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International Hospital Federation

World Hospitals and Health Services

The Official Journal of the International Hospital Federation

University Hospital Governance

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- Governance in Iranian public hospitals
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Learning about Hospital Governance from "Down Under" and elsewhere in the world

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In this Editorial of the World Hospitals and Health Services (WHHS) Journal, we celebrate the upcoming 42nd World Hospital Congress in Brisbane, Australia in October 2018, with a special focus on governance and the role of university hospital in the health care systems.

Health care in Australia, like Canada, New Zealand and the United States had its earliest foundations in the colonial services established by the British Government in the 18th and 19th Century. During the upcoming Congress you will hear much more about how these early colonial health services evolved into one of the most sophisticated health care systems in the world, proving health care for all its residents at an affordable cost.

A unique feature of the Australian health care system is the split in responsibility for policy, governance, management, funding, and service delivery between the Federal Government, the States and Territories and the complex public-private mix in both funding and service delivery. The Commonwealth of Australia Constitution Act of 1900, which united the Australian states, gave individual states responsibility for most health services, while the Federal Government of Australia retained responsibility for quarantine and industrial hygiene.

This split in responsibility for health care between the central government and other levels of government in Australia raises some interesting challenges in governance which is similar to what is experienced in other federal states like Brazil, Canada, India, and the US.

This split in responsibility for health care in Australia raises interesting issues about "what exactly we mean with governance" when referring to health care. In the World Health Report 2000, WHO coined a new term "Stewardship" to capture the highest level of national policy oversight with the term "governance" being somewhat subordinate to this level of oversight. And then the idea of management at the institutional level somewhere conceptually below that. The contributing authors to this issue of the Journal explore these and other dimensions of governance in greater detail and as they relate to university hospitals.

Another interesting aspect of the Australian health care system is the public-private mix in funding and service delivery. The first doctors that settled in New South Wales (NSW), one of the Australian States, established a semi-autonomous NSW Medical Board in 1838 to register and accredit new members. Over time, despite the growth in public sector involvement in Australian health care, patients, civil society and the private sector have continued to play a central role.

The balance between professional independence, self-governance and various degrees of government oversight raises other interesting dimensions of the term "governance" reforms. The introduction of greater hospital autonomy and corporatization of the governance of public hospitals are ways that some countries have tried to shift some decision rights away from central and lower levels of government to the managers of individual institutions, such as university hospitals that enjoy a high degree of management freedom in many countries. There is no real consensus on where to draw the line and countries around the world are still experimenting with greater and lesser degrees of institutional autonomy in the quest for "good governance" of university hospitals and other health care facilities.

Over time, the pendulum has continued to swing back and forth several times in Australia between right-wing coalition governments that expanded the role of private health insurance and left-wing coalition governments that rolled back the role of private health insurance, favouring more tax-based funding. Once again, this highlights another complex dimension of governance – the extent to which patients can influence decisions and the behaviour of providers using their own funding either through direct payments or private health insurance.

The contributing authors to this issue of the WHHS Journal demonstrate how many of these themes are central to the governance of the health care system and university hospitals in France, Iran, Kenya, Netherlands, and countries across the world more broadly.

The 42nd World Hospital Congress in Brisbane provides a unique opportunity for Australia to showcase to the rest of the world the unique features of its health care system, and for other countries to both learn from Australia and share their own experience with those attending the Congress.

How well does your hospital perform on the things that really matter?

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** The opinions expressed herein are those of the author and do not necessarily reflect the official views of the OECD or of its member countries*

The job of a hospital leadership team can be overwhelming. There are many areas to oversee, decisions to make and problems to solve. It would be very easy to spend an entire day responding and reacting instead of focusing on the issues that drive results and add value. Hospital managers are inundated with large amounts of data; for instance, dashboards, score cards, report cards, financial reports, patient surveys, etc., but when it comes down to it, do you know how your hospital is performing on the outcomes that matter?

On average, health spending represents 9% of the GDP in OECD countries, ranging from 4.3% in Turkey to 17.2% in the United States, while hospitals account for nearly 40% of health spending. In most OECD countries, more than 80% of this expenditure is covered by government and compulsory schemes; this is a substantial investment. One of the challenges we face as a society is "are we getting value for money when it comes to our hospitals?", and more importantly "are we getting high-quality, safe and people centred care with minimal waste?".

The OECD helps countries to achieve high performing health systems by measuring and comparing health outcomes and the use of health system resources as well as by helping governments make policies that improve access, efficiency and quality of health care. Three papers written by OECD staff highlight key areas for high performing hospitals and health systems.

There are some alarming statistics in these articles. For instance, Couffinhal found that one fifth of health spending is ineffective at best and wasteful at worst. For example, adverse events occur in 1 out of 10 hospitalisations, thereby adding between 13 and 17% to hospital costs, when up to 70% could be avoided, and many emergency department visits are unnecessary. Ehler and Padget's study found that for an important outcome like 30-day mortality after being admitted to hospital for an acute myocardial infarction, there is an eightfold variation between the highest (28.1% in Mexico) and lowest (3.7% in Norway) rates across OECD countries. A similar variation range exists within hospitals in the same country: the difference between the upper and lower interquartile hospital rates for Sweden is 1.8 deaths per 100 admissions, while for Latvia it is 5.8 deaths per 100 admissions. This significant variation in care not only across but also within countries is so large that it cannot be justified by a difference in need alone.

While these statistics alone appear grim, they may not show the whole picture, as we may not even be measuring all the key outcomes that matter to patients. Slawomirski and Van den Berg argue that, by only measuring mortality and survival, health systems are overlooking outcomes that matter to patients and their families. They highlight this with the example of prostate cancer, where differences in mortality and survival across countries and providers are negligible but the outcomes that matter to patients like erectile function and incontinence are rarely measured. There is significant variation between providers when these are measured. The OECD is working to address such gaps in information, looking to shed light on variation in patient reported outcomes from hip and knee surgery, breast cancer surgery and mental health therapy.

The authors have addressed these challenges by providing best practice examples from across the globe and how the OECD helps countries seek solutions to them. Couffinhal presents four key ingredients needed to reduce waste in both hospitals and health systems, including acknowledging the extent of the problem, systematically reporting unnecessary or low-value care, persuading patients and clinicians that the best option is the least wasteful one and setting payment incentives to reward effectiveness and value. Ehler and Padget provide examples of how countries have successfully reduced within-country variation through the consolidation of services and establishment of care pathways. Slawomirski and Van den Berg outline the Patient Reported Indicator Survey (PaRIS) initiative launched by the OECD at the request of Health Ministers, which builds the international capacity to measure and compare care outcomes and experiences as reported by the patients themselves. As part of the PaRIS initiative, an international survey, the first of its kind, will measure and report outcomes and experiences of patients with one or more chronic conditions across the OECD countries.

These three papers provide some food for thought on how to deliver high quality, safe and people centred care with minimal waste. They point to a need to recalibrate our health systems and hospitals. More importantly, they point to the need for health systems to decisively put patients and the people they serve at the centre of their policies and actions. This is an important objective in and of itself (because health systems are meant to benefit individuals) but it also has other positive outcomes of importance; for example, delivering better outcomes for patients is often the most efficient and equitable way to meet people's needs. To deliver the people centred health systems of tomorrow, we need to change how we provide care and how we measure health systems and hospitals today, focusing more on health outcomes that matter to people rather than simply on those that providers can deliver. It is a question then for all those who work in a hospital, to stop, reflect and ask whether in the boardroom or the ward we "are focussing on the things that really matter to our patients". Of course, it is also a question for policy makers to support and enable this transformation.

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University Hospital Governance

Special Report: IHF University Hospital Special Interest Group

How university hospitals and aligned universities collaborate to advance goals

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The governance structures of university hospitals and aligned universities are an influential ingredient in how these organizations coordinate strategic decision making in clinical care, education, research and innovation. To better understand governance dynamics, the University Hospital Special Interest Group (UH-SIG) of the International Hospital Federation (IHF) collaborated with the University of Eastern Finland to conduct global research in 2016 on how governance is structured and cooperation is achieved between university hospitals and universities (see Sidebar).

ABSTRACT: As a follow-up to a 2017 global study on governance, interviews with four health care leaders spotlight how university hospitals and aligned universities can bridge different cultures to promote collaboration and advance innovation within their institutions. The leaders describe ideas they use to strengthen alignment across clinical care, research and education as well as create environments that stimulate entrepreneurial performance and results. As their institutions face the impact of national health care reform, a selective portfolio approach featuring centers of excellence is deployed to serve key patient groups, achieve financial goals and withstand competition. These thought leaders share why it is critical to develop the next generation of leaders and provide medical education techniques adapted to new clinical practices and team-based learning styles.

Sidebar:
University Hospital Special Interest Group

The IHF University Hospital Special Interest Group (UH-SIG) was formed in 2013 as a unique platform for peer-to-peer knowledge sharing among university hospitals on global health challenges. In 2014, the UH-SIG completed its first global research with a first-of-its-kind study of international end-of-life care practices. The success of this study spurred the 2016 research initiative: the study of governance practices of university hospitals and aligned universities. The UH-SIG and the University of Eastern Finland developed, fielded, and analyzed an online survey completed by executives from 23 university hospitals located in Europe, Australia, the Middle East, South America and North America. The Vizient University Health System Consortium serves as the secretariat for the UH-SIG.

As a second stage of study, the UH-SIG conducted in-depth interviews in 2017 with four health care leaders to explore governance structures and collaborative initiatives for university hospitals and aligned universities. In addition to two of the article's authors (Risto Miettunen, MD, PhD and Peter Butler, MHSA), interviews were also conducted with Paul Dugdale, BMBS, MA, MPH, PhD, FAFPHM, director of the Centre for Health Stewardship at Australian National University and chair of the Australian Healthcare and Hospitals Association, and Marc Noppen, MD, PhD, chief executive officer of Universitair Ziekenhuis Brussel (UZ Brussel), Belgium.

Profiles were developed to capture highlights from the four interviews which can be found in the second segment of this article.

Pace-setting Themes

Six major themes emerged as distinctive and shared issues from the four interviewees:

1. Achieving alignment
2. Facilitating centers of excellence
3. Fostering environments for innovation
4. Navigating reform
5. Developing new leaders
6. Providing 21st century medical education

1. Achieving alignment

The interviewed leaders agreed that university hospitals and their aligned universities must operate as strong partners to be effective. At Rush University Medical Center (USA), success begins with a shared vision and defined metrics to gauge progress. A strategic scorecard measures achievements in clinical care, research, education and community service and employs a common language to encourage cooperation across the enterprise. In Belgium, although UZ Brussel and the university have different cultures, the two institutions have created a joint committee to spotlight solutions for improved operational coordination, appointments of chiefs of staff and other shared decisions.

Another area of alignment at UZ Brussel is research; patient care is advanced and skills sets are optimized when the university's fundamental research is successfully bridged into translational research performed at the university hospital. This thought is mirrored at Canberra Hospital in Australia where new ways to engage busy hospital physicians in translational research are being explored to synchronize their talents with the university's international research facilities.

Sidebar from research:
2016 Governance Research: Value of Cooperation

This study illuminated the value of cooperation between university hospitals and universities, with respondents endorsing cooperation as mutually and economically beneficial. Respondents believed that collaboration is based on mutual respect and understanding and they agreed that cooperation with the university is a crucial part of the university hospital's functions.

2. Facilitating centers of excellence

The interviewed leaders described a portfolio approach to clinical services, where specific areas of expertise have been developed and promoted to serve key populations, achieve revenue goals and position against competition. Epilepsy surgery – performed at only two hospitals in Finland – is a prime example of specialized clinical collaboration between Kuopio University Hospital and the University of Eastern Finland. At UZ Brussel, five signature areas – fertility and genetic techniques, diabetes, cardiovascular cluster, medical imaging and oncology – have been developed and attract patients throughout Belgium and other countries.

3. Fostering environments for innovation

Creating the right environment to stimulate innovative ideas is a major responsibility assumed by these leaders. Often the environment operates outside the university hospital's hierarchical structure, such as the stand-alone Office of Transformation created by Rush University Medical Center to design a new hospital. In Australia, the National Health Sciences Centre was designed to take nascent inventions through the commercialization stage.

Main Strengths of Cooperation *(identified by 2016 survey respondents)*

Area	How demonstrated?
Alignment	Coincidence of strategic interests Objectives and outcomes clearly defined Streamlined decision making Congruent philanthropic focus
Clinical excellence	High-quality care and education Offer new therapies for patients with complex medical conditions Opportunities to develop centers of excellence
Shared services	Medical training done at a university hospital Ease of establishing academic programs in specialties Faculty presence in clinical departments Common research laboratories 24/7 availability of residents Operational efficiencies
Research	High-quality research leading to clinical outcomes for patients Clinician-led research opportunities
Finances	Improved revenue when ranked as a university hospital Stronger contracts with payers Improved competitiveness
Recruitment and retention	Leaders want to practice and learn in an integrated organization Professional workforce to meet demand Easier to attract talent
Reputation	Enhanced brand of the university hospital in a regional market Recognized for achievement

Originally begun as an incubator by the university hospital and university, the center is now a self-perpetuating not-for-profit organization that provides commercialization services to a variety of entities. Kuopio University Hospital pursues a formal strategy to drive entrepreneurship and capture funding as a CEO-led hospital/university work group defines intellectual property rights and coordinates different sources of knowledge. Capitalizing on serendipity is part of the innovation strategy at UZ Brussel, where experimentation within loose social networks (not formal structures) is encouraged.

4. Navigating reform

It is impossible to ignore the effects of health care reform on university hospitals. As Finland organizes its decentralized health services into more centralized counties, the university hospital faces increased competition from private providers. Focused on improving value and reducing costs, the Belgian government is planning a national reorganization into 25 hospital networks, requiring new agreements and governance bodies to operate at the network level. Specialized services will become concentrated in fewer hospitals to control quality, outcomes and costs. Rush University Medical Center is increasingly focused on community health and services in response to U.S. reforms linked to population

health and associated reimbursement.

5. Developing new leaders

The search for new leaders is uppermost in the minds of these executives. In Australia, the government established a local medical school to attract senior clinicians who desired teaching appointments at a highly regarded institution. The talent pipeline is also strengthened through the large number of medical students who choose to stay in Canberra after graduation to develop their careers. At UZ Brussel, scouting for new leaders is an ongoing process and young clinicians are encouraged to collaborate and develop new ideas, such as a multidisciplinary clinic to treat Klinefelter syndrome. Today the clinic attracts patients from throughout the country.

6. Providing 21st century medical education

Interviewees reflected on how medical education techniques change to adapt to new clinical practices and learning styles. Rush University redesigned its curriculum for medical students with more emphasis on team-based learning. The chief medical officer at Kuopio University Hospital participates in work groups tasked with meeting the needs of medical students and high enrollments levels. At Australian National University, the medical school's curriculum is structured around small teams and research exercises, not large lectures, placing a heavy demand on physicians' time.

Sidebar from research:
2016 Governance Research: Shared Decision Making

The majority of university hospitals reported having a member or members in university decision-making bodies (e.g., executive board or faculty council). Similarly, most universities have representation in the university hospitals' decision-making bodies (e.g., board of governors, executive board or management committee).

Most university hospitals participate in systematic feedback and evaluation systems with the medical schools, including satisfaction surveys for students and tutors and shared committees. Most respondents reported systematic feedback and evaluation systems done in concert with nursing programs, including evaluations of students and clinical trainers. Respondents also reported that they organize continuous professional education together with universities, including simulation laboratories, tuition support, specialized courses, lectures and rounds.

Profile
Effective Strategies in a Reform Era

Based on a 2017 interview with Risto Miettunen, MD, PhD and CEO of Kuopio University Hospital

University hospital: Kuopio University Hospital is one of five university hospitals in Finland. Operating 550 beds, the hospital is responsible for delivering specialized care to nearly one million inhabitants of eastern and central Finland and is the country's largest trainer of physicians. The hospital enjoys high international rankings and has distinguished itself in several clinical areas, including epilepsy surgery and neuroresearch. The hospital's health care management and nursing services are also strong.

Aligned university: The University of Eastern Finland is one of the country's largest universities, with 15,000 degree students and 2,800 staff members. The university – established in 2010 as a merger between the University of Joensuu and the University of Kuopio – is ranked among the world's finest in seven subjects by the QS World University Rankings by Subject 2017.

Structure: Kuopio University Hospital is a publicly owned and funded hospital. The hospital and university operate on the same campus (Kuopio Science Park) and the university has representation and voting rights in the hospital's board of directors based on agreement, not ownership.

The impact of reform: Finland is in the midst of a complex health care and social services reform in an effort to better serve the population and curb costs. Dimensions of the reform include moving from a highly decentralized system, where municipalities directed and funded local services, to 18 counties responsible for health and social services (beginning in 2020) and opening up the market to private services.

Hospital leaders are challenged to continue services as they anticipate major changes in a more competitive landscape. While the current health care market is over 90 percent publically managed, reform will create opportunities for private hospitals to enter and compete, especially for primary and secondary care. University hospitals will continue to focus on tertiary care and research.

Reform means that the hospital will become more of a service delivery organization. A patient base is no longer guaranteed within the new regional structure, so it will be critical for the hospital to be extremely competitive and cost effective. From the patients' perspective, they will have more choices and be able to choose private providers where available. In turn, hospitals will need to cater to patient needs and pursue a market share strategy to preserve volume and protect revenue.

Valuable collaboration with university: Both the hospital and university need to be in a strong partnership to be effective. A shared agenda and actively committed board members are key ingredients of success. Board roles and memberships will change with health care reform as responsibilities shift from municipalities to regions.

Epilepsy surgery – performed at only two hospitals in Finland – is a prime example of clinical collaboration between the hospital and university. A strong research base is essential to provide leading practices, and epileptic services have been growing at Kuopio for the past six years. In the midst of reform, it remains essential that university hospitals sustain a strong relationship with an aligned university and a significant research base.

Close presence on a shared campus is a major advantage because students can study and complete their clinical training in nearby locations. Proximity also makes it easier for faculty members to combine their academic and clinical work and be actively involved in patient care.

The university is not impacted by the previously mentioned reform because Finnish academic institutions are directed by a different ministry. However, university leaders are working on curriculum changes with input from the hospital. The hospital's chief medical officer is participating in work groups designed to meet the needs

of students and high enrollment levels. A networking model has been developed where part of the clinical training takes place at other hospitals because Kuopio does not have sufficient capacity.

Building an entrepreneurial culture: The hospital serves as a testing ground for startups in their pre-commercialization phase. For example, technology related to neurostimulation and pharmacy automation has been tested and used in the hospital. Traditionally, these initiatives were pursued opportunistically. To be more effective, the hospital has created a formal strategy to drive competitive entrepreneurship and capture funding for promising projects. A hospital/university work group with CEO members has been formed to fully define intellectual property rights and coordinate different sources of knowledge.

Funding is the greatest challenge in performing research with a university partner. The national contribution to research decreases every year, yet the need for research to accelerate is greater than ever. It is difficult to attract money from multinational pharmaceutical companies and other firms because Finland has strict clinical studies regulations. (Although regulations are the same in all EU countries, national differences do exist.) Work is underway to revise regulations to make Finland a more attractive option for clinical studies.

Advancing national collaboration: Kuopio's innovative cancer services have led to the development of a comprehensive cancer center aligned with other regional cancer centers. Patients from other countries travel to the country for treatment. The five regional cancer centers collaborate with each other and all participate in the country's biobanks for genomics. Since Finland's population and genetic structure are homogenous compared to other parts of the world, the country enjoys a unique opportunity to advance the study of cancer and related drug discoveries with global pharmaceutical partners.

Moving forward, Kuopio's ability to participate in similar national projects while still retaining regional influence is vitally important.

Developing future leaders: Two different leadership roles are needed: clinical excellence and management. Historically, physicians have not been prepared to serve in management roles. Relevant business courses have now been added to the medical school curriculum and high-potential physicians are encouraged to obtain their MBAs. However, physicians report on the difficulties of serving two roles simultaneously (clinical and managerial) and many do not pursue patient care once they go into management.

The younger generation of leaders has arrived and is poised to drive positive changes in the context of health care reform. They are responding to a new emphasis on service delivery and are already comfortable working within diversified teams (representing physicians, nurses, and other key disciplines) to develop robust solutions.

Profile

How Aligned Vision Fuels Innovation

Based on a 2017 interview with Peter Butler, MHSA, Professor and Chair of the Department of Health Systems Management in Rush University's College of Health Sciences and retired president of Rush University Medical Center

University hospital: Rush University Medical Center is a 664-bed hospital in Chicago, IL, USA. The Rush system also includes two other hospitals and numerous outpatient care facilities.

Aligned university: Rush University serves more than 2,500 students and comprises Rush Medical College, the College of Nursing, the College of Health Sciences and the Graduate College.

Background: Originally known for clinical excellence as Presbyterian-St. Luke's Hospital, the hospital sought to bolster and formalize its academic mission by reactivating a closed medical college and becoming a degree-granting entity for medical, nursing and allied health students. Rush University was established in 1972 and the hospital rebranded itself as Rush University Medical Center in 2003. The integration involved the same board of trustees and management team, helping to ensure consistent alignment in governance, leadership and legal issues. Today Rush's educational model is regarded as highly as its clinical model.

Structure: Rush University Medical Center, including Rush University, is privately owned as a non-profit 501(c)(3) entity operating for the purpose of education, research and patient care. There is a joint ownership model and a joint management structure between the hospital and the university.

Benefits of an integrated model: Decisions can be quickly made and implemented due to a fully aligned hospital/university model (e.g., no extra councils). Hospital management is considered part of the academic enterprise and many leaders serve dual roles (executives as well as teachers) so they can "teach what we practice and practice what we teach." The hospital's physician CEO also serves as a professor of internal medicine and distinguished service chair of Rush University. This integrated model extends beyond the medical school into other academic areas, including graduate medical education. For example, the hospital's chief nursing officer is an associate dean at the university's College of Nursing.

However, this unified structure may make it difficult to detect when a function is underperforming, resulting in missed goals and stalled progress. To safeguard against this possibility, Rush University has strengthened its board of governors (acting as a committee to the parent board) to help ensure that the university is performing well and responding to changing expectations in academic services and student amenities.

Emergence of community health: Historically, the hospital has focused on clinical excellence supported by research and education. A fourth driver (community health and services) has emerged in response to local needs and reform related to population health and reimbursement.

For example, thanks to a $5 million donation from BMO Harris Bank, the organization helped to create a multi-pronged initiative called *Building Healthier Communities* in collaboration with several diverse stakeholders. The goal of this work is to improve access, care coordination and quality of care in underserved communities. The donation allowed Rush to enhance its collaboration with a local college to create new curriculums and jobs to match the community's emerging health care needs. As Rush extends its "beyond the walls" services, everyone benefits from more effective workforce training.

Involving multiple stakeholders in the initiative creates complexity, but it also encourages participating organizations to stop viewing challenges through their own lens and discover new ways to partner in the face of limited resources.

Reimagining medical education: Traditionally, the enterprise's

clinical component drove innovation, with education serving a supporting role. Now, Rush's educational model is leaping ahead with a redesigned and innovative curriculum that places more emphasis on team-based and experiential learning.

In 2015, the board recruited a renowned Duke University leader and researcher as the new medical school dean. K. Ranga Rama Krishnan, MB, ChB, had served as dean at Duke-National University of Singapore Graduate Medical School, where he helped establish an innovative learning program. Dr. Krishnan was appointed by Rush to revamp and reenergize its curriculum by de-emphasizing lectures and promoting team-based learning supported by innovative technology. Rush's aligned structure helped the organization to embrace a new educational model designed to produce career-ready students and synchronize advancements in education and clinical care.

The new curriculum debuted in the Fall of 2017, a product of intense cooperation with many of the changes suggested by students desiring a different learning experience.

Using a strategic scorecard to drive change: Regardless of structure and governance, most hospitals (like most organizations) find change difficult. Talented professionals can still become entrenched in old practices and enduring silos. Creating and sustaining change requires strong leadership and a staff empowered to develop new solutions.

Success begins with a shared vision and a process to achieve it. To become fully realized, the vision requires metrics to gauge progress. At Rush, a scorecard is used to measure achievements in clinical care, research, education and community service. While some organizations focus primarily on external or image-related metrics, Rush's metrics focus on internal advances, some of which may not directly support external metrics. The scorecard introduces a common language and encourages cooperation across the enterprise to reach mutually shared destination points.

Innovation is not a part-time job: About 10 years ago, plans were underway to build a new hospital. Realizing that traditional structures are good for performance but not innovation, senior leaders created an Office of Transformation to encourage fresh thinking and accelerate decision-making. Representatives of diverse disciplines were deliberately appointed to the office, including a chair of emergency services, a passionate gerontology specialist, a leader in interventional nursing, a senior information technology expert and an experienced hospital operations manager. These senior leaders worked side by side with architects and construction teams to evaluate care processes and how the new building's design could improve outcomes identified by the scorecard, such as patient satisfaction and staff workflow.

The team was empowered to create a fundamentally different structure and make decisions that larger, more traditional groups and structures might resist. Approximately 50 people worked together in the same space, serving as full-time catalysts to construct a distinctive hospital appreciated by patients, staff and the community at large.

One unexpected outcome of the transformational process was the degree to which specialists were willing to adopt new work patterns. For example, the new hospital design replaced multiple locations for imaging services with one space shared by vascular surgeons, interventional radiologists and cardiologists. The specialists agreed with the concept and supported standardization practices recommended by the transformation team.

A second-generation version of the Office of Transformation still operates at Rush because senior leaders understand that innovation requires a separate structure where individuals can spend significant time in ideation and collaboration.

Profile

New Ideas Flow from Teamwork and Serendipity

Based on a 2017 interview with Marc Noppen, MD, PhD and Chief Executive Officer of Universitair Ziekenhuis Brussel (UZ Brussel)

University hospital: The 729-bed UZ Brussel admits more than 50,000 patients and treats 400,000 national and international outpatients annually. Physicians and staff deliver a comprehensive range of adult and pediatric services and are highly involved in teaching and research.

Aligned university: The Vrije Universiteit Brussel (VUB) operates four campuses in the Brussels Capital Region and delivers quality education to more than 15,800 students (21.5% are international students). Its Brussels Health Campus is home to the faculty of medicine and pharmacy.

Structure: The hospital's governance structure is a direct consequence of legal requirements in Belgium. Out of a total of 100 hospitals in the country, seven are considered university teaching hospitals and each has established a 1:1 relationship with a comprehensive faculty of medicine. The relationships vary, where some universities fully own the hospital and others create affiliations. Universities are accountable to Belgium's Ministry of Education, organized at the defederated (community) level, while hospitals are accountable to the federal Ministry of Social Affairs and Health.

Since its inception, UZ Brussel has been owned by the university. All chiefs of staff serve as faculty for the medical school, and hospital and university staffs work closely together to advance quality in teaching, research and clinical care. However, as stipulated by Belgian law, the hospital has its own governance body with a separate board. The university has representation on this hospital board, but the board operates independently.

The impact of reform: Driven by the need to improve value and reduce costs, the Belgian government is planning a national reorganization into 25 hospital networks, to be fully operational in 2018. This reform will require new agreements and governance bodies to operate at the network level, affecting small community-based hospitals as well as larger university hospitals.

Some low-volume services will become concentrated in fewer hospitals to gain more control over quality, outcomes and costs. For example, major surgeries may be performed in a select group of hospitals while primary care, maternity care and first-line emergency care will remain dispersed throughout network hospitals.

Aligning different cultures: The university and hospital have different cultures. While the university tends to have a more scholarly and stable environment, the hospital operates more as a dynamic enterprise responding with flexibility to a fluid environment.

This difference sometimes causes conflicts, but it points to the vital importance of alignment. With aligned goals and plans, the

two institutions come together and demonstrate real progress. A University Medical Center Committee comprises the chief executives of both institutions and serves as a forum to discuss common interests, such as operational coordination in security, technical installations and maintenance, as well as the appointment of chiefs of staff. The committee spotlights solutions for creating value together.

Another area of alignment is research. When the university's fundamental research is successfully bridged into translational research performed at the hospital, this collaboration optimizes skill sets and advances patient care.

The power of signature areas: From its total portfolio of 41 services, hospital leaders have defined five signature areas: fertility and genetic techniques, diabetes, cardiovascular cluster, medical imaging and oncology (particularly immunotherapy and radiotherapy). These areas signify the hospital's commitment to entrepreneurship and its structural ability to nimbly respond to market opportunities.

The number of signature areas is dynamic, with department heads and other clinicians actively encouraged to be creative and develop plans for new focal areas. For example, a new signature area may evolve as imaging increasingly intersects with cardiovascular and interventional radiology services. Hospital and faculty leaders select projects for development as signature areas. Beginning with internal seed money, the signature teams then go on to attract external (private) funding for their initiatives.

With documented performance and quality outcomes, these signature areas often serve as magnets for patients throughout Belgium and other countries. For example, the hospital's fertility clinic had routinely attracted patients from the Middle East. As demand grew, the concept of offering services in the Middle East evolved and resulted in UZ Brussel clinics opening in Kuwait and Abu Dhabi. This entrepreneurial idea was pursued with three conditions: no upfront investment, must generate revenue back to the hospital and must support the mission and ethics code of the hospital and university. The Middle East clinics had no trouble attracting physicians and staff from Belgium who want to serve several years as expats in a different region of the world.

How serendipity encourages innovation: Serendipity often plays a role in how new ideas evolve. Serendipity is not mere chance, but a state of mind where organizational leaders are open to new opportunities. To be successful, the right innovators must be involved, who are masters in their fields of expertise, have the vision and ambition to drive new initiatives and also have the management skills to direct their teams. Behind the scenes, hospital leaders must have the courage to allow creativity to foster and create the right framework that will prompt new developments.

Ideas do not naturally bloom from a strict hierarchical structure; they often emerge from a loose social network. Experimentation with different formats is important, where sometimes self-steering teams thrive and other situations call for a more formal management structure with a program director and defined key performance indicators. If the early concept is successful, the hospital then contracts with the innovators and defines goals, objectives and accountability to advance to the next stage.

In a complex environment like a hospital, flexibility and agility remain important to accommodate different management structures and timelines. At first glance, this approach may seem chaotic but it creates an open-ended ecosystem primed to extract value out of serendipity.

The human factor: With a staff of 3,800 individuals, it is challenging to identify and nurture talented leaders and still keep everyone involved and aligned. Recently, the hospital achieved its first-time Joint Commission International (JCI) accreditation as an academic medical center. The JCI exercises were designed to strengthen and document interdepartmental teamwork, a staff-wide initiative that produced momentum and pride in their accomplishments.

Scouting for new leadership talent is an ongoing effort. Sometimes the best ideas emerge from young, energetic clinicians who know each other and collaborate easily. For example, the hospital's fertility clinic sees a large number of male patients with a chromosomal condition called Klinefelter syndrome. Astute clinicians understood that these patients often also have metabolic disorders and other comorbidities that require treatment. They assembled multiple disciplines to create a Klinefelter clinic which now attracts eligible patients from throughout the country.

Initiatives are not limited to vertical silos (departments), and specialists are encouraged to drive their own projects. When talented individuals are inspired to cross boundaries, positive things happen. It is vitally important to share this thinking with the next generation of medical students, encouraging them to examine a problem and ask "Why? And why not?" Lessons in teamwork and humility are as important as skills in medicine and pharmacology.

Profile

Partnering with a University to Attract Talent and Deepen Research

Based on a 2017 interview with Paul Dugdale, BMBS, MA, MPH, PhD, FAFPHM, Director of the Centre for Health Stewardship at Australian National University and Chair of the Australian Healthcare and Hospitals Association

University hospital: Canberra Hospital is a 660-bed acute care teaching hospital and a tertiary referral center that provides specialized services to the people of the Australian Capital Territory (ACT). Located in Garran, Canberra, it is the largest public hospital in the region, supporting a population of around 660,000.

Aligned university: The Australian National University (ANU) is owned by the federal government and ranks first in Australia and among the top 20 globally, according to QS World University Rankings for 2018. However, it operates autonomously, similarly to many universities around the world. ANU has seven academic colleges and the current ANU Medical School was formed in 2002, drawing students with its highly regarded curriculum and internationally recognized medical research program.

Structure: Australia has two mainland territories (ACT and the Northern Territory) with self-governments that oversee health, education, social services and other local matters. Since Canberra is a fast-growing region, producing a high demand for services, the ACT strategy is to hold public funding as low as possible until population growth forces more spending.

The ACT's health department operates hospitals directly without additional boards or governance layers. Canberra Hospital and Calvary Public Hospital (owned by the Little Company of Mary Order) are funded by the ACT through contracts. The ACT

government also has an agreement with the university (renewed every 10 years) to support the medical school.

The medical school's curriculum is structured around small teams and research exercises, not large lectures. Hospital leaders look to the medical school to define the optimal curriculum and desired student experiences. The hospital provides training, facilities and access to support such experiences.

Attracting top talent: ACT leaders wanted to establish a local medical school so that students would bond with the host city and remain there to practice. Similarly, senior teaching clinicians would be motivated to come to Canberra and practice at the local hospital because they would enjoy appointments at a highly regarded medical school.

This symbiotic relationship has produced a fruitful partnership and a conduit to attract high-caliber talent. Today, over 231 senior hospital staff members have been granted academic titles by the university, with time allotted for teaching and research. Clinician academics have agreed to be performance-managed by the university; however, an effective system to ensure this happens has yet to be established.

Many medical students stay in Canberra after graduation to practice and develop their careers. This "bonding" is working to a much higher degree than originally forecasted, with at least 70% of graduates applying for positions at Canberra Hospital.

Building a hub for startups: While approximately one-quarter of the city's workforce is employed by the government, the remainder of the economy has to be driven by the ACT. In response, the ACT government has developed a strategy for supporting innovation in Canberra as a university town, pursuing projects in animation, renewable energy and health care, to name a few.

The National Health Sciences Centre was created to take early-state inventions out of the public hospital crucible and through the commercialization stage, thus attracting equity investors. Originally begun as an incubator by the hospital and university, the center is now a self-perpetuating not-for-profit organization that provides commercialization services to the hospital and university as well as other entities.

The center has attracted experienced board members with diverse backgrounds who understand the pitfalls of over-reaching. Rather than pursue complex pharmaceutical business, the center's innovations focus on system products, educational resources, non-implantable devices and other concepts with low capital requirements and potential licensing opportunities. Since the hospital and university were instrumental in launching the center, this common history helps all stakeholders share goals and referrals.

Another example of productive collaboration is The Health Horizon, a startup that was seed-funded by the National Health Sciences Centre. Its mission is to improve the commercialization process for health innovators worldwide through its social media platform where innovators can publicize their work and attract investors.

The research journey: The hospital has an office (directorate) that oversees the ethics committee, clinical trials, scientific conferences and other research-related work, such as providing epidemiological assistance for studies. The office has evolved over the last 15 years as the hospital has become a much stronger research center.

Today, the office is led by an international cancer researcher and experienced grant developer who hopes to guide the hospital into its next phase of research excellence. While not a clinician or medical school faculty member, this new director of research is also the chair of cancer research at ANU, a position developed as a joint initiative between the ACT government and the university within the John Curtin School of Medical Research, a renowned school with prizes unequalled in the history of medical research in Australia.

The role of physicians in research has also evolved. In the 1950s and 1960s, Canberra physicians ran world-class labs at the John Curtin School. In the 1990s, it became more and more difficult for clinicians to maintain a substantial research portfolio while their clinical and teaching duties increased. There is a heavy demand on physicians' time, especially because the ANU medical school curriculum involves small teams and intense faculty/student interaction in the wards and on research projects. Some clinicians find research and publishing very intimidating and spend limited time in this area.

Moving forward, new ways to engage hospital physicians are being explored as part of the larger research strategy. Focusing on translational research and bringing new ideas to the bedside have helped to synchronize the talents of busy physicians working in tandem with international research facilities.

Biographies

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Governance in Iranian public hospitals

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ABSTRACT: Since the early 1990s, Iran has initiated a series of structural and decentralization reforms in its hospital system. Hospitals have experienced many changes in their structures, aiming to increase the quality of hospital services, reduce government spending and enhance control over their own revenues and expenses. Hospital autonomy and boards of trustees were the subjects of main reforms that have influenced the organization and management of hospitals affiliated to the Ministry of Health and Medical Education. It seems that the approach to hospital autonomy and Boards of Trustees has not achieved its desired goals. Hospitals in Iran show a lack of suitable management authority as well as cooperation and coordination between stakeholders, policymakers and hospital management teams in implementing reforms.

Background

Most reforms are taken up in response to common problems such as waste, inefficiency, failure to serve the poor, substandard quality, high costs, brain drain and public dissatisfaction. (1) Several studies have shown that hospitals in Iran are faced with many challenges, particularly in the areas of accountability, efficiency, quality and safety of healthcare services. (2-8)

The Ministry of Health and Medical Education (MOHME) is responsible for providing health services in IR (Iran). MOHME provides medical and training services through 58 medical universities. MOHME owns all medical universities and consequently all the university hospitals. It administers the universities' boards of trustees through their secretaries. Universities hold at least two annual board meetings in Tehran or other major cities and the Health Minister or his official representative participates in these meetings. All the legislations of the boards of trustees are signed by the Health Minister. In total, Iran has 935 hospitals with 121941 beds (Figure 1).

The largest percentage of hospitals have between 100 and 320 beds (44%) while 22% have 32 to 64 beds. Overall, Iran has 1.54 hospital beds per 1,000 people. Figure No. 2 shows the growth process of hospital beds per population in the period 1998 to 2016.

Method: We followed a case-study methodology that focused on content analysis of policy documents, published papers and articles and we held two focus group discussions involving 10 participants, respectively with health system experts including policy makers, healthcare managers, boards of trustees members from selected hospitals and autonomous hospitals and health system caregivers.

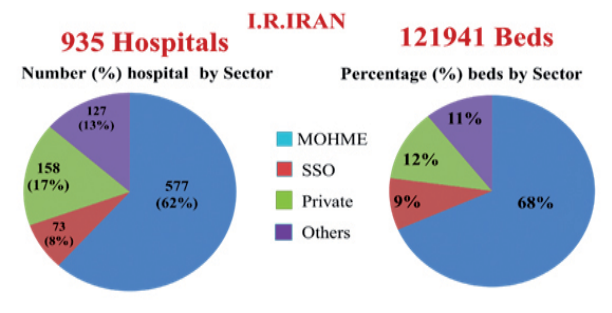
Findings:

Hospitals in the health system

The health system in Iran is organized into three levels. Specialty and super-specialty healthcare services (upper level) are mainly located in big cities. The secondary level includes independent district health networks. District public hospitals as well as specialized policlinics belong in this level (Figure 3). As shown in Figure 4, there are 5 administrative levels in Iran's health sector. At the highest level, there are high councils such as the High Council for Health and Food Security and the High Insurance Council. At the second level, there is the Ministry of Health and Medical Education (MOHME). The Boards of Trustees of Universities are at the third administrative level. All provinces of Iran have at least one university of medical sciences. At the fourth level, there are university hospitals in major cities, most of which are training hospitals. These hospitals are autonomous entities despite being categorized as boards of trustees due to healthcare reforms in the last 15 years. City hospitals are at the fifth level. These public hospitals belong to the health network of each city. They are considered to be the gateway from which people enter the network. The following figure provides an overview of Iran's health system. The High Council for Health and Food Security (HCHFS) has a stewardship role in Iran's health sector.

MOHME is responsible for the provision of healthcare services and medical education through medical universities. In 1988, a law was passed for the establishment of boards of trustees in medical universities. The main tasks of a board of trustees are:

FIGURE 1: PERCENTAGE OF HOSPITALS AND BEDS BY SECTOR



Source: (9)

FIGURE 2: NUMBER OF BEDS PER 1,000 POPULATION IN 1998 AND 2016. (ALBORZ PROVINCE WAS NOT EXISTING IN 1998)

Source: (9)

- Adoption of internal regulations
- Approval of the administrative structure of the institute
- Budget review and approval
- Deciding on allocation and use of dedicated revenues
- Approval of financial and trade regulations.

Hospitals and main reforms in Iran's health system

Iranian hospitals have experienced many structural changes in the past three decades:

1. Integration of healthcare delivery and medical education establishment of MOHME (1985)
2. Financial and structural reform through University boards of trustees (1988)
3. Universal health coverage (1994) as a pre-requirement for hospital autonomy reform
4. Decentralization and new public management in hospitals (1995)
5. Public Hospital Autonomy reform
6. Payment mechanisms changing from salary to fee-for-service
7. Government outsourcing and PPP law (2001):
8. Purchasing services from non-governmental providers
9. Public-private partnership
10. Outsourcing
11. Decentralization and hospital structural reform in six components
    - New financial management reform turning cash accounting to accrual accounting
    - Operational budgeting
    - Payment method (P4P)
    - Outsourcing
    - Information technology in the health system
    - New hospital structure, autonomous hospitals with general director and board of directors
12. New health system decentralization law in 2006.
13. MOH in 2006 decided to turn public hospitals to hospitals with boards of trustees
14. Health transformation plan (HTP) in 2014
15. Autonomous Hospitals (2018)

The first decentralization reform in Iran's health system occurred in 1985; to meet the needs of the country in the area of medicine, medical-related majors were separated from other universities and affiliated to the Ministry of Health. (11) This reform increased the capacity for the training of health-care providers, expansion of the health network system, modification of medical education curricula and increased social accountability of universities. The healthcare system has not been fully integrated; we have inequitable access and use of health services and medical education are not yet community focused. (12)

The newest reform has been the health transformation plan (HTP). (13) One of the main parts of the HTP covers public hospital care. This part had seven programs, each with the aim of increasing fair access to hospital care. These programs were out of pocket payment reduction for in patient services, practitioner retention in remote areas, overnight specialist cover in hospitals, improving the quality of outpatient visits, hoteling and ward upgrades, financial protection of incurable, specific and poor patients and promoting natural delivery. (14)

Hospital Autonomy

Hospital autonomy was aimed at improving quality and performance within the government budget. Hospital autonomy led to long-lasting and often negative changes in the public hospital sector and the entire Iranian health system. The result of this study shows that hospital autonomy appears to be an ill-advised policy to remedy the inefficiency problems in low socioeconomic areas of the country. (15) According to the Jafari et al. (Figure 5) findings, "Autonomous hospitals have had many governance problems. Their structure is mainly a centralized hierarchy of command and similar arrangements exist between the university and the hospitals. The hospital director is a (medical) specialist who is appointed (and also removed) directly by the chancellor of the university." In practice, the hospitals were accountable to different authorities within the university or the ministry of health. "Hospitals are accountable to different university deputies." The hospitals complained that such authorities did not necessarily provide congruent messages. "Hospitals are confused between several commanders who are also confused, one persuading them to generate revenue and the other pressing on quality improvement

or teaching and research objectives." Financial accountability was the most rigid kind of accountability in hospitals. (16)

Markazi-Moghaddam et al. have shown that nine obstacles were recognized for hospital autonomy in Iran, including "autonomous hospitals board composition", "delay in announcing autonomous hospitals' charges by the MOHME", "lack of financing by the committed organizations", "poor reform implementation follow-up", "irregular board meetings", "lack of an external overseer", "shortage of full-time physicians", "lack of management stability" and "delayed payments by health insurance organizations." (17)

Board of Trustees

In 2004, Iran's government introduced the second health reform for the decentralization of hospitals and the achievement of efficiency by moving from budgetary hospitals to semi-private units. The composition of the boards has been a major point of criticism. Another criticism revolves around the status of the board of trustees. If the board of trustees is established to turn universities into autonomous entities and contribute to decentralization, it can be argued that this cannot be achieved in practice, as the board's decisions must be ultimately approved and signed by the Health Minister. The health departments of medical universities directly oversee university hospitals and interact with the Health Department of MOHME in the provision of medical services. The problem here is that hospitals take orders from three university departments, i.e., the Departments of Development, Health and Education, with no unity of command. Many hospital managers believe that the persistent focus of hospitals on the provision of healthcare, autonomy and revenue generation has led to the sidelining of medical education. Others believe that treatment has been sacrificed in favor of education and the academic atmosphere of training hospitals has led to poor provision of medical services.

According to the findings of Doshmangir et al. (18), Sajadi et al. (19), Mehrolhassani et al. (20) and Ferdosi et al. (21), the implementation of the board of trustees policy did not achieve its desired goals in teaching hospitals in Iran. According to the Jafari et al. findings, it appears that "implementing regulation" and "financial problems" involve over 50% of the barriers. Apparently, the new approach to hospital autonomy has not achieved the desired goals. (22) Research on the failure of implementing the Board of Trustees policy concluded that "insufficient budget was the most influential factor." (18, 23) In the hospitals with boards of trustees, the governmental budget diminished considerably or was even omitted, and it was emphasized that these hospitals had to be exposed to the market. Universities were allowed to take 5% - 15 % of the hospitals' income for their administrative costs, but there has been a long delay in returning the rest of the money to the hospitals. Problems relating to faculty members is another of the barriers.

The main difference between these hospitals and the autonomous hospitals was that the hospitals with boards of trustees did not have financial and trade regulations and were administered by a board of trustees. (18)

Autonomous Hospitals

According to the Jafari et al. findings, the autonomy granted to hospitals is "unbalanced and paradoxical." (16) In 2018, a new communiqué by the Minister of Health was aimed at improving quality and performance and creating heterogeneity between different aspects of autonomous hospitals such as human resources, finance, market exposure, residual claimant and other aspects. Hospitals have boards for decision making. These Boards include CEO, Executive deputy, Technical deputy, financial management and Matron. Figure 7 shows the organizational chart of autonomous Hospitals. New structures and authorities will resolve past problems and give greater authority to hospital managers in different aspects of the Harding and Preker model.

Conclusion

Structural and decentralization reforms in the hospital system aim to increase the quality of hospital services, reduce government spending and enhance the hospitals' control over their revenues and expenses. (15) It seems that the new approach to hospital autonomy and their Boards of Trustees has not achieved its desired goals. The abovementioned examples clearly show that the health service in Iran has no master plan. A disparity between public and private service, separated health insurance and an absence of universal protocols and guidelines is hampering this system. (25). Evidence from the implemented structural policy reform in hospitals in Iran shows lack of suitable cooperation and coordination among stakeholders in implementing the policy. The role and power of some stakeholders, particularly insurance organizations, was substantial in policy implementation. (17) To achieve its goals, the Iranian health system must pay attention to context and the key stakeholders should support the reform of Iran's health system.

Biographies

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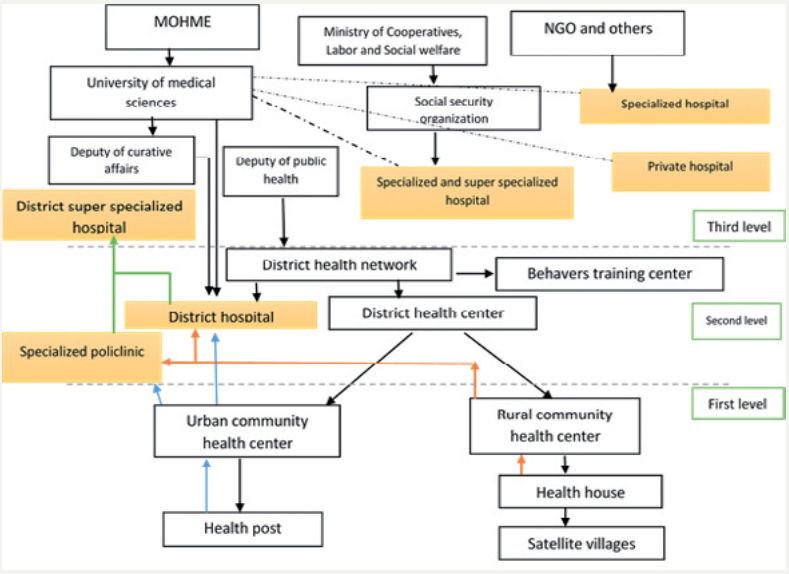
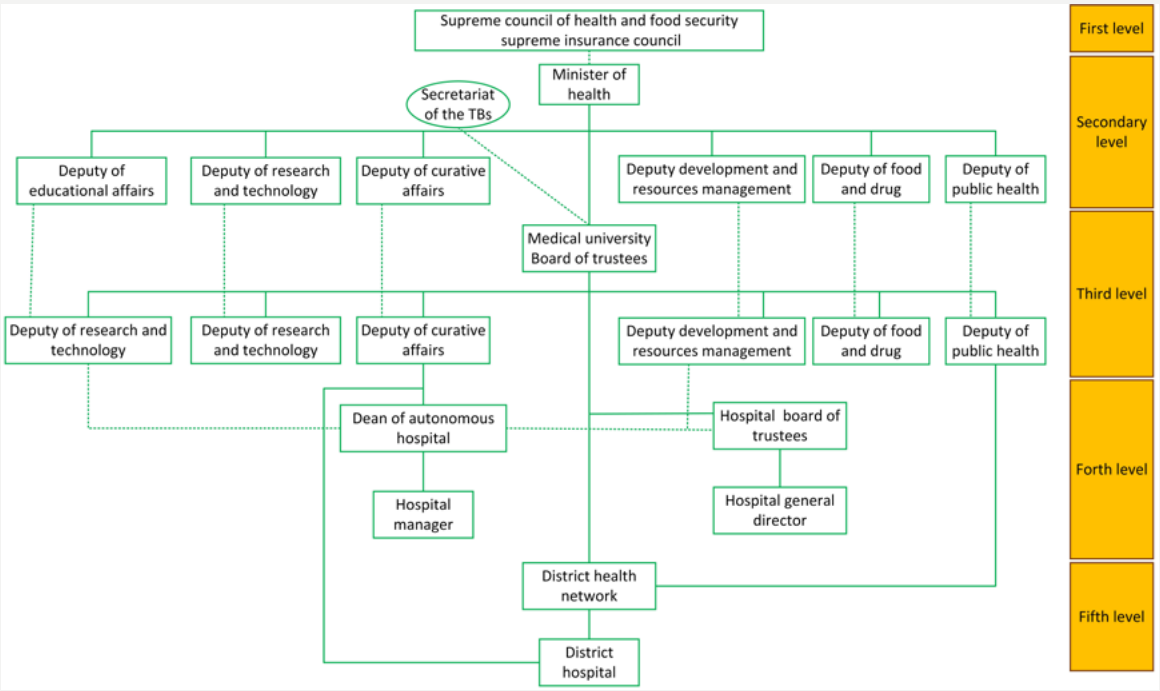
FIGURE 3: HEALTH SYSTEM LEVELS IN IRAN



Source: adapted from Mehrdad (10)

FIGURE 4: ADMINISTRATIVE LEVELS OF IRANIAN HOSPITALS



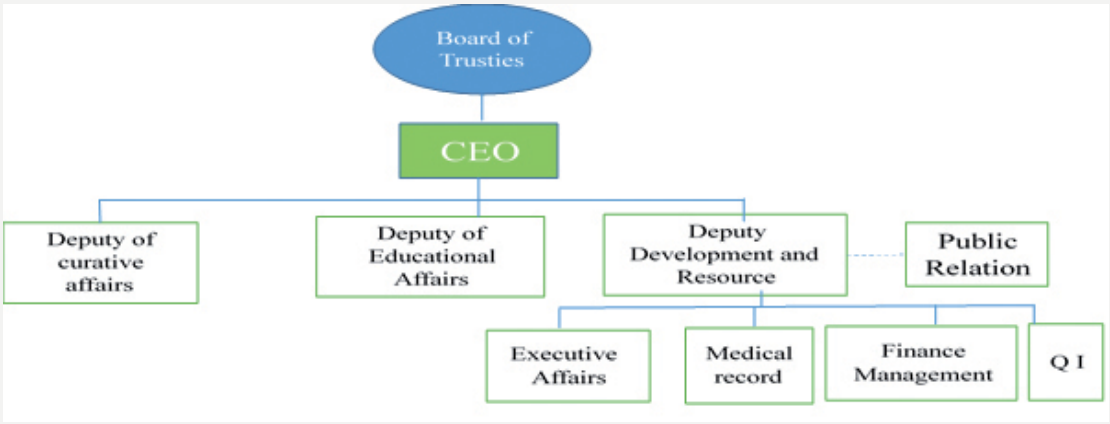
Source: Result of focus group

FIGURE 5: "THE UNBALANCED AUTONOMY IN SELECTED PUBLIC HOSPITALS IN IRAN"

Organisational elements:		Budgetary	Autonomous	Corporatized	Privatized
Strategic Management		→			
Human resources management		→			
Financial Management	Generating revenues	→	→		
	Spending revenues	→	→		
Physical resources management		→			
Product market exposure		→	→		
Procurement market exposure		→	→		
Residual claimant		→	→		
Governance arrangement & accountability		→			
Hospital social functions		→	→		

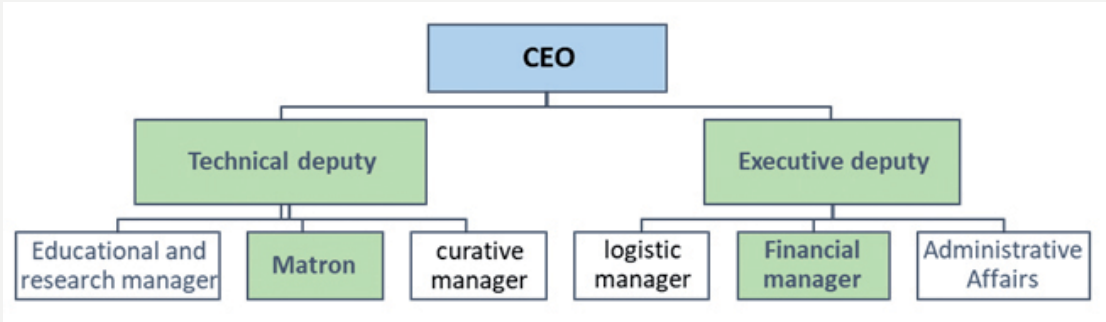
Source: (16)

FIGURE 6: EXAMPLE OF STRUCTURE OF HOSPITAL BOARD OF TRUSTEES IN IRAN



Source: http://emamreza.mums.ac.ir/images/emamreza/test/chart0.pdf http://www.alzahra.mui.ac.ir/sakhtar/sakhtar.html

FIGURE 7: ORGANIZATIONAL CHART OF AUTONOMOUS HOSPITALS



Source: (24)

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Is the French model of a university hospital still relevant?

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The contents of this paper are the sole responsibility of the author.

ABSTRACT: While university hospitals are about to celebrate their sixtieth anniversary, they have never been so challenged. They are now competing with the private sector and they are the envy of lower level public non-university hospitals. A change in their governance system is requested by the universities. They are questioned for their double ministerial supervision and constrained by the national economic and budgetary context. They have also been recently empowered with new missions in their areas. Finally, since the beginning of 2018, they have been at the center of unprecedented criticism by the media. Studies are currently underway to determine what will be the university hospital of tomorrow.

The French model in a few words

Background of the French hospital system

French health facilities are characterized by their diversity. They are differentiated according to their legal status (public and private, for commercial or non-profit purposes), missions (participating or not in public hospital service), specialization (psychiatric or other) and length of stay (short, medium or long).

Broadly speaking, the funding model is the same, based on activity tarification, even if public and private sector tariffs differ. Only for psychiatry, long stay care and specific activities (for instance, care related to vulnerability, prisoners' health and permanent medical treatment) are financed by specific packages.

The three missions of university hospitals: clinical care, teaching and research

When university hospitals were founded in 1958, the basic idea was to unite by convention large public hospitals and faculties of medicine while guaranteeing legal status and financial autonomy to these new structures. The constitutive convention determines the roles and responsibilities of each entity. There are currently 30 university hospital centers across the French metropolitan and overseas territories. All university hospitals are public hospitals.

Three missions are dedicated to university hospitals: clinical care, teaching and research.

- **Clinical care**

  University hospitals have a regional vocation linked to their high specialization. They combine a routine care function for the population of their sector and a referral function for other institutions in the region.

  University hospitals now have 5 million emergency room visits annually. They also have 5 million short-stay admissions, of which 2.7 million hospitalized during the day. Outpatient surgery accounts for more than one-third of surgical procedures (31%): 250,000 out of 788,000.

  20 million patients go to university hospitals for consultations and 120,000 babies are born in a university hospital every year.

  Serving millions of people suffering from rare diseases in France, university hospitals coordinate and inspire the expertise of professionals working in 131 reference centers and 501 competence centers.

- **Teaching**

  In connection with 37 faculties of medicine, 24 faculties of pharmacy and 16 faculties of odontology, university hospitals ensure the teaching of medical staff. More than 16,000 interns in medicine, pharmacy and dentistry are assigned to university hospitals. Nearly 7,000 other interns are managed directly by university hospitals, making up a total of 23,000 interns managed by university hospitals.

  In addition, there are 276 training institutes for paramedical staff, totaling 38,000 students. There are also 28 schools for midwives.

  Teaching methods are innovative: there are 24 simulation

centers located in university hospitals and health faculties.

- **Research**

  By law, university hospitals have a biomedical research mission as they belong to the public hospital service that contributes to research. They also have specific research missions, which they perform in close collaboration with the university's training and research bodies.

  University hospitals and their associated universities define a common research strategy.

  Together, they produced more than 110,000 scientific publications over the period 2006-2015, i.e., 17% of the entire French production. In 2015, university hospitals conducted approximately 2,000 clinical trials, 50% of which were multi-center and included 108,000 patients.

  The largest university hospitals have built a hub for startups, in connection with the university, research institutions and local authorities.

Governance, human resources and financing

University hospitals are characterized by a double ministerial supervision, which is complemented by the regional supervision of the regional health agency.

One of the major innovations of the 1958 reform was to establish "full-time" hospitals-universities for doctors, who chose (on a competitive basis) to work within a University Hospital and Faculty of Medicine. For example, hiring permanent medical hospital-university staff requires a joint authorization from both ministries, based on the joint proposal of the university hospital and the faculty. For these staff, all management acts involve dual management, through the Ministry of Solidarity and Health and the Ministry of Higher Education. They also have two employers: the University and the university hospital; this results in two pay slips!

Being a university hospital has no budgetary consequences; there is no specific funding system for university hospitals and no ministerial support for investment by university hospitals, neither for high technologies equipment nor for buildings. University hospitals benefit from the same funding as other hospitals. For specific activities (research, teaching, centers of excellence), additional specific credits are granted; these credits could very well be granted to non-university hospitals, provided they have obtained the corresponding recognition of their expertise by the Ministry.

University hospitals have a reputation of clinical excellence, research and increasingly innovative equipment; with regard to their international reputation, university hospitals now want to enhance the attraction of rich foreign patients.

The French model heckled

Towards a renovated governance?

Some university voices are being raised for university hospitals to be placed within the Faculty of Medicine and under the direct responsibility of the Dean of the Faculty of Medicine, who would become the Director General of the University Hospital and take on the role of its legal representative. This claim is not yet fully shared by the players in the hospital system, but it comes up regularly in the news, highlighting a French particularity: the management functions are not provided by doctors-managers, but by hospital directors, specially trained at the School of Advanced Studies in Public Health (accessible after a selective competition). For university hospitals, CEOs are appointed by decree of the President of the Republic.

Towards a decrease in the number of university hospitals?

The territorial reform adopted in 2015 has reduced the number of French regions from 22 to 13. As of now, this is not reflected in the organization of French universities or university hospitals. Thus, there are up to four boarding school areas within the same region, which inherently has four university hospitals.

The question of reducing the number of university hospitals has nevertheless been raised and not only as an indirect consequence of the territorial reform. In 2017, a report by the Court of Auditors recommended promoting, in the field of biomedical research, the emergence of five to ten CHUs with international visibility by entrusting them with the responsibilities of being heads of the network and concentrating the means of financing. This proposal has had the effect of a bomb for university hospitals, since it would result in dividing by three or even six the number of university hospitals with research activities, in addition to referral activities and teaching.

University hospitals tend to compete with each other rather than cooperate. Or rather, cooperation is limited to the desire of being recognized for excellence and expertise by one's peers.

Towards extracorporeal university hospitals?

Conversely, for actors in non-university hospitals, research would no longer be carried out by the university hospitals (structure), but by teams, whatever the structure. In the same way, the training of future health professionals would be massively outsourced outside of the university hospitals - closer to future needs - even though there may be insufficient medical teams to ensure this mission. Non-university public hospitals could request a hospital-university certification for some clinical activities while requesting that specialized referral activities that belong typically to university hospitals be maintained or reinforced. This demand from non-university hospitals is now also shared by private clinics. They claim a role of choice in university education and doctoral students in medical research.

These claims to dilute the triple mission of teaching, care and research can lead university hospitals to lose their specificity and substance, as any other institution could in practice play the same role. Assuming the role of territorial leader for the various actors could ensure that university hospitals will maintain their level of excellence in each of their missions, while interacting with other actors in their respective fields of expertise.

New territorial responsibilities assumed

Since July 2017, territorial hospital groups, which group together public health institutions in a given area (of varying size and importance), have developed joint medical projects aimed at building inter-institutional care networks to optimize healthcare facilities and pathways for patients with similar pathologies.

University hospitals have not been excluded from this reform; all of them are part of a territorial hospital group, which they also lead. In addition, as mandated by the law, they perform other territorial missions with territorial groups of hospitals other than the one they manage directly. Also, each university hospital must sign an association agreement with these groups. Each intervention within the framework of this convention aims at organizing patient care and pathways for referral and referral activities, particularly those covered by inter-regional authorizations (mainly cardiac surgery, neurosurgery, treatment of burn victims and organ transplants) or organized in reference centers. They must also promote clinical research in the region, by developing research support services for the benefit of all investigators and encouraging collaborations between researchers. In conjunction with faculties, interventions also include the initial training of professionals, particularly medical ones. A major role is finally also granted to University Hospital Centers in terms of the dynamic and prospective organization of medical demography.

What will "the university hospital of tomorrow" be like?

Thus, the two Ministers (Solidarity and Health and Higher Education) entrusted the Presidents of the World Hospital-University Conferences (CEOs, Presidents of the Medical Establishment Commission, Faculty Deans of Medicine, Dentistry and Pharmacy as well as University Presidents) with the task of determining what tomorrow's university hospitals will be like. Their conclusions must be delivered before the celebration of the 60th anniversary. Proposals are expected to meet the challenges of territorial organization, public health, prevention, multi-professionality, access to care, relevance and quality of care, research, innovation and the initial and continuing training of health professionals.

To be continued…

Biography

Armelle Drexler studied political science and holds two Master degrees in Health Law and Health Economics. Additionally, she graduated from the French EHESP School of Public Health in 2008. She has 10 years of experience as a Hospital Director working with purchasing, logistics and non-medical and medical human resources. Since 2015, she has been working at the Strasbourg (France) University Hospital as the Director of the Department of Medical Affairs, Research, Quality and Territorial Medical Strategy. Since 2015, she is also the National Coordinator of the Medical Affairs Committee of the University Hospitals Conference of CEOs.

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Finding solutions in perfectly imperfect health systems-markets: framing options for the governance and finance of a *Collegium Medicum*

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ABSTRACT: The long-term challenges of governance and finance in university hospitals in Poland and Ethiopia may seem far apart. However, in two recent projects, a common conceptual approach proved remarkably useful in stimulating broad engagement in obstinate financing challenges. This approach links but also challenges traditions in both explicitly (public) financial institution narratives of healthcare 'markets' and explicitly (public) health and medical narratives of 'health systems'. If university hospitals are seen as hubs, in wider social-economic professional and information networks, new intra- and inter-institutional possibilities in governance and finance can open. A thorough international and comparative analysis of these remarkable institutions is needed.

Introduction

In Poland, a university hospital is still commonly referred to by its historical Latin name, a *Collegium Medicum*, i.e. an association of medical professionals. Founded in Krakow in 1364, the medical faculty and hospital of the Jagiellonian University are not only the oldest in Poland but also amongst the oldest continuously operating institutions in the world (Janczukowicz 2013). By contrast, the oldest university hospital in Ethiopia traces its roots back to the establishment of a public health worker training centre in the ancient capital of Gondar in 1954. Only in 1978, under a bilateral agreement between the University of Leipzig (then Karl Marx (1409)) and Addis Ababa University (1960) was a medical faculty established within said training centre. This agreement lay the cornerstone of medical education in that country.

But whether ancient or in their infancy, human organisations that are so interconnected and remain vital and continue to evolve over centuries are clearly extraordinary. It is therefore also remarkable that so little is published, certainly in English, on their governance, finance and indeed performance (Commission Marescaux 2009, Cour des Comptes 2011).

This paper starts by presenting a common framework for describing and comparing the governance and finance of university hospitals in terms of three core functions: medical education, services and training and research and development. This framework was used to develop crude comparative data and options analyses when considering two separate but urgent financing related challenges facing university hospitals in Poland (World Bank 2014) and Ethiopia (Ethiopia, MOF 2017)[1]. This well-established framework was also extended by proposing underlying and dynamic social and economic network characteristics in the governance and finance of university hospital organisations and ultimately health systems (Rhodes 2013a). The resulting model suggests that health care providers - supply-side actors in any national health care system - are systematically socially and/or economically networked, but, as a result, they form only one half of a complex and adaptive two-part system. University hospital organisations have traditionally played a central role in these professional and indeed information networks; but a network-based model not only reframes discussion, it might also be used to consider how and why the social and economic networks of university hospital organisations and the health systems around them might evolve.

In historically 'public integrated' health systems such

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as those of Poland and Ethiopia, this proposition is not an assumption but a logical extension and a *re-framing* of formal arrangements (Tversky 1981). In terms of networks, widely supported 'integrated health care systems' are, for example, simply geographically organized hierarchical networks of health care providers and professionals, with university hospitals as the highest of three referral levels. This then largely (pre-)determines both intra- and inter-organisational finance and governance arrangements. However, if *the health system is rather a health care network*, dialogue can start to move *from* the public heath administrator's (referral pyramid) 'health system' and public financial authorities' (imperfect) 'health care markets' narratives *towards* a new shared 'networks' discourse in which university hospitals are boundary spanning hubs with critical networking functions.

A *Collegium Medicum* is therefore not simply a historical artefact, it is an intergenerational social and economic meta-network of health care providers and suppliers; nor is being the root and trunk of a hierarchical or 'tree' network the only or inevitable destiny of a university hospital organisation. Emerging and observable international variations in the governance and finance of university hospitals, or network topology, can also be quickly explained.

Discussion: hubs and health systems' network topologies

In 2014, university hospitals in Poland faced mounting debt problems (World Bank 2014). To some extent, these challenges are long-term and persistent. As part of various policy dialogue support processes, and in the absence of thorough international comparative work on the governance and finance of university hospitals in the OECD, a comparison framework was prepared and presented at the 2014 Annual Meeting of University Hospital Directors. The initial work was completed on a relatively short notice. Three years later, at a similar moment of some urgency, the same framework proved remarkably useful in bringing together the Ministries of Finance, Health and Education in Ethiopia, after initial attempts to agree on a common approach to developing international standard tertiary services and a "medical hub" had encountered difficulties (Ethiopia, MOF 2017). These cases would suggest that more detailed comparative work on the governance and finance of university hospitals is both possible and necessary, but also that the result of such comparisons might be to suggest that further evolutions are ahead if not already starting, not only for these ancient and illustrious institutions but also for the health care provider networks around them.

In 2014, the accumulated arrears of public university hospitals in Poland had reached €475 million on total annual budgets of approximately €2 billion. As public institutions with a no- rather than perhaps non-profit purpose, such a debt burden obviously represents a structural challenge. Calls were being made to raise case-mix tariffs for medical services. Supported by the Ministry of Health (MOH), the National Health Fund (NFZ) and the World Bank, an international comparative study of university hospital governance and finance was commissioned to explore other options.

The first and immediate observation was that there was little or no international comparative data on university hospitals (OECD 2011). The approach chosen was therefore to first take a common and simple framework to describe the functions of university (college) hospitals and attempt to collect financial performance (input, process, output) data on that basis (Figure 1). The size of any set could then also be adjusted to reflect the relative scale of any function to therefore 'business' operations. However, translating such frameworks into graphical 'sets' also provides a second step and a clear and simple mechanism to illustrate not only financial arrangements but also governance arrangements. Where sets effectively overlap completely, as in both Poland and Ethiopia, organisational governance can be defined as *unified*; i.e. the same posts and/or persons hold parallel leadership and management positions across functional areas of the organisation.

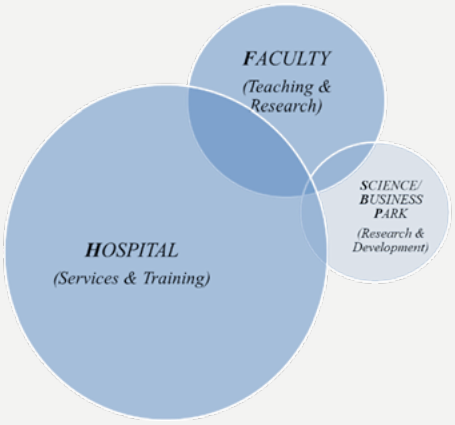
However, using set diagrams also makes it possible to identify and classify a number of further and internationally observable governance and financial/legal structures. A *co-governance* structure is then one in which authority is (by degrees) less concentrated (Figure 2). Functional organisations can also specialize, remaining fully connected only as *subsidiaries* of a (public or private) holding company. Potentially, as in, for example, cases in Belgium, functional organisations may finally evolve towards full legal separation, but doing so while moving to formal cooperation agreements creating social and economic *network* organisations. Relationships thus become less hierarchical and geographical constraints are reduced. If any given university hospital organisation in the world includes governance descriptions and financial accounts in online annual reports, participants in a discussion can even start to construct their own back-of-the-envelope diagrams during a dialogue process.

Within the context of an admittedly limited study in terms of time and scope, it was therefore possible to define and compare four basic types of governance and finance arrangements for university hospital organisations across a sample of OECD countries. A University Hospital Organisation (capitalized proper noun) was then defined as one of a number of financial/legal forms combining at least two distinct organisational elements relating to core and overlapping functional areas related in turn to medical services education and research. For purposes of discussion, a third non-core component could also be added:

- **F**aculty (or medical school) – *Teaching* and Research
- **H**ospital(s) – Services and *Training*
- (**S**cience/**B**usiness Park/**E**state – Research and Development, Logistics, etc.)

Whether the third component can or should be added to the discussion can be debated. In the case of Ethiopia, for example, and not uncommonly, university hospital organisations can have legal entitlement to substantial legacies of land and fixed assets, thereby making this third component of particular interest and potential relevance in

FIGURE 1: TOTAL EXPENDITURE OF UNIVERSITY HOSPITAL ORGANISATIONS IN POLAND BY FUNCTION 2014



Total Expenditure Polish UH by function
(m Euro, 2013)

	Faculty	Hosptial	UH-Organisation	%
Grand TOTAL	485	1,556	2,041	
Health Services	-	1,479	1,479	72%
NFZ		1,366	1,366	
MOH		81	81	
Other		32	32	
Education	334	66	400	20%
Pre-diploma	334	11	345	
Internships		7	7	
Specialization		48	48	
Research	151	11	162	8%
Public sources	150	1	151	
Other	1	10	11	

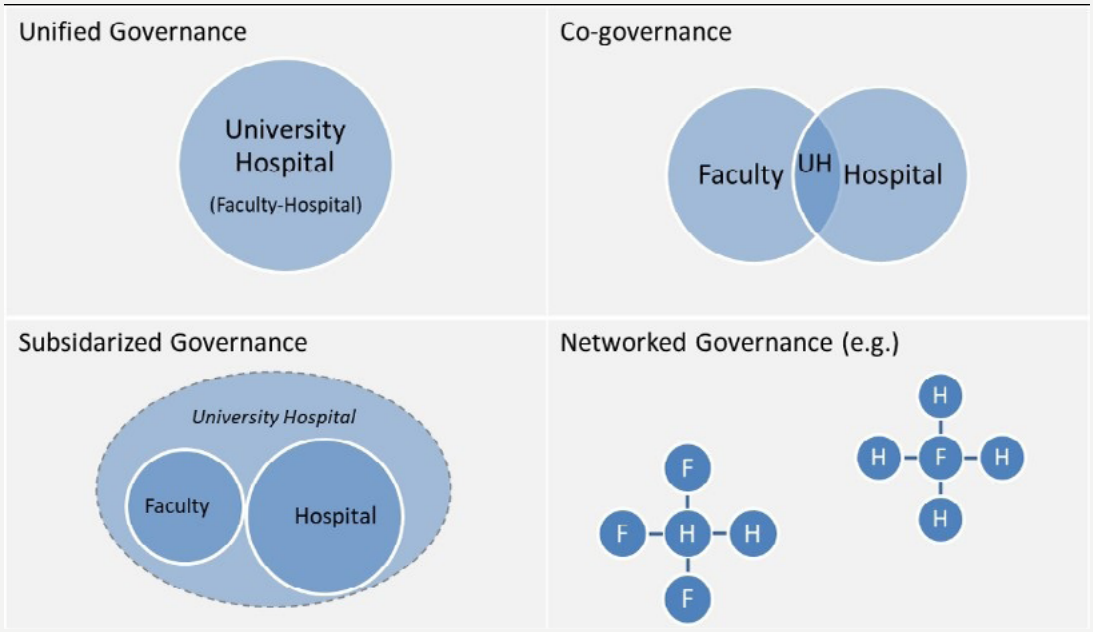
(Source: author estimates, WB 2014)

Source: World Bank 2014

the medium to long term. However, interest in the so-called valorisation of research activities and findings has gradually moved into the mainstream of university and university hospital organisations' operations (University of Amsterdam 2014). Debates on valorisation also make clear a second aspect of governance in specialized medicine: it operates at a number of interacting levels.

The three levels of governance commonly identified are: micro-governance (personnel rules and norms), meso-governance (intra-organisation rules and norms) and macro-governance (inter-organisation/sector rules and norms) (Saltman 2011). The relationship between levels of governance is not clear but cannot be assumed to be purely or even primarily hierarchical. The micro-level, for example,

FIGURE 2: A PRELIMINARY CLASSIFICATION OF GOVERNANCE AND FINANCIAL/LEGAL STRUCTURES



Source: World Bank 2014

and the "formal and informal rules, rule-making bodies and accountability systems and mechanisms affecting the action or manner of governing by individual professionals" is not necessarily subordinate to higher aggregates. Hence, if an individual autonomous professional makes a valuable scientific discovery or, for example, has a popular online lecture series, while information and knowledge may be shared within the professional body in the traditional way, it is no longer necessarily the case that the property rights or even some part of the value flowing from that discovery will necessarily accrue to a university hospital organisation employer. Therefore, valorisation debates make interactions between levels of governance that have always existed particularly clear. Organisational (meso-) and sector (macro-) governance arrangements are increasingly having to adapt to being facilitators of autonomous, knowledge-rich professionals (micro-governance).

With a basic framework for comparison having been established, the preliminary indications for Poland were striking. Firstly, by comparison, European and world-leading university hospital organisations are increasingly financially diversified. Secondly, the governance of these organisations is also increasing diversified, or at least increasingly less *unified*. In terms of financial operations, research and (technology) development are playing an increasingly important and, in some cases, now principal role in the financing of a number of leading institutions. However, even innovations in education can mean that this function is not necessarily an underperformer in terms of financial or peer-to-peer and popular recognition, ((social) marketing) impact and performance. Furthermore, European comparisons from 2010/11 suggest that only in the Netherlands, Spain, Norway and Austria do public health related R&D expenditures outstrip private expenditures (Janssen 2013). In the UK, the rank leader in the same study by some margin, private health related R&D expenditure is >300% higher than public expenditure at >€5 billion per annum (2010/11). Such comparisons raise very important questions of university hospital organisations wishing to continue long and proud traditions. In 2014, for example, not a single Polish university hospital organisation was featured in the top 200 medical schools of the Shanghai Index. As for the African continent, only Witwatersrand features on this list.

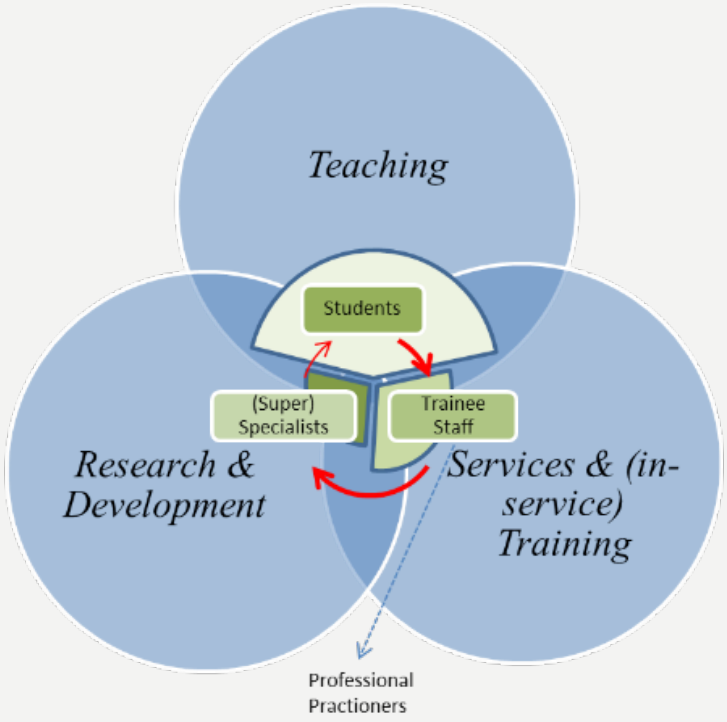
Poland therefore illustrates some of the challenges and opportunities facing university hospital organisations, where the core functional focus is narrow or has been narrowed as a result of diversion from core objectives. In 2014, twelve (public) medical universities directly operated 43 "teaching hospitals". Throughout the post-communist transition, struggling hospital organisations were brought under the umbrella of public medical universities, but rather than creating distributed but networked organisations (or even, but outside the comparison, regional 'integrated' (i.e. three-tier) health systems under university hospital direction, as in, for example, Iran (Mehrdad 2009)), Polish University Hospitals became what might be better characterized as public hospital conglomerates under the *unified governance* of public medical universities. Authority is concentrated on medical faculty deans, but also key departmental leadership positions in both Faculty and Hospital(s) continue for the most part to be held by single individuals. These positions also elect Deans. Authority and financial risk become similarly concentrated. This problem is well recognised. However, despite efforts to provide the legal space, under the 2011 Law on Therapeutic Activities, to reduce dual function holding in university hospital organisations, increase functional specialization and facilitate general hospital sector restructuring, to date, there remain few examples of that legal scope being utilized.

Up to this point, the discussion follows common and accepted rules of engagement in policy advisory services and perhaps the soft-system methods of the social sciences (Checkland 1999). Personal issues are decontextualized, and evidence and context are gathered through a process of consensus forming. However, in alluding to networks, the appeal of the framework outlined above must surely be that it is not difficult to scratch below the surface and move from a general discussion to something much more specific - even hyper-contextualization - to names, faces and even personalities. It is also possible to go one step further and consider social and economic connections over even extended periods of time; this is because the functions and functional areas of university hospital organisations also directly relate to basic steps in a professional life cycle (Figure 3).

Seen in terms of a professional life cycle, the core functions of traditional university hospital organisations, but also their fundamental social and professional network function in health systems, can be seen in a different light. A professional life journey will start as a student, progress through tutelage under a practicing professional and mature as the student in turn becomes the master. In some cases, and particularly for those in university hospital organisations, the path to maturity may ultimately also feed back into the canons of the profession and the teaching as well as training of subsequent generations. It is therefore possible to suggest that the *Collegium Medicum* is precisely that, a single continuously evolving body and social and economic network in which university hospital organisations have traditionally played a central information networking role in terms of human and intellectual (information) capital formation. Indeed, human capital and assets, just like their financial equivalents, may be said to grow or decay logistically (Rhodes 2013b).

While it is therefore perhaps possible to debate precisely how human capital and skilled medical labour forces grow and survive, university hospital organisations certainly play a key role in medical networks. It is therefore perhaps surprising that only recently have countries such as Ethiopia (re-)started initiatives to establish *international standard* university hospital organisations (OECD 2018). Using and expanding upon the framework developed in Poland, an investment 'trigger' action plan for the long-term development of 8 university hospital 'medical hubs' has

FIGURE 3: CORE FUNCTIONS OF UNIVERSITY HOSPITALS AS STEPS IN A PROFESSIONAL LIFE CYCLE



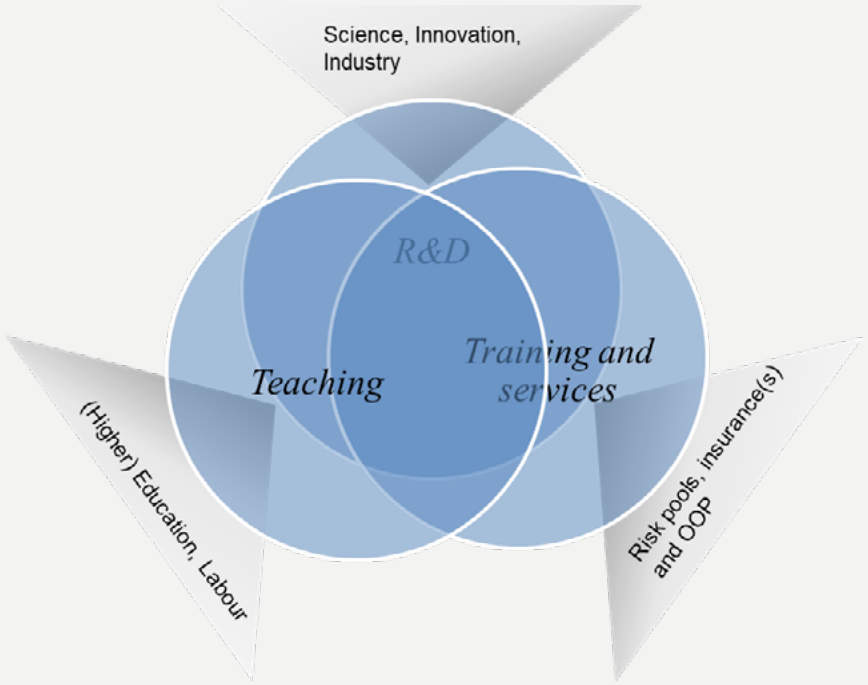
Source: World Bank 2014

recently been developed and agreed between the Ministries of Finance and Health. Initial attempts at interdepartmental agreement had foundered as responsible Ministries focused on their respective areas of authority and internal narratives. For the Ministry of Finance, strong but largely unquantified *effective demand* suggested that private sector investment could be attracted to an emerging *health care market* so as to develop an *international standard* tertiary facility. This would be the first in the country. For the Ministries of Health and Education, respectively the regulator and (for the overwhelming majority) owner of university hospitals across the country, an "investment" in a tertiary facility suggests that at least one of eight core existing public university hospitals could receive a substantial capital injection, hence strengthening the highest point of referral in a (public) *integrated health system*. Together, public finance, health and education authorities have, however, agreed on an investment- trigger action plan which will ultimately cover 8 university hospital organisations, "medical hubs", and hence a *nationwide meta network combining hierarchical and non-hierarchical components*.

Hence, while the immediate challenge in Ethiopia therefore concerned starting to attract substantial financial and human capital investment rather than addressing accumulating debts - by focusing once again on the human capital formation and network processes at the heart of the three core functions of university hospital (tertiary) organisations-, it was possible to expand options and engage a broad base of potential stakeholders.

Public finance related authorities and stakeholders could be persuaded that university hospital organisations are (tertiary) medical profession network hubs that bring together three distinct core functional fields, and that eight nascent hubs already existed across the federal states of Ethiopia in the form of university hospital organisations. Public health, medical service and medical education and research related authorities and stakeholders could be persuaded that university hospital organisations may be the hubs of the larger body or 'system' of medical professional networks; but they are collaborative structures of health care suppliers for whom integration and unification of governance structure, the prevailing arrangement in Ethiopia as in Poland, may not be the only or best solution at any level of governance (see above). The challenges and context were therefore somewhat different to that in Poland in 2014, but in terms of looking for possible solutions, diversification of financial

FIGURE 4: THE SUPPLY-SIDE NETWORK(S) AND DEMAND-SIDE PRESSURES AND OPPORTUNITIES



Source: World Bank 2014

operations seemed to hold the most promise. Furthermore, achieving this was likely to go together with diversification of governance arrangements at all levels to meet and manage expectations across quite distinct areas of *effective demand* or 'industry-markets' (Figure 4). The Ethiopian university hospital organisations' investment trigger action-plan is therefore interesting because it includes elements and activities targeted at all three levels of governance.

Firstly, the investment-trigger action plan is an initiative and will be one of the first activities of a newly proposed (working title) 'Council of University College Hospitals and Medical Education (UCHME)'. This council is non-hierarchical with a rotating chair. No participating institution (or leader) has superiority over any other. The Council is therefore typically collegiate - also to the extent that the potential private sector entrants have been approached and expressed interest to participate - and an innovation in macro- or sector-governance for Ethiopia[2]. Secondly, the strategy behind the investment-trigger action plan is based on a – therefore mutual – recognition of threats and opportunities at the level of practicing professionals (micro-governance) across the functional areas, and hence the broad stakeholder frontiers of the participating organisations. Thirdly, as discussed above, meeting these challenges is likely to require adaptations in organisational meso-governance arrangements. Finally, and leading back to the first step, any changes in meso-governance arrangements are likely to require collective (macro-governance) action. The action plan embodies and indeed employs the adage 'move alone move fast, move together move far'.

Rapid recent economic growth in Ethiopia makes micro-economic and micro-governance challenges and opportunities significantly more visible than is perhaps the case in more mature transitional economies such as Poland. Real gross domestic product (GDP) growth in Ethiopia averaged 10.9% between 2004 and 2014 (IMF 2015). If it continues its current trajectory, this may lift the country from being the second poorest in the world in 2000 to becoming a middle-income country by 2025 (World Bank 2015). The capital, Addis Ababa, is also home to one of the largest expatriate communities in the world, the African Union and various UN regional agencies. Yet, there is currently no internationally accredited tertiary medical facility in the country.

There are 8 established core (public) university hospital organisations in the country, most dating from the early post-colonial period and in most cases established with intensive human capital as well as financial capital support, but they have struggled to respond to opportunities. Over recent decades, public and aid partner budgets have prioritized universal access to essential primary care services and are likely to continue to do so (Wang 2016). As a result, private

2 Informal discussions suggested that, as early as 1963, various senior medical academics across sub-Saharan Africa, included members from Ethiopia, had already attempted to launch not only post-colonial national medical education councils or 'Colleges' but also a continent-wide 'conference of councils'.

(formal and informal) out-of-pocket spending remains the largest source of financing to the sector in general and specialized medicine more specifically. However, without even public *enterprise* status, normalizing and leveraging this cash flow for investment purposes faces severe obstacles (MOH 2017), nor are these opportunities and threats abstract in Ethiopia. A highly credible consortium of Ethiopian-American physicians is entering the market with a 'Medical City' investment in Addis Ababa[3]. The feasibility of the investment was studied and approved on a commercial basis. Phase 1 involves approximately US $100 million for a 300-bed tertiary hospital which is expected to start operating in 2021[4]. Later phases are expected to include a medical faculty and greater participation in medical education and research. Critically, the investment also includes a very long-term concessional land lease by the Government of Ethiopia.

Meso-governance reforms are therefore once again coming into view because alternatives, and particularly numerous so-called public-private partnership initiatives in specialized medicine, have had mixed results over the last decade (HEPCAPS2 2015). Few initiatives have sustained their operations beyond heavily subsidized start-up periods. Public/private initiatives have focused instead on administrative solutions and public contracts to private operators rather than any recognition of the long-term reality and importance of out-of-pocket financing sources for specialized medicine as a whole, and the likely continued prioritization of universal access to essential primary care services through available collective financing sources (MOH 2015). Attention in the investment-trigger action plan therefore shifts towards so-called 'blended finance' solutions in terms of attracting blends of public and private, profit and non-profit (or 'impact') investment capital. But how this may progress is yet unclear. On the one hand, the term itself is only recently gaining favour in public (development) finance institutions, many of whose internal systems are ill-prepared for a return after several decades, however partially or modestly, to financial analyses of therefore *public purpose* rather than *public* investments (OECD 2018); on the other hand, without first meso-governance reforms, *public purpose* institutions may not evolve into a legal and political-economic form able to agnostically combine public, private, profit and non-profit stakeholders, resources and equity stakes.

The initial response of the public university hospitals and health and education sector authorities to the 'threat' of a highly qualified and competitive new entrant therefore appears positive. Experience in Thailand also supports this positive view. Private investments may put increasing pressure on other (public) university hospitals, both in terms of personnel and client defections, but, through long-term and continued participative policy dialogue processes, it is possible to keep large and diversified stakeholder groups together towards long-term societal, and indeed professional body, goals (Pitakdumrongkit 2017). In a rapidly growing population and economy such as Ethiopia, one medium-size international standard university hospital organisation is never going to be enough. On the contrary, and taking the excuse of writing this paper during the World Cup, if governance is "the rules of the game", it is only important, also to the players and teams themselves, that dynamic leagues are created wherein every team has a good chance of winning matches, and even occasional championships, and that all drive each other to constantly higher quality levels of performance. Strategic meta network structure and only tactical intervention in human and capital infrastructure become interesting. If 'health systems' networks do not examine themselves and adapt to an information age; fans may ultimately switch to other sports and (information) channels.

Conclusion

The governance and finance of university hospital organisations can certainly be complicated, but they are not impenetrable. While these institutions are or may become ancient, they are not unchanging, nor, although their mission is perhaps to extend our fundamental understanding of the human condition, are they immune to the humbler problems of good housekeeping. However, a lack of international comparative data and analyses hinders dialogue in countries looking to confront challenges or opportunities in the sector on the occasions that do arise.

This paper presents an approach to comparing university hospital organisations' governance and finance that developed under some time pressure but has proven to be useful in two quite contrasting contexts and in terms of addressing both challenges and opportunities. However, this approach re-frames university hospital organisations as boundary spanning hubs in constantly adapting and evolving professional (supply-side) networks for the dissemination, development and delivery of high-quality and evidence-based professional health and well-being services and information.

How these networks will further evolve in either Poland, Ethiopia or elsewhere is difficult to predict, but what is clear is that far more detailed analyses of these ancient, internationally co-operating institutions - which today dominate cityscapes as cathedrals once dominated those of the medieval world - are needed and timely.

Biography

(Michael) Grant Rhodes is a former World Bank senior economist and, since 2010, freelance researcher and consultant in public finance management and policy related issues in the health and education sectors, or – depending on your view after reading this paper - human information network industries and services.

3 http://ethioamericandoctors.com/. Critically, this investment also includes a substantial long-term human capital commitment by the participating physicians, thus suggesting a more 'social enterprise'.

4 Formulation period discussion suggests potential board level interest to participate in any future council for university hospitals and medical education.

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Geneva: hospitals, state and university join forces for outstanding treatment and care

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ABSTRACT: In Geneva, the university hospitals, the University's Faculty of Medicine and the State form a trio of partners, each of which guarantees an exceptional level of care to the local population, as well as high-quality medical research and cutting-edge medical training. This article presents the system of governance in place between the three institutions and highlights the keys to their success in a context of close collaboration, shared responsibility and regular interaction. It draws parallels between the structure of the HUG's senior governance and those of other Swiss university hospitals, for a closer look at the potential for optimization in each one of them.

Switzerland has five university hospitals[1], and when it comes to activity volume, Geneva University Hospitals (HUG) are in the lead. They represent ten public care institutions, and their mission is threefold: firstly, to provide treatment in all medical disciplines to a community of some 500,000 people in the Canton of Geneva as well as the population of the France-Vaud-Geneva area; secondly, to help train doctors and health professionals; and, thirdly, to do medical and nursing research.

The HUG is Switzerland's leading center for influenza and emerging viral infections, childhood liver disease and pediatric liver transplantation. It is a World Health Organization (WHO) collaborating centre in seven fields.

In 2017, with their 11,560 employees, the hospitals welcomed 63,000 hospitalized patients and handled 118,000 emergencies, over a million outpatient consultations, 27,041 surgeries and 4,182 births. In addition, there are currently 945 doctors, 2,230 interns and 203 apprentices in training at the HUG.

The HUG collaborates closely on various training and research projects with the University of Geneva Faculty of Medicine, WHO, Lausanne University Hospital, the EPFL research institute, the CERN and other key players in Lake Geneva's *Health Valley*. The hospitals' annual budget is 1.9 billion Swiss francs, and their revenue comes from medical revenues and specific income (54% in 2016) as well as a grant from the State of Geneva.

1 For more information : www.hug-ge.ch and in particular https://www.hug-ge.ch/faits-et-chiffres

Close cooperation with the State

The HUG have a public medical facility status and function as an autonomous public institution.

They come under the supervision of the Geneva State Council, specifically the Department of Employment and Health (DES), and work in close contact with the Directorate-General of Health (DGS) to ensure each facility is properly accounted for as far as the public policy is concerned.

Since 2008, their partnership with the State of Geneva has been governed by a four-year service contract, which describes each party's role and serves as a basis for determining the grant. The contract is drawn up by the DGS based on the hypothetical changes to health care needs outlined in cantonal health planning. It also contains quantified targets and KPIs to be met by the institution. The most recent service contract covers the years 2016 to 2019.

The State at the highest level of the HUG

The HUG's Board of Directors is appointed by the Geneva State Council. It makes senior strategic decisions and tackles key topics such as care policy, budgets and accounts, employee status and the strategic plan. Swiss law on public medical institutions stipulates that directors must be appointed by the Grand Council (the Parliament) and the State Council, and chosen on the basis of their skills and/or experience in the fields of health policy and care, management and hospital life.

It also specifies that the board should be made up of the State Councilor in charge of the department, a member of each political party represented on the Grand Council, six members appointed by the State Council and two members representing: 1) the department in charge of health care in the Canton of Vaud and 2) the County Councils of the bordering French departments. The Chair of the Canton of Geneva Doctors, Association and three members elected by the HUG staff complete this 20-member council.

Reflections on the State's governance role

Clearly, there are very close ties between the State and the HUG. Of course, the substantial weight of the public subsidy, helps explain this. For this close connection to be productive, regular dialogue takes place between the cantonal health authorities and the hospitals' governing bodies. Mutual trust is essential and guarantees the hospitals' smooth operation. But this does not prevent the question of the HUG's independence and objectivity from being regularly raised in political debates, with differing opinions, and rightly so.

For us, it is important to note that a certain level of independence is always required, given the highly specialized nature of our medical work and the speed of technological developments, which a political parliament has neither the means nor the responsiveness to handle. On the other hand, certain decisions, investments and hospital planning arrangements have implications that go beyond cantonal borders and have to be managed at the regional or national level. For example, the Lake Geneva area has fifteen or so French-speaking university centers, and regular collaborations have been taking place between Vaud and Geneva since the 1990s. There is also highly specialized medicine, which requires the distribution of responsibilities across the most demanding medical sectors at the national level. This means that every university hospital needs to be able to make quick decisions and act with great agility.

It is also worth pointing out that the government has a number of control mechanisms, which are applied when the authorities deem it necessary, and which judiciously act as safeguards. Here we would like to talk about parliamentary motions and questions, and recourse to the Court of Auditors.

Other governance models exist in Switzerland. For example, Lausanne University Hospital (CHUV) is a State service and therefore falls under the exclusive authority of the State Councilor heading the Department of Health and Social Action. Some might say that this model could potentially prove problematic, "since the Canton finances part of the care and decides how this money is spent within the CHUV framework"[2], which can lead to conflicts of interest.

At the other extreme of governance models, Berne's Insel Gruppe hospitals have opted for a non-political, professional board made up of eight members. Basel University Hospital also has an apolitical ten-member council, with the exception of one national councilor. As for Zurich University Hospital, its board has between five and seven members elected by the State Council and the Grand Council. The Canton also has a representative on the board who is neither the Head of Health nor the State Councilor. The members are chosen for their ability to work together and represent State interests in the fields of hospital management, business conduct, medicine, law, finance, HR and communication.

Geneva falls somewhere in the middle of these different models. Its law provides for the participation of many sectors of society, which is why this council is so important when compared to the rather restrictive practices of modern governance. But the law also says that its members must have proven skills in the fields of health care and hospital management, which is not always easy to find in eligible circles. Ultimately, it has opted for strong political representation, including the presence of the State Councilor in charge of health.

Excellent relations with the University

Geneva has developed a particularly harmonious and collaborative partnership between the University's Faculty of Medicine and its University Hospitals. This has resulted in a work climate that is very conducive to research and clinical activity, and is the envy of several other cantons. It is the joint effort and commitment to providing high-level training, pursuing cutting-edge biomedical research and delivering high-quality local care that has laid the foundations for this collaboration, and been the basis for its growth ever since. Many translational research projects, allowing university researchers to access patients and clinical materials, could not have been made possible without this context of partnership.

One of the key foundations of this collaborative approach is the 2011 regulation on hospital-university collaboration and teaching faculty status, which sets the framework for relations between the two institutions. A convention stipulates the rules of this approach, structures the implementation of the two institutions' shared strategic goals and sets the rules for collaboration between Swiss universities and university hospital networks. It also specifies the rights and responsibilities of the University's Faculty of Medicine with respect to the HUG and vice versa, as well as their reciprocal benefits and commitments.

This collaboration means that professors of medicine who belong to the clinical medicine section simultaneously perform a clinical activity at the HUG and a teaching and research function at the University. As a result, they are recruited and hired jointly by the two institutions based on mutually agreed terms of reference, which determine their hospital, teaching and research duties together with their management and administration tasks.

Intellectual property on creations and research and the allocation of associated income are evenly distributed between the hospital and the university, after deduction of the share owed to the professional concerned. The

2 https://blogs.letemps.ch/claudine-amstein/2017/09/07/le-chuv-merite-une-gouvernance-moderne/

time dedicated to the tasks related to one or the other of the institutions is also fairly flexible, based mainly on the requirements of the projects and tasks concerned. They are remunerated by both institutions, in proportion to their work in each one. University-hospital professors can also devote a small part of their time to third-party or private activities.

The collaboration framework also stipulates some employment terms and conditions, such as gender equality, absence of discrimination, academic freedom and publicity rights issues.

In this two-pronged system, the procedures for appointing, promoting or renewing the professors' terms of office are obviously shared. The Rector of the University and the HUG Board of Directors therefore act as appointing authorities following recommendations from various joint committees, which may also include external bodies such as the Canton of Geneva Doctors, Association.

Another distinctive feature of this close cooperation is that the Dean of the Faculty of Medicine sits on the HUG Board of Directors. He also acts as Director of education and research, responsible - among other things - for the implementation of pre-graduate and post-graduate training, in agreement with the HUG's Medical Director.

A shared philanthropic approach

The close relationship between the HUG and the University of Geneva is also illustrated in a completely different way, through legacies and donations, with the two institutions sharing the same philanthropic approach. The Private Foundation collects donations and legacies for the HUG and the Faculty of Medicine and funds research projects conducted by them. More than 2 million Swiss francs are distributed each year. In a reciprocal approach, the funds allocated to the Faculty of Medicine by organizations such as the Louis-Jeantet Foundation of Medicine also benefit the projects of the other institution and vice versa.

This excellent relationship provides immense benefits to the hospital-university partnership. It helps build a common vision of the objectives and resources that need to be made available to clinical and scientific projects. This valuable partnership has come by leaps and bounds in the last decade; its maintenance and development should be a priority for the future, given the proven benefits of this approach. For example, in recent years, projects have included the hugely ambitious development of Translational research centre in oncohaematology and the Geneva Centre for emerging viral diseases.

As we can see from these two accounts, the State, the University's Faculty of Medicine and the HUG have successfully managed to develop a governance partnership that works smoothly and benefits patients and science alike. As with anything, there is always room for improvement, so the entities concerned regularly reflect on new possibilities. In fact, the HUG Board of Directors started brainstorming last year to define the conditions for optimizing its operation.

Biographies

Bertrand Levrat has been General Director of the Geneva University Hospitals since 2013 and President of the Swiss University Medicine Association since 2016. A former lawyer, he worked at the International Committee of the Red Cross (1994 -2001), as Deputy Director of Geneva's social governmental body DGSA (2001 – 2004) and as General Director of General Hospice (2004 – 2013).

Henri Bounameaux, an internist and vascular medicine specialist, has been Chairman of the Department of Internal Medicine of the Geneva University Hospitals (HUG) from 2002-2010 and is Dean of the Faculty of Medicine and Director of Education and Research at the HUG since 2011.

The International Hospital Federation (IHF) is committed to advancing the UHC agenda throughout the world, giving billions of people better access to critical hospital care and basic health services when needed, no matter their income or geographic location in the world. Since its establishment in 1929, the IHF recognizes the essential role of hospitals and health care organizations in providing health care, supporting health services and offering education to health care providers as a critical partner in during the drive for UHC throughout the world.

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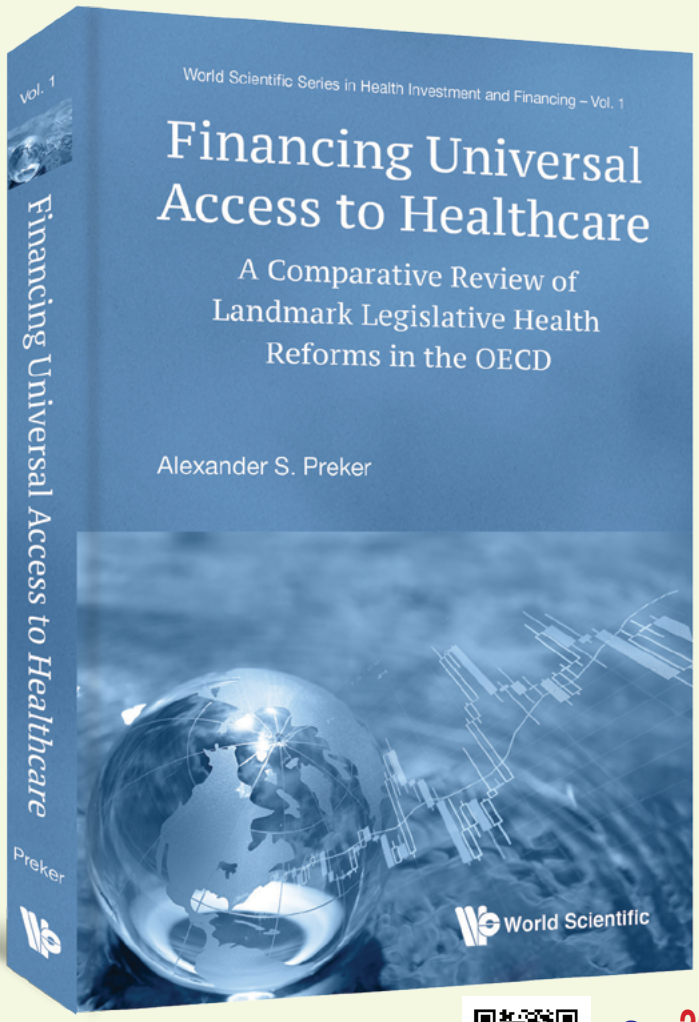
Eric de Roodenbeke, Executive Director
International Hospital Federation Geneva 2018



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Alexander S Preker is a globally recognized expert on health systems development and health policy reform. He has been an advisor to the Ministers of Health and senior policy makers in countries throughout the world on capital investment in the health sector, health financing, health insurance, public-private partnerships and the political process of healthcare reform.

Currently, Professor Preker is an Executive Scholar and Adjunct Associate Professor at Columbia University, New York University and the Icahn School of Medicine at Mt. Sinai in New York.

The role of governance in university hospitals of emerging markets – A case study

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ABSTRACT: The role of Governance has a long track record of implementation in the OECD and emerged markets. Through decades of development, especially in the context of universities and academic medical institutions, governance has been shaped and implemented with key principles embedded in structures that are effective and relevant to the institution. Over a shorter period, emerging markets have adopted governance principles relevant to their institutions based on their country's context, institutional objectives, board leadership and strategic plan. This paper addresses key governance roles and implementation issues based on actual experience at both governance and executive levels. These key lessons learned can be of value to emerging market university hospitals and academic health institutions (which do research) to either strengthen existing boards or set up new governance structures.

Introduction

This case study is based on experience gained from operating and governing large medical facilities, including university hospitals and academic medical centers in emerging markets, including Kenya, Uganda, Tanzania, Ivory Coast, Pakistan, India, Afghanistan, UAE, Panama, Brazil, Chile, Mexico, Lebanon, Singapore and Malaysia. It provides a strategic and pragmatic analysis of key issues and challenges faced by governance boards and offers a framework to address them.

Emerging Market Issues

Perception of governance

The current perception, importance and practice of governance in University Hospitals in emerging markets is varied. Institutional implementation varies from robust governance structures to rudimentary structures to no formal structures. Some successful university systems have adapted better practices to their environments. There is ample evidence of the value of formalized governance in ensuring high performance in university hospitals.

Unique Challenges for University Hospitals

University hospitals in emerging markets have unique opportunities and challenges. They serve as academic hubs that attract experienced medical specialists and health practitioners, where both an academic and a health delivery mission is accomplished. Some also engage in research relevant to the populations they serve (in academic medical centers). Usually, board certified medical specialists acclimated to, or graduated from, OECD health systems and universities and repatriated medical specialists will seek to join these institutions. They provide the range of specialties, access to specialized medical equipment and access to specialized medical service provision that medical staff want as their practice environment. Due to the specialized nature of services these hospitals provide and their accompanying costs, they face challenges involving higher pricing structures.

Defining University Hospitals

While there may be local requirements in each country regarding the registration, certification or accreditation of university hospitals, these institutions are best served by ensuring key criteria are met in order that they may position themselves as such. There are many cases of hospitals representing themselves as *university hospitals* without the requisite credentials, competencies or scale to do so.

These criteria should include:

- A University hospital that provides a range of medical specialties that treats the population, has a wide number of tertiary and/or quaternary services, has a scale in excess of 200 beds for inpatients and ideally also has community outreach services including medical clinics, ambulatory surgical centers, diagnostic centers or community-based services.

- Affiliation with, or ownership by, a University that is registered in the country as an accredited academic institution and offers Medical Sciences, Nursing, Undergraduate, Postgraduate Medical Education and/or Fellowship programs.
- Medical, nursing and allied health interns use the hospital as a primary training facility.

Funding academic programs – governance role

A funding and service provision mechanism followed by many university hospitals is the development of multiple "tracks" for medical specialists on the medical staff roster. These multiple track appointments establish mechanisms to "protect the time" of medical specialists so they can practice in each of their three primary roles of service delivery, education and research. A key governance role of a University Hospital Board is to establish policies to enable the hospital to pursue its multiple roles and align incentives to achieve its goals, one effective method of which is the development of *faculty compensation plans*. The alignment of incentives to ensure the effective pursuit of this tri-partite role is a key measure of success of the hospital and also the University.

A key funding issue faced by many university hospitals is the reliance on health services delivery surplus revenues to fund academic programs, academic tracks of the medical staff, undergraduate medical interns in training, postgraduate medical education interns and nursing academic programs. Since many university hospitals are beneficiaries of these interns when they graduate, the costs associated with these academic programs are borne by the hospitals themselves. The Board should provide clear direction on how university hospital revenues should fund academic and research programs, since cash flows from hospital revenues need to fund hospital-based programs, including capital projects, and there is a natural tension between supporting university funding needs and hospital funding needs.

The role of Private Practitioners

A key governance decision of university hospitals is the role of private practitioners and the physician involvement model. Full time medical staff who also teach may be complemented by a pool of private practitioners who will need to be provided with formal privileges to practice in the hospital after they get approved with their credentials. A "closed model" implies only full time hospital medical staff can practice; a "mixed model" implies both full time and private practitioners can practice. Mixed models enable patients to have a wider access to specialties and also allows practitioners access to specialized hospital services. If a key governance goal is to provide the patient population full access to a range of specialties, then mixed models achieve that more effectively.

Many emerging market countries face difficulties in establishing policies and regulating the *dual practice* of public sector medical specialists who work in public sector facilities and also practice in private facilities. Due to their complex tertiary services provision, University hospitals will attract many specialists from the public sector, especially those that have dual roles in clinical services and academic training. The governing board should provide Management with oversight and direction on the recruitment of dual practice specialists.

Accreditation

Unless university hospital accreditation is a requirement in the country due to regulatory or government payer requirements, this is a key governance decision to be made. University hospitals provide complex care for patients and are hubs for the academic preparation of medical, nursing and allied health staff. There is a high expectation from the population they serve that their services and academic programs are of a standard and quality operating at the highest levels in the country. Accreditation by a recognized (international or regional) body is an important consideration to be made by a Board, if it is to maintain high standards of quality and safety while demonstrating to the community its trust in the hospital is well placed.

Organizing for Effective Governance

University hospitals are most effectively managed by a *Board of Trustees or Board of Directors*. While the distinction between for-profit and not-for-profit Boards are many, the key distinction is that a not-for-profit board has *Trustees* who oversee governance and act as fiduciary agents of the University or Hospital and ensure all surplus funds flow into institutional programs. Private for profit university hospitals have Boards of *Directors* who act as fiduciary agents of the institution in a governance role and allocate surplus funds to shareholders based on resolutions passed by the directors. While each institution will organize its own governance structure, effective mechanisms in emerging markets should, at a minimum, include the following:

- University Hospital reporting through the hospital's CEO or the hospital system group's CEO to the *University* Board of Trustees or Directors. This would work if the university hospital is owned by the University.
- University Hospital reporting through the hospital's CEO or the hospital system group's CEO to the *University Hospital* Board of Trustees or Directors. This would work if the university hospital is affiliated with a University as a teaching hospital.
- Public sector university hospital which has been provided autonomy (depending on range of autonomy from *partial* to *full*) reporting through the hospital's CEO to the autonomous hospital board.

The role of Committees

Board oversight has significant impact on a university hospital and is best implemented in university hospitals through Board appointed committees which have clearly defined and communicated mandates and committed members. Each of the committees should have a Board member (trustee or director) who chairs the committee and implements governance matters on the Board's behalf. Ideally, these committees should meet prior to regularly scheduled Board meetings and committee chairs should provide reports and resolutions to the Board. Hospital management is required to prepare regular reports for the committees and attend committee meetings as and when

required. Effective meetings can be conducted either in person or via video conference. The key governance committees would be at least the following for a University Hospital:

- *Finance* – Oversight of annual and strategic plans and approval of all budgets, including operating and capital budgets. This committee should also approve the long term strategic plan and strategic direction, which also need to be updated annually or bi-annually on a rolling basis. This is arguably one of the three most important roles of the Board. Oversight of Hospital audits, auditors and internal audits is recommended as well, to ensure effective financial systems are in place and manage risks resulting from fraud, waste or abuse.
- *Capital Projects* – Oversight and approval of all key capital commitments, including new services and facilities. Financial viability, feasibility and impact assessment studies should be a regular oversight process for the committee before any new significant project is undertaken.
- *Human Resources* – Oversight and approval of all key HR governance issues; the recruitment of the chief executive officer is a key governance role (and probably its most important contribution).

Membership

Practices that are effective in emerging markets include membership on a Board attracting a wide base of leaders and stakeholders from the community, including: current or past university presidents or deans, community leaders in civil society, hospital or health care delivery chief executives, chief corporate executives and senior executives from affiliated universities. Involvement of the patients' voice in a Board will provide a patients' perspective.

Engaging the Board

Governance effectiveness is significantly enhanced with a fully engaged Board. While Boards have representation by senior executives from both academic and health services domains, the process of induction, education and engagement in the culture of the university hospital is important and so is keeping the Board informed on current practices. While Board members may be from hospital and academic institutions, many will not be involved in current field developments and will need to be updated on these by hospital leadership.

Governing versus management

A critical part of Board leadership (chairperson) is to ensure governance will function in its role and delegate management authority to hospital leadership.

Many countries in emerging markets recruit prominent medical specialists in Chief Executive Officer positions. These CEOs are not trained as hospital executives and Boards should be encouraged to (a) recruit CEOs based on competency and skill at the time of recruitment (b) ensure current CEOs get appropriate hospital management and leadership competency where it is lacking and (c) if medical specialists as CEOs is the standard practice, then these CEO's should also have appropriate hospital management credentials.

Performance Management

The Board of the University Hospital has an obligation and opportunity to steer performance to ensure its strategic objectives are met. There are multiple tools that can be used. The use of *Key Performance Indicators* in key hospital domains is a very effective tool. These domains should include, at a minimum: patient safety and quality, patient engagement and satisfaction, employee and medical staff engagement, financial sustainability and community engagement.

Models of Delivery and Strategic Planning

One of the key governance responsibilities with significant impact is the provision of strategic direction to the University Hospital leadership and its overall model of delivery. This has long term implications, since the hospital will define its own plan and *model of delivery* – a process that will span at least a decade. The key decisions of the Board will include the following:

1. Operate a single university hospital owned by or affiliated with a University and providing a broad range of tertiary and quaternary services for a defined population.
2. Operate a single university hospital with a range of ambulatory centers in the community offering a range of services and diagnostic centers.
3. Operate multiple hospitals (both University and General Hospitals) and ambulatory centers in multiple geographic locations.
4. Operate an integrated delivery system with a range of university and general hospitals and ambulatory and diagnostic services providing a continuum of care in several geographic locations.

Conclusion

The role of governance is key in emerging markets. University hospitals can adapt better governance practices to their environment in order to enable their institutions to be more effective. There are several methods of organization that are shown to be effective and can be used as a platform for governance practice or as a starting point on a roadmap for improved governance practice.

Biography

Salim Hasham is *Executive Chairman of Mediheal Group*, based in East Africa. Prior to this, he served as *Vice President Health Services for Aga Khan University* and was responsible for the university's global health systems enterprise in East Africa, Pakistan and Afghanistan. He has also served as *Senior Vice President - Global Services for Johns Hopkins Medicine International* and was responsible for managing its global strategy and service delivery with oversight of Chief Executives in eight countries including large hospitals and university hospitals. Mr. Hasham has also served as *President and CEO of Hawaii Medical Centers*, a two-hospital and skilled nursing facility system in Hawaii, USA.

International Hospital Federation

World Hospitals and Health Services

The Official Journal of the International Hospital Federation

Driving the value of hospitals and service delivery: an OECD perspective

Exploring variations in hospital performance - an international perspective

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ABSTRACT: National efforts to profile hospital quality have been transitioning from a focus on measuring health care processes to the assessment of outcomes in order to provide a broader perspective on organizational performance. The OECD has supported this transition through the publication of a number of national hospital performance indicators for member countries. One such measure is the 30-day Acute Myocardial Infarction (AMI) mortality rate. While the mortality rates for AMI patients are decreasing over time, significant international variation persists. Recent OECD work also shows large performance variation on the hospital level within countries.Many countries are beginning to shift towards integrated systems of care, encompassing care before, during and after hospitalization, to improve quality outcomes for both hospitals and patients.

Hospitals are key components of health systems and important targets in national efforts to improve the overall system performance (Krumholz et al., 2013; Bucholz et al., 2016). Hospital CEOs are often on the front line of these improvement efforts, and the American College of Healthcare Executives has established that hospital CEOs should be evaluated on a series of organization objectives, including a range of quality and performance indicators at the hospital or health system level (American College of Healthcare Executives, 2003). But how much impact do hospital CEOs have on hospital performance and how much responsibility should they bear?

Empirical evidence confirms that performance can vary widely across hospitals. For example, in terms of hospital outcomes, measures such as acute myocardial infarction (AMI) mortality have been shown to vary across hospital systems and individual hospitals within a system. Prior work on hospital performance shows that a large proportion of AMI mortality variation is not explained by variables such as patient factors, system factors and hospital specific factors, thus suggesting other factors may be important. What are these variables, and who is in the best position to influence them? This paper describes the OECD's approach to international hospital performance measurement as well as recent work undertaken to better understand international variation in hospital performance including the driving factors.

Why measure performance?

Performance measurement starts with a desire for greater health care value. Along with cost, fair access to quality (timely, effective, safe and responsive) care is a fundamental dimension of high value care. Measuring performance can help identify areas of low value and target areas for improvement. Evidence of suboptimal care quality and patient safety, for example, has pushed countries to introduce reforms to make healthcare safer and more effective (OECD, 2010). In recent years, policy makers across OECD countries have shown an increasing interest in quality, due to rising costs, aging populations, market failures, medical errors, lack of accountability and inequalities within systems (Arah et al., 2006).

What is the role of the OECD?

The Organization for Economic Cooperation and Development (OECD) has long led international health system performance measurement through the collection and publication of quality indicators. The current suite of indicators covers the areas of primary care, prevention, acute care and the care of chronic conditions.

These indicators are guided by a conceptual framework developed by the OECD Health Care Quality and Outcomes (HCQO) group and based on five dimensions: effectiveness, safety, patient centeredness (or responsiveness), accessibility and cost (expenditure). By enabling cross-national comparisons and international benchmarking, this framework supports health systems and hospitals in transitioning from measurement to interpretation to quality improvement action, while also stimulating cross-national learning.

AMI-mortality

The OECD currently collects a number of acute care hospital performance measures on a national level. The rate of mortality within 30 days of patients being admitted to a hospital after AMI is one key measure. This measure reflects a number of factors,

including the timely transport of patients and the use of effective medical interventions (OECD, 2015).

The data show that AMI mortality is decreasing overall among OECD countries, with improvements reflecting better and more reliable care processes; however, this reduction is not uniform across all countries (see Figure 1). AMI mortality rates also show high variation across countries. The average rate in 2015 was 7.4% across all OECD countries; but there is up to an eightfold difference between the highest (28.1% in Mexico) and lowest (3.7% in Norway) rates, even after taking into account differences in the casemix (age and gender profile).

These national level comparisons have proven to be informative for countries. For example, data has consistently demonstrated that Mexico has the highest mortality rate among OECD countries (OECD, 2018). This situation has been recognised in Mexico and led to policy action in recent years whereby the Mexico City Government and the National Institute of Cardiology established a pharmaco-invasive reperfusion treatment programme comprised of a care network at all levels (Martínez-Sánchez et al., 2017). The programme is implemented across secondary and tertiary hospitals and projects an estimated 30% reduction in mortality coupled with a 333.8 million pesos ($15.7 million) net benefit over the next 10 years (Secretaría de Salud, 2017).

While these national level comparisons can be useful and informative, AMI 30-day mortality variations at the national level may mask important variations within countries. (OECD, 2017).

Variability in hospital-level performance

International work is moving beyond the consideration of health systems or national level variations in hospital performance to understand variations within countries and enable more meaningful cross-country comparisons. Studies on a regional level show considerable heterogeneity in patient outcomes, care processes, emergency services, resource use and organization (OECD, 2015). For instance, cardiac arrest survival ranges from 2% to 12% depending on the place of residence in the United Kingdom (Perkins and Cooke, 2012). Policy makers are also increasing their focus on reducing performance variation across hospitals within their systems, not only lifting overall care standards but also minimizing the widespread differences in care access and quality that are evident within health systems (OECD, 2015).

What have other studies discovered?

A number of studies have examined hospital-level performance variation in 30-day AMI mortality through the role of various hospital characteristics, including: teaching status, hospital volume, location, ownership type and specialist services (Navathe et al., 2013; Capewell et al., 2006; Hong and Kang 2015; Ukawa, Ikai and Imanaka 2014; Birkhead, Weston and Lowe 2006). For instance, Bertomeu et al. found that AMI mortality is associated with hospital characteristics, types of services offered and whether treatments were performed, while Birkhead et al. found significant associations between mortality, technical capacity and specialist care. Han et al. assessed various hospitals characteristics, including teaching status and ownership, and found an inverse association between mortality and volume, specialists and treatment. Contrary to these findings, Krumholz et al. found that characteristics such as number of beds, ownership, teaching status and technical capacity were not key drivers of performance variation. Overall, hospital structural factors show only moderate associations with risk standardized mortality rates (RSMRs), leaving much of the variation unexplained (Cherlin et al., 2012).

What is the OECD hospital performance project?

Building on formative international initiatives such as the ECHO and EuroHOPE Projects, in 2015, the OECD launched the Hospital Performance Project to better understand performance across countries and strengthen international comparisons. Following two years of methodological work, data on hospital-level adjusted 30-day AMI RSMRs were collected for over 3,000 hospitals across 12 OECD member countries for the years 2013 to 2015. RSMR calculations were made using two approaches; one using AMI hospital admissions as the denominator (admission-based approach) and the other using an entire AMI episode, including transfers and death outside the hospital, (patient-based approach), as the denominator. OECD methodology experts expressed a strong preference for the use of a patient-based approach, as it includes all deaths regardless of location and takes a wider view of the hospital as part of the overall health system. Both measurements are collected and reported, as countries are not always able to make the necessary data linkages for a calculation of the patient-based approach.

A number of hospital characteristics were collected along with RSMR including: hospital ownership (public/private), presence of a catheter laboratory, location (urban/rural), teaching status and the volume of AMI admissions over the observation period.

The scope and scale of this data collection effort is groundbreaking, this being the first time hospital-level performance data have been collected and compared across OECD countries in America, Europe and Asia. Results were first published in the OECD's flagship publication *Health at a Glance 2017*. Hospital RSMR distribution by country is depicted in Figure 2. Countries are ranked according to the interquartile range, or the dispersion among the most common rates. From the figure, we can see that there is a marked AMI mortality rate variation not only across but also within countries. For instance, the difference between the upper and lower interquartile rates for Sweden is 1.8 deaths per 100 admissions, whereas it is 5.8 deaths per 100 admissions for Latvia, thus indicating significant variation in care across and within countries.

Understanding within-country performance variation

In order to better understand variations across hospitals, the OECD conducted an analysis on the impact of hospital characteristics on hospital-level performance using the data collected. Like previous studies, the results revealed a relatively limited role of hospital characteristics in explaining hospital variation, with a high AMI volume as the only factor associated with lower mortality. This relatively small impact may highlight the importance of other variables, such as organizational culture, found to be important in other studies (Bradley 2010), as well as some system level characteristics, such as systems of patient transfer, hospital financing and care consolidation.

How else could these distributions be interpreted? Rate variability within countries may be the result of policy differences. For instance, Sweden has a lower rate of within-country variation than Korea. In Sweden, a national quality improvement programme - including

public reporting, rapid diffusion of technology, use of evidence-based practice and a system of evaluating and reporting care quality and outcomes - is likely to have contributed to a reduced variation in patient hospital care after an AMI (Chung et al., p. 8). In Korea, the findings indicate a hospital variation trend based on location, with an increasing mortality rate corresponding to distance from urban areas (Hong and Kang, 2014).

What is being done to reduce variation?

Encouraged by evidence of better performance among hospitals with greater throughput, many countries are turning toward strategies based on the consolidation of services in order to improve hospital performance and reduce within-country variation. This consolidation also goes hand in hand with the establishment of care pathways. High-cost, high-expertise care is being consolidated in specialist units, and hospitals are being networked with other hospitals to provide services along care pathways in several OECD countries.

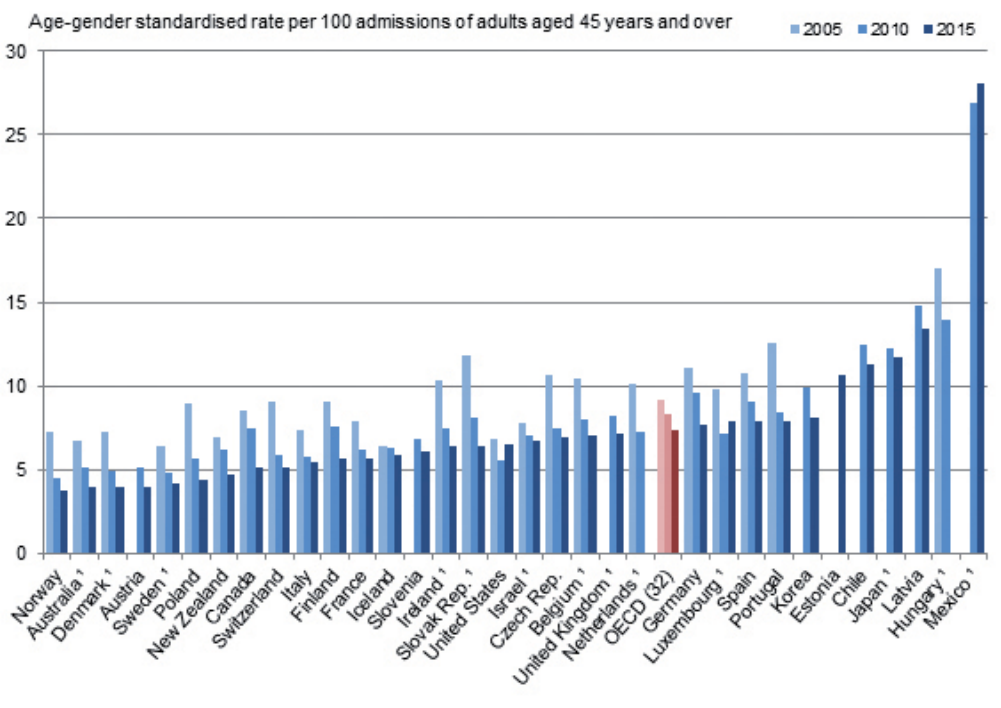
In Eastern Denmark, the implementation of a national reperfusion strategy has considerably changed the outcome for AMI patients by focusing efforts on pre-hospital services. This involves the collaboration of local hospitals, university clinics, EMS and military helicopters in using the same telemedicine system and field triage for STEMI patients. Ambulance services and trained personnel provide PPCI (a superior reperfusion strategy), ensuring patients are transferred alive directly to the centre and prepared for ongoing care, bypassing local hospitals by means of prehospital triage within recommended timelines (Clemmensen et al., 2013). In order to achieve this, the integrated system relies on several factors, including infrastructure, logistics, technology and close cooperation between the parties involved. The results have been encouraging leading to an all-time low 30-day AMI mortality rate of 5.7% (Clemmensen et al., 2013).

In 2002, Norway adopted a model based on service consolidation to improve performance. The main objective was better care coordination and follow-up during and following discharge from hospital to home by developing an integrated care system (Røsstad et al., 2013). Initial results show both cost and technical efficiency gains (Magnussen et al., 2007).

In the United States, one-third of AMI deaths occur during the post-discharge phase, underlining the importance of considering the impact of integrating pre- and post-care to improve hospital outcomes. Higher-performing hospitals engage in multidisciplinary case management services, ensure a follow-up plan prior to discharge, education for patients and families as well as communication between primary care physicians and hospitals (Cherlin et al., 2012). These hospitals effectively leveraged multidisciplinary teams and viewed discharge processes as “broad and inclusive, beginning the moment they met the patient and continuing after the patient was discharged” (Cherlin et al., 2012).

This transition toward care pathways mirrors a general move away

FIGURE 1: THIRTY-DAY AMI MORTALITY AFTER ADMISSION TO HOSPITAL BASED ON ADMISSION DATA, 2005 TO 2015 (OR NEAREST YEARS)



[1] Admissions resulting in a transfer are included.
Note: Three-year average for Iceland and Luxembourg.
Source: OECD Health Statistics 2018, http://dx.doi.org/10.1787/health-data-en.

from episodic care to continuous care of the individual. This requires an evolution in the position of hospitals from being at the top of the care chain, acting as the reference point and implicit care leader, to being an integral player in the overall care lifecycle of the health system.

Care pathways rely on a complex coordination across units, organizations and individuals. CEOs cannot be held accountable for events that occur before and after hospitalization if these processes are not under their responsibility.

Breaking Down Hospital Walls

Despite substantial investment in public reporting and increasing interest in hospital outcomes, we have little understanding of what truly influences these measures. By providing countries with an international context for considering variations in performance within their health systems, greater leverage will exist not only for lifting overall care standards but also minimizing any differences in care access and quality.

Continued improvement means appropriate measurements taking into account the entire care pathway. These measures must rely on data linking and the implementation of a strong data infrastructure.

Multidisciplinary involvement in the hospital setting has been linked to quality improvement for patients with chronic illnesses, increased patient satisfaction, improvement in core performance and improved adherence to evidence-based guidelines. It is imperative that we break down hospital walls to integrate patient care throughout their entire journey, not only for chronic but also acute diseases, in order to continue to improve patient outcomes. Countries are beginning to implement care systems that take into account the patients' setting before and after hospitalization and are experiencing favorable outcomes in the form of improved efficiency and reduced mortality rates.

Biographies

Tamara Ehler works as an intern for the Organization for Economic Co-operation and Development (OECD) in Paris. Her work focuses on hospital performance, more specifically, 30-day AMI rates as a quality indicator for hospitals. Prior to the OECD, Tamara worked on heart failure research at Toronto General Hospital. Tamara is currently completing her Master's Degree in Public Health at the École des Hautes Études en Santé Publique in Paris, France.

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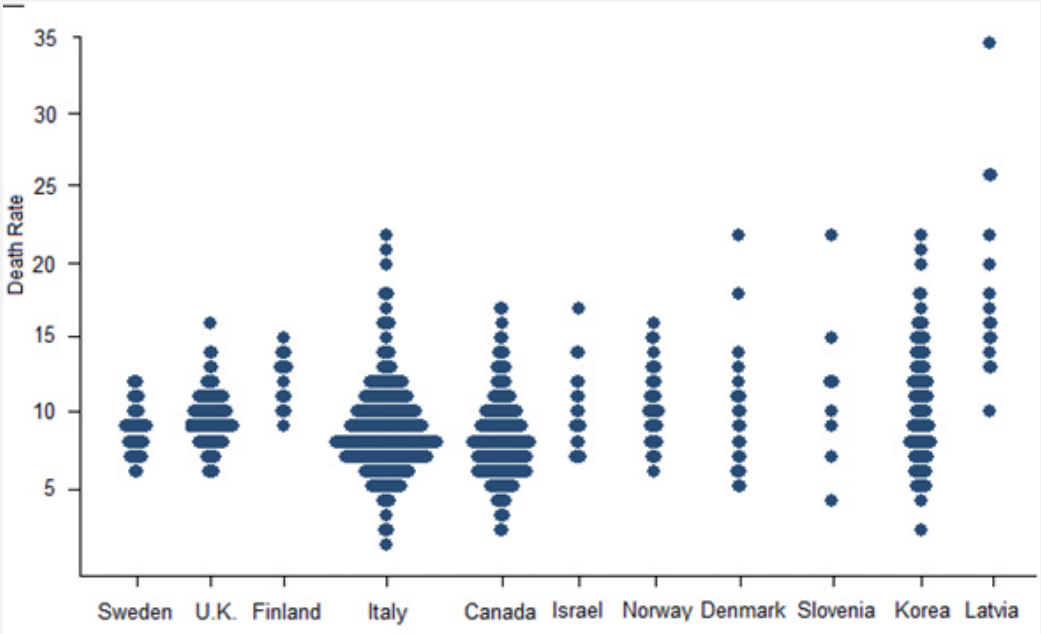
FIGURE 2: THIRTY-DAY AMI MORTALITY AFTER ADMISSION TO HOSPITAL FOR BASED ON LINKED DATA, 2013 TO 2015 (OR NEAREST YEARS)



The width of each line in the figure represents the number of hospitals (frequency) with the corresponding rate. The data is expressed as AMI 30-day RSMRs across hospitals ordered according to ascending dispersion levels measured by the interquartile range.

Source: OECD, Health at a Glance 2017, https://doi.org/10.1787/health_glance-2017-en

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Harnessing the voice of the patient from the ward to the boardroom

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ABSTRACT: A core objective of a healthcare organisation is to maximise the quality of care for every patient, but data on key quality dimensions of safety, effectiveness and people-centredness are not systematically captured from the patient's perspective. This means that governing bodies are basing decisions that determine success in a competitive marketplace on incomplete information. Addressing this requires routine measurement of outcomes and experiences from the patients themselves. The OECD's PaRIS initiative is helping to build the capacity of countries and organisations to capture the voice of the patient through validated, comparable indicators, but successful implementation means engaging front-line staff and patients, and integrating these metrics into existing information infrastructure.

Introduction

A core objective of any healthcare organisation is to maximise the health outcomes of the people in its care. To achieve this objective, organisations must strive to deliver the highest possible quality of care. Quality of care can be defined as "the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge" (Kelley and Hurst, 2006, p. 10). However, although in OECD countries around 10% of national income is spent on health care, it is remarkable how little is known about quality and the outcomes generated.

For healthcare providers, such as hospitals, quality of care can be distilled to three components: (i) patient safety, (ii) clinical effectiveness and (iii) responsiveness/people-centredness. When these are optimised for each patient every time, a healthcare organisation can be said to deliver high quality of care. How do providers know they are delivering high quality care and that this translates to good health outcomes? As it stands, most healthcare organisations – as well as health systems – do not properly and systematically measure the quality of their care and health outcomes achieved.

The problem with traditional performance measurement

Various ways of measuring quality have been deployed, including intervention rates, length of stay, adverse events[1], mortality and readmission. While these are important metrics, they fail to measure all dimensions of quality and capture what matters to patients over the entire care cycle.

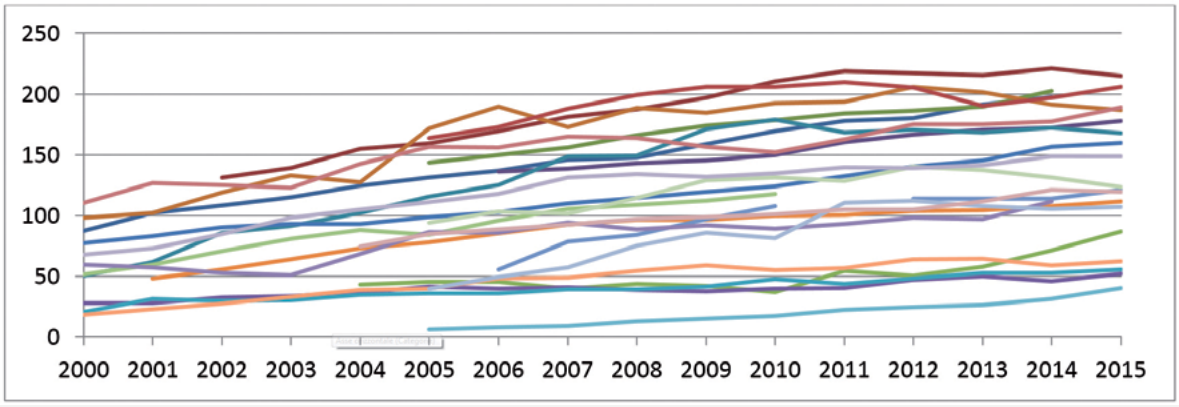
We often confuse outputs with outcomes

Measuring the number of interventions is common, but of limited use as far as quality is concerned. For example, the total knee replacement rate has risen in OECD countries over the past 15 years, but considerable (five-fold) variation exists between them (Figure 1). Similar differences can be observed *within* countries when one compares hospitals or geographic regions (OECD 2014). Such striking variation provokes questions about the value generated for patients and communities.

While combining these numbers with information on length of stay or cost, the data can inform us about the *technical* efficiency of how a procedure is performed, but very little about how successful a health system or organisation is in achieving its core objective. While readmissions or revision rates may shed some light on quality, they still don't reveal in which cases this painful, risky and expensive intervention results in what patients want - more function and less pain

1 Adverse events are incidents during care that result in patient harm. For a discussion on patient safety and harm, see Slawomirski, Auraaen and Klazinga, 2017.

FIGURE 1: TOTAL KNEE REPLACEMENT RATES PER 100,000 POPULATION IN 22 OECD COUNTRIES (2000-2015)



Source: OECD.stat

– nor which patients remain symptomatically unchanged or worse. Without measuring these outcomes from the patient's perspective, our view on performance is limited.

Patient-reported outcome measures (PROMs) can be used to collect these data, and an array of validated instruments is now available to objectively measure results of this and other interventions over time.

Mortality and survival statistics have their limits

In more aggressive pathologies, survival or mortality is often used to measure quality. Certainly, most people wish to avoid death, and it would be difficult to argue that patients with cancer, for example, do not place a high value on survival, but when these patients (and their families) are asked about what matters to them, it is clear that therapeutic 'success' entails more. Pain, function, independence and dignity are also important outcomes. Care that focuses on survival without also considering these other outcomes is not quality care. Yet, measuring performance and quality of cancer care rarely extends beyond comparing mortality (Hamdy et al., 2016; Donovan et al., 2016).

A key problem is that survival can lack sufficient nuance to differentiate between treatment modalities and/or providers. In recent years, differences in cancer mortality have converged across countries (Figure 2) as well as across individual providers (Gurria and Porter, 2017). While little separates the best from the rest on survival, the quality of care is rarely equal. Other outcomes need to be examined to see which patients are receiving optimal care. For example, men with prostate cancer value preserving erectile function and avoiding incontinence – outcomes on which the survival metric is silent, and which can only be detected using PROMs (Nag et al., 2018).

How do patients experience care?

The experience of care is an important part of quality for all patients, and especially those requiring complex, long-term treatment. A good experience means being treated with respect and compassion, being supported and listened to, care continuity, good communication and being involved in the decision making process. This means people-centred care, and is an important component of quality as an end in itself, in addition to a determinant of better clinical outcomes (Luxford et al., 2011).

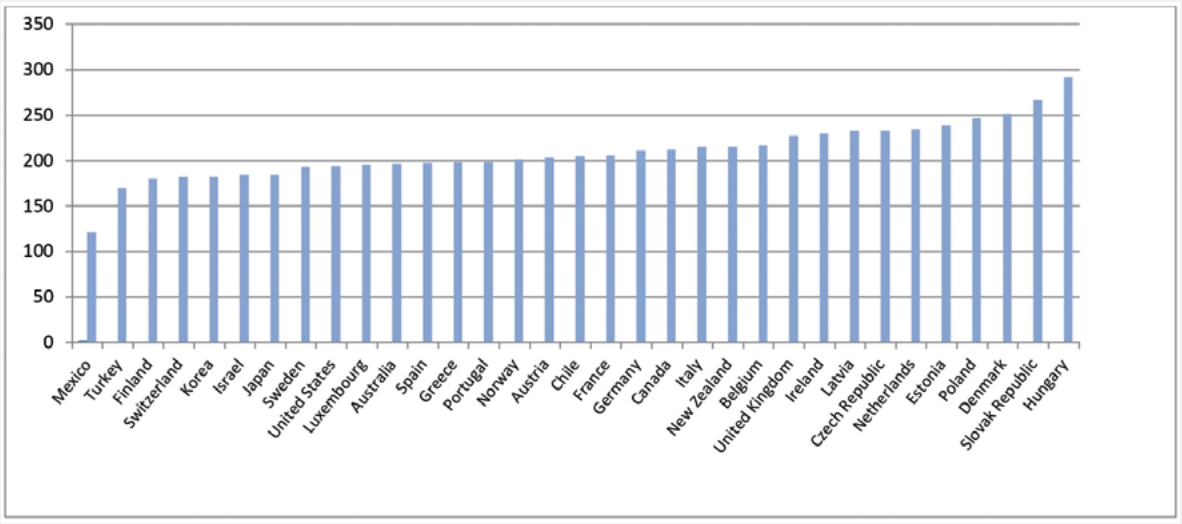
Considerable progress has been made, but patient experience is still not measured systematically, and its inclusion in performance frameworks is still the exception rather than the norm. Similar to PROMs, a range of validated and reliable patient-reported experience measures (PREMs) that capture far more than traditional satisfaction surveys are now available.

Measuring safety neglects the value of the patient's perspective

Patient safety is also rarely measured comprehensively. Traditionally, the occurrence and extent of harm are drawn from three sources: adverse event reporting systems, routine data and/or retrospective clinical record review (e.g. the Global Trigger Tool). However, these have key limitations, including the voluntary nature of incident reporting systems and the depth and accuracy of clinical coding, and they consider only the provider's perspective. These methods provide an incomplete picture of patient harm and safety across an organisation (OECD, 2018).

What's missing is the patient, who is present the entire time. An adverse event unfolds and can provide a unique and valuable perspective on the incident cascade - what went wrong, when and why? This granularity cannot be gleaned with the traditional methods. Patient-reported incident measures (PRIMs) can be deployed to complement the other approaches and ascertain the degree of safety across an organisation (Box 1).

FIGURE 2: AGE-STANDARDISED MORTALITY FROM CANCER, 2013



Source: OECD.stat

Box 1. Potential questions to measure safety from the patient's perspective - PRIMs

1. Did the health professional you consulted know important information about your medical history?
2. Did a member of staff confirm your identity prior to administering your medication?
3. Did a member of staff confirm your identity prior to your procedure/operation/surgery?
4. Before you left the clinic/hospital, were you given any written or printed information about what you should or should not do after leaving the clinic/hospital?
5. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?
6. Did a member of staff explain to you how and when to take the medications?
7. Did you experience a medication-related error (e.g. wrong prescription, wrong dose, wrong time, dispensing error, wrong administration route, reported allergic reaction, omitted by mistake)?
8. Did you see, or were you given, any information explaining how to provide feedback or complain to the clinic/hospital about the care you received?
9. If you experienced mistakes or unnecessary problems in connection with your clinic visit/hospital stay, did the staff handle the mistake or problem in a satisfactory way?

Source: OECD 2018

Turning patient-reported data into routine data

Assessing performance from the patient's perspective has certainly gained traction in recent years (Black, 2013; Porter, 2010), but while 'traditional' data - clinical, prescription and administrative - are collected for every patient, collecting patient-reported measures is far from systematic or routine.

This needs to change at all levels of the health system. Up until now, the collection of patient-reported metrics has been predominantly led by forward-thinking clinicians and health services from the ground up, but all providers and the organisations in which they work need to ensure these data are collected for every patient.

All in all, in order to include the voice of the patient in routine performance measurement, more action is needed at national and international level.

The PaRIS initiative

The meeting of OECD Health ministers in Paris on 17th January 2017 demonstrated clear political momentum to pay greater attention to what matters to patients. The resulting Ministerial Statement calls on health systems to become more people-centred by developing international benchmarks of health system performance as reported by the patients themselves.[2]

Taking forward this mandate, the OECD launched the Patient Reported Indictor Survey (PaRIS) initiative. PaRIS aims to build the international capacity to measure and compare care outcomes as reported by patients, asking patients about their outcomes and experiences and using instruments that enable systematic comparisons. Where measurement initiatives already exist – such as for specific

2 http://www.oecd.org/health/ministerial/ministerial-statement-2017.pdf

conditions like osteoarthritis cancer – PaRIS is supporting countries to accelerate the adoption and reporting of validated, standardised and internationally-comparable patient-reported measures.

However, around 1/3 of people aged 45 and older suffer from multiple chronic conditions in OECD countries - a proportion that will grow as populations age. Most of these people receive routine follow-up care in primary care or other ambulatory care settings. Often, different providers are involved and people face fragmented, uncoordinated and, as a result, substandard care. Systematic data on the quality of care for this group of patients is virtually non-existent.

The PaRIS initiative is developing a new international survey on outcomes and experiences of patients with one or more chronic conditions. This new survey will measure both PROMs and PREMs. All measures will be selected on the basis of criteria such as reliability, validity, relevance, feasibility and fitness for use. The survey will make variation within countries visible. Together with other data, this will help shed light on how successful healthcare systems and organisations are in responding to the needs of this group of patients.

To raise performance and competitiveness, healthcare leaders must listen to the voice of the patient

The leadership of a healthcare organisation, such as a governing board, is ultimately accountable for organisational performance. If a core objective is indeed providing the highest quality care, performance includes patient outcomes and experience. Measuring and benchmarking success in this regard in a routine and longitudinal fashion is therefore critical.

Benefits are felt in the ward and on the balance sheet

Measuring and benchmarking quality can align clinical and corporate performance, and foster continuous improvement within an organisation. Comparison across organisations and services can also motivate quality improvement. In some contexts, evidence of high quality can deliver a competitive advantage in a crowded market - a signal to insurers and patients than an organisation takes patient outcomes and experience of care seriously.

In other contexts, triangulating patient outcomes with input and cost data can improve value and efficiency. For example, it can help organisations identify cheaper technologies (e.g. implants or prostheses) with similar outcomes. Why pay more for a piece of equipment if results are no better than a cheaper alternative? (Partridge et al, 2016; Jameson et al, 2015). This can help improve value across an organisation.

Guidance is available…

Implementing a complete and rounded picture of performance that includes quality and outcomes can be a challenge (Bismark & Studdert, 2013), but guidance and formal requirements to help governing boards 'harness the voice of the patient' are now available in many jurisdictions.

In the United Kingdom, for example, the official *Guidance for boards of NHS provider organisations* recommends a strategic integrated performance dashboard that includes, inter alia "…patient experience surveys; complaints, claims and patient safety incident reporting; Patient Reported Outcome Measures (PROMS) …. and staff surveys" (NHS Monitor 2013). The last item – staff surveys – is important because it can inform a board about the levels of engagement of the organisation's personnel. Without strong engagement, collecting - and acting on - patient-reported metrics is difficult.

In Australia, the National Safety and Quality Health Service Standards - which form the basis for a mandatory national accreditation scheme of all public and private health care organisations - require that timely reports on safety and quality systems and performance are provided to the organisation's governing body. The Standards specify that these reports should include "consumer experience and patient-reported outcome measures" (ACSQHC 2017).

Implementation is critical

The benefits can be felt throughout the organisation - in the ward as well as on the balance sheet - but collecting patient-reported data must be implemented carefully and slowly. Implementing new reporting practices and the mechanisms driving improvement based on results require a change in behaviour throughout the entire organisation. Unlike other types of data that are collected by specialised personnel such as coders, or are automatically harvested from existing databases (e.g. mortality), the nature of collecting patient-reported metrics requires action by care providers, support staff and patients.

Data collection must be as efficient as possible for personnel and patients alike. A move away from paper-based instruments to digital ward platforms for collecting patient-reported measures can be useful. Careful integration with an organisation's information infrastructure is advised. If applied intelligently, collecting PROMS and PREMS through an online patient platform can even be used to reduce the administrative burden (Wagle. 2016). Incorporating patient-reported measures into the EHR – both in terms of data measurement and feedback to clinical teams - can enhance uptake.

Most importantly, personnel need to be engaged and comfortable with the metrics used, how they are collected and – most importantly – for what purpose. The successful implementation of patient-reported measures relies on being available to and mindful of clinical practice work. One of the best improvement tools is performance information that is trusted by and relevant to care providers. Therefore, providers (and patients) must not only take ownership of measurement and data collection (which ultimately relies on them) but they must also be reassured that the results will not lead to financial penalties or other sanctions, and that comparisons across wards and with other organisations are appropriate and fair, accurately factoring-in patient risk and casemix.

Conclusion

A core objective of healthcare organisations is to ensure the best possible quality of care for every patient, yet, data on the dimensions of quality are rarely captured from the perspective

of the patient. This means that many healthcare organisations have limited information on their performance. The governing bodies of these organisations are ultimately responsible for the outcomes and quality of care. They need a complete picture of organisational performance to guide decision-making for ongoing success and viability in a competitive marketplace.

The only way to transmit the voice of the patient from the ward to the boardroom is through systematic measurement of patient-reported outcomes and experiences. The OECD's PaRIS initiative is helping build the capacity of countries to capture the voice of the patient through validated, comparable indicators that will enable benchmarking across organisations. Implementation should be deliberate and planned. Without support and engagement from front-line staff and patients, and integration with existing information infrastructure, organisations will struggle to collect these data and use them to improve performance.

Biographies

Luke Slawomirski is a health economist and policy analyst at OECD. His current responsibilities include eHealth governance, knowledge-based health systems, patient safety and health policy implementation. He previously worked at the Australian Commission on Safety and Quality in Health Care; he is a former clinician and a Visiting Fellow at the University of Technology Sydney.

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Tackling wasteful spending as a strategy to improve hospital service capacity

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The opinions expressed and arguments employed herein are those of the authors and do not necessarily reflect the official views of the OECD or of the governments of its member countries.

ABSTRACT: As much as one fifth of health spending is wasteful and could be eliminated without undermining access to and/or quality of care. This article points to the many ways in which hospitals, which absorb two fifths of all OECD health expenditure, are involved in wasteful spending. When it comes to low-value procedures or adverse events, hospitals can be held partly responsible for generating wasteful spending. However, minimising avoidable admissions, unwarranted ER visits or delayed discharges requires systemic responses. Even if tackling waste could mean seeing fewer patients, hospitals, which often struggle to meet the demands they face, may ultimately find it in their interest to be proactively involved.

Wasteful spending: a difficult but worthy conversation?

No one wants to hear that they are responsible for wasting money.

Despite this, a couple of years ago, Ministers of Health requested the OECD to produce an analysis of wasteful spending in health care systems. The resulting report (OECD 2017) produced a number of sobering as well encouraging messages.

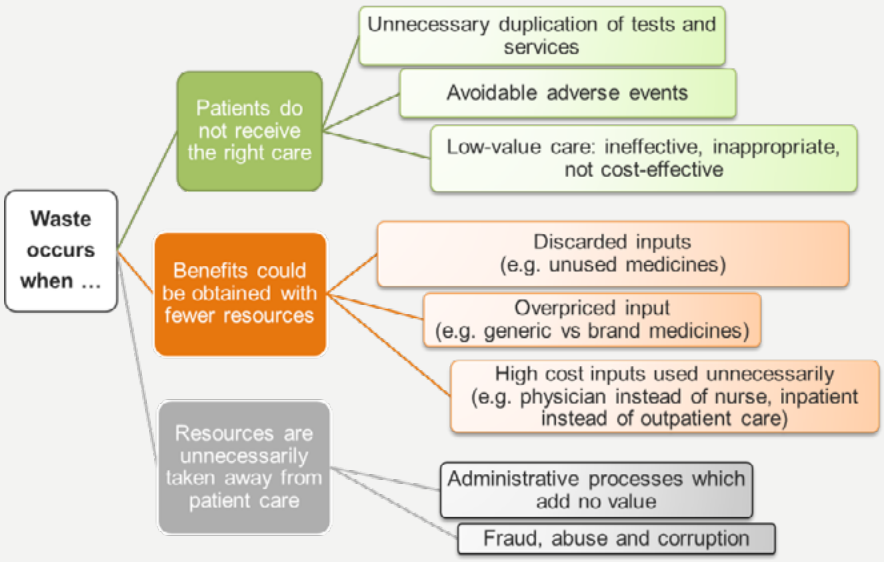
First, up to a fifth of health spending is probably wasteful. This alarming estimate is seldom challenged by experts and more often than not supported by available data. Berwick and Hackbarth (2012) first suggested that waste probably represents more than 20% of total health expenditure in the United States, with an upper bound nearing 50%. In France, a sample of physicians reported that on average they viewed 28% of medical procedures as not fully justified (Vanlerenberghe, 2017). A study in the Netherlands estimated that 20% of spending on acute care could be saved by reducing overuse, increasing the integration of care and involving patients in care decisions (Visser et al., 2012). In Italy, which spends less on health than many other Western European countries, the proportion of inefficient or wasteful public spending was estimated to be around 19% in 2017 (Fondazione GIMBE, 2018).

Second, wasteful spending occurs at all system levels, and patients, providers, managers and policy-makers all bear a responsibility in generating wasteful spending. Wasteful spending takes three main forms (Figure 1):

- Wasteful clinical care, which comprises care provided to patients that makes little or no difference to their health outcomes or even harms them unnecessarily.
- Operational waste, which characterises situations where resources are expended to obtain a given benefit when cheaper and equally effective alternatives could be used. For example, some health systems have low utilisation of generic medicines, while others provide care in resource-intensive places such as hospitals when it could be provided in the community.
- Waste related to the system's governance, comprising administrative processes which add no value, as well as funds lost to fraud and corruption.

Interestingly, rather than being controversial, the 2017 OECD report was well received by a diverse range of stakeholders. This positive reception may be explained by three reasons. Firstly, discussions about improving the efficiency of health systems can be uncomfortable; the notion appears somewhat conceptual, abstract and may have been used too often to justify budget cuts. On the other hand, confronted with evidence that money is being squandered, spent on care which does not contribute to improving patients' health or ends up in the pockets of people who cheat the system, people are much more ready to engage. Consequently, while the idea that wasteful spending occurs in the health system may seem shocking at first, it can in fact help garner support for actions that ultimately improve the value delivered by health systems given the available, always limited, budgets. Secondly, tackling wasteful spending is a concrete strategy which holds the promise of releasing - rather than necessarily cutting - resources which can be put to better use. In other words, it can help alleviate the pressure felt by all to do more

FIGURE 1: WASTEFUL CLINICAL CARE, OPERATIONAL WASTE AND GOVERNANCE RELATED WASTE: A SIMPLE IDENTIFICATION STRATEGY



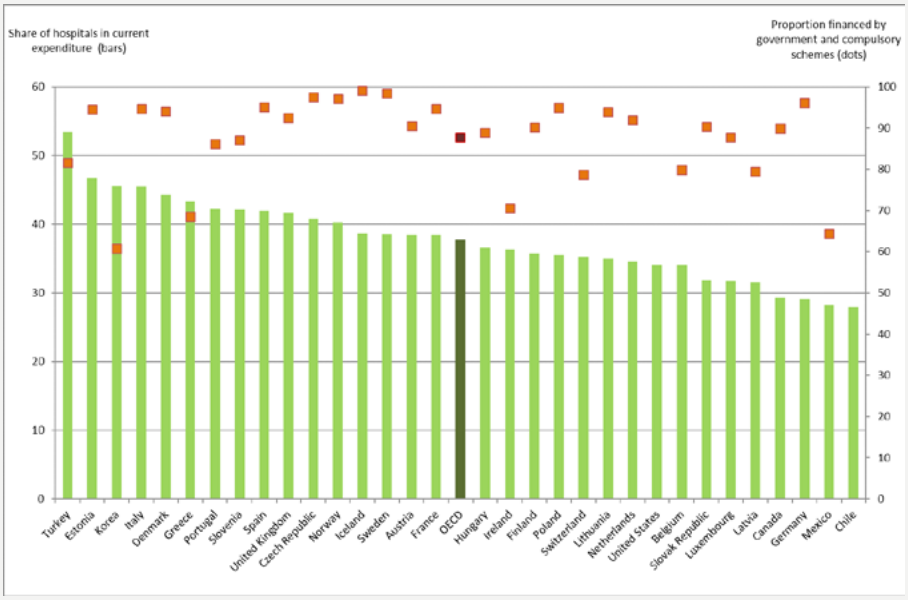
Source: Author, based on OECD (2017)

and address growing needs within resource-constrained environments – be it because front-line staff are overstretched or because budgets are not increasing. Thirdly, solutions exist.

How do hospitals fit in this picture?

In 2016, health services delivered in hospitals accounted for nearly two-fifths of all OECD health expenditure and represented the largest spending category for most countries (Figure 2). In the vast majority of OECD countries, more than 80 percent of this expenditure was covered by government and compulsory schemes. Additionally, the hospital sector is under structural pressure to reform as the

FIGURE 2: HOSPITALS ACCOUNT FOR NEARLY 40% OF HEALTH SPENDING AND FINANCING IS OVERWHELMINGLY PUBLIC

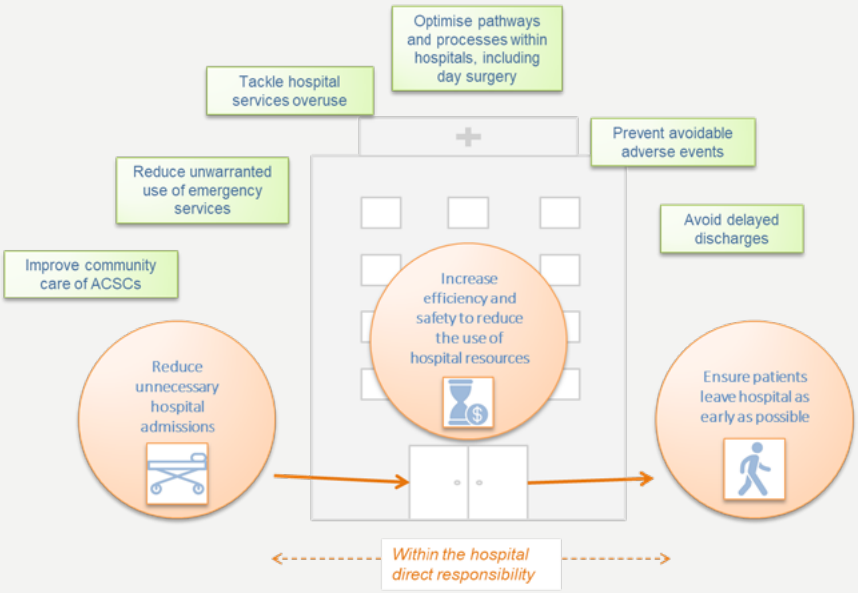


Source: OECD Health Statistics 2018

sustainability of the health system hinges on keeping the bulk of care for the elderly and patients with chronic conditions in the community. Clearly, talking about wasteful spending in hospitals is important.

Envisaging a hospital stay as part of a patient's journey provides a simple lens through which to scan the various points of entry for opening discussions about wasteful spending in hospitals (Figure 3).

FIGURE 3: PRESSURE POINTS ON WASTEFUL HOSPITAL SPENDING



Source: Author.

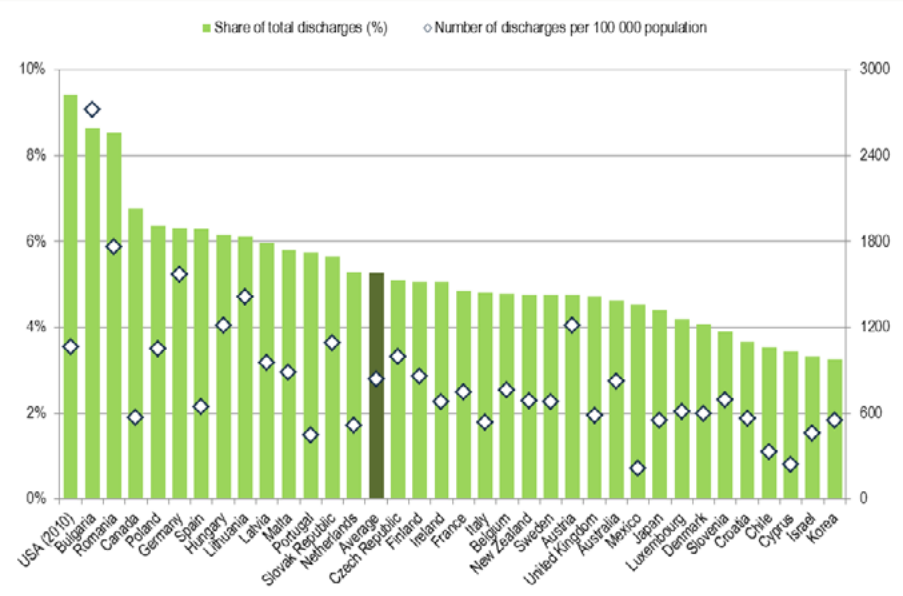
The first step is to consider ways to reduce unnecessary hospital admissions and attendances.

- Many people turn up at hospitals who do not need hospital care. This often manifests as attendances at Emergency Departments (ED) for low-urgency problems that could be dealt with elsewhere in the health care system. These visits could be avoided through better patient management in primary care settings or the community, whether by a primary care physician or a broader primary care clinical team. Studies found inappropriate ED visits accounted for nearly 12% of ED visits in the United States and England, 20% in Italy and France, 25% in Canada, 31% in Portugal, 32% in Australia and 56% in Belgium. In Slovenia, estimates show that more than 50% of ED visits are unnecessary (OECD, 2017).[1]
- A second group of hospital attendances is based on a genuine need for hospital care, but one that should have been avoidable with better management of the underlying ambulatory care sensitive conditions (ACSCs). On average, admissions for just 5 of these ACSCs, all chronic diseases, represented more than 5% of all hospitalisations in 2015, with large variations across countries (Figure 4).
- Thirdly, not all the care that patients receive in hospitals is either necessary or beneficial. Many health services that are delivered offer either very modest benefit to patients or benefit only some patients, or the evidence of benefit is weak or lacking (Brownlee et al., 2017). Overuse of low-value care can occur at all stages of the care pathway, from diagnostic tests to the most complex treatments and end-of-life care (OECD, 2017). In a recent effort to identify services overused in hospitals, researchers reviewed more than 800 recommendations on low-value care issued in the United States, Canada, Australia and the United Kingdom. Two thirds of them pertained to services delivered in hospitals (Chalmers et al., 2018), including investigations and surgical procedures. Another recent study in the United Kingdom identified 71 low-value interventions performed in general surgery alone (Malik et al., 2018). Low-value services can be the reason for unnecessary hospital stays, which could sometimes be avoided altogether, but can also be delivered within the context of a hospital stay, for instance, in the form of unnecessary preoperative testing.

The above leads to the second point of a patient's journey, during which questions about the optimal use of resources can be raised: the hospital stay. Some are operational and administrative in nature, ranging from the

1 While these figures provide a useful approximation of the scale of the problem, definitions and estimation methodologies are subject to debate and differ across countries, making cross-country comparisons difficult.

FIGURE 4: DISCHARGES FOR FIVE AMBULATORY CARE CHRONIC CONDITIONS, AS A SHARE OF TOTAL DISCHARGES AND PER 100,000 POPULATION, 2015



Source: OECD Health Statistics 2018; Eurostat Database.
Note: the conditions are: diabetes, hypertension, heart failure, chronic obstructive pulmonary disease and bronchiectasis and asthma

selection and procurement of equipment and medicines to the optimal management of space, or the search for efficient administrative processes. Other aspects are more clinical in nature, and pertain, for instance, to the earlier mentioned low-value care delivered in hospitals. A greater use of day surgery can also make a significant contribution to reducing the utilisation of hospital resources, with the added benefit that most patients prefer day surgery as it allows them to return home the same day. The use of day surgery has increased in all countries over the past few decades, thanks to progress in surgical techniques and anaesthesia, but the pace of diffusion has varied, with some countries leading the way in adopting day surgery earlier and faster, whereas other countries are still lagging behind. Figure 5 shows that, while in many advanced countries cataract surgery is now massively undertaken on a day-case basis, the development of day surgery for tonsillectomies - incidentally, a surgery whose value, beyond restricted indications, is under question (Burton et al. 2014) - remains very uneven.

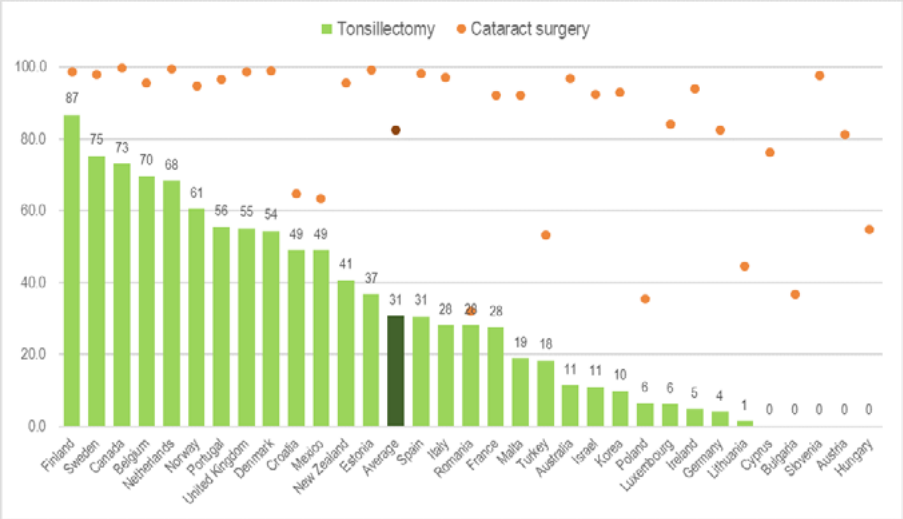
Even if hospitals deliver the right care in the most resource-efficient way, too many patients are harmed while receiving care. In England, recent estimates indicate that six common adverse events resulted in nearly 36,000 healthy life years lost each year, comparable to diseases such as HIV/AIDS and cervical cancer (Hauck et al., 2017). The financial cost of these events is also significant, due to additional medical examinations and treatments and longer hospital stays. In England, the costs associated with common adverse events in hospitals are equivalent to those of 2,000 salaried GPs or over 3,500 hospital nurses each year (Slawomirski, Auraaen and Klazinga, 2017). Across OECD countries, approximately 15% of all acute care expenditure is a direct consequence of patient harm sustained in hospitals (ibid). The cost of venous thromboembolism alone is estimated between EUR 1.5-13.5 billion each year in hospital costs for EU countries (Barco et al., 2016). In France, the cost of hospital-acquired infections has been estimated at nearly EUR 60 million per year (Lamarsalle et al., 2013). Large proportions of adverse events could be avoided, and as such, they contribute to wasteful spending in hospitals.

The final step in the patient's journey is the discharge, which can be unnecessarily delayed, often because of poor planning and coordination with follow-up care either at the patient's home or in another setting. A recent cross-country review estimated that the cost of delayed discharge ranges from EUR 230 to 650 per patient per day (Rojas-García et al., 2018). Delayed discharges from hospital also contribute to high-cost care through their effects on the patients' health. A longer hospital stay increases the risk of hospital-acquired infections and can accelerate functional decline, particularly among elderly patients. Few countries systematically measure delayed discharges, but the magnitude of numbers differs markedly, from 5 bed days per 1,000 population in Denmark to 43 bed days per 1,000 population in Ireland, the EU country with the highest bed occupancy rate (94%). This last example is perhaps the perfect illustration of the idea that tackling this – and other types of – waste could release much needed hospital resources for better purposes.

Key ingredients of a strategy to reduce waste

Naturally, each type of wasteful spending listed above requires a different, context-specific reduction strategy.

FIGURE 5: SHARE OF TONSILLECTOMY AND CATARACT SURGERY PERFORMED AS DAY CASES, 2016 (OR LATEST YEAR)



Source: OECD Health Statistics 2018; Eurostat Database.

Nevertheless, the 2017 OECD report, which took detailed stock of the available options, pointed to four key ingredients which often underpin successful strategies:

1. **Acknowledge**. Raising awareness about wasteful spending can be a useful starting point. In 2013, the Ministry of Health, Welfare and Sports of the Netherlands launched a campaign to encourage citizens and professionals to report anonymously instances of waste they encountered. The experience yielded 16,000 responses and various initiatives were subsequently launched to address the problems identified.
2. **Inform.** Most data systems are ill-equipped to track wasteful spending; databases on services and procedures provided are often geared towards payments and provide sufficient information to assess whether care was appropriate or not given the patient's circumstances, reporting and learning systems for adverse events are unevenly developed and few countries monitor inappropriate emergency visits or delayed discharges. Where available, information can be leveraged to encourage change: an increasing number of countries (most recently France in 2016) publish Atlases of variation in health care which highlight differences in the frequency of low-value services across geographic areas. The UK publishes a procurement Atlas which shows how much Trusts around the country are paying for similar products. Its first iteration showed that the price of patient identification wristbands varied in a ratio of one to two and that there was a 50% difference in the price paid for syringes.
3. **Pay.** Incentives need to be aligned for stakeholders to pay more attention to value than volume. The coverage of services by third-party payers needs to be designed in a way which encourages the delivery of appropriate care and value. Health Technology Assessment is helpful in this regard and increasingly used. For example, today HTA informs coverage decisions for medicines in 23 EU Member States and for medical devices in 20. The ongoing Medicare Benefits Schedule Review in Australia[2] is the first comprehensive effort to better align reimbursement rules with best practices and improve value for money. Provider payment systems are also an important component of strategies to reduce wasteful spending and should reward the provision of correct services rather than their quantity. As many as a third of OECD countries already seek to reward different types of providers for the results achieved rather than for the number of interventions. To reduce the incidence of unnecessary health care services and wasteful failures in coordination, a handful of payers, most notably in the United States but also in Sweden, Portugal and the Netherlands, have moved towards bundled or population-based payments, with some promising results.
4. **Persuade.** Sustainable change, however, can only be achieved if patients and clinicians are persuaded that the best option is the least wasteful one. Approaches such as the Choosing Wisely® campaign illustrate what is possible. This clinician-led initiative aims to reduce low-value care by encouraging patient-provider conversations about whether specific services truly add value. It is now active in at least a third of OECD countries. Changing habits is often

2 http://www.health.gov.au/internet/main/publishing.nsf/content/mbsreviewtaskforce, consulted on 26 July 2018.

a necessary and key step to tackle waste, whether to improve adherence to clinical guidelines, thus increasing the safety and appropriateness of care, or to convince patients not to rush to the emergency department or request antibiotics at the first sign of a cold.

Conclusion: where does this analysis leave hospital managers?

Given their preponderance in total and public health spending, putting the spotlight on wasteful spending in hospitals is undeniably sensible. Hospital managers, including clinical leaders and in fact everyone working in hospitals, probably bear some responsibility for some of the wasteful practices, processes and spending. However, hospitals cannot be directly held accountable for the fact that patients come to the emergency room with minor ailments or for the fact that a diabetic patient requires an amputation, even if the costs associated could have been prevented. Wasteful hospital spending is a systemic problem, not just a hospital problem.

When it comes to solutions, it would be naïve to ignore the fact that interests may diverge in reducing waste. Ultimately, putting aside fraud and abuse, more often than not, one stakeholder's wasteful spending is another stakeholder's legitimate income. Reducing waste should mean that a patient's needs will be addressed in a different, less costly way, possibly by another provider. Tests and procedures not carried out in the hospital can mean a reduction in revenues. The challenge then becomes to find systemic solutions behind which stakeholders interests are aligned enough to make sure they all steer the system in the same direction. On the other hand, hospital CEOs who have trouble retaining overextended staff and/or struggle with overflowing emergency departments and/or have beds occupied by patients who could be discharged may find it in their self-interest to engage or even initiate conversations on how to reduce wasteful spending in their catchment area and focus the hospital on its core mission.

Biography:

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University Hospital Governance Volume 54 Number 3

Résumés en Français

Comment les hôpitaux universitaires et les universités affiliées collaborent à l'avancement des objectifs

À la suite d'une étude mondiale de 2017 sur la gouvernance, des entrevues avec quatre dirigeants du secteur de la santé mettent en lumière la façon dont les hôpitaux universitaires et les universités affiliées peuvent faire le pont entre différentes cultures pour promouvoir la collaboration et faire progresser l'innovation au sein de leurs établissements. Les dirigeants décrivent les idées qu'ils utilisent pour renforcer l'harmonisation des soins cliniques, de la recherche et de l'éducation, ainsi que pour créer des environnements qui stimulent le rendement et les résultats des entreprises.

Alors que leurs établissements font face à l'impact de la réforme nationale des soins de santé, une démarche de portefeuille sélectif avec des centres d'excellence est déployée pour servir des groupes de patients clés, atteindre des objectifs financiers et résister à la concurrence. Ces leaders d'opinion partagent les raisons pour lesquelles il est essentiel de former la prochaine génération de leaders et de fournir des techniques d'éducation médicale adaptées aux nouvelles pratiques cliniques et aux styles d'apprentissage en équipe.

La gouvernance dans les hôpitaux publics iraniens

Depuis le début des années 1990, l'Iran a entrepris une série de réformes structurelles et de décentralisation de son système hospitalier. Les hôpitaux ont connu de nombreux changements dans leurs structures, visant à améliorer la qualité des services hospitaliers, à réduire les dépenses publiques et à améliorer le contrôle de leurs propres revenus et frais. L'autonomie des hôpitaux et les conseils d'administration ont fait l'objet des principales réformes qui ont influencé l'organisation et la gestion des hôpitaux affiliés au Ministère de la Santé et de l'Éducation Médicale. Il semble que la démarche concernant l'autonomie des hôpitaux et des conseils d'administration n'a pas atteint les objectifs souhaités. Les hôpitaux iraniens souffrent d'un manque d'autorité de gestion appropriée, ainsi que de coopération et de coordination entre les parties prenantes, les décideurs etles équipes de gestion des hôpitaux dans la mise en œuvre des réformes.

Le modèle français d'hôpital universitaire est-il toujours d'actualité ?

Alors que les hôpitaux universitaires sont sur le point de célébrer leur soixantième anniversaire, ils n'ont jamais été aussi contestés. Ils sont aujourd'hui en concurrence avec le secteur privé et ils font l'envie des hôpitaux publics non universitaires de niveau inférieur. Un changement dans leur système de gouvernance est demandé par les universités. Ils sont remis en question pour leur double tutelle ministérielle et limités par le contexte économique et budgétaire national. Ils ont également été récemment dotés de nouvelles missions dans leur région. Enfin, depuis le début de 2018, ils sont au centre d'une critique sans précédent de la part des médias.

Des études sont actuellement en cours pour déterminer ce que sera l'hôpital universitaire de demain.

Trouver des solutions dans des systèmes-marchés de santé parfaitement imparfaits : définir des options pour la gouvernance et le financement d'un *Collegium Medicum*

Les défis à long terme de la gouvernance et du financement dans les hôpitaux universitaires en Pologne et en Éthiopie peuvent sembler très éloignés l'un de l'autre. Toutefois, dans deux projets récents, une approche conceptuelle commune s'est révélée remarquablement utile pour stimuler une large participation dans des défis financiers persistants. Cette approche lie mais remet aussi en question les traditions dans les récits explicites (publics) des institutions financières sur les « marchés » des soins de santé et les récits explicites (publics) médicaux et sanitaires des « systèmes de santé ». Si les hôpitaux universitaires sont considérés comme des plaques tournantes, dans des réseaux d'information sociale, économique et professionnelle plus larges, de nouvelles possibilités intra- et inter-institutionnelles en matière de gouvernance et de financement peuvent s'ouvrir. Une analyse internationale approfondie et comparative de ces institutions remarquables est nécessaire.

Genève : les hôpitaux, l'État et l'université unissent leurs forces pour des traitements et des soins exceptionnels

À Genève, les hôpitaux universitaires, la Faculté de médecine de l'Université et l'État forment un trio de partenaires qui garantissent chacun un niveau exceptionnel de soins à la population locale, ainsi qu'une recherche médicale de haute qualité et une formation médicale de pointe. Cet article présente le système de gouvernance en place entre les trois institutions et met en évidence les clés de leur succès dans un contexte de collaboration étroite, de responsabilité partagée et d'interaction régulière. Il établit des parallèles entre la structure de la haute direction des HUG et celle d'autres hôpitaux universitaires suisses, afin d'examiner de plus près le potentiel d'optimisation de chacun d'entre eux.

Le rôle de la gouvernance dans les hôpitaux universitaires des marchés émergents - Une étude de cas

Le rôle de la gouvernance a une longue expérience de mise en œuvre dans les pays de l'OCDE et sur les marchés émergents. Au cours de décennies de développement, en particulier dans le contexte des universités et des institutions médicales universitaires, la gouvernance a été façonnée et mise en œuvre avec des principes clés intégrés dans des structures efficaces et pertinentes pour l'institution. Sur une période plus courte,

les marchés émergents ont adopté des principes de gouvernance adaptés à leurs institutions en fonction du contexte de leur pays, de leurs objectifs institutionnels, de la direction de leur conseil d'administration et de leur plan stratégique. Le présent document traite des principaux rôles de gouvernance et des problèmes de mise en œuvre sur la base de l'expérience réelle tant au niveau de la gouvernance qu'au niveau de la direction. Ces leçons-clés apprises peuvent être utiles aux hôpitaux universitaires et aux établissements de santé universitaires des marchés émergents (qui font de la recherche) pour renforcer les conseils d'administration existants ou mettre en place de nouvelles structures de gouvernance.

Explorer les disparites dans la performance des hopitaux - une perspective internationale

Les efforts nationaux visant à définir la qualité des hôpitaux sont passés d'une approche axée sur la mesure des processus de soins de santé à l'évaluation des prestations afin d'offrir une perspective plus large sur le rendement organisationnel. L'OCDE a soutenu cette transition en publiant un certain nombre d'indicateurs nationaux de performance des hôpitaux pour les pays membres. L'une de ces mesures est le taux de mortalité par infarctus aigu du myocarde (IAM) à 30 jours. Bien que les taux de mortalité des patients atteints d'IAM diminuent avec le temps, des variations internationales importantes persistent. De nombreux pays commencent à s'orienter vers des systèmes de soins intégrés, englobant les soins avant, pendant et après l'hospitalisation, afin d'améliorer la qualité des résultats tant pour les hôpitaux que pour les patients.

Exploiter la voix du patient de la salle de soins à la salle du conseil d'administration

L'un des objectifs fondamentaux d'une organisation de soins de santé est de maximiser la qualité des soins pour chaque patient, mais les données sur les dimensions clés de la qualité de la sécurité, de l'efficacité et de l'approche centrée sur les personnes ne sont pas systématiquement prises en compte du point de vue du patient. Cela signifie que les organes directeurs fondent les décisions qui déterminent le succès sur un marché concurrentiel sur la base d'informations incomplètes. Pour y remédier, il faut que les patients eux-mêmes évaluent systématiquement les prestations et les expériences. L'initiative PaRIS de l'OCDE contribue à renforcer la capacité des pays et des organisations à faire entendre la voix des patients au moyen d'indicateurs validés et comparables, mais une mise en œuvre réussie implique la participation du personnel de première ligne et des patients ainsi que l'intégration de ces paramètres dans l'infrastructure d'information existante.

Lutter contre les dépenses inutiles comme stratégie visant à améliorer la capacité des services hospitaliers

Jusqu'à un cinquième des dépenses de santé est inutile et pourrait être éliminé sans nuire à l'accès aux soins et/ou à la qualité des soins. Cet article souligne les nombreuses façons dont les hôpitaux, qui absorbent les deux cinquièmes de toutes les dépenses de santé de l'OCDE, sont concernés par les dépenses inutiles. Lorsqu'il s'agit de procédures de faible valeur ou d'événements indésirables, les hôpitaux peuvent être tenus en partie responsables de générer des dépenses inutiles. Toutefois, pour minimiser les admissions évitables, les visites injustifiées aux urgences ou les sorties tardives, il faut des réponses systémiques. Même si lutter contre les dépenses inutiles peut signifier voir moins de patients, les hôpitaux, qui ont souvent du mal à répondre aux demandes auxquelles ils sont confrontés, peuvent finalement trouver qu'il est dans leur intérêt de participer activement.

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Resumen en Español

Cómo los hospitales universitarios y las universidades alineadas contribuyen para alcanzar objetivos

Como resultado de un seguimiento de un estudio mundial en 2017 sobre gestión, las entrevistas que se realizaron a cuatro líderes de asistencia sanitaria desvelan cómo los hospitales universitarios y las universidades alineadas pueden ser un puente entre culturas diferentes para promover la colaboración y fomentar las innovaciones dentro de sus instituciones. Los líderes describen ideas que usan para fortalecer el alineamiento en los cuidados clínicos, la investigación y la educación, así como también, para crear espacios que estimulen un desempeño y resultados empresariales.

Debido a que sus instituciones enfrentan el impacto de la reforma de asistencia sanitaria nacional, se emplea una estrategia de cartera selectiva que presenta centros de excelencia para atender a grupos de pacientes clave, alcanzar objetivos financieros y oponerse a la competencia. Estos intelectuales comparten por qué es crucial desarrollar la próxima generación de líderes y proveer técnicas de educación médica adaptadas a las nuevas prácticas clínicas y los estilos de aprendizaje basados en equipos.

La gestión en los hospitales públicos iraníes

Desde los principios de 1990, Irán ha iniciado una serie de reformas estructurales y de descentralización en su sistema hospitalario. Los hospitales han transitado muchos cambios en sus estructuras, con el fin de incrementar la calidad de los servicios hospitalarios, reducir el gasto público y tener un mejor control sobre sus ganancias y gastos. La autonomía de los hospitales y los consejos de administración fueron objeto de las reformas principales que han influenciado la organización y la gestión de los hospitales afiliados al Ministerio de Salud y de Educación Médica. Parece que el enfoque de la autonomía de los hospitales y los Consejos de Administración no ha alcanzado los resultados esperados. Los hospitales en Irán presentan una falta de autoridad administrativa, así como también, de cooperación y coordinación entre los accionistas, los legisladores y los equipos de gestión de los hospitales a la hora de implementar reformas.

¿Es el modelo francés de hospital universitario aun pertinente?

Mientras los hospitales universitarios están a punto de celebrar su sexagésimo aniversario, nunca habían estado tan comprometidos. En la actualidad, se enfrentan a la competencia del sector privado y a la envidia de los hospitales no universitarios públicos de menor nivel. Las universidades exigen un cambio en sus sistemas de gestión. Se les cuestiona la dualidad en la supervisión ministerial y se encuentran restringidos por la economía nacional y el marco presupuestario. También se los ha empoderado con nuevas misiones en sus áreas. Finalmente, desde el comienzo del año 2018, se encuentran en el centro de críticas sin precedente por parte de los medios.
Actualmente se están realizando estudios para determinar cuál será el hospital universitario del mañana.

Encontrar soluciones en mercados de sistemas sanitarios perfectamente imperfectos: enmarcar opciones para la gestión y la finanza de un *Collegium Medicum*

Los desafíos de gestión y finanza a largo plazo en hospitales universitarios en Polonia y Etiopía parecieran estar muy distantes. Sin embargo, en dos proyectos recientes, un abordaje conceptual compartido demostró ser de gran utilidad para estimular amplios compromisos en desafíos financieros tenaces. Esta propuesta une, pero también desafía tradiciones tanto en narrativas de «mercados» sanitarios de instituciones financieras explícitamente (públicas) y narrativas médicas y de salud explícitamente (públicas) de «sistemas sanitarios». Si los hospitales universitarios son vistos como núcleos, en redes de información socioeconómicas más amplias, pero profesionales, pueden abrirse nuevas posibilidades intrainstitucionales e interinstitucionales en la gestión y las finanzas. Es necesario un exhaustivo análisis internacional y comparativo de estas instituciones destacadas.

Ginebra: hospitales, Estado y universidad unen fuerzas para lograr tratamientos y cuidados de excelencia

En Ginebra, los hospitales universitarios, la facultad de Medicina de la universidad y el Estado forman una triada de colaboradores, en la que cada uno garantiza un nivel de cuidado excepcional para la población local, así como también, investigaciones médicas de alta calidad y capacitaciones médicas de vanguardia. Este artículo presenta el sistema de gestión vigente entre las tres instituciones y resalta las claves para su éxito en un contexto de estrecha colaboración, responsabilidad compartida e interacción regular. Traza paralelos entre la estructura de la gestión superior del HUG y las estructuras del resto de los hospitales universitarios suizos, para tener una mirada más cercana del potencial de optimización en cada uno de ellos.

El papel de la gestión en los hospitales universitarios de mercados emergentes - Un caso de estudio

El papel de la Gestión tiene un largo recorrido de implementación en la OECD y los mercados emergentes. A través de décadas de desarrollo, especialmente en el contexto de universidades e instituciones médicas académicas, se ha transformado e implementado la gestión con principios clave integrados en estructuras que son efectivas y relevantes para la institución. A lo largo de un período más corto, los mercados emergentes han adoptado principios de gestión importantes

para las instituciones que se basan en el contexto de su país, los objetivos institucionales, la estructura de liderazgo y el plan estratégico. Este artículo de investigación aborda roles de gestión clave y problemas de implementación basados en experiencias reales tanto en la gestión como en niveles ejecutivos. Estas lecciones clave aprendidas pueden ser valiosas para los hospitales universitarios en mercados emergentes e instituciones sanitarias académicas (que realizan investigaciones) ya sea para fortalecer estructuras existentes como para establecer nuevas estructuras de gestión.

Exploración de variaciones en el desempeño hospitalario - una perspectiva internacional

Los esfuerzos nacionales por describir la calidad de los hospitales han ido variando desde un foco en la medición de los procesos de asistencia sanitaria a un foco en la evaluación de resultados con el fin de brindar una perspectiva más amplia del desempeño organizacional. La OCDE ha apoyado esta transición a través de la publicación de una cierta cantidad de indicadores de rendimiento de los hospitales nacionales en los países miembros. Una de estas medidas es la tasa de mortalidad por infartos agudos de miocardio (IAM) a 30 días. Mientras las tasas de mortalidad para pacientes con IAM están disminuyendo con el paso del tiempo, aún persisten variaciones internacionales importantes. Un trabajo reciente de la OCDE también mostró una amplia variación de rendimiento a escala de los hospitales dentro de los diferentes países. Muchos países están comenzando una transición hacia sistemas de atención integrados, lo que comprende una atención previa, simultánea y posterior a la hospitalización, para mejorar la calidad de los resultados tanto para los hospitales como para los pacientes.

Aprovechar la voz del paciente desde el pabellón hasta la sala de juntas

Un objetivo central de una organización sanitaria es maximizar la calidad del cuidado de cada paciente, pero los datos sobre dimensiones clave de calidad de seguridad, efectividad y centralización en las personas no se miden sistemáticamente desde la perspectiva del paciente. Esto significa que los órganos de gobierno están apoyando decisiones que determinan el éxito en un mercado competitivo sobre la base de información incompleta. Abordar esto requiere mediciones de rutina de resultados y experiencias por parte de los pacientes mismos. La iniciativa PaRIS de la OECD está ayudando a moldear la capacidad de los países y organizaciones de capturar la voz del paciente a través de indicadores comparables y validados; pero una implementación exitosa implica el compromiso por parte del personal de atención al público y los pacientes, y la integración de estas métricas a la infraestructura de información existente.

Afrontar el gasto excesivo como una estrategia para mejorar la capacidad de servicio hospitalaria

Aproximadamente una quinta parte del gasto sanitario es derroche, y podría eliminarse sin comprometer el acceso al cuidado o la calidad del mismo. Este artículo señala las numerosas formas en que los hospitales, los que absorben dos quintas partes del gasto sanitario de OECD, incurren en gastos excesivos. En el caso de los procedimientos de poco valor o eventos adversos, los hospitales también pueden ser considerados responsables de generar un gasto excesivo. Sin embargo, la minimización de las admisiones evitables, las consultas de emergencia injustificadas o las altas retrasadas requiere respuestas sistemáticas. Incluso si abordar el gasto pudiera implicar atender a menos pacientes, los hospitales, que a menudo luchan por cumplir las demandas que enfrentan, podrían finalmente verse interesados en involucrarse proactivamente.

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中文摘要

大学附属医院与联盟大学怎样通过合作来达到各项目标

作为2017年全球管理研究的后续报道，我们通过对四家医疗保健主导机构的采访，来集中报道大学附属医院与联盟大学可以怎样在不同的文化之间进行沟通，以在他们各自的机构内促进合作和推动创新。这几家大型机构介绍了他们为加强临床护理、科研和教育之间的联系以及为创造可以激发创业绩效和成果的环境所采纳的各种理念。

随着他们的机构面临着全国卫生保健改革所带来的冲击，他们采用了精心选择的以品质为中心的方法来服务主要患者群体，实现财务目标，以及应对竞争压力。这些大型机构分享了自己在发展成下一代大型机构、提供与新的临床实践和短期学习风格相适应的医学教育技术的关键原因方面的经验。

伊朗的公共医院管理

自从九十年代初期以来，伊朗就在自己的医疗系统中开展了一系列结构改革和去中心化改革。

医院的结构进行了许多改变，旨在提升医院的服务质量，减少政府开支，加强对医院对自身收支的控制。医院自主管理和理事会成为了改革热点的主题，对伊朗卫生及医疗教育部下属各家医院的组织和管理产生了深远的影响。但医院自主管理和理事会的方法看上去并没有达到预期的目标。在改革的实施过程中，伊朗的各个医院缺乏适当的管理机构，利益相关方、决策者和医院管理小组之间缺乏合作和协调。

法国的大学附属医院模式还有意义吗？

随着大学附属医院60周年庆的步伐越来越近，这一系统面临着前所未有的挑战。

现在，它们与私人医院相互竞争，成为了下一级公共非大学附属医院嫉妒的对象。各所大学均要求它们对其管理系统进行改革。它们因为双重部级监管以及在国家经济和预算方面的限制被大众所质疑。最近，它们还在各自的领域被赋予了新的使命。最后，自2018年初以来，它们就一直是媒体前所未有的激烈苛责的对象。

目前，正在通过研究来决定大学附属医院未来的发展方向。

为非常不完美的保健系统—市场体系寻求方案：为Collegium Medicum的管理和财务制订方案

波兰和埃塞俄比亚各个大学附属医院在管理和财务方面所面临的长期挑战看上去各不相关。

但是，在最近的两个项目中，一个共同的方法被证实可以很有效地刺激大范围的参与，以应对财务挑战这一顽疾。而且，这个方法还把卫生保健“市场”的明确（公共）财务机构的叙述，和“卫生系统”的明确（公共）卫生保健和医疗叙述相结合起来。如果大学附属医院被当成枢纽的话，在更广泛的社会经济和专业化信息网络中，就有可能出现新的机构内外管理和财务形势。需要对这些出色的机构进行全面的国际分析和比较分析。

日内瓦：医院、国家和大学携手实现优质的治疗和护理

在日内瓦，各个大学附属医院、大学医学院和政府形成了三位一体的合作伙伴，各方都保证向当地市民提供优异的医疗服务，以及高质量的医学研究和先进的医疗培训。

本文介绍了这三类机构之间现有的管理系统，强调了他们在密切合作、责任分担和定期互动这样的大前提之下取得成功的关键之处。它对“政学医”高级管理结构和瑞士其它大学附属医院的结构进行了比较，来进一步研究对其进行优化的潜力。

新兴市场中大学附属医院的管理职能——案例研究

管理职能已经在经合组织和新兴市场实施了很长的时间。

经过几十年的发展，特别是在各个大学和医疗研究机构，已经形成了管理格局，并根据对本机构有效和相关结构内的主要原则加以实施。短期内，根据各自所在国家的实际情况、机构目标、董事会的领导和战略计划，新兴市场已经采用了与它们的机构相关的管理原则。根据管理层和执行层两方面的实施经验，本文讨论了主要管理职能和实施方面的问题。对于新兴市场的大学附属医院和医疗研究机构而言，这些关键教训在加强现有董事会管理和设立新管理结构方面很有价值。

“探索医院绩效的各种变化”——从国际视角的角度出发

各个国家为了解医院服务质量的总体情况作进行的工作，已经从侧重于衡量医疗保健的过程过渡到了对其结果进行评估，以对这些机构的绩效有更全面的了解。经合组织通过为成员国公布若干国家医院绩效指标来支持这种转变。其中一个指标就是30天急性心肌梗塞（AMI）死亡率。随着时间的推移，急性心肌梗塞病人的死亡率不断降低，国际间各个国家的情形千差万别。近来经合组织的工作也显示了各国医院的巨大绩效差异。最终，各个国家开始转而使用能在入院前、中、后提供医疗护理的统一医疗系统，从而改善院方和患者双方的质量成果。

治理从病房到董事会会议室的患者之声

卫生保健机构的主要目标是为每位患者提供优质的护理，但是，安全、有效性和以人为本方面的主要质量数据却没有从患者的角度来系统地采集。

这就意味着，监管机构在根据不完全的信息来为竞争市场的成功做决定。解决这一问题需要对患者本身的结果和体验进行常规测量。经合组织的患者报告指

数调查项目正在通过经验证的可比指数，帮助增强各个国家和机构的能力，以收集患者的意见。但要成功实施，需要一线员工和患者的参与，并将这些衡量标准纳入到现有的信息基础结构中去。

对浪费支出进行跟踪作为一项策略来提升医院的服务能力

高达五分之一的卫生保健支出属于浪费支出。这笔支出可以在不破坏医疗途径和质量的条件下节省下来。本文指出了各家医院在支出浪费方面的许多途径。这些医院吸收了所有经合组织五分之二的医疗开支。在低价值程序或不良事件方面，医院应该为浪费支出的产生承担部分责任。但是，想要把可以避免的入院治疗、未经担保的急诊室治疗或推迟出院的发生降到最低，需要系统反应。即使治理浪费问题也可能意味着诊治更少数量的患者，通常努力去满足自己所面临的需求的各个医院最终会发现积极参与才符合它们的利益。

Meet the IHF Award Sponsors

IHF/Dr Kwang Tae Kim Grand Award

Dr. Kwang Tae Kim is a surgeon with immense contributions to the healthcare sector both nationally and internationally. He was President of the International Hospital Federation from 2013 to 2015, President of the Asian Hospital Federation in 2008-2009 and President of the Korean Hospital Association in 2003-2004. He has been the Chairman of Daerim Saint Mary's Hospital in Seoul, his own hospital, since 1969.
As a strong advocate of excellence in clinical governance, leadership, quality and safety, Dr Kim initiated and generously donated to set up the IHF Awards Program during his presidency to promote IHF's visibility and its role as a knowledge hub. Because of this, the Grand Award, the most prestigious among all the IHF Awards, was aptly named after him.
The IHF/Dr Kwang Tae Kim Grand Award will be bestowed to health system, healthcare organisation or facility which achieves excellence in multiple areas including, among others, quality and patient safety, corporate social responsibility, innovations in service delivery at affordable costs, healthcare leadership and management practices. This Award is only open to healthcare service provider organisations which are either IHF Full or Associate Members.

IHF Excellence Awards Sponsors

Austco is the sponsor of the Excellence Award for Quality & Safety and Patient-centered Care
Austco Communication Systems is a global manufacturer of Nurse Call and Clinical Workflow solutions for hospitals and aged-care facilities.
Austco's flagship solution, Tacera, is an integrated IP-based Critical Communication System that delivers safety solutions for patients. By linking nurses and patients in real-time, Tacera enhances the quality of information available to caregivers, enabling them to provide immediate assistance and measurable improvements to patient's quality of care.
Pulse Mobile is the newest component of Austco's innovative Tacera Pulse software suite of next generation clinical business intelligence solutions. Pulse Mobile enhances staff efficiency and caregiver response times, which help improve patient/resident outcomes.
More information about Austco: www.austco.com

Bionexo is the sponsor of the Excellence Award for Corporate Social Responsibility
Bionexo is a technology company that offers digital solutions for purchasing, sales and process management in healthcare. In the healthcare supply chain, there has never been a greater need to reduce costs and operate more efficiently. Through high performance digital solutions, Bionexo offers process automation, increasing the visibility and transparency of information for faster and more intelligent decision making.
More information about Bionexo: bionexo.com/en/

EOH is the sponsor of the Excellence Award for Leadership and Management in Healthcare
EOH provides the technology, knowledge, skills and organisational ability critical to Africa's development and growth. Following the Consulting, Technology and Outsourcing model, EOH provides high value, end-to-end solutions to its clients in all industry verticals. Listed in 1998, EOH attributes its 36% compounded annual growth to a culture of remaining prudent, and not just meeting, but exceeding, customer expectations. More information about EOH: www.eoh.co.za

IHF events calendar

2018

IHF

42nd World Hospital Congress
October 10-12, Brisbane, Australia
www.hospitalcongress2018.com
For more information, contact
2018congress@ihf-fih.org

2019

IHF

43rd World Hospital Congress
November 7-9, Muscat, Oman
For more information, contact
patricia.mencias@ihf-fih.org

2020

IHF

44th World Hospital Congress
November 3-5, Barcelona, Spain
For more information, contact
patricia.mencias@ihf-fih.org

2018

MEMBERS

ARGENTINA
XXIV Congreso Internacional
Camara Argentina de Empresas de Salud - CAES
October 25, Sheraton Libertador Hotel, Buenos Aires
http://www.caes.com.ar/index.php/xxiii-congreso-internacional-2018

AUSTRALIA
Redefining Healthcare
Australian Healthcare & Hospitals Association
October 8-9, Brisbane, Queensland
http://ahha.asn.au/events/redefining-healthcare
*Places for this workshop are strictly limited and registration is exclusively available only to delegates of the World Hospital Congress

AUSTRIA
European Health Forum Gastein (EHFG)
Federal Ministry of Health
October 3-5, Bad Hofgastein
https://www.ehfg.org/

BRAZIL
6th Conahp (Brazilian Hospital Congress)
National Association of Private Hospitals (ANAHP)
November 7-9, São Paulo (SP)
http://www.conahp.org.br/2017/

CANADA
National Health Leadership Conference
Healthcare innovation: Advancing better outcomes and economic growth
Healthcare*CAN*
June 10-11, 2019, Toronto, ON
http://www.nhlc-cnls.ca/

GERMANY
German Hospital Conference
German Hospital Federation
November 12-15, Düsseldorf Fairgrounds
www.medica.de

NORWAY
Leader Conference 2019
Norwegian Hospital & Health Service Association (NSH)
February 8-9 2019, Oslo Congress Center, Oslo
http://www.nsh.no/lederkonferansen-2019.6115702-375023.html
** This event is in Norwegian*

PHILIPPINES
69th Annual National Convention
Philippines Hospital Association (PHA)
November 14-17, Manila Hotel, Manila
http://www.pha.org.ph/

PORTUGAL
7th International Hospitals Congress
Portuguese Association for Hospital Development (APDH)
November 21-23, Lisbon
http://www.apdh.pt/eventos/3

SPAIN
VIII Meeting for hospital managers: charismatic leadership
Unió Catalana d'Hospitals
October 25, Parc Sanitari Sant Joan de Déu

IX Annual Members meeting
Unió Catalana d'Hospitals
November 23, Hospital de Sant Pau

TAIWAN
2018 Taiwan Joint Conference in Healthcare
Taiwan Hospital Association
November 1, Taipei Veterans General Hospital, Chih-Teh Building, Taipei, Taiwan
**This event is in Chinese*

UNITED ARAB EMIRATES
Arab Health 2019
Dubai Health Authority (DHA)
January 28-31, 2019, Dubai International Convention and Exhibition Centre, Dubai
https://www.arabhealthonline.com/en/Home.html

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: info@ihf-fih.org or visit the IHF website: https://www.ihf-fih.org

www.hospitalcongress2018.com

Missed out on early bird registration for the World Hospital Congress? Luckily this year it is in Australia where there are plenty of helpful koalas - there is even one hiding on the Congress website with a discount code! Just go to the website and look through the pages to find our helpful koala and save on registration fees.

While you are there, take a look at the great program which will feature over 160 speakers from more than 30 countries and will address key issues of innovation, transformation, integration and value. The World Hospital Congress 2018 is sure to inspire you with the journey to date and the opportunities for the future to come.

2018 IHF BRISBANE

42nd World Hospital Congress

10–12 OCTOBER 2018 BRISBANE AUSTRALIA