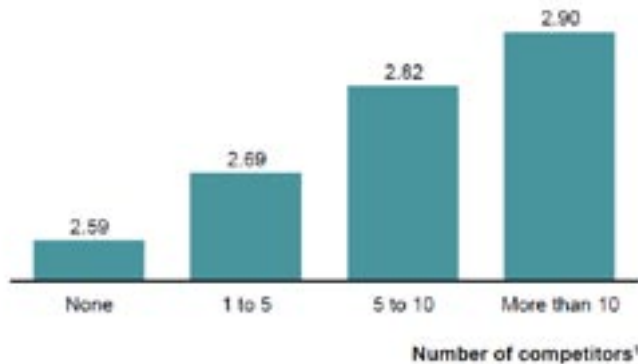
There is a strong relationship between an increase in the number of managers with a clinical degree and an improvement in the organization's management score

McKinsey's and LSE's research led them to focus on five factors which affect and lead to better management

1. Competition- competition appears to foster better management

Management quality is strongly correlated with perceived competition

Management practice score



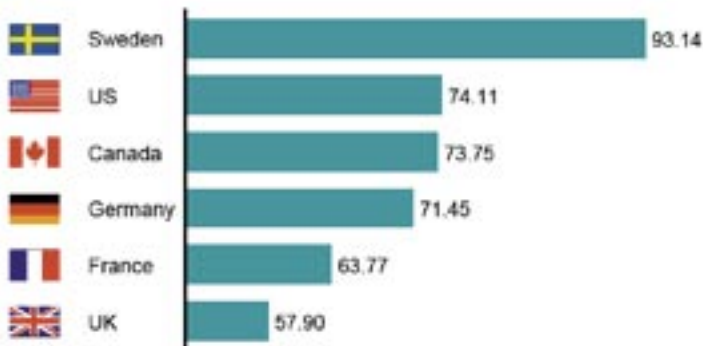
2. Skills- hospitals with more clinically trained managers enjoyed better overall managerial quality

Hospitals with more clinicians as managers have better management scores
Management practice score relative to national mean*



There is wide variation in the prevalence of clinically trained managers by country

Percentage of managers with a clinical degree*



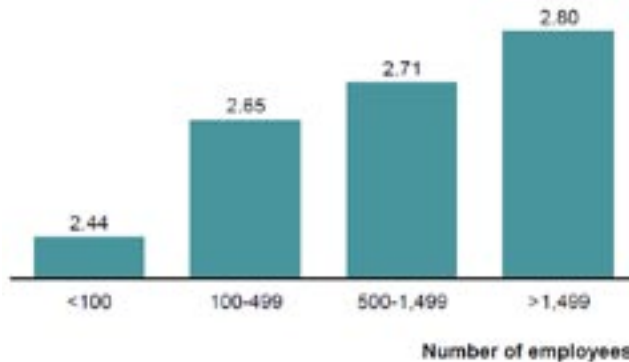
* Italy excluded as it is a legal requirement that all general managers have clinical degrees



3. Scale- management practices are better in larger than smaller hospitals

There is a strong relationship between hospital size and management practice

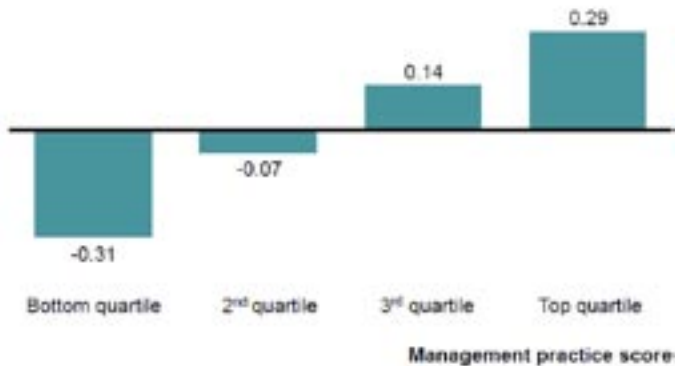
Management practice score



4. Autonomy- higher-performing hospitals have managers (who are often clinicians) with higher levels of autonomy than lower-performing hospitals

Managerial Autonomy is correlated with management practice

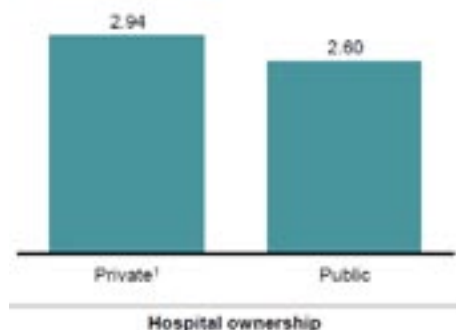
Managerial Autonomy



Ownership type- a robust cross-country finding is that private hospitals score higher than public hospitals in our management measures

Private hospitals tend to have higher management practice scores

Management practice



¹Private includes both for profit and not for profit organization

Putting it all together- management matters in hospitals and furthermore, people who combine clinical and managerial skills are the key to better management performance

These findings pose some questions for UK policy makers

- How can the trend to more clinically qualified managers be accelerated to close the gap with other countries ?
- How can greater competition be fostered ?
- Which conditions need to be in place to give managers increased autonomy ?
- What role could diversity of provision play in raising the bar ?
- How could greater talent management flexibility be realistically introduced into the system ?



- using techniques more commonly applied to identify excellence in manufacturing industry. The hospitals with the best management practices (analysed as if they made things rather than curing people) also ranked best on a standardised measure of medical success: death rates among emergency patients experiencing heart attacks.

Among the questions to be discussed are:

- What should physicians learn when they study management, and what they do?
 - Does management training influence their performance, and how?
 - Can physicians achieve managerial skills and even excel in performance without special training? Perhaps by natural selection the best doctors with managerial skills will surface among the clinicians without training imposed from the outside.
-
- What are the various stakeholder interests surrounding this issue?
 - Do we really need physician/managers, or should we rely on professional managers? Are hospitals really all that different when it comes to management?
 - Are the answers to these questions different or special when we speak of the role of Hospital Director?

CORPORATE GOVERNANCE IN A PUBLIC HOSPITAL UNDER PRIVATE OWNERSHIP: THE HMO EXPERIENCE

Yossi Nitzani

Many years ago, I received a telephone call at my office. At that time I managed and owned an investment house in the Israeli capital market. On the other end of the line was a woman who spoke to me in English, and she suggested that we meet over a cup of coffee at a location of my choosing. The woman introduced herself as the National President of Hadassah, Women's Zionist Organization of America, or as formally known HWZOA.

Within the hour, Marlene Post arrived at my office; a very pleasant woman, brimming with vitality and with a sparkle in her eyes. Every word that she spoke was full of excitement, creativity, passion, leadership and genuine charisma. She told me about the decision taken by Hadassah, the largest Jewish organization in the world (outside of Israel), to establish a Board of Directors that would take responsibility for managing the Hadassah Medical Organization (HMO) its Medical Center in Israel. She added that the board's job would be similar to that of a business run by a Board of Directors, with similar managing authorities, and she requested that I be a member of that board.

After Mrs. Post outlined the key characteristics of Hadassah and its main activities, which at the time I was not familiar with, I asked her three questions prior to giving her an on-the-spot positive response:

1. Is management of the organization in full agreement with HWZOA's decision and does the organization recognize and understand the key ramifications of this decision, i.e. transferring responsibility for managing the organization from HWZOA to the Board of Directors?
2. How frequently would the board and its committees meet and where will the headquarters of the medical center be located?
3. What will be the makeup of the board's members in terms of skills and citizenship, and who will chair the Board?



When I asked these 3 questions, I believed that the information was critical for me in order to make my decision. I did not realize how truly important it would be in the future.

I emphasized to Mrs. Post, that my expertise in the healthcare industry is only slightly greater than one who reads the daily newspaper. Fortunately, I had only several days' experience, having been hospitalized within the Israeli healthcare system, and my experience was generally complimentary. That was the extent of my experience, and it had nothing to do with Hadassah.

Mrs. Post responded that HWZOA had investigated my background and I had what they were looking for: experience in running a business, a rich management background, and the ability to lead.

This is how the first Board of Directors of the Hadassah Medical Organization was established in 1996. I had the honor and privilege of serving as a member of the board, from the day it was established until March 2010, and during the last two years I served as its Chairman.

The control and management structure of the Hadassah Medical Center are unique in Israel, a consequence of the type of initiative it took to establish it and the nature of its controlling interests. HWZOA, which was established in the US as a voluntary organization almost 100 years ago, numbers nearly 300,000 members and has branches on just about every continent. The headquarters of the organization is located in New York. The organization under the leadership of its founder, Mrs. Henrietta Szold, set as its first goal to establish public health services for Jews, who were beginning to gather in Israel at the beginning of the 20th century. To this day, the jewel in the crown of its activities is its Medical Center in Jerusalem, situated on two campuses: Ein Kerem and Mt. Scopus.

The Medical Center in Israel is its largest and most pivotal project. The Medical Center employs close to 6,000 employees including 850 physicians, 1,940 nurses, and over 1,000 paramedical staff. HMO treats more than one million patients annually, without regard for religion, nationality, race, gender or political belief.

As a key part of the Medical Center and the medical services it provides, HWZOA, together with The Hebrew University of Jerusalem, established Israel's first medical school.

Based on this background, I would like to focus on two key elements: the governability structure of the Medical Center and its management i.e. its corporate governance and the role of the regulator directing the health system, as well as some of the regulator's dilemmas.

With its establishment, the Board of Hadassah received similar authority to that of a public company:

- ◆ To design business policy
- ◆ To develop auditing tools and supervise management
- ◆ To formulate and establish work plans, operating and development budgets
- ◆ To appoint the CEO and approve senior management.

Key insights that owners and management of HMO had to adopt were that each level of organizational hierarchy needs to know its place, its functions and its areas of authority. In the event that one of the three levels directing the corporation: owners, management or board attempts to make inroads into the other's leadership and/ or enter the others' shoes, the organization's activities will be disrupted and its ability to function and develop will be damaged.

With the establishment of a Board of Directors, HMO had to deal with its first challenge: a change in management culture from one that had been in place for many years. In essence, the Medical Center had been managed directly by Hadassah's National President and her team, representing the owners and they directed HMO's Director General, its CEO. The entry of an intermediary factor, i.e. a Board of Directors, between the two was not a trivial matter. It required a change in duties, functions and attitude toward the board, from the standpoint of both owners and management, as well as the labor unions.

As in any business, the board of directors and the General Assembly of shareholders serve not only to provide direction and supervision, but also as a "tool" in the hands of management. They need to make resources available to the organization and to be of assistance to management in fulfilling their difficult assignments and responsibilities. The central role in a company



is fulfilled by management. Management is generally the initiator and the promoter, struggling with the daily challenges, and is the first to see the shining rays of the strategic vision that will illuminate the path forward. In most cases, management will provide the Board and owners, with the needs, characteristics and advantages of the path down which the organization is going.

Every organization, whether or not a business, must formulate and stick to a multi-year strategy while being alert to external changes that may require adjustment to the strategy over time. In doing so, the organization should adjust its available resources, so that the Board can successfully cope with the changing business and professional environment in which it operates.

Medical center management, even if controlled by the public sector, should function the same as any business entity. I come from one of the most supervised and regulated sectors in Israel, as well as in most Western countries: the capital markets. HMO, even though it is not owned by the public sector, as is the case with most of Israel's other medical centers, has and continues to operate under the supervision of a regulator: the Israel Ministry of Health.

Generally, there is a need for regulatory supervision in the public services sector. This supervision is designed:

- ◆ To create an ethical framework in which the organization operates;
- ◆ To intervene when the market fails;
- ◆ To prevent conflicts of interest; and
- ◆ To ensure a proper balance between business and social welfare considerations, an issue that today fills the pages of the Israeli press.

Throughout the years, the construction of Hadassah's two hospitals and their ongoing equipment needs were almost entirely funded by HWZOA – the “Hadassah Women” – via their fundraising efforts among American Jewry. Today, more than 90% of HMO's annual income is as a result of the selling of services and the commercialization of scientific innovations. The balance is provided by financial support received from the owners, the majority of which is funneled towards the development and equipment budget. The Government's involvement in HMO's activities was, throughout the years, very sporadic and marginal, to zero.

I do not want to delve into the financial structure of HMO, but suffice it to say, that any comparison of HMO to most large Israeli medical centers, some of which are owned by the government while the rest are owned by the health funds, is similar to comparing different NBA basketball teams with each other. The common denominator is that they have owners who participate in financing or claim to finance their activities. Everyone is looking for sponsors who will provide the necessary funding for equipment (players) and development. All are developing auxiliary activities in order to broaden the scope of their activities, aimed at increasing financial resources, and all are dependent on steady customers or subscribers. An additional common denominator is that both aspire to excellence and are judged by results.

In contrast, each and everyone has a different owner, a different target audience, not just in terms of business guidelines and attitude, but also in regard to the “depth of their pockets”.

Returning to the Israeli hospitalization system, HMO does not have an “affluent captive audience” and does not have anyone to cover its financial deficit. In some years HMO does not have “deep enough pockets” to absorb the budget deficits, well-known to most Israeli medical centers. Additionally, in the case of HMO – as opposed to other Israeli hospitals where the government fulfills the role of both owner and regulator – the government is only the regulator and not an owner.

As previously noted, HMO’s owners are the Hadassah Women. The Board has one third American representation by the owners, including HWZOA’s national president; one third of American directors from the field of medicine and other varied business endeavors; and only one third of the directors are Israeli business people or scientists. To date, the CEO has always been Israeli.

I am proud to say that the establishment of a managing structure such as this by HWZOA, ignoring for the moment the composition of the board that will be discussed later, was a breakthrough that set benchmarks, in several different spheres, in the desire to incorporate hospitals in Israel.

At this point, I would like to note the similarities, not between publicly run hospitals in Israel, but rather between the Hadassah Medical Center and a different business of which I have the honor to sit on its board.



Three years ago I joined the board of Teva, a well-known company in the health industry. Teva is a multinational public company that manufactures medications. It is the largest generic drug company in the world; established in, and managed from Israel. Teva is located in 60 countries and employs 40,000 employees, of which only a small minority are Israeli. The majority of the stock holders are American investors and there is no single controlling group.

The relevancy of the comparison between HMO and Teva can be noted in several different parameters:

Ownership: Teva is a publicly owned company, with no single controlling interest. HMO is owned by HWZOA, the Hadassah Women's Zionist Organization of America.

Location of activities and markets: Teva is an international company whose business is spread across the world. HMO is located and provides medical services to the public, mostly in Israel.

Venue of Management: TEVA and HMO are almost similar in this regard. Teva's board, management and CEO, all operate from Israel. HMO's board operates from Israel and from NY. The CEO and management of HMO are located in Israel.

Composition and nationality of management and the board: The CEO of both TEVA and HMO are Israeli, however the majority of Teva's board is Israeli, while HMO's Board is comprised mostly of Americans.

In summary, Teva shares are listed and traded on the Israeli Stock Exchange, its head office is in Israel, and the majority of its directors and senior management are Israeli. The CEO is Israeli and operations are directed from Israel. HMO is a privately owned Israeli entity with its head office in Israel and an Israeli CEO, but the majority of its directors are American and the board operates mostly from NY.

This leads us directly to the importance of understanding the environment and culture within which the Medical Center operates:

- ◆ As mentioned, the Hadassah Medical Center operates in Israel. It is subject to the law and regulations of the state, and functions within the Israeli healthcare system.
- ◆ The vast majority of its employees is members of Israeli labor unions, and is bound by national work agreements. As a result, approximately 75% of HMO's operating expenses are under marginal control of management, if at all.
- ◆ HMO operates mostly in Jerusalem. On the one hand it is Israel's largest city, but on the other hand, its population is among the weakest economically.

A board that does not live within this reality may find decision-making to be disconnected from the facts on the ground, as was, from time to time the case with HMO, thus creating unnecessary difficulties. The board is locked into a position where two thirds of its members are residents of the US and are familiar and well versed in the environment surrounding the American healthcare but not the Israeli one.

I do not rule out the participation of knowledgeable and experienced residents from other countries on the board of an Israeli medical center or any other business entity. Hadassah's board has been blessed with many such individuals. However, this is a prime example of where quantity which later turns into quality, is not necessarily the desired outcome.

There is no doubt that hospitals must be part and parcel of the society they serve. They must be managed by a board and CEO who are well acquainted with the culture of the customers, providers and employees. If this is OK for Teva, it should also be OK for Israeli medical centers.

As in all business activities that function within a legal framework, it imposes limitations on the one hand, but is designed to create a balance between business interests and the public good. When it comes to medical centers we are dealing with public health and life.



The biggest challenge for the regulator, both in the capital markets and in the healthcare industry, is to allow for maximum professional freedom while simultaneously ensuring an optimum level of professional services to the public, and allow for fundraising and business considerations. It was for good reason that recently the Israeli regulator defined medical centers as “companies for the public benefit” and not just another “non-profit organization”.

In view of the above the following should be noted:

1. It is up to the Regulator to deal with an equation of three unknowns. The first is the legal obligation to provide every citizen insured with national health insurance, optimal health services within the framework of budget limitations. At the same time the State should encourage scientific excellence on the one hand and minimal intervention in allocating customers within the hospitalization system on the other. This is not an easy task for any country, and particularly so when there is a significant geographic and social gap between the center of the country and its periphery.

The second is limiting auxiliary activities that accompany direct medical services and are provided by medical centers, as long as these limitations are dependent on the national budget and – as it is claimed – are being imposed, in order to free up resources that will be directed to serve the general public good. Certain types of limitations, such as limitations on private medical services or on medical tourism, are mostly imposed in order not to give preference in supplying health services to affluent communities. At the same time, preventing medical centers from generating additional resources for their development, will damage their ability to develop and serve the general public in the future, at a higher level.

The third unknown in the equation, is a lack of funds to build new hospitals in Israel. Until now, the construction of new hospital buildings in Israel was in most cases financed by major donors. The limited size of the government’s budget and the government’s priorities prevents the allocation of resources for the renewal, expansion and construction of new buildings for public hospitals, with state-of-the-art technology, as is necessitated by improved standards of living and scientific and technological levels advancements being achieved in Israel.

The development and placement of healthcare services, ranked among the finest and most advanced in the world, will allow for successful competition with other advanced international medical centers, and will, in the future, increase health services resources in Israel.

2. It is up to the board to formulate appropriate modern management norms, suitable to managing business entities while being bound to the Regulator. As an example, several years ago, Hadassah's Board, in cooperation with the professional union, instituted for the first time in Israel rotating chairmanships of hospital departments. I see this as a key milestone in improving the management and operation of Israeli medical centers.
3. We must preserve "the separation of duties and functions" between the three levels of organizational control: owners (separate from the Regulator), the board and management.

The Israelis among us are familiar with the case, regarding the debate on strategic issues, which, in recent years, took place between the owners and the Board of Directors of the Hadassah Medical Center. The debate centered around two issues: the appointment of the CEO and prioritization in the allocation of resources in favor of the Medical Center's development. As Chairman of the Board, I was fortunate to have lead that debate and believe that it can serve as an example of issues that continue to arise. It is the prerogative of each controlling or managing level to define boundaries, within which it functions at the relevant level.

In conclusion, I would like to note that despite the difficulties mentioned above, the Israeli healthcare system is advancing in the desired direction in terms of: construction projects at its disposal; the most advanced technology that it acquires; and with regard to the high scientific level that exists and would not put any medical center in the most advanced country in the world to shame.

The Israeli healthcare system has a long way to go but I have faith in the abilities of medical center managements, together with the Government of Israel via the Ministry of Health (as regulator), to advance in this arena as well.



What makes medical doctors the ideal hospital directors?

Leonid A. Eidelman, MD
President
Israeli Medical Association

International Workshop on "Governing Public Hospitals"
The Israel National Institute for Health Policy Research
March 9, 2011



Running a hospital is not like running any other enterprise

- Heart of medical practice and research
- Decision-making on medical policies required on an hourly basis
- Tough choices in prioritizing medical vs. budgetary needs
 - Patient provision of the most clinically & cost effective drugs
- Medical knowledge and expertise tested every day
 - Ever changing myriad of complex medical conditions e.g. H1N1
- Director must answer questions of life and death
 - Withdrawal of life support



Running a hospital is not like running any other enterprise

- Need to distinguish between ordinary and unusual circumstances
- Daily encounters with medical doctors, patients, families, researchers, etc.
- Constant need to balance medical routine with emergency situations
- Serving mass populations / public health whilst subject to strict financial constraints
- Complex hierarchy and interpersonal relations among medical personnel



Why doctors are the best qualified to run hospitals

- Education
- Training
- Research
- Human/social experience



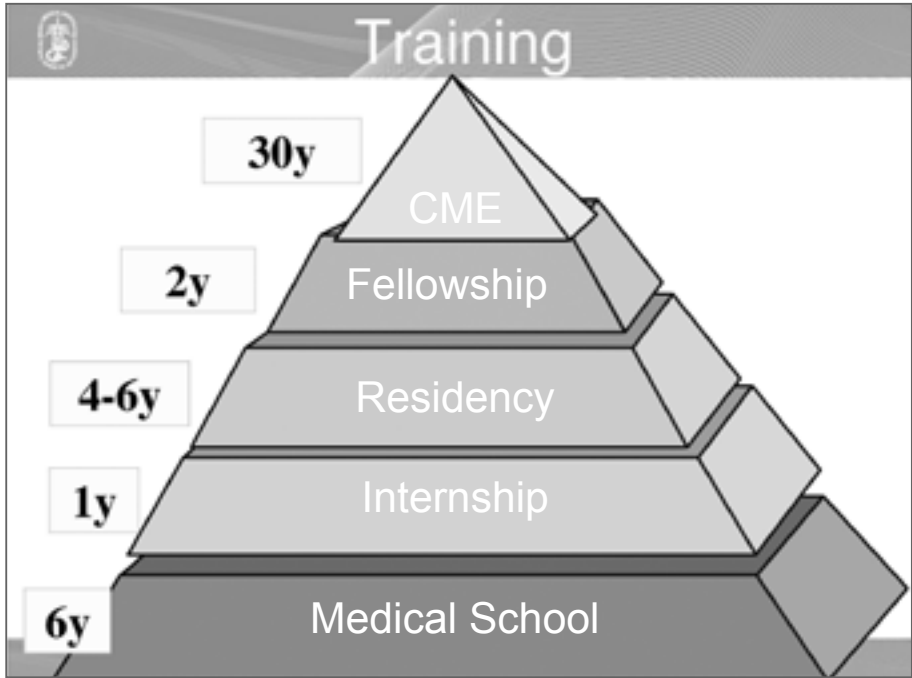
Education

- Selection
- Long process
- Demanding process



Traits of personality

- Ability to learn
- Competiveness
- Perfectionism
- Practical approach
- Person-concentrated approach



-
- The slide is titled "Training" with a logo in the top left corner. It contains a bulleted list of factors:
- Responsibility
 - Stresses
 - Challenges
 - Demands
 - Hours
 - Problems




World of medicine

- Peculiar people
 - Specific people (doctors, nurses etc.)
 - Regular people in specific situation (patients)
- Values
- Language
- Hierarchy
- Tradition




Why doctors are the best qualified to run hospitals

- Most experienced at coping with hospital challenges
- Possess the most relevant knowledge and expertise: medicine
 - improve responsiveness to 'changing patient demands'
- Understand how doctors/medical professionals think and behave




Why doctors are the best qualified to run hospitals

- Have coped with the most challenging medical dilemmas starting from internship
- Have passed a tough selection process throughout their careers
- Proven skills in learning and decision-making
- Strong background in sciences and mathematics (for applying to business, economics, etc)



Additional learning



Management

Physician

Legal studies

Social studies



Doctors' greatest advantage as hospital directors

When making hard decisions, doctors can't be manipulated by "heartbreaking" human stories nor can they turn into corporate machines that forget about people and consider only money. Doctors know about hospitals more than any professional manager and draw from their experience in the field

Conclusion

There is no substitute for doctors in coping with the challenges of hospital management

HOSPITAL CEO: Physician or Non Physician? Pros and Cons

Ehud Kokia
March, 2011

What is Hospital management?

Hospital administration is the management of the hospital as a business. This requires the providing leadership and direction for medical and health care managers as well as conducting the business aspects of the hospital's operations

Responsibilities - Business Aspects

- ✓ Management of human resources and personnel
- ✓ Determining the appropriate organizational structure
- ✓ Establishing policies and procedures
- ✓ Maintaining of computer systems and databases
- ✓ Allocation of budgets
- ✓ Tracking Accounts and Finances
- ✓ Coordinating with professionals, staff members and other employees and assigns their duties and tasks



Responsibilities – Address Doctors’ Needs

- ✓ Interact, engage and coordinate with physicians, surgeons, nurses, health care technicians and other staff members involved in the care, treatment and rehabilitation of patients
- ✓ Address specific needs of the medical staff
- ✓ Make sure medical staff able to perform primary duties of looking after patients, professionally and ethically

Responsibilities –Patient’s Medical Care and Well-being

- ✓ Ensure availability and deliverability of quality facilities and amenities for all patients
- ✓ Motivate medical teams and allied health professionals to perform roles, tasks and functions to best of their abilities to make patients feel comfortable at all times

Other Responsibilities

- ✓ Interact with governing board
- ✓ Interact with regulators
- ✓ Undertake review of policies and frameworks
- ✓ Establish programs for medical research
- ✓ Public awareness campaigns
- ✓ Public Relations and fundraising
- ✓ Attend fundraising events, Professional industry conferences, other relevant community events

Physician or Non- Physician?

- ✓ Historically, many countries required that a hospital CEO be a physician
- ✓ Over the past 50 years, this requirement has been dropped in most countries in favor of advanced degrees in administration
- ✓ Today, most countries require a graduate degree in healthcare, public or business administration
- ✓ Doctors who have graduate degrees in administration and proven success in management of healthcare institutions are often seen as preferred candidates

Physician or Non- Physician?

Physician managers who are also qualified administrators have an advantage over non physician managers:

- ✓ in addressing doctors' needs, coordinating with and supervising doctors and other health professionals
- ✓ in motivating medical teams
- ✓ In understanding complex medical issues



Physician or Non- Physician?

Despite the advantages of a medical degree for a hospital administrator, it is not a prerequisite:

- ✓ The need for high level administrative and management skills outweighs the need for medical knowledge
- ✓ A high level administrator can supplement his lack of medical knowledge by hiring a qualified medical director
- ✓ The “business aspects” of hospital management are more compelling in today’s, modern complex healthcare delivery systems

What Should Physicians Learn When They Study Management?

- The ability to think about the organization or administrative unit for which he is responsible globally.
- The ability to understand organizational structure and processes as well as know-how in implementing organizational processes
- The ability to lead strategic planning and to oversee its implementation
- The ability to persuade, motivate and influence others

What Should Physicians Learn When They Study Management?

- Effective communication in writing, interpersonal discussions and formal presentations
- Computer skills
- Skills in financial administration and personnel management
- Understanding the business of medicine as well or better than the practice of medicine

Does Management Training Influence Their Performance and How?

- Management training that provides physicians with the understanding and skills described above does influence his performance
- It influences performance by changing the way in which he thinks and perceives and it provides him with a new skill set that enables him to act on what he perceives and thinks



Can Physicians achieve managerial skills and even excel in Performance without special training?


- There are always people – both physicians and non- physicians, who are “natural managers” – that is intuitively have many of the personality characteristics and skills required for leadership and good management
- This is a minority of people and even they perform better with special training
- Those who excel in performance are those who understand that they need to be constantly improving and expanding their knowledge and skill sets.

Do we really need physician managers or should we rely on professional managers?

- In every case, it should be whoever has the better training, the appropriate personality and skill set . “Prior to training in management, doctors are missing a lot of the fundamentals of management because they never took them as part of their medical training – they never even thought about managing” (Jim Pealow, Canadian College of Health Services Executives)

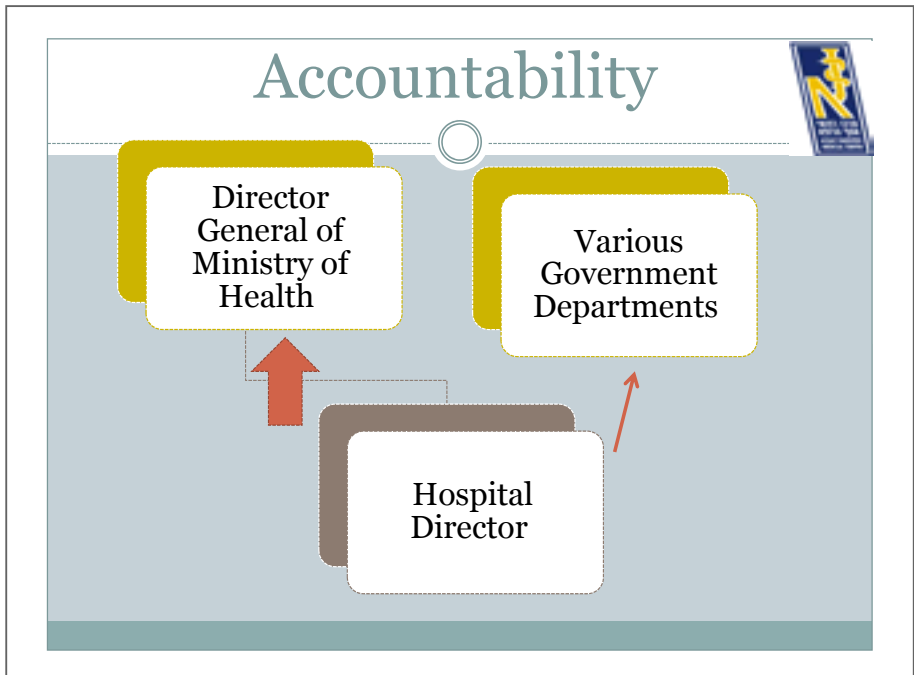

Do we really need physician managers or should we rely on professional managers?

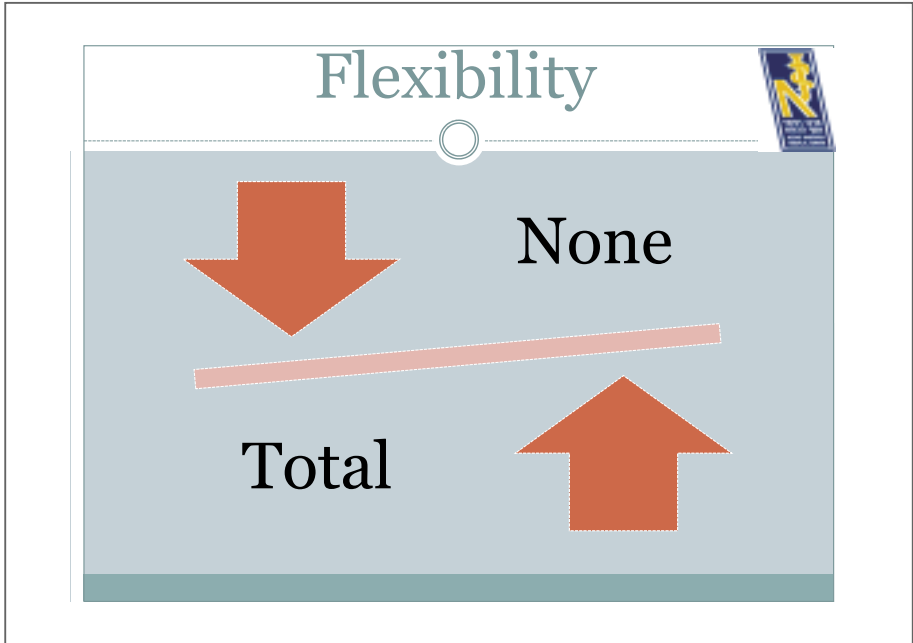
- Physicians make better health care administrators because they have a feel for the bottom line in healthcare, which is the provider –patient relationship.
- In a healthcare system that is complex, troubled and challenging, the physician CEO brings a unique set of skills to the business of medicine providing he understands the business of medicine as well as he understands the practice of medicine.



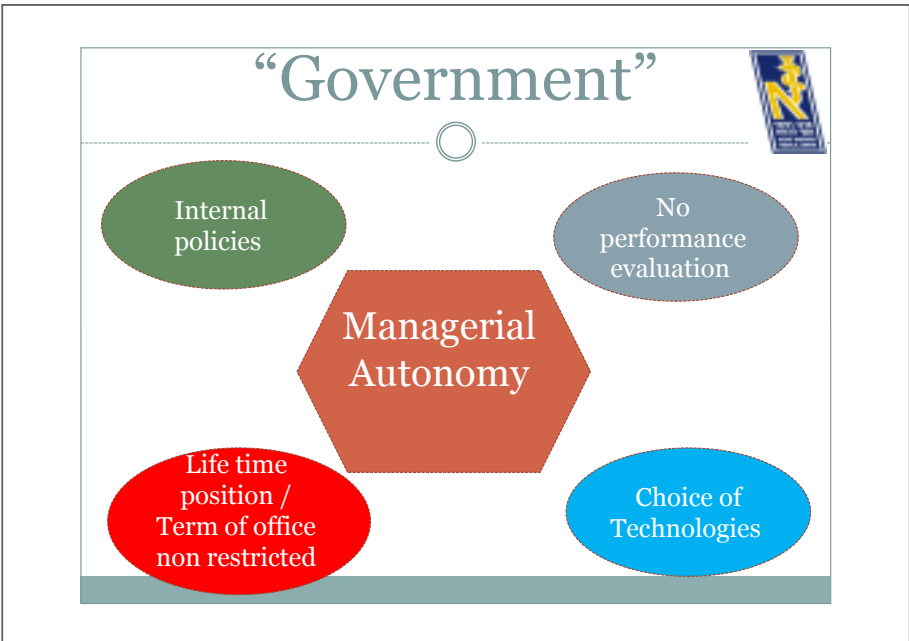
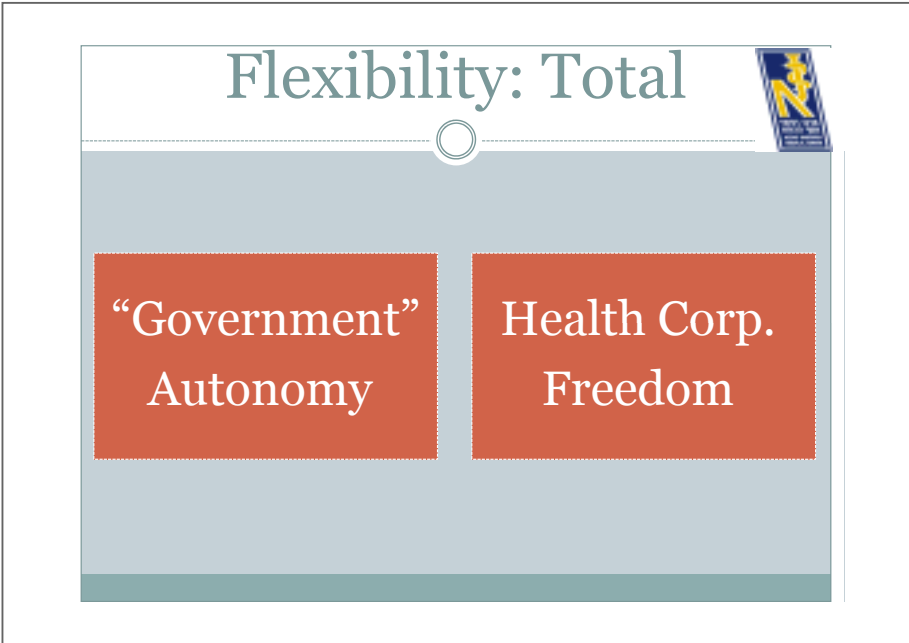
Managing a Government Hospital

Benny Davidson M.D, M.H.A
Assaf Harofeh Medical Center





- ### Flexibility: None
- Laws, Regulations , Directives
 - Hire & Fire
 - Budget
 - 75% salaries
 - 20% Autopilot....
 - **5% flexibility.....**





Health Corp.



15% of the government budget:

- Hire and Fire
- Purchasing
- Building
- New projects

ALL IN ALL

“IT AIN’T TOO BAD...”

Governance of Hadassah Hospitals

Yair C. Birnbaum, MD, MPA
Associate Director General
Director Medical Services
Hadassah Ein Kerem Hospital



A Few Comments Before Starting ...

On Hebrew Words

On Hebrew Words

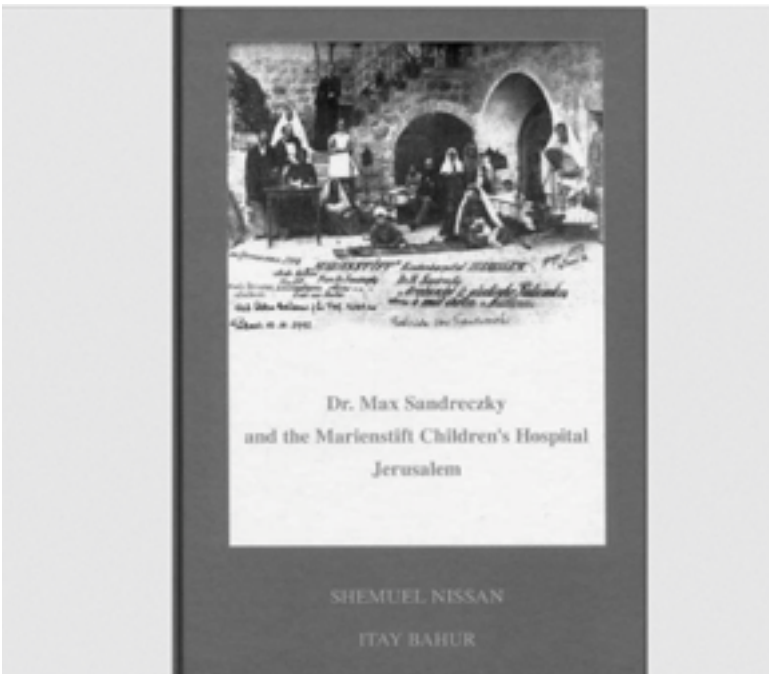
- **What do these numbers stand for**
 - 8150
 - 25000
 - 450000



On Hebrew Words

- **What do these numbers stand for**
 - 8150: Number of words in Bible
 - 25000: Number of words in Hebrew Dic.
 - 450000: Number of words in Webster Dictionary

Governance: An Historical Glimpse...



A Glimpse on Governance in Jerusalem Hospitals

- **Between the years 1872-1897, a German Catholic pediatric surgeon operated a children's hospital in Jerusalem.**
- **The hospital served the multi-ethnic population of the greater Jerusalem area.**
- **Although operated by a fervent Catholic believer, the hospital was approved ("kosher") by rabbinical authorities during the later half of its activity.**

The Governance of the Marienstift Children's Hospital

- **Dr. Max Sandreczky used to correspond with existing and potential donors.**
- **The communications dealt with a range of issues which are common, even today:**
 - **Personal stories of patients and staff**
 - **Needs of the hospital**
 - **Capital development**



Ward in the Marienstift



Kinderhospital Marienstift Jerusalem

The Governance of the Marienstift Children's Hospital

- **In 1893, Dr. Sandreczky felt he had to explain to his supporters why "the Marienstift Children's Hospital had no governing board". (ועד מנהל)**
- **The first board was dissolved with no intervention by Dr. Sandreczky. The members did not suit the purpose for which they were nominated.**
- **Dr. Sandreczky could not form a second German board because all the possible candidates from the small community in Jerusalem were already involved in their own institutions or connected to one another in other ways.**

The Governance of the Marienstift Children's Hospital

- **The formation of a Germany-based board was not practical. In order to accomplish this, Dr. Sandreczky felt he had to spend significant time in Germany.**
- **"But there are those who know that my work and family obligations did not allow me to visit my homeland during the last 19 years."**



Experience has shown that success can be accomplished even without a governing board, like the Schneller Orphanage.



The Governance of the Marienstift Children's Hospital

- **At the end of his words regarding the issue of a governing board, Dr. Sandreczky refuted the notion in theological terms that such a board is necessary.**
- **The fact that the hospital was active and successful without a board was a sign that this was the will of the Lord (voiding the mistaken human notion).**
- **"I will work as He wills and as He guided me."**

Fast Forward to Hadassah Hospitals



Glossary

- **HWZOA: Hadassah Women’s Zionist Organization of America**
- ~~HMO: Health Maintenance Organization~~
- **HMO: Hadassah Medical Organization**
- **BOD: Board of Directors**

Background

HWZOA, the owner of the HMO in Jerusalem, was founded in 1912.





Background

- **The organization laid the framework for the public health system in Israel and later on, for the hospital system.**
- **In 1918, Hadassah took over a small hospital in the center of Jerusalem and opened its own hospital on Mt. Scopus in 1939.**

First Hospital Opened in 1918



Mount Scopus Campus Completed in 1939



Hadassah Medical Organization's Hospitals in Israel

- **Jerusalem**
- **Tel Aviv**
- **Haifa**
- **Beersheva**
- **Safed**



Background

- **During the War of Independence, the hospital on Mt. Scopus was vacated and inpatient services were provided in a few locations in the center of town.**
- **After the War of Independence, Hadassah handed over the public health system and all hospitals outside of Jerusalem to the government. Hadassah dedicated its efforts to create a strong academic tertiary care center in Jerusalem.**

Background

In 1961, the Ein Kerem campus was dedicated.







Background

In 1976, Hadassah returned to the renovated Mt. Scopus hospital.



Governance Up To 1997

- **Governance was based on the leadership of HWZOA interacting mainly with the Director General.**
- **After some stormy years and the recognition that managing a hospital needs a variety of capabilities, a BOD was founded.**

HMO Board of Directors

- **The Board is comprised of three main groups:**
 - HWZOA: represented by the leadership.
 - American public/professional figures
 - Israeli public/professional figures
- **The Board meets four times annually for two days with committee teleconferences in between scheduled meetings.**

Governance of Hadassah Hospitals





HMO Board of Directors

- **HMO BOD has the following permanent committees:**
 - Executive
 - Finance
 - Investment
 - Business Development
 - Research
 - QA & Safety
 - (Audit)



Audit Committee

- **External to the Board.**
- **Approves audit plan for the year.**
- **Meets regularly to review comptroller reports, management response and give recommendations.**
- **Reports to Board on main findings.**
- **Approves audited financial reports prior to BOD approval.**

HMO Board of Directors

- **Examples of recent topics debated:**
 - Major capital development



The Front
Yard

החצר
הקדמית



The Back Yard

החצר
האחורית

HMO Board of Directors

Examples of topics debated:

- Major capital development
- Risk management and self-malpractice insurance
- Affiliation of other hospitals with Hebrew University-Hadassah Medical School
- Business development (medical tourism, quality of life)
- Significant issues in the Jerusalem and national health care system.
- Strategic planning
- Hadassit (technology transfer arm of Hadassah) IPO

HMO Board of Directors

- **The HMO BOD nominates the Director General of HMO in Jerusalem.**
- **Board approval is necessary for the following:**
 - **Yearly financial reports**
 - **Nomination of heads of department**
 - **Real estate issues**
 - **Opening bank accounts**

Issues for Discussion (1)

- **The HMO BOD has no resources available as an independent board.**
- **The HMO Board's approval for capital development or yearly support goes for further approval to the HWZOA BOD.**



Issues for Discussion (2)

- **HMO is funded mainly by the National Health Law via the sick funds.**
- **The government has curtailed the power of foreign citizens in the higher education arena due to the fact that the majority of funding comes from national sources.**
- **The majority of HMO BOD members are not Israeli citizens and not well acquainted with the local health care circumstances and practices.**

And What about the MOH?

A Final Word

- **There is no doubt that BOD supervision of a hospital is necessary and can improve the overall quality and development of the institution.**
- **The issues to be considered are balancing between different systems and cultures and setting borders between micromanagement and oversight.**





**As she sat for her
portrait one day,
Henrietta Szold cried
out to the artist:
“Make my eyes look
towards the future.”**



CONCLUDING OBSERVATIONS



CONCLUDING OBSERVATIONS

Richard B. Saltman

The workshop's central focus was on how to improve the effectiveness of hospital governance at the meso, or institutional, level of the health system. "Effectiveness" is defined here as the ability to design, implement, and maintain accountability for hospital level strategic and financial initiatives.

In the country case studies from western and central Europe, two structural changes appear to be central to this process:

- a. giving public hospitals a greater degree of operational decision-making independence – what the Governing Public Hospitals study referred to as “semi-autonomy” since no public hospital could or should be entirely independent of political responsibility
- b. establishing a hospital-level Board of Supervisors that has legal responsibility for strategic and financial decisions

In the Israeli context, however, there is a different set of structural conditions regarding hospital ownership, management and supervision. Briefly, as covered in the Israeli case study by Chinitz and Israeli, there are four types of hospitals: 1) Ministry of Health owned institutions 2) not-for-profit private hospitals 3) health fund owned hospitals 4) for-profit private hospitals. Of these four types, the main form of public hospitals are in category #1 – eg those owned by the Ministry of Health. Thus the effort to improve governance of public hospitals would logically focus on these 11 institutions.

Drawing on the discussions held over the course of the workshop, the following reflections can be made about the current status of governing public hospitals in Israel:

1. Function has out-run structure. A framework for making strategic and operating decisions about public hospitals in Israel that was designed in the 1940s doesn't correspond to the complexity of hospital decision-making in 2011. This structural problem also existed in pre-reform public hospitals in other countries as well, such as England and Norway.


2. Israeli government hospitals already have considerable semi-autonomy, in two respects: first, as a result of the “health corporations” that they have put in place for up to 30% of their activity, and, second, due to the overload at the Ministry of Health, which reduces meaningful supervision of hospital-level activities. As a result, hospital CEOs can have considerable discretion, within certain established boundaries (eg union wage agreements etc). The degree of discretion varies considerably for different public hospitals and different CEOs.
3. A new structure for governing Israeli public hospitals will need to fit the existing function, and to support that existing function. This creates a challenge to design a new system that enables, for example, Tel Hashomer to retain the substantially higher level of hospital-level autonomy that it currently has, while not granting a substantially higher level of semi-autonomy to other government hospitals that currently have considerably lower levels of autonomy.
4. The existing structure has a single system logic to it that no longer reflects the actual function of the current public hospitals. A reformed system of hospital governance would need to be multi-pronged, to accommodate the range of semi-autonomy that already exists, both in terms of regular as well as health corporation decision-making activity. Thus a major challenge will be to design a health reform that can fill the existing vacuum of public hospital governance without creating disruptive controls over hospital activities.
5. A reformed system will have to reflect careful assessment of the current level of semi-autonomy in each public hospital. Otherwise there is a danger that a new system, seeking to grant hospitals more semi-autonomy, might give them a formal level of semi-autonomy that would in fact be less autonomous than their current situation under the existing de facto arrangement. Any hospital that found itself being more restricted than it is today could be expected to attempt to carve out new de facto zones of semi-autonomy, in order to retain what it already had.



APPENDIX I

R.B. Saltman, A. Duran, and H.W.F. Dubois, eds., 2011

GOVERNING PUBLIC HOSPITALS: RECENT STRATEGIES AND THE MOVEMENT TOWARD INSTITUTIONAL AUTONOMY. EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES, OCCASIONAL SERIES NO. 25, BRUSSELS.





INTRODUCTION

INNOVATIVE GOVERNANCE STRATEGIES IN EUROPEAN PUBLIC HOSPITALS

Richard B. Saltman, Antonio Duran, and Hans W.F. Dubois

This book explores recent changes in how public sector hospitals are structured and steered in Europe. While these changes necessarily reflect different national circumstances and needs, there appear to be two underlying factors that are driving this organizational re-alignment: first, rapid technological improvement in clinical and informational capacity among hospitals generally (both public and private alike), and, second, growing political pressures on public authorities to re-structure the state-society relationships embedded within the governance of publicly owned institutions. While the first development has generated new managerial needs and possibilities within public hospitals, the second has served to push national health policymakers to consider new organizational mechanisms and strategies for ensuring that publicly owned hospitals provide the range and standard of clinical services that the citizenry increasingly expect as countries become wealthier and societies become more middle class (Saltman and von Otter, 1992).

Through to the mid-to-late 1980s, publicly owned hospitals in Europe were predominantly focussed on delivering acute medical care, including emergency and scheduled elective inpatient procedures, and also (in many countries) on treating a wide range of less serious acute conditions in outpatient clinics (Healy and McKee, 2002). During this period, efforts to coordinate care at various service delivery levels were not well articulated, especially between intra-mural and extra-mural care.

Overall, the central emphasis for public hospitals was placed on the importance of equity of access to appropriate clinical care for all residents/citizens regardless of income or profession. Additionally, these institutions were viewed as a central element within a larger system of public responsibility for public health generally, and were linked to other similarly public services at the local level, which were expected jointly to provide needed individual services (especially to children and elderly) as well as collective preventive

services (Healy and McKee, 2002). In the view of many commentators, these equity-oriented efforts were highly successful from a population-based epidemiological perspective (Holland, 2010).

At this point in time, however, although the 1978 Alma Ata Declaration had emphasized the importance of primary health care in health systems development, efforts to prioritize the role of primary care services and primary health care services in developed countries were only in their initial stages (Saltman, Rico and Boerma, 2006). Similarly, discussions about how to better integrate chronic and elderly care services across primary care and hospital sectoral boundaries also were still at the stage of exploring alternative organizational solutions (Nolte and McKee, 2009).

Starting in the late 1980s (Sweden) and the early 1990s (England), a wave of health system reforms began across Europe, triggered by efficiency and quality concerns particularly in the (predominantly public) hospital sector (Saltman and Figueras, 1997). Drawing on new management strategies found in private industry, these reforms sought to introduce more flexible service delivery arrangements, seeking governance models that could stimulate greater institutional autonomy and, in turn, more effective integration across different types of services. In its initial stages, this reform process was highly contested, particularly by defenders of the traditional public system who viewed the changes as politically driven. Over the ensuing years, however, many of these reforms have been “normalized” and are increasingly seen as simply one potentially useful element within the broader hospital management spectrum (Saltman, 2009).

During this same period, the academic field of “governance” theory emerged and grew. A number of different social science disciplines (e.g. sociology, economics, political science, public administration, management, organisational theory) have each sought to articulate their own particular theoretical perspective on the process of governance in the public sector. These widely varying academic efforts have now transformed what had been an undifferentiated if somewhat vague notion into an umbrella concept that incorporates a wide range of public sector decision-making activities. Reflecting this development, there is now a substantial social policy literature around a broad notion of sectoral and institutional governance that reflects numerous social phenomena and thus has the potential to support multiple policy solutions for public sector institutions.



One useful overview of this broader understanding of public sector governance strategies can be seen in Table 1 below. This framework contrasts structural characteristics of the traditional Weberian (Post-World War II) bureaucratic state with the considerably more diffuse approach to governance that emerged in the new (Post Cold War) “postmodern” state:

Table 1: *Characteristics of Bureaucratic vs Post-Modern States*

Weberian bureaucratic state	A postmodern state
Government	Governance
Hierarchy (Weberian)	Heterarchy (networks, etc.)
Power (1): zero-sum game	Power (1): positive-sum game
Power (2): concentrated	Power (2): diffuse
Elitist	Pluralist
Unitary, centralized, monolithic state	Decentralized, fragmented, hollowed-out-state
Strong, central executive	Segmented executive
Clear lines of accountability	Blurred/fuzzy lines of accountability
State central control	State central steering
Single homogeneous public service ethos	Heterogeneous service cultures

Source: Richards D. and Smith M.J. (2002) *Governance and Public Policy in the UK*, Oxford: Oxford University Press, page 36.

This broader “post-modern” framework of state governance has direct implications for how policy and decision-making activities are conceived and conducted within publicly operated health systems across Europe. Over the initial decade of health sector reforms during the 1990s, research studies tended to focus on the ability of specific health sector reforms to improve overall performance in terms of key objectives such as equity, efficiency, and competition (for example, Robinson and Le Grand, 1994; Harrison and Calltorp, 2000; Jonsson, 1996; Glennerster and Mangannis, 1994). The ability to improve outcomes on these objectives has been applied particularly to assess changes in decision-making strategy within the hospital sector. More recently, however, health policy researchers have begun to turn from content-focussed evaluation to consider the impact of the underlying process-oriented frameworks that steer and constrain overall health reform behaviour (World Health Organization, 2000; Mossialos et al, 2010). Underlying both successful and not-so-successful reform strategies are substantially different approaches to what has now been termed hospital governance in Europe.

The term “hospital governance” is somewhat complicated to apply. Policy makers as well as economists traditionally have tended to view key elements of hospital performance through the related but narrower lens of “hospital management.” Moreover, the term governance itself, like other similar English language policy-directing terms (e.g. stewardship and accountability) does not easily translate into some European languages, so that the concept of governance itself may have different meanings in different national contexts. Both conceptually and practically, then, the term “hospital governance” may have structural limitations as a description of new concepts and institutional arrangements for public hospitals.

As currently used, the process-focused notion of “hospital governance” encompasses three different levels of hospital-related decision making. Each level has its own distinct characteristics, with its own separate group of decision-makers. All three levels blend together to define the actual “governance structure” for hospitals, and in particular for the publicly owned hospitals that are the subject of this study.

At what can be termed the “macro” level, there are national government decisions that determine the basic structure, organization, and finance of the entire health care system, and of the hospital sector within it. The decision to maintain publicly operated, tax-funded hospitals, for example, is just such a “macro governance” decision. The parameters of this “macro” level differ notably in different countries, with the range and specificity of requirements and regulations that fall under “macro governance” varying considerably between countries. What is seen as appropriate regulatory rule making for public hospitals in one country (for instance, England) may not be seen as appropriate state behavior at all in another (Spain). Moreover, an increasing proportion of these “macro” decisions are now being made by European Union level institutions (Mossialos et al, 2010). Taken overall, the “macro” level of hospital governance is that part of traditional national and supra-national policymaking that relates to the hospital sector.

An intermediate “meso” level of hospital governance concerns decision making at the institutional level of the hospital. In some instances (see Norwegian case) this level may incorporate two or more physically separate hospital sites that are operated as a single corporate entity. The “meso” level focuses on the senior decision makers for each separately operated hospital. As the eight case studies demonstrate, in a growing number of countries, this “meso”



level for public hospitals now focuses on a separate institutional Supervisory Board and the hospital's Chief Executive Officer (CEO). To a degree, these publicly operated hospitals increasingly have a meso level governance structure that resembles that of a private company. It is at this meso level, then, that all important organizational policy decisions that the hospital is allowed to take (e.g. that are not restricted by "macro" level regulatory constraints) are made.

Lastly, the "micro" level of hospital governance focuses on the day-to-day operational management of staff and services inside the organization. This level of "governance" is in fact what has traditionally been known as "hospital management" and incorporates such subsets as personnel management, clinical quality assurance, clinic-level financial management, patient services and hotel services (cleaning services, catering, etc.).

This broad conceptual framework of macro, meso, and micro levels of hospital governance serves a variety of useful purposes. First, it clarifies and specifies the large number of different activities that contribute to the governance process in the hospital sector. Second, for publicly operated hospitals in particular, it separates out the three levels of decision-making that often get comingled and/or confused within traditional state-run health systems.

Third, regarding this volume, the framework clearly categorizes the aspects of hospital governance that are the subject of consideration here. Since all three levels of macro, meso, and micro contribute to overall hospital governance, they all receive some degree of attention in the Part I chapters that follow. However, this book does not seek to focus on or emphasize either the macro, state policy-making dimension or the micro, intra-organizational managerial dimension of hospital governance. Rather, its main purpose is to better understand the meso, whole-hospital level of governance, and how that level has changed in a set of countries with predominantly publicly operated hospitals over the past two decades of health sector reform in Europe.

This decision to concentrate on the meso level reflects several factors. First, there is already a large literature available about both the macro level e.g. state health system decision-making, and the micro level, e.g. technical intra-hospital management. While both of these dimensions are clearly essential to a full picture of hospital governance, they reflect areas of decision-making for which considerable analysis has already been conducted and can be drawn upon.

Second, it is at the meso level of hospital governance that some of the more interesting and innovative reforms have been made in publicly operated hospitals across Europe. Seven of the eight case studies in Part II, which serve as the basis for analysis in Part I, are taken from countries that have been at the forefront of efforts to re-design meso-level hospital governance. The eighth, Netherlands, has a meso-level governance structure composed 100% of not-for-profit private hospitals, and thus can serve as an outer baseline for how far the process of meso-level change has gone within the other seven publicly operated hospital systems.

Third, this meso-level process of change in hospital governance has to date received insufficient analytical attention. As Chapters Three and Four highlight, there is a considerable amount to be learned as to what has been changed at the institutional level of hospital governance, and the extent to which it has achieved its intended objectives.

The interest in this “meso” level continues to be very strong at the national political level in a number of European countries. Further, in countries that have introduced meso-level structural reforms of their public hospitals, there is strong interest in learning what other countries have done, and how well it has worked. In other countries which are currently contemplating meso-level reform, there is a desire to know more about the methods and results of existing reform efforts.

Within this meso level of hospital governance, this study has further restricted its focus on several important parameters. As already noted, the study focuses exclusively (with the exception of Netherlands) on countries in which all or nearly all hospitals are publicly operated. Also these publicly operated hospitals are publicly funded, either via tax revenues, or (in Estonia and the Czech Republic) through social insurance funds which, in the hybrid central European model, are administered by or are closely controlled by national government agencies. The study does not consider or evaluate meso-level hospital governance in other Western European social insurance countries. Moreover, given its focus on changes within publicly operated hospitals, it does not discuss or assess hospital governance issues with regard to private for-profit hospitals, either in the eight case study countries or elsewhere (see Jeurissen, 2010 for an overview of for-profit hospitals).



Further, as also noted above, the eight countries that have been selected for the case studies have each recently put in place innovative reforms at the meso-level of hospital governance. These reforms make their hospital governance experiences useful to compare, and valuable for national policymakers and academics seeking to learn more about potential new meso level strategies.

It should be noted that this study is qualitative rather than quantitative in nature. The volume seeks to understand changes in the process of institutional level decision-making for publicly operated hospitals, and the degree to which such changes are effective and/or sustainable over time. It does not incorporate quantitative efforts to evaluate “micro”-level management, nor does it attempt to assemble or review performance management data about hospital quality or clinical outcomes.

Lastly, and importantly, this study focuses in particular on one specific and highly controversial dimension of meso-level institutional governance, eg the numerous recent reforms that seek to make public hospitals semi-autonomous, with their own separate Supervisory Boards and with considerable independence of decision-making. This pursuit of a viable model of semi-autonomous self management inside the public hospital sector has been underway now for nearly two decades. Efforts to create self-sustaining models of “public firms” (Saltman and von Otter, 1992) or “quasi-markets” (Legrand and Bartlett, 1993) in the public hospital sector began in the late 1980s in Sweden and in April 1991 in England with the first wave of self-governing trusts. Jon Magnussen rightly points out in his conclusions to the Norway case study that the reality of macro-level hospital governance at the state level means that meso-level governance for public hospitals can never be more than “semi-autonomous.” However, as Gwyn Bevan of London School of Economics commented (Bevan, 2010), both the degree of decision-making autonomy enjoyed by these different meso-level models, as well as the tipping point at which governments begin to regret such grants and re-assert their central authority (Saltman, 2008 EJPH), inevitably differ based on national political conditions and the prevailing cultural expectations within each country (see introduction to Saltman and Bergman, 2005; also Vrangbaek, 2007). Stated somewhat differently, differences in these semi-autonomous models across countries may well reflect differing degrees of “publicness” in their mandates, such that different frameworks of semi-autonomous meso-level governance may in practice reflect substantial differences in the public/private mix of mechanisms, obligations, restrictions, and incentives (Saltman, 2003).

This question of institutional autonomy within the public hospital sector may have implications that go beyond service structure and perceived financial effectiveness. Several recent academic analyses have suggested that autonomous institutional decision-making is associated with higher quality “micro” level clinical outcomes (Bloom et al, 2010). While this finding is of great interest to policymakers, this volume, as noted earlier, focuses on qualitative issues at the meso-level rather than quantitative issues at the micro-level.

Following from these observations, this study has two linked objectives. The first is to examine the core characteristics of governance theory generally, and to distill those elements that might be usefully applied to publicly operated hospitals. In keeping with this objective, Chapter One examines the changing position of the hospital in society, as well as central concepts of governance theory, as developed by social scientists to address public policy issues generally. Chapter Two then follows with an exploration of different models of governance applied to the hospital sector, and presents a four part framework for analyzing specifically meso-level hospital governance. Both of these chapters reference existing literature, and are intended to help define the conceptual context within which national policymakers can develop their own specific strategy for reforming meso-level hospital governance.

The second objective of the book is to map the more prominent models of semi-autonomous public hospital governance adopted by European countries, and to explore the structure of these different models with regard to operating and decision-making autonomy. This second objective is pursued through the eight national case studies presented in Part II. The different models that countries have established, the differing degrees to which these models reflect broader policy and management strategies in the health sector, and, to a limited extent, the degree to which these differing models have achieved their intended organizational outcomes, are assessed in Chapters Three and Four. Extensive comparative tables that document the degrees of similarity and dissimilarity in the case study responses to the questions asked by the editors can be found in the Appendix at the end of Chapter Four.

These four initial chapters, dealing with first the theory and subsequently with current strategies to reform hospital governance, form Part I of this volume. As already noted, for those readers who would like more detailed information about current semi-autonomous models, Part II of the volume presents the eight edited country case studies.



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GOVERNING GENERAL HOSPITALS, THE ISRAELI CASE

David Chinitz and Avi Israeli

Introduction

Israel's health system is pluralistic, meaning that services are financed and provided by multiple sectors, including government, voluntary-non profit and private agents. This pluralistic structure has, over time, become subject to greater government regulation. Since 1995, four non profit sickness funds, or health plans, that previously provided uneven, segmented coverage, are now required, under the National Health Insurance Law, to provide a standard basket of services. The health plans charge no premiums directly to citizens, who instead pay an earmarked health tax to the National Insurance Institute (NII). Government supplements the finance of the standard basket of services with budgets derived from general tax revenues. In addition, the system is financed by copayments and various forms of supplemental insurance. Overall, health expenditures account for about 8% of GDP (Bennun et al 2005, Rosen and Hadar 2009).

The health plans receive an age adjusted, capitated budget paid to them by the government. Citizens are free to switch among the funds several times annually without restriction. The sickness funds are able to selectively contract with providers, including primary care physicians, specialists working in the community and hospitals, and, in so doing, compete for enrollees (Rosen and Hadar 2009). The health plans have strong networks of primary care physicians, however, citizens may also self refer to community based specialists and hospital outpatient departments.

General hospitals are owned by government (under the aegis of the Ministry of Health, MOH), sickness funds and non profit associations. Approximately 80% of hospital revenue comes from sales of services to health plans. Other sources of revenue include the IDF Medical Corps, private insurers, the NII, maternity care services and out-of-pocket payments. The reimbursement of public hospitals in Israel takes place in the form of fee-for-service payments, per diem fees and case payments, and is subject to a revenue cap. A fee-for-service charge list established by the Government regulates payment for hospital outpatient care in ambulatory clinics and Emergency Departments. Most inpatient



admissions are reimbursed on a per diem basis. The per diem rate is set by the Government, through a joint Ministry of Health and Ministry of Finance committee, primarily on the basis of information regarding current operating costs in the government hospital sector. In recent years, for a range of conditions a case payment reimbursement mechanism was established (as an alternative to per diem reimbursement) and there are now over 150 Israeli diagnosis-related groups (DRGs). A hospital revenue cap was established in 1995, at the same time as the establishment of the NHI, in response to the health plans' concerns that hospitals were inappropriately increasing volume and therefore also the health plans' expenses (Rosen and Hadar 2009).

MOH, together with the Ministry of Finance, as discussed below, sets reimbursement rates and suggests the revenue cap mechanism. After Parliamentary approval, these parameters serve as benchmarks for the hospital system. This (among other issues) puts government in a conflict of interest, as it can set conditions to the advantage of its own hospitals. Therefore, reforms have been put forth, especially since 1995, to convert government hospitals to the status of independent trusts. This reform has not been implemented. However, the spectre of the reform has had its effect, as discussed below (Ministry of Health 2002, 2004; Rosen and Hadar 2009; Feder-Bubis 2006)..

Case Studies

Before getting into the specific cases, it is worthwhile mentioning some of the common governance features that apply to all the hospitals so that these will not have to be repeated throughout the different cases. First, all of the hospitals are subject to all relevant laws of the government and the public service, especially the Public Health Ordinance (State of Israel 1940), first instituted during the British Mandate in 1940, which, among other things, provides the basis for licensing of medical institutions in the country. This statute governs credentialing of hospitals and the medical fields that must be included in the hospitals' service basket.. All general hospitals are required to include certain basic services and departments: internal medicine, orthopedics, obstetrics and gynecology and general surgery. They are required to obtain MOH approval for expansion of beds, as well as purchase and operation of certain equipment such as MRIs. Minimum staffing levels are determined by MOH together with the various professional associations A particular set of statutes, enacted in 2002, are the Health Corporation Regulations (HCR)

which regulate hospital activities that operate outside the publicly budgeted financial structure of the hospital (State of Israel 2002). The enactment and significance of the HCL will be discussed in the cases below. Finally, in addition to revenues that come from sale of services to the health plans, all hospitals obtain some revenue from sources such as the National Insurance Institute (for birthing mothers), road accident insurance, services provided to military personnel, and medical tourism.

Thus, regarding the hospitals reported on this draft, the ability to define their ownership status, the degree to which there is separation between purchase and provider and between regulation and provision of services.

Israel has four main types of general hospitals:

- ◆ Government owned, about 46% of the total beds: These hospitals are owned, budgeted and operated by MOH, with salaried employees paid by government
- ◆ Sick fund owned, about 30% of the total beds: These hospitals are owned, budgeted and operated by the Sick Fund, with salaried employees paid by the Sick Fund.
- ◆ Independent, non profit, about 19% of the total beds (all in Jerusalem): These hospitals are owned by charitable organizations, financed based on the revenues they generate from selling services, and independently operated.
- ◆ Privately owned, about 5% of the total beds.: This hospital is owned by shareholders and is independently operated.

But even this categorization is now inadequate, since one of the sick funds now owns and operates its own “private” hospitals, and another is partner in a private hospital.

One result of this blurring of boundaries is that hospitals appear to be both completely constrained by central government mandates and limitations, and to have a high level of autonomy at the same time. This obviously complicates the governance picture. We will return to these issues in the discussion.



In this paper, we will discuss four hospitals, one government owned, one independent, one sick fund owned, and the new sick fund owned private hospital mentioned above. In this draft we briefly describe two large general hospitals in terms of the questions posed in the briefing paper for this project. One of the hospitals is a large voluntary non-profit institution, while the other is of similar size, but owned by the government, specifically the Ministry of Health (MOH). Regarding the other two hospitals, Instead, some educated first impressions are provided to indicate the rich variety represented by the cases. Notwithstanding this, at this point it is anticipated that the directions pointed to in the discussion will hold up overall. To foreshadow: Israeli hospital governance is illustrative of blurred boundaries and a combination of highly regulated portions of the system together with extremely autonomous ones. The advantages, disadvantages, and viability of such a framework will be explored.

The descriptions here are based on the knowledge of the author, based on existing descriptions of the Israeli hospital system, his own research, media reports and discussions with experts

Case 1: A Large Non Profit Hospital in Jerusalem

Strategic Governance Issues

Structural institutional framework

The hospital is required to provide certain basic departments such as internal medicine, orthopedics, pediatrics, obstetrics and gynecology and basic surgery. However, due to its history, founded well before the state, and its university affiliation, it views itself and others view it as being expected to provide the highest level of tertiary care. So in addition to departments such as cardiology, psychiatry, urology, oncology (including radiation), bone marrow transplantation, the hospital provides sophisticated diagnostics such MRI and PET scans, transplantation surgery and neurosurgery. Moreover, the hospital is a major trauma treatment and emergency medicine hospital, which, given the Israeli security situation, establishes the hospital as one of the country leaders.

The decision to provide high level tertiary services is in the hands of the directorate of the hospital, subject to the approval of its owners, a US based Jewish Women's Organization (JWO), and approval of the Ministry of Health

(MOH). If the Directorate decides to pursue a new initiative, such as purchase of an MRI, either of these two agents, one an internal governance structure and the other an external regulatory body, may intervene, especially the latter, but, in general the hospital directorate has wide latitude in such investments.

Within the hospital, Department Directors, who are very powerful actors, very often propose new services, based sometimes on acquisition of new technology and the Directorate will evaluate the benefits and costs to the hospital and if the project is found as desirable will give its approval. In addition, the hospital, with the implicit backing of the Women's Organization will create a center based on existing services, such as the hospital's Mother and Child center. This does require approval of the MOH.

Financial framework

The conditions for employment of physicians and nurses, and minimum staffing levels in terms of staff per bed, are determined nationally in a set of negotiations and national collective agreements involving the MOH, the Ministry of Finance (MOH), the Israel Medical Association (IMA), and the unions representing physicians and nurses. These employees are paid salaries. The hospital, however, is permitted due to historical precedent, to offer private medical services which enable the patient to choose the physician for a consultation or procedure. The private service provides the opportunity for physicians, and the hospital, to garner additional revenues. By law, the hospital is not allowed to earn more than a certain percentage of its revenue from this source, and physicians receive only 19% in pre payroll tax income of the payments made by patients.

Investment capital is provided by contributions, mostly through JWO. While the latter itself provides only about ten percent of the budget, it no doubt helps with raising contributions from major philanthropists. The hospital has also combined revenue- raising with physical expansion by renting out land and space for consumer oriented activities, such as a shopping mall contiguous with the hospital. These kinds of expansions are initiated and approved by the Directorate, subject to approval by the Board. Funds for new equipment are usually also provided through contributions. Officially, the hospital needs approval of MOH for this, but it is difficult to turn back contributions.

The sources of income for day to day expenses are mainly through the sale of services to the sick funds. Under the oversight of MOH, the hospital, like other



general hospitals, negotiates a capped annual budget with each sick fund, based on anticipated volume of service multiplied by the fees that are determined by MOH. However, hospitals can offer discounts to sick funds in exchange for channelling of patients to them by hospitals. In the case of this hospital, this is an active bargaining game, since in Jerusalem the sick funds face little resistance from patients told to go to the hospital. The situation can fluctuate from year to year, however, as the hospital's main competition in Jerusalem, a nearby midsize hospital can also offer discounts to sick funds. To paraphrase the director of that hospital, the amount raised in contributions by the two hospitals is used each year to cover losses that occur when sick funds transfer volume from one hospital to the other. In addition to payments from the sick funds, which account for about 80% of the budget, the hospital takes in revenues for childbirths, which are paid for separately by the National Insurance Institute (NII), service provided to the military, and private pay.

Accountability framework

The hospital director is accountable to the Board of Directors, of which one third are representative of the JWO. The hospital, since it receives some government subsidy, must report its financial status to the MOH and the MOF.

The MOH keeps track of hospital admissions, discharges, length of stay, and bed turnover, broken down by major departments. Quality measures, such as adherence to process guidelines are collected by the MOH in the context of a national effort to improve hospital care, but these data are not made public. In the past, case mix adjusted measures of mortality from heart surgery were collected by MOH, but when the data leaked to the press, physicians, on a nationwide basis, ceased cooperation with the monitoring effort. The hospital conducts surveys of patient satisfaction that are used for internal purposes. There is a safety and quality improvement unit that monitors infections, medical error and adherence to safety measures within the hospital, the authority of which is based on backing of the hospital Directorate.

Hospital mortality must be reported to the MOH, and in cases of suspected error or malfeasance, the MOH may create an investigatory board with the possibility of sanctions, such as loss of medical license for a period of time regarding the specific staff involved. There are conflicting opinions over whether investigation by peers under the auspices of MOH leads to severe enough sanctions in many cases of medical error and accidents.

Operational Governance Issues

Limits on Hospital Strategy

The hospital does not face serious limitations from a political authority in terms of setting its overall goals and objectives, or expanding its activities.

Internal operational structure

The hospital is free to determine its own internal structure, but this is subject to the strong role played by Department heads in the hospital hierarchy. In the past decade a number of hospital divisions, such as internal medicine, have been created, but Department heads still are very powerful. Departmental budgets have been implemented in some cases, but these budgets do not include personnel costs, as these are determined by national staffing requirements and pay scales. The hospital does have some discretion in allocating nurses across departments. The management can seek to improve coordination and communication, for example in the use of common resources such as pharmacy. But the strength of Department Directors limits the degree to which changes in structure and behavior at the departmental level can be managed by the hospital directorate. The professional structure of the hospital is influenced primarily by the medical staff, which, again, is dominated by Department Heads.

Responsibility and Decision Capacity

Department heads have the lion's share of responsibility and decision capacity. Other actors, such as unions, elected officials and even the hospital directorate, have little say in the internal management of the departments. If a decision involves creating a new service, purchasing new equipment with implications for the overall hospital budget, the hospital directorate will become involved. But decisions that are within the framework of a departmental budget, for example, to obtain certain drugs or supplies through outsourcing, need not involve directors above the department level. Decisions such as whether to introduce experimental drugs not covered by NHI, are more or less made at the level of the individual physician, and there are no definitive directives from hospital management on this type of matter.



Monitoring and Internal Intelligence

The hospital monitors financial data of departments, patient flows, utilization of resources such as pharmaceuticals, laundry, etc. The monitoring system is created by the hospital, over and above the minimal requirements to report to MOH about admissions, discharges, length of stay and bed turnover, which are reported at the department level. The hospital has begun to monitor infections, adherence to practice guidelines, mortality and hospital based infections at the department level. These measurements are more or less on a voluntary basis, although the hospital has cooperated with MOH measurements of process measures of quality, with confidentiality maintained. The hospital has an Electronic Patient Record in place which is accessible to any physician in the hospital who has the national identification number of the patient in question. This system is internal, and is not immediately able to be interfaced with external patient records such as those maintained by the sick funds. These various data bases can be used by the hospital directorate to evaluate performance at the departmental level and relate these measurements to hospital goals, although the latter, as mentioned above, are largely determined by the Department Heads.

Incentive Schemes

Outside of private practice, there are few financial incentives that can be applied to medical, nursing and other staff. Performance of individual staff is measureable, but rewards take the form of formal recognition, prizes, prestige and the like, and not financial.

Case 2: A Large Government Owned Hospital in the Tel Aviv area

Strategic Governance Issues

Structural institutional framework

The hospital is required to provide certain basic services, but has wide latitude to provide additional services. The main difference with regard to the latter, relative to Case 1, is that the government owned hospital is prohibited from providing private service and offering choice of physician in exchange for private payments. It is important to note that until 2004 this hospital had arrangements in place called “research funds,” to which patients were “encouraged” to contribute by their specific physicians. This arrangement

was declared illegal by the State Attorney General in 2004, and the question of whether this hospital should be permitted to have the type of private service arrangements that are permitted in Case 1. The issue has not been resolved.

Much like Case 1, the hospital is very involved in creating new services, and it does so subject to approval of MOH. If the changes do not involve new budgets or salaries it is unlikely that MOH will intervene. Much like in Case 1, initiatives of Department Directors lead to creation of new services, new institutes and purchase of equipment. The Directorate has to approve these initiatives, but if the business plan is right, there is little reason not to.

Financial framework

Like hospital 1, hospital 2 is subject to staffing levels and salary scales determined in national negotiations among the IMA, various unions, MOH and MOF.

This hospital also is very active in raising contributions for creation of new services, physical expansion and purchase of new equipment. It has “friends of” organizations in an number of countries that raise money for the hospital. Again, once earmarked contributions have been obtained, it is difficult for MOH to intervene and deny permission to use them.

Case 2 is subject to the same reimbursement arrangements as Case 1 in terms of contracting with the sick funds, within an overall negotiated budgetary ceiling. The hospital agrees to discount arrangements with the sick funds, but also has aggressively responded to attempts by sick funds to transfer patients to other hospitals, by threatening to deny access to highly sophisticated treatments and publicly decrying the interference of the sick funds in the choice and treatment of the insured.

Accountability Framework

In most government owned hospitals, there is no public board of trustees. However, this particular hospital is a leading innovator in the system due to the charismatic leadership of its long time Director. Thus, the hospital has appointed a board of directors on its own, but the question is how much control this board has over the operating managers. The hospital Director is technically subordinate to the Director General of the MOH, but is largely an independent agent, due to precedents set by an earlier, very entrepreneurial



Director, who still retains extensive influence in the hospital and the wider health system. At this point it is important to mention that Directors General of MOH have often come from and return to the post of Director of an MOH hospital. This creates the perception of conflict of interest, but perhaps highlights even more the blurred boundaries and patterns of informal influence that exist in the system. The hospital reports the same basic patient flow data as hospital 1 to MOH and MOF, which keeps data on its financial performance. The hospital participates on a voluntary basis in the various quality improvement efforts being run by MOH.

Operational Governance Issues

Limits on Hospital Strategy

Once again, aside from providing certain core services, the hospital is largely free, without significant intervention from MOH or MOF, to develop strategic initiatives aimed at provision of new services, creation of new institutes, physical expansion and purchase of equipment., as long as these do not implicate the hospital budget or involve opening of additional beds.

Internal Operational Structure

The hospital is free to determine its own internal structure, for example, whether to create a divisional structure, but as in Case 1, Department Heads are very powerful and so the department level remains the key subsystem in the formal structure. With the cooperation of the department heads, the hospital directorate can reallocate personnel subject to national staffing level requirements. The directorate can also initiate communication and coordination arrangements and create the necessary information and other systems necessary for this.

Responsibility and Decision Capacity

Decisions regarding allocation of resources, such as departmental budgets and use of central services, such as pharmacy, laundry etc. are decided by the directorate with the cooperation of department heads. As in hospital 1, medical decisions are largely in the hands of the treating physician, with little intervention by higher ups in the hierarchy.

Monitoring and Internal Intelligence

Like hospital 1, hospital 2 has in place EPR that enable tracking and coordination of patient care. The hospital monitors the financial and medical performance of the different departments.

Incentives

Without the incentive of private practice, the hospital is quite concerned with any external temptations, such as that provided by a new private hospital recently opened by one of the sick funds, enticing physicians to leave early in the day, or perhaps altogether, in order to perform private procedures elsewhere.

Case 3: A Large non Profit Sick Fund Owned Hospital in the Tel Aviv Area

This hospital operates much like Case 2, and is a major competitor for the latter. The main difference is that since it is, by ownership, part of the Sick Fund, its autonomy is influenced by the degree to which its strategies and tactics must conform to the goals of the mother organization. Moreover, as the Sick Fund is divided into regions, the hospital functions within the managerial sphere of influence of the regional level. But since it is the flagship hospital of the Sick Fund, it is directly linked to national level management. In sum, the hospital appears to enjoy levels of autonomy similar to those of Case 2, since, among other things, it can and does conclude service contracts with other sick funds. The hospital has initiated many special services and institutes, such as a major children's hospital, funded to a great extent by funds raised abroad.

Case 4: A Private Hospital owned by one of the Sick Funds in the Tel Aviv area

This hospital is most different from the other cases. It can determine its own portfolio of services, and it emphasizes mostly elective surgery. It appeals to those who have supplemental insurance (80% of the population). It relies on physicians who have come from the public sector, or combine public and private work, the latter during later hours in the afternoon and evening. The governance structure, and the role of the Sick Fund owner in it, is not clear. It is also not clear to what extent the hospital, which is new, will give priority to members of its umbrella sick fund as part of sick fund strategy, or autonomously determine its own patient load and sources of reimbursement.



It is also not clear how its profits will be allocated, especially between itself and the Sick Fund.

Discussion

When considering governance of hospitals in Israel, it is important to take into account a number of background factors:

- ◆ Like many systems in Israel, the hospital sector is both pluralistic and centralized at the same time, due to the fact that many institutions began to function before the state was created in 1948, and thus strain against the attempts of central government to exert control.
- ◆ Israeli political and managerial culture, in general, is characterized by blurred boundaries among sectors, as well as incompletely developed concepts and approaches regarding regulation and accountability. Israeli actors are caught between a naïve belief in technocratic planning and a cynical belief that in the end management is a matter of improvisation and “hand to hand” political combat.
- ◆ Like all systems, formal rules of ownership and regulation cannot capture all the nuances of the hospital environment, and in a country notable for “informal” arrangements of all kinds (Israel Democracy Institute 2010), this carries special import. Policy ideas, both imported and domestic, play an important role in both understanding
 - ◆ The hospital policy process
 - ◆ The perceptions of key actors regarding the environment in which they are functioning
 - ◆ The behaviors of key actors
 - ◆ The results of the system in terms of quality and cost

Thus, even if the Israeli case is very fluid, or perhaps due to this fluidity, MOH has been able to institutionalize quality measures in the hospitals. This involves, among other elements, a great deal of trust among the players. Hospitals grant access to MOH staff who observe and gather quality and performance data, with the cooperation of hospital staff. The data remain privileged information for the individual hospitals, but aggregate data are made available so that each hospital can see how it is doing in the area of quality

improvement. Such a cooperative, rather than coercive approach, may be an important element of governance in many health systems.

In terms of the approach to governance taken in this book, the Israeli case may or may not be a case of good, or at least workable, order, but one would be hard pressed to say that it reflects any clear governing body or set of rules. What we have is a patchwork of different frameworks, especially a peculiar combination of centralized control and autonomy.

From the centralized point of view, hospital staffing levels and pay scales are centrally controlled, based on negotiations among parties that do not really include the hospitals, per se. Representatives of the IMA, individual labor unions, MOH and MOF are the parties to these negotiations and the hospitals, more or less, are passive recipients of the results. Since about 70% of every hospital's budget goes for salaries, this proportion of the budget is largely not controlled by the individual hospital directors and managers.

However, and perhaps ironically due to the overlapping authorities implicit in these arrangements, there is little centralized control over what the hospitals do in the framework of the other 30% of their budgets. Hospitals use this smaller, but still significant wedge of the pie to carry out their own strategies, which usually involve developing new services, expanding physically and purchasing expensive equipment. Much of the 30% is raised through contributions for fixed assets, the operation of which has a claim on operating budgets. So instead of a unified, integrated way of allocating resources and expending them, there are two main pipes of money operating somewhat separately but with symbiotic effect one on the other.

In the area of quality of care, safety and information systems, the ball game is mostly in the hands of the individual hospitals, but the MOH tries, and succeeds, to an extent, in trying to introduce common measures and processes. Thus, while, at least in the 30% realm, the hospitals are very much competitors, there seems to be some implicit interest in cooperating in quality improvement and some potential for creation of common and perhaps even linked data sets.

This raises the interesting question of whether governance, at least from the national level, should aim to create a unified, consistent, accountable structure for general hospitals. Perhaps a more implicit balance, based on a combination of centralized control and high levels of autonomy can constitute



a health balance between a rigid national bureaucracy and an unfettered free market, is more realistic and even preferable.

Conclusion

The case of hospital governance in Israel is perhaps best captured by putting it in the context of overall Israeli governance pattern that seem to combine a high degree of cynicism regarding formalisms and rules, strong input from the legal system, and increasing professionalism among planners, regulators and providers in the health system. Thus, the Israeli hospital, to different degrees in different sectors. is at one and the same time highly constrained and also able to find “room to manoeuvre.” It would seem reasonable to think that such an approach would be applicable in social services more broadly. However, the Israeli health system, with all of its problems, seems to have achieved a better form of governance that other sectors such as education and welfare, at least insofar as public perceptions of system performance are concerned (data on public views of different services). Perhaps it is the link to medical science that enables the system to coalesce around issues of quality and cost in a flexible form of governance that is perhaps a recipe for all health systems.

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HOSPITAL GOVERNANCE IN THE SPANISH HEALTH SYSTEM

Arturo Álvarez & Antonio Durán

I. The unexpected birth of new governance arrangements in Spain

The Spanish national health system (Sistema Nacional de Salud, SNS) offers universal coverage for all residents in Spain and provides publicly funded health services, mainly financed through national taxation. Publicly funded health services are in general free at the point of use and responsibility for their organising largely rests with the 17 regions – Autonomous Communities (García et al 2010), .

Over the last two decades Spain has explored new hospital governance arrangements. It has done so while decentralising hospital management however, via ad-hoc, politically-driven and last-minute legislation, which has resulted in a rather confusing, fragmented regulatory framework, with various national and regional norms superseding each other. Yet this section will sustain the thesis that such development, the result of a highly political process in the highly political environment of post-Franco politics in Spain, has opened the way for innovative governance approaches.

1. Birth of the Spanish National Health System

Evolving from a bureaucratic, centralized, resource-lacking and fragmented system funded by social insurance contributions, the current tax-funded National Health System in Spain (Sistema Nacional de Salud, SNS) provides (almost) universal and comprehensive coverage to all residents free at the point of use. These principles were already in the 1978 Spanish political constitution after Franco's death.

Political transition to democracy came alongside political devolution to the regions (autonomous communities, ACs – comunidades autónomas). A few ACs received powers to develop their own regional health policies (Cataluña, País Vasco, Navarra, Galicia and Andalucía) with the INSALUD, established in 1978 as the national health system executive, responsible for managing the healthcare system in those regions to whom power had not been devolved. Each AC established their health executives to run their own regional health system



along the years; when health power was transferred to these ACs in 2002, the INSALUD was abolished (Durán et al. 2006). ACs, however, copied the inherited bureaucratic model of the national public administration, resulting in heavily centralised, politicised administrative structures (Ballart and Ramió 2000), which means that devolution to the regional level did not translate further down the scale to the local levels. An additional systemic change of the Spanish health system involved ideas and practices from the new public management paradigm (Hood 1991), which was fashionable in the 1980s around the world and led to a number of changes in the Spanish public administration (Gallego 2002). In this context, public management attracted the attention of some national policymakers, civil servants and an enthusiastic group of managers within the newly-born SNS, who sought to modernise the management of hospitals and healthcare centres. The first modernising wave however lacked strategic vision and political support, and innovations had only limited impact (Belenes 2003). The detachment in 1981 of the Ministry of Health and Consumer Affairs from the Ministry of Labour and Social Security also paved the way for deeper reforms of the mid-1980s.

The 1986 General Healthcare Law (*Ley General de Sanidad 14/1986*) sought to integrate the various healthcare structures, coordinate levels of care and even considered in Article 67 the possibility of establishing partnerships with the private sector. However, the Law did not address alternative management models for the SNS, which retained many features of the old administrative model, especially a statutory position for health care staff (in fact, currently regulated by the *Ley 55/2003 de 16 de Diciembre del Estatuto Marco del Personal Sanitario de los Servicios de Salud*), which kept salaries not related to performance (Martín and López del Amo, 2003).

By then, some of the concerned new management tools were already being gradually incorporated in the system without resistance and continued doing so. For example, health targets started to be used at regional level even before the 1986 *Ley General de Sanidad* (which referred generically to them in articles 43 and 54) –although there never was a nationwide health target strategy (Alvarez-Dardet 2002). There were also Consortia in some parts of Spain (specifically Catalonia) which were run along slightly different lines compared with regular public health care centres.

In 1991 (that is, only five years after approving what was supposed to be the long-lasting health law of the democratic period), the Parliament

sponsored a Commission for the Analysis and Evaluation of the SNS (Comisión de Análisis y Evaluación del SNS, known as Comisión Abril for its chairman, former center-right Minister Abril Martorell, one of the architects of the political transition after Franco). The Commission identified administrative rigidity, excessive centralisation and staff apathy as specific problems and made 64 suggestions for modernising the SNS, including a purchasing-provider split and the adoption of new management tools (Gómez de Hita 2000). Proposals from the Commission encountered great opposition from unions and other healthcare groups (Guillén and Cabiedes, 1998).

In that context, “managerial” improvements continued. In 1991 a Minimum Basic Data Set (Conjunto Mínimo Básico de Datos, CMBD) was introduced to codify hospital discharges. In 1994 as a mechanism to promote activity planning within hospitals and make more explicit the link between funding and performance INSALUD started using Program-Contracts (contratos-programa) with hospitals (Martín 1996). Retrospective payment systems for hospital activity were – at least formally– replaced around 1997 by prospective budgets based on Diagnostic Related Groups (DRGs) and supported by different accounting tools; DRGs were first piloted in 18 public hospitals and after evaluation they were “supported” by national and regional health authorities the following year (García-Cornejo 2008).

2. Altering the original hospital plans

Within this “tradition” of tentative innovation in the regions later on partly or wholly accepted by the centre, a particular Law was issued regulating the above-mentioned Consortia (Consortios, Ley 30/1992, 26 noviembre, de Régimen Jurídico de las Administraciones Públicas y del Procedimiento Administrativo Común). This law complemented a previous Law 7/1985 on the same matter (Ley 7/1985, de 2 de abril, Reguladora de las Bases de Régimen Local) and opened the way to merging resources from several administrations so that a more efficient use of resources could be made. For the first time, the need for pragmatic arrangements in the field of hospital governance was expressed.

Somehow signalling an identity of its own while emphasizing the opposition to its main rival’s policies, the government of Andalucía (ruled by the Socialist Party, PSOE) subscribed to a model of hospital governance named the Empresa Pública Sanitaria (Public Healthcare Enterprise). In 1993, the Empresa Pública Hospital Costa del So was established in Marbella, a tourist city (Disposición



adicional Decimoctava de la Ley 4/1992 de 30 de Diciembre de Presupuestos de la Comunidad Autónoma de Andalucía para 1993 and the statutes approved by the Decree 104/1993 de 3 de Agosto).

Another key development took place in 1994 when regulating the model of Foundations (Fundaciones, Law 30/1994 de 24 de Noviembre de Fundaciones de Incentivos Fiscales a la Participación Privada en Actividades de Interés General). While this norm applied to the constitution and functioning of foundations in all sectors, it was particularly sought by health policy makers to bring in more flexible organisational arrangements alongside the separation of the purchasing and provider functions that the INSALUD was (timidly) introducing (Ferrándiz Manjavacas, 1999). Later on in 2002 (as already indicated, the year when the process of devolving health power to the regions was completed and the INSALUD was abolished), an updated Law of Foundations (Ley 50/2002 de Fundaciones) would be issued to replace the Law 30/1994.

In 1996, with the conservatives of the Partido Popular (PP) for the first time in power at national level after 14 consecutive years of socialist government, legislation was introduced explicitly promoting new types of hospital governance. The Royal Law-Decree 10/1996 (Real Decreto Ley 10/1996, 17 de Junio, Habilitación de Nuevas Formas de Gestión del INSALUD) allowed for the use of various governance models for managing the INSALUD hospitals, including consorcios, fundaciones, etc. Notably, the use of the Real Decreto Ley legal tool, only recommended for fast-tracking legislation through Parliament under exceptional and urgent conditions, was justified “based on the need to set up a new governance model before pilot hospitals were built” (sic). This exceptional mechanism was duly replaced later on in its essential components by a more conventionally produced Law 15/1997 (Ley 15/1997 de 25 de Abril de Habilitación de Nuevas Formas de Gestión del SNS).

With the explicit aim to “introduce more flexible mechanisms for managing statutory hospital staff”, the government tried to promote a Parliamentary Agreement for the Reform and Modernization of the NHS (Acuerdo Parlamentario para la Reforma y Modernización del SNS, Diciembre 1997), but failed. It then created the model of Public Health Foundations (Fundaciones Públicas Sanitarias) by promulgating at the very last minute a law with the most peculiar title of Law on Fiscal, Administrative and Social Measures (Ley 50/1998, 30 Diciembre, Medidas Fiscales, Administrativas y del Orden Social) annexed to the Budget Law (Ley de Acompañamiento a los Presupuestos del Estado). It was also a remarkable move in another way, since the above-

mentioned Law 30/1994 on Foundations was fully available and could have been used but probably due to the fear of conflict with the militant trade unions a new model was created instead retaining the statutory status – permanent jobs– of the existing health care staff (as opposed to making them non-statutory, ordinarily contracted workers).

In 1999, the AC of Valencia, also governed by the conservatives, made use of the opportunities offered up by the Law 15/1997 (and the 1995 Procurement Law, Ley 13/1995 de Contratos de las Administraciones Públicas) and granted to a private group of companies by means of an “administrative concession” (Concesión Administrativa) the right to run the public hospital in Alzira. This was the first case of such openly pro-business concession and originated a vivid discussion in the Spanish health community.

Soon afterwards, the Royal Decree 29/2000 (Real Decreto 29/2000 de 14 de Enero sobre Nuevas Formas de Gestión del INS) listed the existing types of hospital self-governance models, including Fundaciones Públicas Sanitarias, Consorcios and Fundaciones. This norm confirmed the management autonomy of these entities while preserved and guaranteed their condition of public service through controls and mechanisms in order to ensure the observance of the constitutional principles and the coordination and cooperation between health centres.

After another political change in the country at central level in 2004, the new government ruled out any attempt to homogenize the situation in the various regions (the slogan for its political alliances with the nationalists was “España plural”). At the same time, the 2007 Public Sector Procurement Law (Ley de Contratos del Sector Público) seems to have indeed narrowed the autonomy of most new governance initiatives as designed in the previous period. The debate on the real value of the innovative experiences of hospital management entered the Parliament in 2008 through the Parliamentary Health Committee (Comisión de Sanidad del Congreso de los Diputados) but no clear conclusion has been reached.

By the end of 2009, the possibility of developing a Health Pact (Pacto por la Sanidad) has been discussed (some speak about it being signed immediately); it seeks the agreement of all parliamentary parties on key founding principles of the SNS and on a number of key goals on the basket of services the SNS should provide, the level of health expenditure to make the system sustainable, the expected quality levels to be guaranteed, etc. Hospital governance and



new management models are also on the table, not anymore as a technical issue but rather as part of the political agenda. New experiences in the AC of Madrid, for example, have mobilised a strong opposition from those arguing that it will lead to the privatisation of the public health system.

II. Five Self-Governed Hospital types in Spain?

The previous section has explained how a genuinely enthusiastic, pro democracy political change brought on almost silently some five “different models” of self-governed hospitals coexisting with both typically public and typically private hospital management arrangements.

In order to further assess each model's characteristics, we have contacted CEOs and Presidents of the Board of Trustees of one representative of each of them. The main selection criteria across the country were (i) that the concerned hospital was the first one adopting such managerial model; (ii) “popularity” – meaning that the hospital is well known and usually mentioned when debating this issue among commentators; (iii) similarity of size (four of the hospitals provide services in an area with around 245,000 people); and (iv) availability of information about it on the web, publications, etc.

1. The **Empresa Pública Sanitaria** (EPS), [Public Healthcare Company]

The first and most remarkable example of EPS is the Hospital Costa del Sol de Marbella (Andalucía). In 1993 the government of this 8-million-population region introduced this model with the declared purpose of granting more managerial freedom to hospital managers. The brand new Hospital Costa del Sol in Marbella thus became an enterprise (“empresa”) regulated by private law. In subsequent years additional examples have been the Hospital de Poniente, the Hospital Alto Guadalquivir and the Empresa Pública de Emergencias Sanitarias (in charge of all the emergencies in Andalucía). The Hospital de Fuenlabrada in Madrid is also an EPS.

The main feature of EPSs is that healthcare professionals are non-statutory staff (*contratados laborales*) instead of civil servants. They are consequently regulated by the common Workers Statute (*Estatuto de los Trabajadores*) and related legislation. There is a performance-related salary scheme for the clinical staff. Both changes were expected to lead to more productivity, better quality of care and higher patient and workers satisfaction. Some available results seem to confirm it, but traditionally-run top hospitals in the Region

keep on performing better in various areas (perceived quality, average waiting time for selected procedures, selected unit costs, etc).

In spite of ambitious intent, however, exhaustive control by public authority seems to have been the main driver of EPSs. At present, for example, although the Board of Governors (Consejo de Administración) is legally expected to oversee the functioning of the hospital in practice it seems to have been far more active in controlling the finances than in developing business strategies or innovative planning. Upwards accountability from the CEO seems to be rather ad-hoc. Also EPS hospitals suffer from three annual inspections (from an external auditing company; from the auditing unit of the regional government (Intervención); and from the Cámara de Cuentas of the Andalusian Parliament, respectively) all requiring basically the same paperwork.

The hospital budget was since the beginning approved annually by the regional Parliament (each Public Healthcare Company has in fact its own annual budget in the overall budget of the Regional Government). However, although the hospital leadership prepared it as a prospective budget according to both population size and needs, representatives of the regional Finance Department (Hacienda) at the Board of Governors have always opposed any budget increase in line with increases in the reference population or in the expansion of services provided. In fact they have imposed funding increases not bigger than 2%-3% per year, similar to increases granted to virtually all other hospitals in the region.

The regional finance department established in 1996 the prohibition for the hospital to make use of any profit – not even for reinvesting them in facility improvement or new technology purchasing: any net profit the hospital would achieve at the end of the fiscal year should simply be returned to the finance department. In fact, the EPSs seem to have been losing financial autonomy almost completely in recent times. While originally they were not obliged to abide by the Public Sector Procurement Law, for example, they were soon included under such regulation, which leaves little room to negotiate prices with providers.

Since 2008 (article 27 of the Ley 3/2008 de 23 de diciembre, del Presupuesto de la Comunidad Autónoma de Andalucía para el año 2009) any new post to be advertised in any Andalusian public hospital (including the EPS hospital) has to be approved by the Regional department of Finance (Consejería de Hacienda) and the regional department of Justice (Consejería de Justicia). Both



departments review the profile of the job post before it is advertised – although they do not get involved in the actual process of candidate selection.

2. **The Fundación Pública Sanitaria (FPS), [Public Healthcare Foundation]**

The most prominent example of the FPS model is the Hospital del Oriente de Asturias “Francisco Grande Covián” in the north of Spain (although the hospital was originally established as a fundación in 1997, barely six years after the establishment of the first EPSs. It became an FPS after a change of political sign in the regional government in 2008. The Hospital de Inca in the Balearic Islands is another example.

Like the EPS, the FPS is a public entity but the key difference between them is that this model is staffed by statutory personnel. The governing body is a board of governors (Consejo de Gobierno), formed by representatives of the regional health department plus the local authority as well usually, with the responsibility to appoint the hospital CEO.

The results of this experience (as different from ordinary public sector management) seem to be much more disappointing than those of the EPSs even if FPSs were described at the time as “the most radical change that has ever taken place in Spanish public hospitals” (Freire, 1999). Also it is probably worth mentioning that after repeatedly contacting both above hospitals we have been unable to properly interview anybody (in fact, the CEO of the Hospital de Inca argued a “need of prior authorisation to speak to us” and referred us to the regional health department for obtaining such permit. We interpreted this as a self-evident (negative) indicator of autonomy and refused to proceed further.

3. **The Fundación (F), [Foundation]**

The Law 30/1994 de 24 de noviembre, sobre Fundaciones e Incentivos Fiscales a la Participación Privada en Actividades de Interés General, established the model of Fundaciones to run public hospitals. The Hospital Universitario Fundación Alcorcón (Madrid) as an important example, well known among UK health commentators since former Secretary of State for Health Alan Milburn visited it in 2001 and allegedly got inspired for setting up the English foundation trusts model.

Another examples of Fundación are the Hospital de Manacor in the Balearic Islands and some hospitals in Galicia (Barbanza, Virxe da Xunqueira, Verín and Salnés - although their condition as Fundaciones was abolished in July 2008 by a left-wing coalition government, reverting to the traditional model of hospital governance.

A Fundación is a not-for-profit organisation regulated by private law, which means that the Public Sector Procurement Law does apply to them only marginally, related to “harmonized contracts - contratos armonizados”. Hospital activity is agreed by means of an annual contract with the regional health authority, with the main objectives tending to fit those of the regional programme-contract (Contrato-Programa).

The Fundaciones employ non-statutory healthcare professional staff and have performance-related payment schemes, usually up to a 10% of total earnings. They operate certainly more autonomously than the previous two models; it has the capacity, for example, to decide about the basket of services to be provided (although in practice agreement with the regional health authority tends to be previously sought). It is also free to provide services to patients covered by private health insurance and even fully private patients discretionarily. Importantly, the not-for-profit nature means that all possible profits need to be re-invested in the hospital.

Foundations are free to manage their own cash-flows and pay their providers directly, either monthly or bi-monthly, which allows them to negotiate better deals with their providers; they also have autonomy to choose where to invest and whether to rent or buy their equipment. The only financial requirement is that the Fundación cannot go below 20% of the original capital. Keeping the hospital patrimony (the property, real estate) is therefore subject within that context to achieving the goals established in the hospital regulatory statutes.

The governance body of a Fundación is its board of trustees/governors (Patronato), where public institutions such as the town hall, local university and so on may sit. By law this body is only obliged to meet twice a year, so its control is at arm's length and upward accountability from the management is rather weak and. Experience shows that the regional health authorities often engage with the Fundación management as much as they do with any other public hospital.



As explained regarding the EPS, control seems to be heavy on bureaucracy and red tape; the hospital interviewed for example also undergoes three annual inspections (from an external auditing company, from the auditing unit of the regional health authority and from the Tribunal de Cuentas of the Madrid Parliament).

It is worth mentioning again that the updated Law of Foundations (Ley 50/2002 de Fundaciones) issued in 2002 to replace the Law 30/1994 had the stated purposes to ease the rigid control mechanisms and reform the organisation of the board of trustees/governors. The law was rhetorically presented as an “effort to incorporate innovative experiences with administrative law taking place in other countries”. It is unclear at this stage whether those goals have been achieved, as illustrated by an increasing control by the politicians and the very conversion into FPS of some Foundations (see above)

4. **The Consorcio (C), [Consortium]**

This figure is probably best represented in Spain by the Consorci Sanitari del Maresme (Cataluña), one of the biggest consorcios in Spain, established in 1998 to replace a previous consorcio functioning for almost a decade. A consorcio is a legal figure resulting from merging resources from several public authorities, usually the regional government and a lower local authority (ayuntamiento y comarca). Most examples of this model are located in Cataluña such as the Consorcio Sanitario Integral de Cataluña; the Consorcio de Vic; or the Consorcio de Tarrasa. In Andalucía, a Consorcio Sanitario Público del Aljarafe (Hospital San Juan de Dios) has recently been established in Seville.

The Consorcios employ as staff non-statutory healthcare professionals (contratados laborales) and offer them performance-related incentives amounting to 8%-10% of their income. They agree an annual contract with the regional health authority (Catsalut in Cataluña) in line with the broad objectives of the programme-contract (contrato-programa) which the latter signs with hospitals servicing publicly covered patients. Catsalut used to pay hospitals by activity but two years ago they changed to a mixed system of capitation and activity.

The Consorcios have real autonomy to decide on the basket of services the offer, often supplementing the public basket with extra services in dental care, “maxillofacial” surgery, natural therapies, etc. – although in practice

they agree such expansion of services with the regional health authority. In other words, they also provide services to patients covered by private health insurance (around 5% - 6% of their income comes from this source) and treat fully private patients, usually restricted to ambulatory care. They have autonomy to decide whether to rent or buy equipment as well, etc.

For those reasons, Consorcios are subject to the Public Sector Procurement Law for a limited set of issues and quantities only, being allowed to outsource (“externalise”) most support activities. The shared and agreed financial requirement is to break even – thus ensuring the sustainability of the hospital – but they remain free from having to return the benefits to the hospital, and are not obliged to return the money to the regional government.

Consorcios also have autonomy to choose where to invest – yet in the case of important volumes, they need to discuss the case with the regional health authority. The process starts with the chief executive elevating the investment plan proposal to the Board of Governors (Consejo Rector) which includes representatives of the regional health authority and the local authorities and meets monthly. In addition to overseeing the functioning of the Consorcio, the board is responsible for approving: the Business Plan and the budget, approving investment decisions, creating new posts, appointing managers and approving the contract with the regional health authority. This board holds the CEO accountable for the day-to-day management of the hospital and monitor quality, activity, financial situation, waiting lists, etc. It formulates any proposal to change hospital norms (estatutos) but the regional health authority really decides on these territories.

Hospital managers are free to re-organise posts and functions, with the previous approval from the Board of Governors. Each hospital has the right to design its own health information system. Data on waiting lists has to be send to the regional health authority monthly and quarterly updates on the financial situation of the hospital has to be sent to the auditing unit of the regional government.

As before, the hospital undergoes annually three inspections (from an external auditing company; from the auditing unit of the regional government – Intervención- and from the Sindicatura de Cuentas in the case of the Catalan Parliament.



5. The **Concesión Administrativa** (CA), [Administrative Concession]

Through the *concesión administrativa*, a private concessionary company (in Spain, usually a joint venture between private health insurers, health groups, building societies, or banks) is given the right to build up a hospital and provide health care services to a defined population. The first and best known CA hospital is the Hospital de la Ribera in Alzira (Valencia), which at the moment integrates primary and specialised care. Following the Alzira initiative, this region established three other hospitals under the same management model: the Hospital de Torrevejeja; the Hospital Marina Alta de Denia; and the Hospital de Manises. The AC of Madrid has established one CA, the Hospital Infanta Elena in Valdemoro. The concession is usually for 10 years, with the possibility of extending it for 5 more years.

Differently to most other Private Finance Initiatives in for example the UK, the CA hospital is managed by the concessionary company but the funding is public. Madrid region is currently building seven new hospitals in Majadahonda; San Sebastián de los Reyes; Coslada; Madrid-Vallecas; Aranjuez; Arganda del Rey and Parla; all are Private Finance Initiatives in terms of building up the hospital but do not include the management or the provision of services.

70% of the CA hospital staff is non-statutory and the other 30% is statutory. In the studied case of el Hospital de la Ribera de Alzira, statutory staff was given a choice between being transferred to a non-statutory scheme or keeping the statutory status (30% of the existing personnel refused to change) but afterwards all new staff becomes non-statutory automatically.

Although alignments with the overall objectives of the regional program-contract (*contrato-programa*) always exist, the CA hospital is in itself fully not-linked to the regional hospital programme-contract, and may negotiate its own contract (*acuerdo de gestión*) with the regional health department instead. It is also free to decide about its sources of capital investment for large new equipment, renovations, etc, including bank loans, and about the sources of operating capital for regular day-to-day expenses. The CEO can decide on specific financial arrangements for any given equipment, propose increases in its service basket and contract-out services if required. The only pre-established requirement the hospital should comply with is that there is a limit to the “authorised” annual profit rate, capped at a 7.5% (any additional profit after taxes has to be reimbursed to the regional health authority).

The CAs studied operate under a strong accountability regime and strong controls preclude the hospital from selecting risks and patients. The day-to-day control is exercised by a regional health ministry delegate (in Alzira, the Comisionado de la Consejería de Sanidad) based at the hospital, supported by a number of units (information, quality control, finance, etc.) directly under his/her command and with capacity to control, inspect, and sanction. This arrangement ensures his/her full access to intelligence on hospital activity, patient satisfaction, financial performance, etc. A critical responsibility of the Comisionado is to approve the treatment of patients who do not belong to the primary care district, as well as to later ensure the correct billing for the services provided to them as adequate.

The hospital is entitled to contract new staff without using the official regional employment list, an official job-seekers list. Both groups of staff have in fact separate management lines – the non-statutory personnel are managed by the hospital CEO, while the Comisionado manages the statutory staff. Likewise, statutory and non-statutory staff have different incentive schemes; incentives for non-statutory staff are agreed with the unions.

The hospital Chief Executive is appointed and removed by the concessionary company – the CEO's contract is signed by the representative (apoderado general) of the company, but approval of the regional health department is required. The Joint Commission (Comisión Mixta) between the company and the regional health authority, which meets 3 times per year, is a second layer of accountability. The CEO is finally also accountable to the concessionary company shareholders, usually through a joint shareholders-CEO committee which meets monthly.

Clinical quality and hospital activity data is submitted to the regional health ministry on a regular basis, as well as ad-hoc information when requested. CA hospitals undergo annually two main inspections: 1) from an external auditing company; 2) from the auditing unit of the regional government.

III. Discussion

The five “models”, described in some detail above configure in our opinion a sort of continuum in terms of self-governance (hence the order in the previous section) as follows: (a) the Empresa Pública Sanitaria; (b) the Fundación Pública Sanitaria; (c) the Fundación; (d) the Consorcio; and (e) the Concesión Administrativa. In the extremes, the rather top-down managed



EPS is just a slight deviation from the traditional publicly owned, publicly managed hospital while the more independent CA is almost a fully fledged commercial company whose owner is the public sector. Paradoxically enough, such abundance of nuances attests in the Spanish context to the unplanned nature of the concerned developments. The coincidence of two highly polarised political parties in “going beyond the written norm” only 5 years after the joint approval of a core general health law is highly revealing.

In other words, the fact that all five Spanish models of hospital self governance have been established by ad-hoc, politically-driven and last-minute legislation resulting in a fragmented regulatory framework with various national and regional norms is revealing: as seen in many other areas, innovative governance arrangements do not necessarily come about only after conscientious planning exercises. The various “models” of self-governing hospitals so far tried in Spain (including the very ups and down, forward and backward steps within each model) show that, far from being simple technical solutions, those models get embedded in powerful political and social structures which can both limit or enhance their capacity for change. In other words, context and politics matter.

One very plausible explanation as to why new governance schemes have almost only been applied to newly built hospitals is the opposition of trade unions and the fear of politicians to clash with them. The experience in the Valencia AC (Alzira and others) comes to illustrate both the feasibility of introducing those changes whenever the political will exists but also the need to do so by means of give-and-take and trade-offs -for example, parallel managerial lines according to staff regimes, statutory and non-statutory).

More importantly, the very description of those models illustrates the limitations of traditional managerial arrangements for solving the problems of a fast changing Western society as Spain. Irrespective of frequent grandstanding, quick-fix management approaches left unresolved most of the critical problems of the building of a highly de-centralised State. While confirming the idea that autonomy is a key dimension of governance, our study highlights that neither the macro, purely political level nor the meso- and micro-management domains fully explain what is happening in many Spanish health system and healthcare settings.

Those changes would be better addressed not through the concept of management but through the concept of governance as defined in

the Introduction – that is: changes in the ways and the tools for governing the public sector, away from old models of command and control, public administration or management in response to changes in the state-society relationships that are transforming social structures, policy processes, political systems and institutions, organisational arrangements, etc.

The surveyed strategic and operational dimensions of the proposed framework seem to be relevant for assessing the level of hospital autonomy in Spain. Within such framework, the key analytical dimensions that best seem to reveal whether each of these hospitals do have the autonomy that they are supposed to enjoy are, in our understanding:

- a. The different accountability arrangements that exist. Actually, the more arms-length, the stronger and more efficient the accountability arrangements seem to be (this is probably the case in England as well, with Foundation Trusts strongly accountable to Monitor; NHS hospital trusts, however, while directly accountable to the Department of Health through PCT and Strategic Health Authorities, do not, however, “suffer” the close watch a strong regulator such as Monitor). The accountability structures of the CA model, for example in the Hospital de la Ribera de Alzira, seem to be very effective in holding managers to account. There should be a consistent single auditing scheme. Inspection and control requirements in Spain perhaps entail too much bureaucracy at present. Excess (futile) control as opposed to accountability seems to be a problem in all hospital models.
- b. The ability to contract out services with providers and healthcare staff is important. In Spain, the key difference seems to be whether and to what extent the hospital is bound to the stringent Public Sector Procurement Law.
- c. The status of the workforce (whether they are statutory staff, on contracts, etc.) is relevant, but probably less so than originally understood.

Some of the innovative features of hospital self-governance models in Spain have been eroded by strong centralising forces at regional level (this has proved to be the case for EPS and FPS in particular, whose room for manoeuvring has gradually being reduced since they first were established by the concerned health authorities). In our understanding, this is only an expression of the highly dynamic nature of these changes in the highly



politically loaded environment of present Spain. This is but one more signal that the wider institutional context beyond the specific health sector arrangements also affects and determines the true autonomy of individual hospitals. Hospital autonomy, in other words, is not a specific, encapsulated feature of the health field but it rather responds to broader political and social characteristics.

Regulatory Framework: Laws, Royal Decree Laws, Royal Decrees used in the text

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TYPE OF LEGAL ENTITY	SERVICE DELIVERY MODALITY	REGULATION MODALITY	PRECISE LEGAL FRAMEWORK
Public Healthcare Company - Public Law Entity	Direct (public sector coverage and delivery)	Legal personality as public sector entity but resource use and management according to private law	<ul style="list-style-type: none"> • Specific law by Andalusian Parliament (Disposición Adicional 18 de Law 4/1992 de Presupuestos de la Comunidad Autónoma de Andalucía) • The national law that regulates these public entities is the Law 30/1992 Régimen Jurídico de las Administraciones Públicas • Statutes by Decree 104/1993 de 3 de Agosto Empresa Pública Hospital Costa del Sol • Staff under private employment law (Workers Statute -Estatuto de los Trabajadores) but possible civil service or statutory law • Public Sector Procurement Law (Ley 2007 Contratos Sector Público) (Material resources management and contracting of goods and services) • Public sector budget law (Financing and budgetary management); control by auditing
Public Healthcare Foundation (state-owned foundation)	Direct (public sector coverage and delivery)	Entity with legal personality of its own, created by public and/or not-for-profit persons and with its own assets ascribed to “general interest” goals.	<ul style="list-style-type: none"> • Law 50/1998 de Medidas Fiscales, Administrativas y de Orden Social • Specific statutes • Statutory Staff • Civil law for goods and services contracts

INTERNATIONAL WORKSHOP

TYPE OF LEGAL ENTITY	SERVICE DELIVERY MODALITY	REGULATION MODALITY	PRECISE LEGAL FRAMEWORK
Foundation	Direct (public sector coverage and delivery)	Entity with legal personality of its own, created by public and/or not-for-profit persons and with its own assets ascribed to “general interest” goals.	<ul style="list-style-type: none"> • Law 50/2002 de Fundaciones (to replace Law 30/1994) • Specific statutes • Staff under private employment law (with own agreement “convenio propio”) • Civil law for goods and services contracts
Consortium	Direct (public sector coverage and delivery)	Entity with legal personality and assets of its own, created by several public administrations and/or not-for-profit private entities	<ul style="list-style-type: none"> • Law 30/1992 de Régimen Jurídico de las Administraciones Públicas (complementing the Law 7/1985 Reguladora de Bases de Régimen Local) • Specific statutes • Staff under private employment law (Workers Statute -Estatuto de los Trabajadores) • Contracts for goods and services: public sector procurement law • Financial control by means of audits



TYPE OF LEGAL ENTITY	SERVICE DELIVERY MODALITY	REGULATION MODALITY	PRECISE LEGAL FRAMEWORK
Administrative Concession	Mixed, indirect (public sector coverage and private sector delivery)	Hospital building and running by means of concession. Both Primary Health Care and Specialised Care included	<ul style="list-style-type: none"> • Law 15/1997 de Habilitación de Nuevas Formas de Gestión del SNS (and Law 13/1995 de Contratos de las Administraciones Públicas) • Public tender: Terms of Reference (Pliego de Condiciones) • 70 % Staff under private employment law + specific collective working agreement) and 30% statutory staff • Fully fledged private law.

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SPAIN

INSTITUTIONAL FRAMEWORK

	LEGAL FORM / OBJECTIVES	ROOM FOR DECISIONS ON CLINICAL SERVICES, LOCATIONS, SERVICES & SANCTIONS	RELATIONS WITH STAKEHOLDERS (STAFF, UNIONS, PROFESSIONAL ORGANISATIONS)
EPS	<p>EPS were created under specific regional laws (that is, an Act, rather than an executive order) and the hospital statutes were approved by the regional executive with the quite explicit objective to get increased autonomy to innovate, improve flexibility, etc. This may explain why no EPS has ever been shut down by health authority even if their original level of autonomy “by design” has gradually been rather eroded.</p>	<p>EPSs do not treat private patients and have little ability to choose their own strategic niche. All key decisions (on clinical services, sanctions and rewards, mayor alterations of the standard rules, etc) are in fact made by the regional health department.</p>	<p>The status of healthcare workforce is only partially associated to the level of hospital autonomy; all EPS healthcare professionals (as it is the case with F, C and 70% of CA) are non-statutory staff with labour agreement of their own with the hospital. This does not seem to make major differences in terms of governance (compared to for example FPS). Trade unions negotiate labour agreement with the hospital management and sit in the hospital staff-employer committee.</p>
FPS	<p>Both FPS and F were set up upon secondary legislation issued by the regional executive, which can be overruled rather easily by the very executive. Hospital statutes were approved by the regional executive. FPS and F seem to be more exposed than the other models to being re-integrated into the traditional public management type (that was the case in March 2010 with the FPS Hospital Grande Covián in Asturias).</p>	<p>FPS do not treat private patients and have little ability to decide their own strategic niche. All key decisions (on clinical services, sanctions and rewards, major alterations of the standard rules, etc) are in fact made by the regional health department.</p>	<p>Healthcare professionals are statutory staff as in the rest of the health system. Trade unions negotiate labour agreement with the hospital management and sit in the hospital staff-employer committee.</p>

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F	<p>Both FPS and F were set up upon secondary legislation issued by the regional executive, which can be overruled rather easily by the very executive. Hospital statutes were approved by the regional executive. FPS and F seem to be more exposed than the other models to being re-integrated into the traditional public management type (as was the case in Galicia in 2008, when all Foundations were abolished).</p>	<p>Hospital management has some rather limited autonomy to decide on services portfolio. The hospital provides services to patients with private health insurance and to a small number of fully private patients.</p>	<p>All healthcare professionals are non-statutory staff and sign with the hospital their own labour agreement. Trade unions negotiate labour agreement with the hospital management and sit in the hospital staff-employer committee.</p>
C	<p>C are created upon agreement between public administrations and/or non-for-profit organisations (although the regional health department is clearly the most powerful partner). There are examples of several Cs being forced to merge by the regional health department as a way to ensure their economic viability. Proposal to change hospital norms are formulated by the Board of Trustees but the ultimately decision is with the regional health department.</p>	<p>Have autonomous capacity to decide about service portfolio, but they try to align with the regional health policies. C provide services to patients with private health insurance and also treat fully private patients mostly in ambulatory care. C may outsource most support activities</p>	<p>All healthcare professionals are non-statutory staff. Trade unions negotiate labour agreement with the hospital management and sit in the hospital staff-employer committee.</p>



CA	CA is run as a specific endeavour by a fully-private company, after winning a contract issued by the regional executive. No CA has ever been closed by health authorities.	The company makes decisions within the scope granted by the contract signed with the regional health department. The hospital is free to modify service portfolio and to treat private patients. The hospital may outsource services as required.	In Alzira, 70% of the staff is non-statutory (1,500 staff) and the other 30% is statutory (around 500 staff). The hospital has its own labour agreement. Different incentive schemes for statutory and non-statutory staff. Incentives for non-statutory staff have been agreed with the unions.
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FINANCIAL FRAMEWORK

	CAPITAL INVESTMENT: SOURCES, CONSTRAINTS, CONDITIONS	ADJUSTING CAPITAL AND OPERATIONAL EXPENSES	ABILITY TO RETAIN FINANCIAL SURPLUSES
EPS	<p>Entitled originally to contract with suppliers of goods and providers of support services outside the national public procurement framework (major difference with traditional command-and-control model). One year later, however, politicians changed this situation and reverted the hospital to the common framework which has resulted in less room to negotiate prices with suppliers and providers in general.</p> <p>The source of investment capital for new buildings, equipment, renovations etc is only the budget.</p>	<p>The source of operating capital for day-to-day expenses is the budget approved annually by the regional Parliament after prospective budget (based on population size and needs) prepared by hospital management. Yet the Finance Department representatives in the Board of Governors have always opposed hospital budget increases linked to "special" needs and set a fixed % increase (usually 2%--3% per year), irrespectively of increases in the reference population, new services, etc.</p>	<p>Andalusian finance department decided in 1996 that any net benefits that the hospital may get at the end of the fiscal year should be returned to the finance department. This inability to retain surpluses is seen as a major expression of lack of governance autonomy by those concerned.</p>

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FPS	<p>Obligated to adhere to the national Procurement law. Budget is the only source of investment capital for new equipment, renovations and new buildings.</p>	<p>Operating capital for day-to-day expenses etc. is the budget, set annually by the regional health department.</p>	<p>No freedom to retain financial surpluses, which is seen as a major expression of lack of autonomy.</p>
F	<p>The hospital has a global, not earmarked to item lines, budget and enjoys autonomy to choose where to invest, whether to rent equipment rather than buying, etc. Hospital assets (the property, real estate) subject permanently to the achievement of established goals in the hospital 'statutes' (regulations) with the only financial requirement of not going below 20% of the original invested capital. For high volume contracts the hospital is obliged to adhere to national Procurement law.</p>	<p>Regional health service pays the hospital specific monthly allotments by activity, but hospital can manage its own cash-flow and pay their providers directly. This is seen as a key autonomous tool for governance. The hospital gains leverage before its stakeholders as the ability to pay quickly allows the hospital negotiate better contracts with providers/ suppliers.</p>	<p>F are able to retain surpluses but only to reinvest them into the hospital.</p>



C	<p>Have autonomy to choose where to invest –but need to discuss important investment volumes with regional health department.</p> <p>CA managers have autonomy to decide whether to rent equipment rather than buying, etc. No special financial requirements other than at least breaking even to ensure sustainability of the hospital. Obligation to follow the national Procurement law, but not for all issues and quantities and exempt of ex-ante intervention and. More conditions have been imposed regarding this law recently.</p>	<p>Mixed payment by activity and capitation in the case studied, but probably other financial arrangements involved also.</p>	<p>Able to retain surpluses but need to reinvest them in the hospital.</p>
CA	<p>The hospital is free to decide any sources of capital investment for large new equipment, renovations, etc. It is not subject to the national procurement law.</p>	<p>The hospital is free to decide any sources of operating capital for regular day-to-day expenses.</p>	<p>Annual profit rate capped at 7.5%. Additional profit after taxes should be reimbursed to regional health authority.</p>

ACCOUNTABILITY FRAMEWORK

	SUPERVISORY BOARD: ROLE, SIZE	CITIZEN & PATIENT INVOLVEMENT	REPORTING OBLIGATION: CONTENT (items & completeness), TRANSPARENCY, TIMING
EPS	<p>Board of Governors with 10 members, chaired by regional health minister acting as president of the board and with deputy regional health minister acting as vice-president. The regional health authority appoints 5 other members to the board, the regional finance department holds 2 more seats. The Chief Executive also seats in the board (highly revealing composition in terms of reflecting dependency upon the regional health department). The board seems to show more concerned with controlling hospital finances than with developing business strategies or plans.</p>	<p>No citizens and patients role in decision-making processes in any of the models and no avenues of direct citizen participation. Board meetings are not open to the public.</p>	<p>EPS are not obliged to officially register their accounts, but an annual report is very often published (usually appearing a year later). The report includes basic data on clinical performance, financial performance, staff numbers, patient satisfaction and objectives included in what is known as the 'contract-programme'.</p>
FPS	<p>Board of Governors formed by (usually 3) members appointed by the regional government (through the regional department of health); other representatives appointed by the local authority (usually 2 members).</p>	<p>No avenues of direct citizen participation. Board meetings not open to the public.</p>	<p>No legal obligation to officially register accounts. In one case studied no regular report published and available to the public but some data on waiting times for certain services available. In the second case studied, a summary of key activity indicators publicly available.</p>



F	<p>The governance body is the Board of Trustees, in which the local authority (major of the town) and the local university participate. The regional health minister is the president of the board. The board meets twice a year. It seems fair to say that its supervisory role is hardly effective.</p>	<p>No avenues of direct citizen participation. Board meetings not open to the public.</p>	<p>Obligated to register their accounts annually at the Registro de Fundaciones (difference with traditional public hospitals, EPS and FPS). Annual report published a year later including basic data on clinical performance, staff numbers, financial performance and patient satisfaction.</p>
C	<p>Board of Trustees (“Consell Rector”, CR), including president, vice-president and other representatives of the regional Health Authority; second vice-president and other representatives of local authority (town hall) or the district council. No legal requirement but regional government and local authority agree to include local business people from the area. Monthly 2-hour meeting of the CR. Board responsible for approving: the business plan and strategy; budget; investment decisions; new posts; managers appointment and contract with regional health department. Also they monitor: quality indicators, activity, financial situation, waiting lists, etc.</p>	<p>No avenues of direct citizen participation. Board meetings not open to the public.</p>	<p>Differently to traditional public hospitals & to EPS and FPS, annual report regularly published a year later including basic data on clinical performance, staff numbers, financial performance and patient satisfaction.</p>

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CA	<p>Rather radically different accountability system (arguably, far tougher). Day-to-day control by regional health ministry exercised on permanent bases by a commissioner with capacity to control, inspect, normative intervention and sanction. Appointed by regional health department, the commissioner is based inside the hospital and is supported by a number of (own) units; full access to all data on hospital activity, patient satisfaction, financial performance, etc. A Joint Committee between the company and the regional health department meets 2/3 times per year.</p>	<p>No avenues of direct citizen participation. Board meetings not open to the public.</p>	<p>Obligated to register accounts annually at the Registro Mercantil. (difference with traditional public hospitals, EPS and FPS). Annual report published a year later including basic data on clinical performance, staff numbers, financial performance and patient satisfaction.</p>
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“OPERATIONAL GOVERNANCE”: DECISION CAPACITY VERSUS RESPONSIBILITY

	ROOM TO ADJUST TO UNEXPECTED TRENDS AND FREEDOM FROM POLITICAL INTERFERENCE	POWER-SHARING WITH CLINICIANS AND STAFF	INTERNAL MONITORING FLEXIBILITY AND FOLLOW UP AND EVALUATION
EPS	Little room to make specific adjusting decisions. In fact, for example, the tendering of a new post has to be previously authorised by the Andalusian department of Finance. Rather intense political scrutiny of daily operations	No significant variation between the 5 models in this regard. Information partially shared with staff; Chiefs of services and clinical managers have some degree of freedom to organise and run their own units (e.g. adjust schedules and organise workload) but not for purchasing equipment or hiring staff on their own.	Hospital has autonomy to decide on the parameters for monitoring day-to-day activity. No links with public information system networks other than voluntary
FPS	Little room to make specific adjusting decisions. Rather intense political scrutiny of daily operations	Information partially shared with staff; Chiefs of services and clinical managers have some degree of freedom to organise and run their own units (e.g. adjust schedules and organise workload) but not for purchasing equipment or hiring staff on their own.	Hospital has autonomy to decide on the parameters for monitoring day-to-day activity. No links with public information system networks other than voluntary
F	Little room to make specific adjusting decisions. Rather intense political scrutiny of daily operations	Information partially shared with staff; Chiefs of services and clinical managers have some degree of freedom to organise and run their own units (e.g. adjust schedules and organise workload) but not for purchasing equipment or hiring staff on their own.	Hospital has autonomy to decide on the parameters for monitoring day-to-day activity. No links with public information system networks other than voluntary

INTERNATIONAL WORKSHOP

C	Some room to make adjusting decisions. Relatively high freedom from political interference (although this may be ascribed to the political culture in Catalonia which has traditionally left health policy out of the political discussion.	Information partially shared with staff; Chiefs of services and clinical managers have some degree of freedom to organise and run their own units (e.g. adjust schedules and organise workload) but not for purchasing equipment or hiring staff on their own.	Hospital has autonomy to decide on the parameters for monitoring day-to-day activity. No links with public information system networks other than voluntary
CA	Substantial room to adjustment. At least externally the model seems to be out of traditional continuous political scrutiny and interference.	Information partially shared with staff; Chiefs of services and clinical managers have some degree of freedom to organise and run their own units (e.g. adjust schedules and organise workload) but not for purchasing equipment or hiring staff on their own.	Hospital has autonomy to decide on the parameters for monitoring day-to-day activity. No links with public information system networks other than voluntary, A key feature is that monitoring and continuous evaluation can be done by both the CEO and the commissioner.



REINVENTING AUTONOMOUS HOSPITALS IN THE ENGLISH NHS: FOUNDATION TRUSTS

Nigel Edwards

1. Introduction

The current context

The English NHS is currently based on a quasi market system with the following characteristics:

- ◆ Primary care gate keeping: patients register with a primary care practice and get access to specialists through referral
- ◆ A purchaser – provider split: Primary care trusts cover geographical areas of between 120,000 and 1million population and are responsible for purchasing care and for health improvement. Increasingly payers (Primary Care Trusts) delegate budgets to groups of general practitioners who can act as purchasers for the services they use. It is intended that by 2013 the Primary Care Trusts will be abolished and the payer function will be taken over by groups of general practitioners.
- ◆ Hospital reimbursement is largely via an activity payment system based on case mix groups.
- ◆ Training, education and research: paid on a separate basis from hospital activity.
- ◆ National policy and direction: standards and policy objectives are set nationally.
- ◆ A more mixed economy for providers – the development of autonomous foundation hospitals and the encouragement of independent sector provision, especially in planned surgery
- ◆ The NHS is now required to be much more transparent and accountable. Increasing amounts of information about providers are available publicly and FT providers are required to produce a quality account alongside their financial statement and annual report. Standards are enforced by independent regulators whose scope and powers have expanded a great deal over the last 10 years. And patients now have legal rights to choice and maximum referral to treatment times.

A theme of this book is the divergence between the legal and theoretical basis of hospital governance and the experience in practice. In the UK while there is often a significant gap between rhetoric and reality in public policy and an important role for informal networks and local political influence, the formal rules that describe how hospital governance operate are quite close to what happens in reality.

This chapter looks at the experience of creating autonomous hospitals in the English National Health Service (NHS), how the governance arrangements have evolved and how they operate.

We have selected University College Hospitals London (UCLH) as the basis for a case study as it is a complex organisation serving a large number of payers and with an important role in research and education (see Box X). We have also been able to reference a small body of research and other material which allows more general conclusions to be drawn.

First, we present the history and background of the policy which contains some important policy lessons. We then examine the main features of the model and its prospects for the future including the early indications of further reforms, following the election in May 2010, which will increase the level of autonomy given to providers.



2. The emergence of autonomous hospitals

Background

Compared with many other European systems, the NHS is unusual in that the extent to which the ownership and management of health care providers has been highly centralised and government controlled. Until the early 1990s NHS hospitals and other providers were managed by health authorities which were under the direct supervision of central government. Whilst they had their own management structures they had little discretion over many important areas:

Box 1: Pre-1990 Hospital governance

- ◆ Pay and conditions determined by central government
- ◆ Control of staff numbers for some staff groups – but not junior doctors, specialists and management
- ◆ Specialist medical consultants appointed, employed and very rarely dismissed by regional authorities
- ◆ Very limited discretion on capital spending. The largest capital schemes had to be by central government and even regional authorities had limited delegated powers
- ◆ Global budgets set by district level authorities, largely on an historic basis
- ◆ Assets owned by central government
- ◆ Large contracts had to be approved and were often made at health authority or regional level

In the Thatcher reforms in 1989 hospitals and other providers were allowed to apply to become self governing organisations with some additional freedoms. During the 1990s many of these freedoms were eroded although in many cases the culture of the NHS had prevented some of them from being fully exercised. After Labour came to power in 1997, a resurgence of central control led to many of freedoms being removed or discouraged.

Box 2: The Thatcher reforms and beyond

Post 1990 Trust providers	Position by 2000
Freedom to set pay and conditions locally - not exercised widely	This freedom was removed by the incoming Labour government
Light touch performance management separate from main NHS	Performance management had reverted to regional health authorities and after 1997 central government reasserted even more control
Assets transferred to the trust	No change
Ability to make contracts	Retained but with limits on capital
Limited freedom to make capital decisions	Capital rationing and approval taken back by centre but some capital freedoms remained
Board of executive & non-executive directors with full budget responsibility	No change but de facto Chief executives became subject to appointment & removal by higher tiers as well as their board
Senior medical staff employed by the trust rather than regional authorities	No change
Purchaser provider split introduced	Retained but weakened
Ability to retain surpluses	Eroded - required to break even each year. This was then extended to being able to breakeven over a three year period if centrally set conditions were met
Autonomy granted and could be withdrawn if performance was poor	Autonomy was expected to be earned in return for improved performance

Change under Labour 2001-2010

The 2000 NHS Plan contains a number of important proposals but most of these were to be driven by central initiatives. By 2002 it was becoming clear that the Department of Health's highly centralised performance management regime was creating significant collateral damage. It centralised blame and forced politicians to become involved in the minutiae of hospital management, reaching its nadir when the Secretary of State found himself explaining in detail why bodies had been left on the floor of the chapel of rest at Bedford Hospital.¹ Also there was concern that the regime was increasingly felt to be destroying initiative and alienating clinical staff.



The Secretary of State and his advisors looked for alternative approaches to creating radical reform in the NHS including self governing organisations and the greater use of incentives and quasi market mechanisms –although in fact many of the trappings of central performance management remained in place. Following visits to autonomous hospitals in Spain and Sweden the Secretary of State announced that hospitals that met certain performance criteria would be allowed to apply to become NHS foundation trusts (FTs). The Labour government promoted this reform but the model was in fact copied from approaches that were modified versions of the original Thatcher reforms. The publication of an updated NHS plan which contained these proposals was part of a wider package of changes to the reform process which introduced more reliance on incentives and quasi market mechanisms. This can be seen as part of a long-term direction of travel in which the NHS has moved from being a monolithic organisation, to being a more loosely connected system and eventually (post 2010) to becoming more of a regulated industry.²

New governance model

Foundation trusts were announced as a new governance model with some important new characteristics enshrined in the Health and Social Care (Community Health and Standards) Act 2003³:

- ◆ They were established as public benefit corporations, a novel form of organisation with a legal status specifically created for the purpose of creating foundation trusts.
- ◆ They had a new form of governance designed to create greater connection with and accountability to local people, patients and staff who could become members of the Foundation trust. Foundation trusts members could form a constituency to which the organisation would be accountable and elect governors with responsibility for appointing board members. FTs were allowed to tailor their governance arrangements for local circumstances in contrast to the heavily prescribed model in the rest of the NHS. While each constitution was unique to the NHS foundation trust it related to, legal requirements were set for the governance structure that apply to all NHS foundation trusts.
- ◆ FTs were to be allowed to retain surpluses
- ◆ They could borrow commercially (within a defined code) and invest

in capital. They had access to public capital but Private Finance Initiative deals (a procurement method for the NHS and other parts of the public sector) had to be underwritten by the Secretary of State.

- ◆ They could set up joint ventures and other subsidiary businesses
- ◆ The trust could sell surplus land and buildings but assets were 'locked' to prevent privatisation of the provision of healthcare.
- ◆ To change the culture of the organisation and make it more innovative, entrepreneurial and responsive to its different constituencies FTs were granted freedom from direct instruction by the Secretary of State for Health and from top-down performance management by the regional tier of the NHS.
- ◆ The legislation stipulated that a failure regime would be designed which would be different from the commercial insolvency regime applied to normal enterprises. This was necessary because the assets of the FT are 'locked' and they cannot be used to guarantee debt or sold to pay creditors. However, developing this regime based on commercial principles proved very difficult and after four years it was decided that in the case of failure the FT would be deauthorised and returned to the management of the Secretary of State for Health.

The role of overseeing financial stability and compliance with regulatory standards was split: a regulator for foundation trusts (known as Monitor) was given responsibility for ensuring financial viability and compliance with the terms of the FT's license; and the Healthcare Commission (now the Care Quality Commission) responsible for ensuring compliance with regulatory standards for quality and safety for all public and private providers. The proposal to create Foundation Trusts was politically controversial with both trade unions and some members of Parliament. They were concerned that the measure threatened to reduce accountability and could undermine centrally negotiated pay and conditions – a key source of power and influence for the unions. There was also some concern that the hospitals would pursue private patient income and that the profit motive would undermine NHS values.

As a concession to this it was agreed to limit the percentage of private patient income that a foundation trust was able to earn to the level it was when the organisation was an NHS Trust in 2002–2003. However, this has proved counterproductive as it has prevented some organisations whose income from private patients has grown from becoming FTs.



Foundation Trusts were required to sign up to national terms and conditions for staff although they have some freedoms in this area which we examine in more detail later. The proposal to allow borrowing freedoms was resisted by the Treasury (Ministry of Finance) as it removed an important lever to control public sector borrowing and capital expenditure; for National accounts FT borrowing counts against the overall public borrowing requirement. After some high-profile political negotiation it was agreed that foundation trust borrowing would remain part of the capital expenditure limit of the Department of Health and that new regulator, Monitor, would design a prudential borrowing regime. A fourth, less political, concern related to the experience of the quasi market operating in the 1990s in which organisations sometimes failed to co-operate appropriately with the wider system. A significant amount of UK government policy requires cross organisational working so foundation trusts were given a duty to co-operate with other parts of the health system.

Initially it was envisaged that foundation trust status would not necessarily be universal. However, in common with previous policy designed to create an 'elite' form of organisation, it quickly became clear that the Department of Health expected foundation trust status to become the default position and that organisations would be required to achieve FT status relatively quickly.

Box 3: University College London Hospitals NHS Foundation Trust (UCLH)

The hospitals which make up UCLH are:

University College Hospital

Eastman Dental Hospital

Hospital for Tropical Diseases

National Hospital for Neurology and Neurosurgery

The Heart Hospital

The Royal London Homoeopathic Hospital

The organisation has a turnover of €770 million and contracts with more than 150 Primary Care Trusts to provide services. The trust provides more than 500,000 outpatient appointments and more than 100,000 inpatient and day case admissions each year.

It is a major research centre and has funding from the government's National Institute for Health Research for its Biomedical Research Centre. Income to support research infrastructure is in over €60 million. In partnership with University College London it has recently been designated as an Academic Health Sciences Centre modelled on similar partnerships in the USA.⁴

UCLH has close links with the Royal Free and University College Medical School and London South Bank and City universities to offer training and education for the doctors, nurses, midwives and associated healthcare professionals.

UCLH became a Foundation Trust in 2004, the first year of the policy's operation.

The trust is proud of its high quality outcomes. It has developed a strategy of actively recruiting high quality academic clinicians assisted by its close association with one of the top Universities in Europe.



3. Foundation trust status

NHS providers of hospital, mental health and ambulance services can apply to be a foundation trust when they are capable of demonstrating that they meet the performance, governance and other criteria.

3.1 The application process

Applicant organisations have to complete a three-part process.

1. *Strategic Health Authority (SHA)-led Trust Development Phase*⁵

The purpose of this is to prepare NHS trusts for the application process and Secretary of State support; This consists of the preparation of a draft business plan and financial mode, a 12 week public consultation on the proposal and a final assessment of the business plan Entry into the application process is controlled by the regional strategic health authorities (SHAs) and they were often reluctant to initiate the process in circumstances where they have not determined the strategy for the shape of the local health care system. The former executive chair of Monitor also raised questions about the SHAs' capability to undertake the development of new FTs and their interest in the process.⁶ As a consequence of this and because of the effect of the economic down turn on trusts' financial plans the Department of Health's target for organisations achieving foundation trust status has been revised so that all organisations must have become an FT, or part of a FT through take over, by April 2013.

The SHA reviews the application against seven domains:

- ◆ That the organisation is legally constituted and has carried out the consultation with the public required by the legislation They must also demonstrate that they have a sufficiently large and representative membership to allow them to conduct elections for governors. (See below for an explanation of these groups)
- ◆ That there is a viable business strategy that is consistent with the strategy of their purchasers and has been consulted on.
- ◆ That the organisation is financially viable and has well developed approaches to long-term financial planning
- ◆ The quality of its existing governance arrangements including risk

management, compliance with regulatory standards, evidence of ability to meet statutory targets and performance management systems

- ◆ The capability of the individuals that make up the board and any potential conflicts of interest that they may have
- ◆ The organisation's record of performance, including the delivery of government targets such as waiting times in the emergency room, and waiting time targets for planned surgery The characteristics of the local health system are also assessed – to ensure the financial performance of purchasers does not pose a threat and to check that other strategic changes, such as plans to change services, will not destabilise the organisation

2. *Secretary of State Support Phase*

Having passed the first phase of assurance the Trust can then go forward to seek the approval of the Secretary of State. The SHA has to demonstrate that the applicant trust is fit for purpose to a committee convened by the Department of Health.

3. *Monitor Phase*

In this phase Monitor assess whether the Trust passes the standard required. Three criteria are used to assess this: Is the Trust well governed, is it financially viable and is it legally constituted? Organisations that have been subject to review by Monitor report that it is a very robust and rigorous process and often significantly more challenging than previous NHS organisational or performance reviews. Monitor has been very clear that it is not willing to lower its entry criteria to meet a political timetable for organisations to achieve FT status.

3.1 The conditions for becoming a foundation trust

When FTs are authorised the terms of their licence specifies the broad range of services that they are required to provide to ensure they are meeting their obligations as part of a public healthcare system. The licence includes:

- ◆ A description of the health services that an NHS Foundation Trust is authorised to provide;



- ◆ A list of services it is required to provide to the NHS in England – this may include teaching and research functions as well as health services.
- ◆ A requirement to operate to national standards and targets
- ◆ The circumstances in which major changes to services (for example, in response to a changing local population) need to be discussed locally and agreed by Monitor;
- ◆ A list of assets such as buildings, land or equipment that are designated as 'protected' because they are needed to provide required NHS services;
- ◆ The amount of money an NHS Foundation Trust is allowed to borrow;
- ◆ The financial and statistical information an NHS Foundation Trust is required to provide;
- ◆ The private patient income limit

The rationale for specifying services that the foundation trust is required to provide is that organisations might choose to stop providing loss making essential services in favour of more profitable activity. The UK's relatively concentrated pattern of hospital provision means that many hospitals enjoy a monopoly position for a number of services, in particular, in emergency care and so the unplanned exit of a provider would present a problem in many areas.

3.2 Deauthorisation

Foundation trust status can be withdrawn through a deauthorisation process. Monitor has the power to do this if the terms of the license have been breached in a sufficiently serious way and remedial action is either inappropriate because of the scale of the problem or has failed, but it has to consult the regional strategic authority and the payers.

The grounds for deauthorisation were extended in the 2009 Health Act and include action where there is serious concern about:

- a. the health and safety of patients;
- b. the quality of the provision by the trust of goods and services;
- c. the financial position of the trust;
- d. the way it is being run.

If deauthorised the trust is returned to the control of the Secretary of State. If it has not already been removed the Secretary of State can replace the Board and has powers to appoint an administrator to produce proposals for the future of the organisation including closure, breaking it up or having it taken over. To date, these powers have not been used and are expected to be only employed in the most extreme circumstances.

In what was seen by some as an attempt to reassert some form of political control over Foundation Trusts the 2009 Act contains a power to ask Monitor to consider deauthorisation if the Secretary of State considers that there has been a serious enough breach of its licence. It would be difficult for Monitor to resist such a request but it can refuse deauthorisation as long as it can justify its reasons. Many commentators thought this represented some reassertion of central authority in an otherwise politically arms-length process.

4. Strategic governance

Foundation Trusts are embedded in wider health care systems and so their objectives are obviously shaped accordingly. The NHS has become increasingly diverse in recent years leading to more interest in what shared principles and values hold it together. As part of this organisations are now expected to follow a set of principles for co-operation and competition, overseen by an advisory panel appointed by government. More recently an NHS Constitution was developed to articulate the underlying values of the NHS as a whole and define what is offered to patients and staff.⁷

4.1 The shape of services

Creating Foundation Trusts changed the governance of organisations rather than their configuration. In common with most hospitals becoming foundation trusts UCLH determined the shape of its organisation some time before applying for FT status. The NHS has seen a significant number of mergers between hospitals in the last 20 years, driven by the need to reconfigure clinical services and in some cases the potential for economies of scope and scale. In common with what happened at UCLH, provider organisations that are now becoming foundation trusts are inheriting this legacy.

It is likely that organisations not in a position to become foundation trusts by 2015 will be taken over or split up. However, the process for



this is not yet clear and, while central government and regional authorities are keen to see foundation trusts take over struggling organisations, there are few incentives to do so, especially given that hospital mergers have historically been very disappointing.

Instead, there is significantly more interest in various types of 'vertical integration' including the management of out of hospital services and partnerships with primary care. UCLH is considering options for developing more out of hospital services for services that have a close relationship to some of its own specialist services. In common with a number of other hospitals it is also interested in the potential to become sufficiently integrated to take a capitation payment for care for a defined population group, but this would require some changes in the current policy framework.

5. Financial management

5.1 Financial freedoms

Foundation Trusts have significant financial freedoms including procurement, how they invest spare cash and the ability to set their annual budget. But the principles of probity and transparency in the use of public money which apply to all government bodies also apply to Foundation Trusts.⁸ Monitor's risk rating process determines the extent to which the organisation may borrow.

Foundation trust boards have complete freedom to choose the level of surplus (in the case of UCLH this is around 2.7% of income before exceptional items) although this is an important point of debate with the governors who would prefer to have a lower surplus and more money to be dedicated to improving quality and service to patients. The level of contingency reserves, procurement decisions and the target for the risk rating assessed by Monitor are all within the full discretion of the trust.

5.2 Mergers, acquisitions and investments

Mergers with other organisations require the Foundation Trust to be dissolved and reconstituted using Monitor's assessment process which is used to assess the initial application. This, along with the appropriate due diligence investigation makes the process potentially expensive and time consuming. UCLH regard the merger process as unwieldy and the requirement to dissolve

the existing organisations as a complete barrier to its use as a method of expansion. On the other hand acquisitions, while still requiring significant investment in time appear to be a much more accessible route to organisational change. There have been 4 major acquisitions since the start of the Foundation Trust process, three in mental health services and one in general hospital services.

Acquisitions, investments and high risk transactions – for example involving equity, securities, profit shares, royalties have to be reported to Monitor which has issued guidance designed to encourage a prudent approach. But this only applies to funds generated by activities for the NHS and not to any charitable funds owned by the trust. This represents an important shift from a situation in which mergers were often promoted by regional strategic authorities sometimes against the wishes of local organisations. It also makes the decision making process for mergers and investment much more rigorous than before and has significantly weakened the role of external bodies such as the regional strategic health authority.

Foundation Trusts have freedom to borrow within the prudential borrowing regime set by Monitor. They also have access to low cost finance from the FT Financing Facility, a Department of Health internal banking function that treats applications on a commercial basis. However, trusts that have used this report that it has been difficult to access and somewhat risk averse. FTs may also enter into private patient partnership (PPP) and public finance initiative (PFI) deals, although these may require underwriting by the Secretary of State who remains the residual owner in cases of insolvency.

UCLH recently decided to invest £100m in a new cancer centre, funded through a combination of land and property sales and a loan from the FT Financing Facility. Obviously the views of payers, the university, the regional strategic health authority and other bodies with an interest have been taken into account but the board has the authority to take the final decision. In this case, Monitor was consulted but its role was to ensure that the regulatory regime relating to borrowing was complied with, not to review the decision itself.



5.3 Joint ventures and commercial undertakings

Foundation Trusts are allowed to form joint ventures and run commercial businesses as long as this is in line with their, generally permissive, licence. However, a recent court decision has inhibited this; a case brought by a trade union found that income from joint ventures that provide non-NHS health care must be counted as part of the FT's private patient income.

UCLH has a number of commercial activities including the outsourcing of its private medical services to a specialist company.

6. Operational Governance

6.1 Management structures

All Foundation Trusts have complete discretion in the design of their management structures.

UCLH has opted for a divisional structure with 4 divisions headed by a medical director (usually but not exclusively a doctor) supported by management and accounting staff. These divisions have full income and expenditure responsibility and there is recharging for the use of common services. However, managing profit and loss is not delegated as decisions on cross subsidisation have to be taken centrally and to avoid some perverse incentives to ensure the optimal use of shared facilities such as laboratories. Decisions to procure these from outside of the trust could damage important services and leave fixed cost uncovered. At UCLH the four divisions operate with their own board of management and are held to account for the delivery of performance targets, financial performance, and quality and safety. Overseeing quality and safety, external reporting and the identification of emerging trends not identifiable at Directorate level is the responsibility of a central team.

The managers of the four divisions have a high level of discretion within the parameters set by the Board and the Trust's annual business plan.

6.2 Performance management

Foundation trusts are subject to a large number of externally set performance requirements from a number of sources:

- ◆ Government targets and standards for speed of treatment in the emergency room; maximum referral to treatment times; waits for cancer treatment, healthcare acquired infections etc.
- ◆ Performance requirements and quality standards set by payers including a small element of pay for performance contracting
- ◆ Regulatory requirements set by the Care Quality Commission (see below)
- ◆ Monitor's financial risk and governance requirements

These last two are more about achieving minimum standards and the government has pledged not to introduce new targets. Within this relatively prescriptive framework the trust can set its own performance management targets.

UICLH has a very sophisticated internal performance management system which provides the Board, clinical boards and managers with detailed information. It is designed based on the organisation's top 10 priorities which include a number of externally set requirements but mostly are set through an iterative process within the organisation. Sub-objectives are set for most of these. The requirements for individual managers and departments are derived from these corporate priorities and are incorporated into the appraisal requirements for individuals. The priorities and sub-objectives are reviewed frequently (at least once a quarter) with individual directorates being asked to present to the Board on their progress.

6.3 Human Resources and workforce

Foundation Trusts are free to determine numbers of staff they need and to hire and fire. When they were established they were required to accept the nationally negotiated pay system and existing staff have a contractual right to the terms of the national contract and pay systems. FTs can only alter terms by agreement, or by terminating and reissuing new contracts which is a legal minefield in UK law. For new staff FTs could choose to pay their own rates but this would create some risk of challenge on equal pay grounds. A small number of FTs have created new roles, for example support worker roles



or physicians' assistants. If used properly there is also considerable scope for this within the national pay arrangements. One has its own fully fledged pay structure and a few have more limited organisational bonus schemes. A sizeable number have changed managerial pay arrangements. It is likely that over time there will be much more interest in moving to more localised pay arrangements.

Pay

The history of a nationally negotiated deal for pay, conditions and contracts of employment means that the expertise and infrastructure for this has not been developed in individual organisations. The costs of developing this are thought to be high and there is a risk of being an early innovator or first mover as staff might leave for other organisations with more advantageous terms.

There are also some political hazards. The Trades Unions have a strong interest in preserving national negotiation. It is anticipated that over time there will be some further moves for Foundation Trusts to negotiate significant variations from national pay and conditions; this may need to be done in regional groups. At present UCLH has no plans to depart from nationally set pay and conditions.

7. Accountability framework

Foundation trust boards are responsible for the management of the hospital and a board of governors, elected from a constituency made up of the members of the Foundation Trust and a number of appointed governors, appoint board members. External scrutiny is exercised by Monitor, purchasers, local government and a number of external regulators. Each of these elements is examined below.

7.1 The Board

The Board is responsible for the overall governance of the Foundation Trust, its strategy, compliance with regulatory requirements and overall performance. The chair and non-executive directors are appointed by the governors who also approve the choice of chief executive made by the Board. The board must have a chief executive and finance director and the Act specifies that should be a medical practitioner and a nurse amongst the executive directors.⁹

There is a requirement for there to be a majority or equal number of non-executives. Beyond this there is considerable freedom about how the board is constituted, how often it meets, whether it meets in public and how business is conducted.

Box 4: The UCLH Board¹⁰

Board members

Chairman
Chief executive
Deputy chief executive
Chief nurse
Medical director
Finance director
Workforce director
Non-executive directors x 5

What is the role of the Board?

- ◆ To set the overall policy and strategic direction for the Trust
- ◆ To approve and monitor UCL Hospitals' business plans, budgets and major capital expenditure
- ◆ To monitor performance against objectives
- ◆ To be members of committees such as the remuneration committee and audit committee

What are the responsibilities of the Board?

- ◆ As the Board of a public service body, the Board should meet regularly, retain full and effective control over the organisation and monitor the executive management of the Trust.
- ◆ Board members have corporate responsibility for:
- ◆ establishing the strategic direction of UCL Hospitals within the policy and funding framework laid down by Parliament
- ◆ defining annual and longer term objectives and agreeing plans to achieve them



- ◆ overseeing the delivery of planned results by monitoring performance against agreed objectives and targets, ensuring corrective action is taken when necessary
- ◆ establishing an effective system of corporate governance
- ◆ safeguarding the public reputation of the Trust
- ◆ supporting internal and external communications and to participate in meetings with other external organisations.

UCLH has taken responsibility for selecting its own non-executive directors and has taken considerable care to ensure that the skills, knowledge and experience of these individuals are complementary to those of other board members. This approach puts the selection of board members beyond the influence of national or local politicians although clearly there are advantages in appointing individuals who are well connected with political and local influence networks.

Operational issues such as performance, financial reporting, quality and other matters relating to the running of the organisation dominate discussion at the UCLH Board but the Trust estimates that about 30% of the time of the Board is dedicated to long term and strategic issues. A small executive board meets weekly with one meeting a month involving a wider group of senior leaders – this tends to focus on some aspect of change management or planning.

7.2 Members

The rhetoric underpinning the creation of Foundation Trusts was largely about autonomy to make decisions free from central government interference. The idea of there being a transfer of ownership was also important and reference was made to the tradition of mutual organisations when the original policy was discussed. The idea that the Trust would be owned by its members was thought to have significant advantages in changing the orientation of the organisation to being more focussed on the needs of its users, rather than those of government. It was also thought that this would increase the stake that staff, patients and the public had in the organisation and would bring important and more diverse influences on the development of its strategy. Originally it

was proposed that members should pay £1 in equity – forfeit if the organisation was wound up – to create a sense of ownership but this was dropped, as the costs of doing this were high and the gesture largely symbolic.

Trusts applying for FT status are required to demonstrate a robust strategy for engaging people as members and to ensure that they match the socio-economic, ethnic and other characteristics of their patients, local public and staff. Where appropriate, children and young people are also encouraged to join. In March 2010 the 129 Foundation Trusts had approx 1.6m members between them.

7.3 The Governors

Typically Foundation Trusts have between 18 and 39 governors with an average of 33. The size and composition of their Board of Governors is determined locally but the legislation specifies that every board of governors must have:

- ◆ A majority of governors elected by members in the public constituency;
- ◆ At least one governor representing local NHS Primary Care Trusts;
- ◆ At least one governor representing Local (government) Authorities in the area;
- ◆ At least three governors representing staff;
- ◆ At least one governor appointed from the local university (if the trust's hospitals include a medical or dental school).

Governors are required to meet three times a year although in a review of FT membership, Ham and Hunt found that governors tend to meet more frequently than this.¹¹ There is obviously some danger of overlap with the responsibilities of the executive board but three key roles are identified for governors. Firstly they are advisory bodies that provide a view about how the Foundation Trust should operate to meet the needs of the members of the wider community. Secondly they act as guardians to ensure that the Trust operates in a way that fits its statement of purpose and complies with its authorisation. Thirdly, governors have a strategic role advising on the longer term direction for the Foundation Trust.

It is not yet clear how much governors have real influence over the operation of foundation trusts. Governors meeting minutes suggest that a significant



amount of the business consists of executives reporting recent developments and explaining the context in which the organisation is operating. There is much less evidence of active challenge by the governors or of them setting a significant amount of the organisation's agenda. However, it is clear that UCLH governors have had an important role, particularly in quality, safety and issues relating to patients. The system is in the early stages of development and it would be premature to make judgements about how effective this model is likely to be. Research of governors' opinions in 2008 found that they had a good understanding of their role, were generally satisfied with the level of involvement they had with their trusts' executives and felt they understood the organisation's strategy. Their role in representing the community was thought to be important although they reported that ensuring that they were really being representative was challenging.¹² More recent research suggest that while governors have the potential to exert significant influence through their power to appoint the Board that this has not been realised. They often felt that they were easily controlled by Chief Executives and did not have access to information to allow them to exercise their role. The researchers comment 'governors reported that they did not feel that directors genuinely expected them to make any significant input.'¹³

Research conducted in 2005 found that many of the elections for governors were competitive and there was more than one candidate for 85% of the posts of governor drawn from the public and 73% of the posts of governor drawn from patients.¹⁴ However, the turnout rate varied between NHS Foundation Trusts, from 19% to 67% for the posts of governor drawn from the public, and 31% to 70% for patient governors. Initially average turnout was 40% but the most recent data suggest that the figure has fallen to 27% with 20% of governor positions being uncontested. Turnout for staff governors was the lowest and in 37% of cases there was only one candidate.¹⁵

Box 5: UCLH Governors and members¹⁶

The Governing Body is composed of 33 people, 23 of whom are elected by the Trust's patient, public and staff members. Three governors' represent the local public, 14 our patients and six our staff . 10 other governors are appointed by local partner organisations including the PCT and University. Elections to the Governing Body are held each year.

Members are drawn from local people, recent patients, their carers and staff. In April 2009 the Trust had 14,000 members.

There are three formal meetings a year, a joint meeting with the Board and an Annual General Meeting. There are also a number of informal meetings and subcommittees including remuneration, patient issues and high quality patient care. Governors also sit on the sub-committees of the Trust.

Communication between governors and their constituencies is managed by the Trust through regular newsletters and the organization of informal meetings.

7.4 Monitor

Monitor, the regulator of foundation trusts, is responsible for authorising new FTs and ensuring that all FTs are compliant with the terms of their authorisation. In addition, it also plays an active role in developing organisational capability in foundation trusts. Monitor is independent of government and responsible directly to parliament.¹⁷ Its regulatory role is to ensure that foundation trusts comply with their terms of authorisation including:

- ◆ A requirement to operate effectively, efficiently and economically
- ◆ Requirements to meet healthcare targets and national standards
- ◆ The requirement to cooperate with other NHS organisations.

Monitor regards the board as the first line of regulation in NHS foundation trusts. It receives an annual plan and regular reports on performance and uses these to make judgements on the organisation and to identify where problems might arise. This includes calculating an annual risk rating, from an annual plan with financial projections, which gives an assessment of the probability that the trust will breach the terms of its authorisation. The rating



then determines how closely Monitor will examine the Trust's performance. Monitor states that 'a successful NHS foundation trust can expect to be given considerable latitude to exercise its freedoms. Financially secure NHS foundation trusts are given an increased ability to borrow. Monitor will not involve itself in determining healthcare strategy or operational policies in NHS foundation trusts.' This risk based approach has been consistently applied and is well received by Foundation Trusts. Within these constraints there is a very high degree of freedom Monitor reviews risk ratings relating to financial performance and governance on a quarterly basis. This includes the organisation's performance in the delivery of national targets, for example, waiting time in accident and emergency, infection rates, etc. On occasions Monitor has also shown itself to be concerned about decisions taken by boards which appear to have high levels of risk associated with them. Monitor has intervention powers where foundation trusts have high levels of risk or are in significant breach of their terms of authorisation.

Initially, Monitor did not concern itself with issues relating to quality other than areas that were government targets for improvement or compliance. However, a number of well publicised problems in some hospitals, one of which was a Foundation Trust, has led to it taking a more active role in ensuring that FTs have systems for ensuring high performance in managing infections, quality and safety. Even so, it has been selective, targeted and risk-based in its approach, tending to favour approaches to encourage problem solving and improvement - for example in the cases of organisations failing in their performance on national targets on MRSA bacteraemias or thrombolysis in MI.

Although it is a well managed and successful organisation, UCLH has had some experience of Monitor's intervention regime. For a period it experienced a serious financial problem resulting from the increased requirement for cash to pay the initial charge for the new PFI hospital which, had the organisation not become a FT, would have been underwritten by the Department of Health. This resulted in Monitor exercising its intervention powers to require the appointment of a financial turnaround team to work alongside the trust management. Once a sound financial regime had been restored the relationship reverted to being at arms length.

That the Board was not removed is unusual and reflected the fact that the problem which was outside the control of the trust. In circumstances where there has been a loss of financial control or other serious breaches of governance the Board, or substantial parts of it, have been replaced by direct

action by Monitor.

Monitor has shown itself to be a very sophisticated regulator with the ability to make accurate judgements about the level of risk that foundation trusts are exposed to in relation to their business strategy and finances. This has been extended in recent years to pay more attention to the quality of services.

In addition to the functions of authorising and regulating foundation trusts, the third strand of Monitor's work is focused on supporting their development to make sure they take full advantage of the freedoms that come with foundation trust status.

The level of supervision that Monitor exercises is based on its perception of risk which has limited the burden of regulation on hospitals. It has also assisted in the attempt to change the culture of continually looking upward for direction. It has taken some time for previously directly supervised hospitals to learn a new more independent form of operation and Monitor has commented that trusts are still too ready to refer questions to them that are within their competence to decide. This is changing. Senior UCLH staff report that Monitor is viewed as an important body and that its opinion is influential. It is seen as helpful in providing advice and has been very careful to stay within its mandate and avoid interfering in wider operational and strategic issues.

7.5 Other external scrutiny

The main external regulator is the Care Quality Commission (previously the Healthcare Commission) which sets minimum standards and legally registers all organisations that provide NHS services. All providers are required to satisfy the regulator that they meet a range of minimum standards and that they have internal assurance processes to ensure that they continue to do so. Some of this is done by self assessment against published standards supplemented by analysis of data and periodic and unannounced inspections.

All hospitals, foundation trusts or otherwise, are answerable to a number of other external regulatory bodies which all require information.



These include:

- ◆ The Health and Safety Executive
- ◆ The Clinical Negligence Scheme – a mutual insurance scheme
- ◆ Regulators for fertility treatment and tissues
- ◆ Local Fire and Environmental health authorities
- ◆ Bodies responsible for approving post-graduate medical education and training

In common with other NHS organisations foundation trusts are also subject to external scrutiny by local government oversight committees. These vary very significantly in their effectiveness and capability; their direct powers are limited although they have the statutory right to be consulted. However, they have the power to object to large scale changes and refer these to the Secretary of State (who can only intervene if the Foundation trust is in breach of its licence).

7.6 Payers

In a significant number of cases a FT will have one Primary Care Trust that is the majority purchaser of its services. This gives them potentially very large amounts of influence but also means there are limits about how far they can take action that threatens the survival of the organisation. PCTs have become active in trying to influence the shape of patient pathways and the location of certain specialist activities. UCLH has no single PCT which has a decisive influence and, unusually, the two PCTs covering the local population only represent 19% of total income.

7.7 Reporting to the Public

There is an increasing expectation that public bodies are transparently held to account for the quality of their services and their use of public money. Each foundation trust is required to produce an annual report covering the activities of the trust, its performance against its objectives and information for local people and patients about how it is performing. This has to include a full set of financial accounts including information on the remuneration of the senior executives and, since 2010, a quality account – see box X.

Box 6: UCLH Quality account

UCLH has been piloting the development of quality accounts. The content of this includes some nationally mandated information but the Trust has chosen to focus on five areas:

1. Achieving an overall patient satisfaction rating in the top 20 of NHS hospitals
2. Achieving reduction in the hospital mortality rate of 5%
3. To reduce incidence of all falls, and those with serious injury by at least 30%
4. To reduce the level of healthcare associated infections
5. Continuous quality improvement: To develop quality dashboards in all divisions in the coming year with indicators and goals in patient experience, safety and effective treatment with good outcomes

The account contains:

1. The Trusts performance in the view of regulators and Monitor
2. Responses to feedback from public engagement
3. Performance on a wide range of quality measures including:
 - ◆ Safety
 - ◆ Infections
 - ◆ Mortality rates
 - ◆ Patient experience
 - ◆ Patient outcomes
 - ◆ Staff views
 - ◆ Performance against key external targets

Foundation trusts are subject to the same requirements as all public sector organisations in terms of disclosure under freedom of information legislation. There is a legal requirement for substantial changes to be subject to extensive public consultation. Generally this responsibility is exercised by purchasers but there are circumstances in which the Foundation Trust would be required to do this - for example where it is instigating a major change in services or where they are located.



The UCLH Board meet in public although there is no requirement to do so and a significant number of foundation trusts meet in private, despite some exhortation from ministers that they should not. Boards can meet in closed session where they need to deal with commercially sensitive issues or where patient confidentiality may be an issue. The remuneration committee report is taken in the public part of the UCLH Board meeting and the pay of senior managers is reported in the Annual Report. The Governors meet in public.

8. Changes since May 2010

Following the UK general election in May 2010 the new coalition government has announced a programme of very significant change to the NHS in England, a number of which have very significant implications for Foundation Trusts.^{18,19} These include:

- ◆ Trusts will be given freedom to change elements of their constitution with the approval of their board
- ◆ Some of the barriers to merger will be removed – particularly the requirement to dissolve the boards of merging organisations
- ◆ Barriers to organisations taking over others will also be reduced although the effect of this may be somewhat offset by the introduction of a new and powerful regulator to enforce competition policy
- ◆ For some providers, the possibility of having a staff-only membership will be considered
- ◆ The removal of the restrictions on Foundation Trust's ability to earn income from private medicine and other sources.
- ◆ Consideration of the potential to remove the restrictions imposed on FT borrowing. This is to be accompanied with removing access to government capital for major investment programmes.
- ◆ The removal of Monitor's role in overseeing FT's performance and compliance with the terms of their authorisation or other aspects of performance management. This is a very significant change as it removes the oversight of the management of the FTs and is a further step towards much greater autonomy. While Monitor will remain as an organisation it

will take responsibility for price setting, the economic regulation of the healthcare market, competition regulation and setting licence conditions for the provision of essential local services – i.e. those where continuity is required and there is a need to ensure that providers can not withdraw services without notice.

- ◆ To reflect these changes and as an additional safeguard for the assets where the state remains the owner and to redress perceived shortcomings in accountability the government will consider whether to strengthen the nature of the accountability to the organisation's governors by giving them additional powers. The forthcoming Health and Social Care Bill will make explicit the duty of governors to hold the board of directors to account, through the chair and non-executive directors (whom they have power to appoint and remove). It will also give governors power to require some or all of the trust's directors to attend a meeting. For transparency, the FT's annual report would have to list any occasions when this power was used. It will extend to FT directors the duties imposed on directors under company law, such as the requirement to promote the success of the organisation;
- ◆ FTs will be required to hold an annual general meeting for its membership, at which members would be able to discuss the trust's annual report and accounts including the remuneration of directors.

The regime in which the Foundation Trusts operate will move to being one based more on the rules of a market. This will include the adoption of an approach to insolvency based on commercial law and may lead to the removal of some competitive advantages accruing to Foundation Trusts which they have gained when they were under state control. These include the state underwriting of a generous pension scheme, access to borrowing at advantageous rates, access to staff in training and some tax advantages. In addition to this the government intends to remove a large number of the performance targets that have been used to create pressure for improvement in the system and to drive performance improvement

If all of these changes are enacted the impact on Foundation Trusts will be very significant. In particular the level of oversight provided by external organisations will be greatly reduced. Foundation Trusts will be much more 'on their own' and take complete responsibility for ensuring that they are successful. At the same time a much more plural and potentially competitive market for providers will be established and there will be changes in responsibility for purchasing that may make the environment more dynamic.



There are a number of unresolved issues. Liabilities and commitments as part of the private finance initiative are currently underwritten by the state and are a barrier to more flexible models of care delivery. The state retains very substantial interests, in the form of debt, in the Foundation Trusts and this is an obstacle to the development of a private banking market to support FTs in making changes.

9. Success and sustainability of the model

Reaching a view on the success of the model is difficult because of the very significant level of policy and other change over the last five years and the fact that the criteria for becoming a FT meant that early applicants were already successful organisations. A further problem is that for much of the period policy was directed at improving providers; the purchasing function was left undeveloped and subjected to a very disruptive and extensive programme of restructuring.

Monitor's analysis seems to suggest that the process of becoming a FT had a significant and beneficial impact on the quality of financial control, strategic planning and governance arrangements. It suggests that while the sector has started to innovate and change, progress has been significantly less marked than the advocates of the policy predicted and that post-assessment Foundation Trusts did not improve any faster than non-Foundations.²⁰ The reasons for this might include:

- ◆ There is a strong cultural legacy persisting from the last 60 years of the way the NHS has been managed as a highly centralised institution in which the expectation was that new ideas and strategic direction came from the top.
- ◆ The under developed purchasing function which meant that it was difficult to get payer approval for new services
- ◆ Payers and providers still had a very long list of targets and requirements to comply with which absorbed managerial time
- ◆ There is relatively limited competitive threat to hospitals due to the concentrated nature of provision. Early indications from research suggest that increased competition may be more effective in improving outcomes and quality than governance changes.

The example of UCLH seems to suggest that some of these difficulties can be overcome. However how far this is an indicator for other organisations is questionable as there are some special factors including: having a high quality and stable leadership team; the fact that, unusually, there is no one payer with a very large share of the hospital's income; association with a world class university and that there is well developed and high calibre clinical leadership.

An important question about the success of the model is the extent to which it is likely to be sustained in the long term. There was a strong expectation, based on the previous experiment with provider autonomy, that the system would try and reinvent methods to exert control. Indeed, according to the advisor to the secretary of state at the time the policy was being developed, one of the reasons why the freedoms and governance model were embodied in legislation was to remove politicians' temptation to intervene. It appears that a number of politicians and officials in positions of influence in later years either did not understand or support the underlying principles of the policy and have sought to find ways to reassert influence. For example there was a very public and somewhat acrimonious debate when Monitor objected to the Chief Executive of the NHS writing directly to the chief executives of foundation trusts about improvements in infection control.

Following a scandal of poor care at the Mid Staffordshire Hospital Foundation Trust the Secretary of State sent in senior officials, despite having no legal power to do so. He was however, reflecting widespread public and media concern about the apparently unaccountable nature of the FT and responding to an expectation that he would act. This incident led to a widespread questioning of the lack of accountability of the foundation model. Mid Staffordshire FT appeared to have over enthusiastically embraced the financial targets required by Monitor and achieved these by reducing the quality of care, in particular staffing levels in wards and the emergency department.²¹ The governance systems failed to identify the deterioration in the quality of services and the regulator, which relies extensively on self certification, was very slow to identify the problem, as were the purchasers and the regional strategic health authority. They all failed to respond to warning signals including complaints from an active group of local patients and their carers. This pattern of insular behaviour and a tendency to ignore warning signals has been found in a number of non-Foundation Trusts and so is not a consequence of the model; rather it can be seen as giving legitimacy to this pattern of behaviour where it is already present. The incident was important and led to many commentators questioning whether more intrusive regulation was required. New powers



were inserted into legislation to allow the Secretary of State to ask Monitor to consider reauthorization.

The direction of travel for increased independence for providers will now be difficult to reverse.

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APPENDIX II





INTERNATIONAL WORKSHOP GOVERNING HOSPITALS

MARCH 8-9, 2011
HOTEL DAN CARMEL, HAIFA, ISRAEL

Tuesday, March 8, 2011

09:00 – 10:00 **Gathering & Morning Coffee**

10:00 – 13:00

Opening Session:

Hospital Governance – Around the World

Chairperson: Shlomo Mor-Yosef

Richard B. Saltman – Re-designing Public Hospital Governance: How much Semi-Autonomy?

Antonio Duran – The Changing Role of Hospitals in the Modern Healthcare Systems and its Effect on the Governance – The Spanish Experience.

Nigel Edwards – Governing Hospitals – The English Perspective

13:00 – 14:00 **Lunch**

14:00 – 16:30

Second Session:

Hospital Governance in the USA and Israel

Chairperson: Richard Saltman

Omry Yadlin – Who Are the Beneficial Owners of Health Organizations in Israel?

Paul F. Levy – Creating Effective Hospital Governance: The Fine Line Between Steering and Meddling

David Chinitz – Governing Hospitals – The Israeli Case

Discussion

INTERNATIONAL WORKSHOP

16:30 - 17:00 Five O'clock Tea

19:30 - 22:30 Dinner Session:

Medical Informatics - Present and Future

Ronni Gamzu - Director General, Ministry of Health

Paul Levy - Beth Israel, Boston

Dinner

Wednesday, March 9, 2011

09:00 - 11:00

Third Session

Chairperson: Avi Israeli

Yossi Nitzani - Governance and Management,
Private and Public: Personal Perspectives

**Panel: Should The CEO of a Hospital Be a MD,
or Not?**

Leonid Eidelman - Israel Medical Association

Ehud Kokia - Maccabi Healthcare Services

Yonatan Halevi - Shaare Zedek Medical Center

Paul levy - Beth Israel, Boston

Discussion

11:00 - 11:30 Coffee Break



11:30 – 13:00

Fourth Session :

Israel: Different Governance – Different Experience

Chairperson: Alik Aviram

Panel:

Rafael (Rafi) Beyar – Rambam Health Care Campus

Yair Birnbaum – Hadassah Medical Organization

Benjamin Davidson – Assaf Harofeh Medical Center

Eitan Hai-Am – Assuta Medical Centers

Discussion

13:00 – 14:00 Lunch

14:00 – 16:30

Fifth Session:

What Have We Learned? Prospects for the Future

Chairperson: Shlomo Mor-Yosef

Panel:

Richard Saltman

Paul Levy

Antonio Duran

Roni Gamzu: Concluding Remarks

Coffee to Go

List of Speakers, Chairpersons and Organizers

Prof. Alik Aviram,	Scientific Director NIHP Organization
Prof. Rafael (Rafi) Beyar,	CEO and Director General Rambam Health Care Campus
Dr. Yair Birnbaum,	Associated Director – General Hadassah Medical Center, Jerusalem
Prof. David Chinitz,	School of Public Health, Hebrew University and –haddasah Hospital, jerusalem
Dr. Benjamin Davidson,	Director, Assaf Ha’rofe Medical Center
Dr. Antonio Durán,	International Consultant for the WHO
Prof. Leonid A. Eidelman,	President of the Israeli Medical Association
Dr. Ronni Gamzu,	Director General, Ministry of Health
Dr. Eitan Hai-Am,	CEO Assuta Medical Center
Prof. Yonatan Halevi,	Director General of Sha’arei Tzedek
Prof. Avi Israeli,	Head of the Health Policy, Health Care Management and Health Economics Department at the Hebrew University – Hadassah Faculty of Medicine.
Prof. Ehud Kokia,	Director General, Maccabi Healthcare Services
Dr. Osnat Levzion– Korach,	Deputy Director Assaf Harofeh Medical Center
Mr. Paul Levy,	President and Chief Executive Officer of the Beth Israel Deaconess Medical Center in Boston, USA
Prof. Shlomo Mor-yosef,	Director General, Haddassah Hospital, Jerusalem
Mr. Yossi Nitzani,	Chairman of the board of Migdal Investments Management, and a board member of Teva Pharmaceutical Industry
Prof. Richard Saltman,	Health Policy and Management, Emory University School of Public Health, Atlanta, Georgia, USA
Prof. Omry Yadlin,	Faculty of Law, Tel Aviv University



Biographies

Prof. Alexander (Alik) Aviram

MD Hebrew University, Jerusalem - 1961. Specialist in Internal Medicine, Nephrology and Medical Management Formerly head, Department of Nephrology and of Rokach ("Hadassah") Hospital, Tel Aviv.

Associate Director - General of Hadassh Medical Organization, Jerusalem.
Director - General of Assuta hospital, T.A. Medical Director, Maccabi health Services. Currently Scientific Director, The Israel National Institute for Health Services and Health Policy Research.

Prof. Rafael Beyar

Professor Rafael (Rafi) Beyar, Chief Executive Officer & Director General of Rambam Health Care Campus. Prof. Beyar graduated from the School of Medicine of Tel Aviv University in 1977 (MD), the Faculty of Biomedical Engineering at Technion in 1983 (DSc) and the Bloomberg School of Public Health, Johns Hopkins University in 2008 (MPH). In 1983, he founded the Heart System Research Center at Technion where he served as Coordinator and Director. He completed his residency in medicine at Rambam (1983–1985) and a fellowship in cardiology at Johns Hopkins University (1985–1987). He was appointed Professor of Biomedical Engineering and Medicine at Technion in 1996 and served as Director of the Division of Invasive Cardiology at Rambam. He served as Visiting Professor at Johns Hopkins University for several years. In 1998, he was elected as Dean of the Rappaport Faculty of Medicine at Technion and served for the full term.

Professor Beyar has received prestigious prizes over the course of his career, among them the Taub Prize for excellence in Research in 1999 and the Michelle Mirowski Award for Accomplishments in Cardiovascular Medicine, Israeli Heart Association in 2002. In 2005 he was nominated to the prestigious Johns Hopkins Society of Scholars for his worldwide contribution to cardiovascular science and for establishing the Technion Johns Hopkins Collaboration Program on Biomedical Sciences and Engineering.

Beyar's research and clinical interests range from mathematical simulation to imaging and analysis of the cardiovascular system, as well as the development of stents and new technology in cardiology. He has authored over 150 scientific publications and 11 books, is founder and editor of *Acute Cardiac Care Journal*, endorsed by the European Society of Cardiology and is organizer and founder of leading professional cardiovascular meetings.

Since February 2006, Beyar has been serving as General Director of the Rambam Health Care Campus in Haifa, Israel, which is the major academic hospital serving Northern Israel. In the summer of 2006, he led the hospital through the second Lebanon war when Rambam was treating patients under fire. Beyar is now spearheading a major development plan in both clinical and research facilities at Rambam, focusing on the combination of medicine science and technology that will most benefit patients' health care.

**Dr. Yair C. Birnbaum**

Dr. Yair Birnaum is Associate Director General of HMO and Head of Medical Services at the Hadassah Medical Organization, Jerusalem. He completed his medical degree at the Hadassah-Hebrew University School of Medicine and a residency in Pediatrics at the Shaare Zedek Medical Center. He also received and MA degree in Public Administration from Harvard University in 1999 and completed a residency in Medical Management.

From 2001 up to the end of 2007, Dr. Birnbaum served as Associate Director General of HMO and as Director of the Hadassah Ein-Kerem Medical Center.

Prior to his joining HMO, he served as Deputy Director General of Shaare Zedek Medical Center and Associate Medical Director of Maccabi Health Care Services. (Second largest HMO in Israel)

In addition to medical training Dr. Birnbaum is also an ordained Orthodox Rabbi who wrote his thesis on "The Status of the Physician in Jewish Sources".

Prof. David Chinitz

David Chinitz is Associate Professor of Health Policy and Management at the School of Public Health of Hebrew University–Hadassah. His PhD is in Public Policy Analysis from the University of Pennsylvania. He served as a Senior Staff Person for the State Judicial Commission of Inquiry into the Israeli Health System (the Netanyahu Commission) and Senior Researcher at the JDC/Brookdale Institute Health Policy Unit. He is well known and active in both the research and practitioner communities in the US, Europe and Israel dealing with health policy and management. He was chair of the Scientific Advisory Board of the European Health Management Association from 2001–2006, and is active in a number of other international associations and currently serves on the advisory board of the Journal of Health Economics, Policy and Law, and serves as recurrent temporary consultant to the World Health Organization, European Region. He has edited four books, and authored over seventy articles, chapters and research reports on health policy and management. He has particular expertise on the interrelated roles of science and politics in addressing issues such as environmental policy.

**Dr. Benjamin Davidson**

Col (ret.) Benjamin Davidson MD, MHA is the Director and CEO of the Assaf Harofeh Medical Center, an 800-bed hospital situated in the center of the country. Following medical studies in the Hebrew University Medical School in Jerusalem, Dr. Davidson was enlisted into the Israeli Air Force, commencing a 24-year career, which led to his appointment to Surgeon General of the Air Force in 1995. His initial specialization was in General Surgery with a further specialization in both Surgical Oncology (Roswell Park Memorial Cancer Center in Buffalo) and Aviation and Space Medicine (U.S. Navy, NAS Pensacola, Florida). He retired from active Military duty in 1998 and took up the position of Deputy Director of the Assaf Harofeh Medical Center, promoted to Director and CEO in 1999. In addition to directing the hospital, he teaches medical students through the Sackler Faculty of Medicine, Tel Aviv University, is the present Chief Medical Officer of El Al, Israeli airlines; as well as serving on numerous committees, Dr. Davidson is the President of the National Advisory Board for Medical Logistics.

Dr. Antonio Durán

Through almost 20 years, Dr Duran has achieved a broad professional record as International Consultant especially for the WHO, the WB, DfID, the EU and IDB. He has gained particular expertise in working in and leading health care reform projects. His experience in Eastern European Countries has provided him with particularly deep knowledge of Transition Countries Health Systems. He has also worked in Latin America and Asia.

He is a visiting Lecturer at the Andalusian School of Public Health, where he teaches Health Systems and Health Policies Theory. He is a regular lecturer on the same topics for the Management Centre in Innsbruck, Austria and a frequent speaker at national and international forums. He holds an honorary appointment as Technical Adviser for the European Observatory on Health Systems and Policies.

He also acts as CEO at Técnicas de Salud, a private company which delivers services in the fields of Health Policies and Systems and which holds a long-term partnership with Indra and other private firms in the development of the Health Information System for the Regional Health Services in Andalucía (Diraya Project) and related areas

**Prof. Leonid A. Eidelman**

Dr. Leonid Eidelman serves as the President of the Israeli Medical Association, a position he has held since 2009. Prior to this appointment, he served as the Vice President of the IMA and held the position of Chairman of the Israel Society of Anesthesiologists from 2002–2005. He completed his medical degree at the Riga Medical Institute in Latvia in 1975 and received his Israeli medical license in 1987. Dr Eidelman went to complete specialist licenses in both Anesthesiology and Intensive Care Medicine.

Since 1997 Dr Eidelman has held the positions of Head of Anesthesiology and Acting Clinical Director of the Operating room management at Rabin Medical Centre–Beilinson Campus in Petach Tikva. Dr Eidelman also serves in various international roles. Presently he serves as a Council Member of the World Medical Association and a member of various international health policy workgroups.

In addition, Dr. Eidelman is a frequent lecturer in both Israel and abroad on health and medical issues and is currently a lecturer to sixth year and NY program medical students in Anesthesiology and Critical Care Medicine Department at Sackler Faculty of Medicine, Tel Aviv University.



Prof. Ronni Gamzu

Prof. Ronni Gamzu is the Director General of Ministry of Health.

He completed his medical degree at the Tel-Aviv University School of Medicine and a residency in Gynecology at the Tel-Aviv Medical Center. He also received PhD, MBA and Law degree from Tel-Aviv University in 1997 – 2008 and completed a residency in Medical Management.

From 2002 up to the end of 2007, Prof. Gamzu served as Associate Director General for health economics in the Tel-Aviv Medical Center.

From 2008 – 2010 Prof. Gamzu served as the Director of the General Hospital in Tel-Aviv Medical Center

**Prof. Jonathan Halevy**

- 1973 Graduate of Sackler Faculty of Medicine, Tel-Aviv
Summa Cum Laude
- 1988 – Director General, Shaare Zedek Medical Center, Jerusalem
Head of an internal medical service within the hospital
- Medical Specialties – Internal Medicine, Gastroenterology and
Health Management
- Clinical Associate Professor of Medicine, Faculty of Medicine of
the Hebrew University
- 1993–2003 Chairman, Medical Risk Management Forum, The Medical Risk
Management Company, Ltd.
- 2000–2006 Chairman, Israel Transplant Center

Prof. Abraham (Avi) Israeli

Professor Abraham (Avi) Israeli has returned to his role as Head of the Health Policy, Health Care Management and Health Economics Department at the Hebrew University – Hadassah Faculty of Medicine. Prior to this he was the Director General of the Israel Ministry of Health (2003–2009) and the Director General of Hadassah Medical Organization (1998–2001).

He is the Dr. Julien Rozan Professor of Family Medicine and Health Promotion Chair at the Hebrew University–Hadassah Medical School, Jerusalem (since 1996) and teaches there regularly. Professor Israeli is the chair of the Master program in Health Administration (MHA) in the Braun School of Public Health and Community Medicine, Hadassah – Hebrew University Faculty of Medicine.

Professor Israeli chaired the national committee to update the Israeli national standard basket of health services (2000–2003).

Professor Israeli received his medical degree and his master in public health from the Hadassah – Hebrew University Medical School. He completed residencies in Internal Medicine and in Health–Care Management at Hadassah University Hospital. He received his Master’s Degree from the Sloan School of Management at MIT, Boston.

His scientific activities are related to applied, methodological and theoretical research in the fields of health policy, health care management, and the epidemiological, economic, social and cultural basis for decision–making.

His publications deal with translation of academic knowledge and inputs from the field into policy setting and decision–making processes.

Two additional key research foci are rationing / priority setting and comparative health care systems.

**Prof. Ehud Kokia**

Prof Ehud Kokia was born in Israel, Graduated (Cum Laude) from Sackler school of Medicine Tel Aviv University, 1974.

Board certified OBGYN.

Research fellowship- University of Maryland at Baltimore - 1990-1992. MHA-2002, Ben Gorion University of the Negev.

Current Position- CEO- Maccabi Healthcare Services (MHS).

Former Positions - Medical Director - MHS, Hanegeve District Manager - MHS. General Director - Ramat Marpe, Hospital, Petach Tikva, Israel/Commande: Israeli Air Force Aeromedical Center.

Dr. Osnat Levtzion-Korach

Graduated from Hadassah University Medical School (1995), board certified in both Pediatrics and Hospital Management from Hadassah Medical Center.

Dr. Levtzion-Korach's expertise is in Patient safety, quality of care and improvement of processes, an area which she furthered developed in her 3 years work at the Center of Excellence for Patient Safety at Brigham and Womens' Hospital (BWH), Boston. At Brigham she worked on various issues of patient safety. One of her more important works was a comparison of the information gathered from the different systems (risk management, adverse event reporting system, patient complaints, malpractice claims and executive walk rounds), using an innovative set of categories. Along with her work at BWH, Dr. Levtzion-Korach was a senior consultant at the program of Management and Variability in Healthcare Delivery, Boston University and later at Patient Flow Technology company; consulting hospitals around the US on how to optimize the flow of the patients and the usage of resources in the operating room, cath. lab and the emergency department.

Since November 2008, following her return from Boston, Dr. Levtzion joined Assaf Harofeh Medical Center as the Deputy Director.

Dr. Levtzion-Korach is involved in national committees with regard to patient safety, risk management and quality improvement and is a co-founder of "Shevet" - a patient-physician partnership organization, with a goal to improve cooperation between patients and their families and health care professionals, with the aim of promoting safe medical care within the health system.

**Mr. Paul F. Levy**

Paul F. Levy served as President and Chief Executive Officer of the Beth Israel Deaconess Medical Center in Boston from January 2002 to January 2011. BIDMC is one of the nation's preeminent academic health centers, providing state-of-the-art clinical care, research, and teaching in affiliation with Harvard Medical School. Licensed for over 600 beds, BIDMC annual revenues are over \$1.4 billion. Previously, Mr. Levy was the Executive Dean for Administration at Harvard Medical School, where he was responsible for administrative, budgetary, and facility issues, as well as community and governmental relations. He was also involved in coordinating collaborative ventures between HMS and its affiliated hospitals. Before joining Harvard Medical School, Paul Levy was Adjunct Professor of Environmental Policy at MIT, where he taught infrastructure planning and development and environmental policy for seven years. He also maintained an independent consulting practice, providing strategic, negotiation, and regulatory advice to firms in the energy, water, and telecommunications arenas.

Mr. Levy has served as Executive Director of the Massachusetts Water Resources Authority, Chairman of the Massachusetts Department of Public Utilities, and Director of the Arkansas Department of Energy. At the MWRA, he had primary responsibility for the "Boston Harbor Cleanup," one of the largest pollution control projects in the world. In operating the water transmission system for 46 communities at the MWRA, Mr. Levy carried out an aggressive demand management program which decreased water consumption by 15% over a three-year period. As Chairman at the MDPU, Paul Levy regulated the electricity, telecommunications, natural gas, and water utilities in Massachusetts. While at the Arkansas Department of Energy, Mr. Levy directed energy programs, planning, policy and advocacy for the State, including such areas as energy conservation, renewable and fossil energy resource development, and regulatory and legislative matters.

Mr. Levy is the author of numerous articles in a variety of fields and co-author of *Negotiating Environmental Agreements* (Island Press, 1999). He is author of a blog formerly entitled "Running a Hospital," and in that regard was one of very few hospital CEOs to share thoughts publicly about hospitals, medicine, and health care issues.

INTERNATIONAL WORKSHOP

Mr Levy is a member of the MIT Corporation, ISO-New England, and the Celebrity Series of Boston. He previously served on the Board of the Risk Management Foundation. He coaches and referees youth soccer, plays on an adult team, and also enjoys bicycling and woodworking.

**Prof. Shlomo Mor-Yosef**

Prof. Shlomo Mor-Yosef is the Director General of the Hadassah Medical Organization since 2001. He graduated from the Hebrew University-Hadassah Medical School in 1980, completing his obstetrics and gynecology specialization at the Hadassah University Medical Center at Ein Kerem in 1987. In 1989 Prof. Mor-Yosef completed a subspecialty in Gynecological Oncology in England. In 1994 Prof. Mor-Yosef completed studies at Harvard University where he received his Master's Degree in Public Administration from the John F. Kennedy School of Government. Prior to his current appointment as Director General, Prof. Mor-Yosef served as CEO of the Soroka Medical Center in Beer Sheva.

Prof. Mor-Yosef has directed many medical education programs and was a fellow at the Harvard University Institute of Economics and Social Policy of the Middle East. He has authored more than 100 scientific publications and has served on the faculty of several universities and boards of various organizations and companies. Among his present responsibilities, Prof. Mor-Yosef is Chairman of Hadasit, the Technology Transfer Company of Hadassah Medical Organization (HMO) and serves as Chairman of the Board of the Israel National Institute for Health Policy and Health Services Research.

Mr. Joseph (Yossi) Nitzani

Joseph (Yossi) Nitzani, has extensive experience in management positions in the Israeli, private, and public, business sectors. He served as a board member in Hadassah Medical Center for almost 15 years and as a chairman of its board between 2008 and 2010.

Mr. Nitzani held various positions in the private business sector. Among others - Executive Vice President, Head of Capital Markets and Private Banking Divisions in Mizrahi-Tefachot Bank Ltd.; director of Tefachot, Israeli Mortgage Bank Ltd.; CEO of the Tel-Aviv Stock Exchange for 11 years; founder and CEO of an Investment House; and a board member of Teva Pharmaceutical Industry and its Finance Committee Chair, Building and Construction Ltd.; Dor Chemicals; Dor Gaz and Hamashbir Retail Chain.

Mr. Nitzani also held various positions in the Israeli public sector: Managing Director of The Government Companies Authority; chairman of a special committee appointed by the Minister of Education, for budgeting a cultural nonprofit organizations; and committee member of a committee formed by the Minister of Defense, to plan the future structure of the defense, private and public, business sector in Israel.

Mr. Nitzani received his B.A. in Economics from Bar-Ilan University and his M.B.A (with distinction) from Tel Aviv University.

**Prof. Richard B. Saltman**

Ph.D., Stanford University, 1980; M.A., Stanford University, 1971 ;B.A., Dartmouth College, 1969. A Professor of Health Policy and Management at the Emory University School of Public Health in Atlanta, Georgia. Has been involved with the European Observatory on Health Systems and Policies in Brussels, since its inception in 1978.

He is an Adjunct Professor of Political Science at Emory University, a Visiting Professor at the London School of Economics and Political Science, and Visiting Professor at the Braun School of Public Health at the Hebrew University in Jerusalem. From 1991 to 1994, he was Director of the Department of Health Policy and Management at Emory.

He holds a doctorate in political science from Stanford University. He has published 15 books and over 100 articles on a wide variety of health policy topics, particularly on the structure and behavior of European health care systems, and his work has been widely translated. In 1987 and again in 1999, he won the European Healthcare Management Association's annual prize for the best publication in health policy and management in Europe. His volumes for the European Observatory book series published by McGraw-Hill Education have been short-listed for the Baxter Prize by the European Healthcare Management Association in 2002, 2004 and 2006.

Prof. Omri Yadlin

Omri Yadlin joined the TAU Law School in 1994 after completing his LL.M. and J.S.D. studies at Boalt Hall School of Law, U.C. Berkeley. He is a magna cum laude graduate of the TAU Law School (LL.B. 1988) and of the Industrial Engineering School (B.Sc. 1988). He passed the Bar Exams in 1990 after clerking for Dr. J. Weinroth. During his studies at U.C. Berkeley Dr. Yadlin won the Olin Fellowship and worked as a teaching and research assistant. In addition he was a consultant with the Law and Economics Consulting Group.

In TAU, Dr. Yadlin is the Vice Dean and a Senior Lecturer, teaching Corporate Law, Securities Regulation, Capital Market Regulation and Law and Economics. In 1999 he spent a year as a visiting Professor at U.C. Berkeley, teaching Corporate Finance and Law and Economics. In 2001 he taught at Ann Arbor Law School the basic course in corporations (entitled "Enterprise Organization") and an advanced course on The Economics of Corporate and Securities Law.



Steering Committee:

Prof. Shlomo Mor-Yosef - Co-Chairmen

Prof. Richard Saltman - Co-Chairmen

Prof. Alik Aviram

Prof. David Chinitz

Prof. Avi Israeli

Dr. Osnat Levtzion-Korach

List of Participants

Adler	Yehuda	Misgav Ladach Hospital, Jerusalem
Aharonson	Zeev	Meuhedet Health Fund
Aviram	Alik	The Naional Institute for Health Policy and Health Services Resarch
Barbash	Gabi	Tel-Aviv Sourasky Medical Center
Bar-El	Yaron	Rambam Medical center, Haifa
Beyar	Rafael (Rafi)	Rambam Medical center, Haifa
Birnbaum	Yair	Hadassah Medical Center, Jerusalem
Bisharat	Bishara	English Hospital Nazareth
Chinitz	David	Hebrew Univrsity and Haddasah Hospital, Jerusalem
Davidson	Benjamin	Assaf Harofeh Medical Center, Zerifin
Doron	Haim	The Naional Institute for Health Policy and Health Services Resarch
Duran	Antonio	WHO
Eidelman	Leonid	Israeli Medical Association
Elhayany	Asher	Meir Medical Center, Kfar Saba
Epstein	Leon	School of Public Health, Jerusalem
Farbstein	Jacob	The Baruch Padeh Medical Centre, Poriya
Gamzu	Ronni	Ministry of Health
Goldberg	Avi	Joseftal Medical Center, Eilat
Hai-Am	Eitan	Assuta Medical Center, Tel-Aviv
Halberthal	Michael	Rambam Medical center, Haifa
Halevi	Yonatan	Sh`arei Tzedek Medical Center, Jerusalem
Halpern	Eyran	Rabin Medical Center, Petah Tikva
Harel	Ronen	Maccabi Health Services
Haver	Eitan	Kaplan Medical Center, Rehovot
Israeli	Avi	Hebrew University - Hadassah, Jerusalem
Itzhaki	Gidi	Managerial Leadership
Kaplan	Avigdor	Clal Insurance
Kfir	Roi	Ministry of Finance
Kokia	Ehud	Maccabi Healthcare Services



Levy	Paul	Beth Israel Deaconess Medical Center, Boston
Levzion-Korach	Osnat	Assaf Harofeh Medical Center, Zerifin
Litvak	Ziva	The Naional Institute for Health Policy and Health Services Resarch
Meilik	Ahuva	Tel-Aviv Sourasky Medical Center
Mor-Yosef	Shlomo	Hadassah Medical Center, Jerusalem
Ofer	Gur	Hebrew University, Jerusalem
Oren	Meir	Hillel Yaffe Medical Center, Hadera
Porath	Avi	Maccabi Healthcare Services
Reisner	Shimon	Rambam Medical center, Haifa
Revach	Moshe	Maccabi Healthcare Services
Rosenbaum	Ziv	Clalit Health Services
Saltman	Richard	Emory University, Atlanta, Georgia, USA
Schlaeffer	Pnina	Assuta Medical Center, Tel-Aviv
Shapira	Chen	Carmel Medical Center, Haifa
Shapiro	Yair	Ariel University Center
Shemer	Joshua	Assuta Medical Ceneter, Tel-Aviv
Stern	Zvi	Hadassah Medical Organization, Jerusalem
Weiss	Yossi	Ariel University Center
Wirtheim	Eytan	Clalit Health Services
Yadlin	Omri	Tel-Aviv University
Zaidise	Itzhak	Sheba Medical Center, Ramat-Gan
Zilonka	Shaia	Maccabi Healthcare Services

