Management Performance Evaluation - The Case of Social Solidarity Hospitals

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Abstract

Hospitals performance can be evaluated at Board, Management and Employee Levels. “For profit focused” privately operated hospitals tend to be budget efficient; yet, their refusal to treat non-insured/non-paying patients while maximizing profit versus the sufficient essential make them clinically less efficient. Bureaucratic Public Hospitals, while efficient on the treatment side, are a blank check in the budget balancing area. Studies suggest: The Social Solidarity Hospitals, while funded by capital earned from profit making enterprises and donations and volunteers work, seem to offer better value for money than alternatives. Information showing how decisions are made and with which criteria boards are being evaluated, is a gap in current academic literature. Further research is needed on Hospitals board performance evaluation criteria and KPIs. The SMMM tool based on the Data Envelopment Methodology is used to evaluate board performance and examples of social solidarity hospitals good practices from Greece are presented.

Keywords: Performance Management Evaluation, Social Solidarity Hospitals, SMMM tool

1. Introduction

While the medical field is full of efficient doctors, nurses, support personnel and administrators, many of which are customer focused and work ethically. Unfortunately the last decade has seen an increase of newspaper and trade articles discussing pending and ongoing lawsuits and scandals pointing to Hospital mismanagement and shortcomings. We may ask how in spite of all the best practices information availability and specialized training we still manage to have Hospital managers get caught in scandals (for instance of mismanagement of hospital supplies or overcharging of medical insurance charges). This complex subject can in practice be evaluated by shareholders by monitoring one or more of these three levels: Board, Management and Employee Levels. Historically, “For profit focused” privately operated hospitals tend to be budget efficient; yet, their refusal to treat non-insured/non-paying patients while maximizing profit versus the sufficient essential make them clinically less efficient. Bureaucratic
Public Hospitals while efficient on the treatment side are a blank check in the budget balancing area. The quality and the value of health services for the money spent they provide is, in most cases, not proportional to the investment (waste of resources is common practice). Recent Studies suggest that the Social Solidarity Hospitals, while funded by capital earned from profit making enterprises and donations and volunteers work, (with limited range of offerings) seem to offer better value for money than alternatives. Besides financial criteria, non-financial could prove equally important to the three criteria used for financial performance (e.g. community offering, value for money invested, value for patients, etc.).

In this paper we discuss how the performance of Private versus Public versus Social Solidarity Hospitals can be measured. In the next section, reference will be made to some of the more significant literature search findings and existing gaps not adequately covered by recent studies and journal or conference publications. Further in the article, we will attempt to suggest recommendations from the World Health Organization (WHO) that are considered best of class practices for hospital management. The SMMM tool, based on the Data Envelopment Methodology, will also be examined as a possible means to evaluate hospital board performance. Illustrative examples of success stories from Greece will be presented together with a current conclusion on the current state of affairs and future perspectives worthy to be pursued by Hospital Boards in the coming years.

2. Measuring Hospital performance

Measuring Hospital Performance requires the commitment and involvement of the Board of Directors (BOD). According to the American Governance Web site (www.americangovernance.com/checklist) which provides scorecards and checklist, there are six dimensions by which a hospital board can be measured (Mission, Allocation, Culture, Strategy, Performance and Leadership). In the Performance dimension component, the Board has an essential role in overseeing that the strategies and policies set by executive management officers gets implemented in accordance with some agreed quality plan of action and within specific deadlines. The measurement of the efficiency of the implementation of that quality plan consists in checking if specific achievements have been accomplished at specific deadlines as originally scheduled and observing and explaining any deviations that occurred in that quality plan. The plan can be monitored at best by an audit process conducted by certified public accountants in conjunction with management consultants, to confirm the Hospital follows a policy of transparency which can be considered valid by all internal and external stakeholders. In that respect let us observe the six sample evaluation questions suggested on the American Governance Web site: (Their intent is helping auditors determine the current level of maturity of the measured Hospital in comparison to others which might be considered leaders in that field) “1) Do we have a Quality Improvement Plan (QIP) that identifies specific Gaps in performance and targets improvement by certain dates? (Yes/No)
2) Do we have the right measures to evaluate our quality performance? (Yes/No)
3) Do we have the right tools to monitor our progress? (Yes/No)
4) Are we benchmarking against high-Performing organizations and/or the theoretical limit? (Yes/No)
5) Do we have the right Board processes in place for reviewing and evaluating quality performance? (Yes/No)
6) Do we share our performance with our patients, employees and the community? (Yes/No)

With respect to that last of the suggested questions, good practice around the world has benefited from feedback of patients. One very successful program that did just that, was deployed over the last five years in western London and ran in roughly half the hospitals of the UK under the name “Friends & Family Test” (see Figure 1)

Figure 1: Friends and Family Test: Capturing Patient Feedback. (UK 2014).

One of the better attributes of that program was that patients were asked to rate the value for money of their hospital experience and sharing that experience with other patients over the internet (Figure 2) thus giving the whole health system reputation reasons to improve.

Figure 2: Friends and Family Test - Grading the Patient experience with stars and leaving comments for other patients to see on the internet. (UK 2014)

This Feedback is very valuable for shareholders to measure the patients and reputation of the hospital in addition to the financial indicators and, in an ideal world, should be
tied to the bonuses perceived by board members. In the next section we examine some of the most significant literature publications on hospital performance and current gaps for future resolution.

### 3. Indicative Literature & Gap in existing studies for future research

In this section, the indicative literature review focuses on five more significant references. We then expose the Gap in the aforementioned studies for future research.

This report demonstrates convincingly that there is no one-to-one relationship between resources made available to sectors like health care and education and the overall performance of the public health sector (as stated on p25 in the summary). High health spending provides no guarantee whatsoever of good system performance. This is best illustrated by the US and Germany. The same can also be said of the privatization of health care.

**Analysis:** Some of the main reasons can be attributed to factors such as: 1) Demographics, 2) Wage Levels (If wage levels in the labor intensive production of public services are relatively low, taxpayers get more and arguably better services), 3) large bureaucracies often have trouble handling an outpour of new money, 4) Policies aimed to stimulate economic growth and policies to further equity are not mutually exclusive. The hypothesized negative correlation between the level of government spending and taxation vs., economic growth is much weaker than is often maintained.

This article discusses the measurement of the social performance of firms’ operations using the Data Envelopment Analysis (DEA), a mathematical programming method for evaluating the relative efficiencies of firms (Charnes et al. 1978, Cook and Zhu 2006) that does not require a priori weights to aggregate different CSP dimensions.

**Analysis:** DEA computes an efficient frontier that represents the best performers in a peer group. The DEA Social Performance score represents the distance of a firm to the efficient frontier and the extent to which a firm can reduce its current concerns, given its strengths relative to those of the best performers. The SMMM tool suggested later in this presentation for evaluating the performance of hospital management is based on this methodology.

The central theme in much of the research relates to whether it is appropriate for non-profit organizations to converge or diverge with the corporate governance practices of for profit organizations.

**Analysis:** In arguing this case, they evaluate both stakeholder and stewardship approaches to corporate governance in the non-profit social enterprise sector (a key difference between for profit and non-profit organizations identified by Steane and Christie (2001, p. 56) where ‘non-profit Boards can mimic some aspects of a
shareholder approach to governance’ but, in fact, have priorities and activities that indicate ‘a stakeholder approach to governance’.

1- The primary purpose of a performance evaluation is to achieve continual improvement in the governance of the Board.

2- Any relevant evaluation can only be made against criteria established by the Board as to what constituted responsible governance.

3- To improve performance, evaluation must be frequent and continuous.


This rapport discusses:
1) The changing context of capital investment
2) Influencing capital investment
3) Economic aspects of capital investment
4) Translating hospital services into capital asset solutions
5) Conclusions and critical success factors

Analysis: There is more to performance than spending, the greater budget does not guarantee success, several counter examples demonstrate that much spending usually leads to waste.

5) Uwe E. Reinhardt, “The Economics of For-Profit and Not-For-Profit Hospitals, Nonprofit hospitals owe society community benefits in exchange for their tax exemption, but what is a fair amount?” (2010), HEALTH AFFAIRS – Volume 19, Number 6.

This rapport discusses the main findings and comparison of differentiators between legal and financial aspects of these hospitals in Europe, the US and some other countries outside Europe. It mentions best practices and several success stories for not for profit hospitals.

Analysis: Several investments in not for profit hospitals are demonstrated to be worthwhile (remember that If Net Present Value (NPV) > 0 or (Internal Rate of Return (IRR) > rate, this implies => A Good Investment as shown in the three exhibits of Figure 3 below for some non-profit hospitals.

| EXHIBIT 3 |
| Not cash Operating Income Flows For Two Hospitals, H0I And CMO |

<table>
<thead>
<tr>
<th>Year</th>
<th>For-Profit Hospital's perspective</th>
<th>Nonprofit Hospital's perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-4,000,000</td>
<td>-4,000,000</td>
</tr>
<tr>
<td>1</td>
<td>916,000</td>
<td>976,000</td>
</tr>
<tr>
<td>2</td>
<td>1,078,000</td>
<td>976,000</td>
</tr>
<tr>
<td>3</td>
<td>899,200</td>
<td>976,000</td>
</tr>
<tr>
<td>4</td>
<td>791,520</td>
<td>976,000</td>
</tr>
<tr>
<td>5</td>
<td>791,520</td>
<td>976,000</td>
</tr>
<tr>
<td>6</td>
<td>715,700</td>
<td>976,000</td>
</tr>
</tbody>
</table>

Net present value (NPV) = -4,000,000 + 916,000 + 1,078,000 + 899,200 + 791,520 + 791,520 + 715,700 = 496,560

Internal rate of return (IRR) = 8.44%

SOURCE: Author’s analysis.
Gap Areas Identified in Literature Search: We identified two gap areas in existing academic literature which includes:

1) A lack of a commonly accepted standard on how Hospital Boards’ Performance should be evaluated (in practice this rarely happens – strategy should be tied to achievable and measurable objectives and deadlines, bonuses should be tied to achieving these objectives.)

2) Information showing how Hospital Board decisions are made and with what KPIs criteria boards are being evaluated (most hospital boards do not transparently share and publish the measures with which their performance will be evaluated – shareholders should demand that these be published and monitored for progress).

4. Recommendations from the World Health Organization (WHO 2009)

In order to circumvent some of the more frequent problems with hospital management the WHO developed a task force and published in 2009 what could be called “the Ultimate” Best Practices. These recommendations, while achievable at various degrees, require that hospital boards invest in changing established cultures and changing practices to be more in line with a Total Quality Management process approach to solving business issues. Several years later, some of the better hospitals with regards to being considered leaders around Europe, have implemented many of the recommendations at various degrees, while many other hospitals have not even started.

Let us look at some of these recommendations. Figure 4 (WHO table 1.1) addresses the primary reason why some hospitals never reach their potential because patients forget they are the client who has rights to choose between hospital offerings and the power to express how their tax money is spent for the value received.
Table 1.5 Potential changes in the way that patients use services

<table>
<thead>
<tr>
<th>Old approach</th>
<th>New desired approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients use the system in a series of unconnected episodes</td>
<td>Need to anticipate and forecast and health systems develop methods to manage the</td>
</tr>
<tr>
<td></td>
<td>whole journey of disease, support patients in their own homes and have electronic</td>
</tr>
<tr>
<td></td>
<td>records that link to a comprehensive set of data</td>
</tr>
<tr>
<td>Patients are passive recipients of care</td>
<td>Patients are involved in the management of their own care</td>
</tr>
<tr>
<td>Patients are dealt with in batches and spend most of their time within the</td>
<td>Patients flow through the system with minimal waits, resolving the system and</td>
</tr>
<tr>
<td>system setting - this is because it is expensive to keep expensive staff and</td>
<td>having staff busy is less important than achieving a smooth flow through the system</td>
</tr>
<tr>
<td>support healthy</td>
<td></td>
</tr>
<tr>
<td>Patients are treated as though their time is free and so required to</td>
<td>Conservation of time and increasing importance of many people means that a</td>
</tr>
<tr>
<td>understand the significance of the work and movements for the convenience of</td>
<td>comprehensive service will be placed on convenience and speed</td>
</tr>
<tr>
<td>the provider</td>
<td></td>
</tr>
<tr>
<td>Services are designed around the needs of providers and treatment</td>
<td>Services are designed to meet the requirements of patients</td>
</tr>
<tr>
<td>Patients go to hospital for round the clock monitoring</td>
<td>Home based technology and diagnostic equipment outside the hospital reduce the</td>
</tr>
<tr>
<td></td>
<td>out of hospitalities</td>
</tr>
<tr>
<td>Interaction is face to face and on a one to one basis</td>
<td>E mail and telephone can be used and groups can be set up for some issues</td>
</tr>
<tr>
<td>Providers do not follow up and keep referrals</td>
<td>Patients can initiate follow up and have a</td>
</tr>
<tr>
<td></td>
<td>right of return or direct access to specialist help if they think they need it</td>
</tr>
<tr>
<td>Patients often die in hospital when they would have preferred to die at home</td>
<td>Patients have plans for end of life care</td>
</tr>
</tbody>
</table>

Figure 4: Potential changes to the way Patients Use Services

The solution does not require a blame on the part of the patients but also a shared responsibility on the side of the care givers of that service which often forget to be patient centric in their culture and their approach to doing business (potential changes in the way hospital staff work) as seen in Figure 5 (WHO table 1.2).

Table 1.2 Potential changes to the way staff work

<table>
<thead>
<tr>
<th>Old approach</th>
<th>New designed approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek a junior member of staff who excels</td>
<td>Seek a senior member who makes decisions and delegations - this should reduce the</td>
</tr>
<tr>
<td></td>
<td>number of patients admitted to hospital and reduce the length of stay of those who</td>
</tr>
<tr>
<td></td>
<td>are admitted</td>
</tr>
<tr>
<td>See a doctor</td>
<td>See the most appropriately professional</td>
</tr>
<tr>
<td>Reduce the time to save money</td>
<td>Increase the time to improve efficiency and outcomes</td>
</tr>
<tr>
<td>Staff develop ‘work around’ for problems</td>
<td>Staff undertake case analysis to create solutions</td>
</tr>
<tr>
<td>Large amounts of time are wasted by poor work process design - safety may</td>
<td>Unnecessary staff movement can be reduced by the proper design of work processes and</td>
</tr>
<tr>
<td>also be compromised</td>
<td>the work environment as well as the use of IT systems</td>
</tr>
<tr>
<td>Many services stop at weekend and in the evening</td>
<td>Specialist consultation, diagnostics and other support is available for much longer</td>
</tr>
<tr>
<td></td>
<td>time than the traditional working week</td>
</tr>
<tr>
<td>Beds are a mark of prestige and a source of income</td>
<td>Beds are a cost and emergency and surgical admissions are seen as a sign of modernity</td>
</tr>
</tbody>
</table>

Figure 5: Potential changes to the way hospital Staff work
Comparing system descriptors can serve as a guideline with regards to what has worked in the past for various categories of hospitals (private for profit, public non-profit, social) as seen in Figure 6 below.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Characteristics</th>
<th>Northern Ireland</th>
<th>Netherlands</th>
<th>Portugal</th>
<th>Spain (Valencia - Alcoy model)</th>
<th>Italy (Tuscan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Across systems integration</td>
<td>Acute care and primary care are part of an integrated system.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute care and primary care are not part of an integrated system.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Social care is part of the same system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social care is part of a separate system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital governance</td>
<td>Private interest company (private model)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Publicly owned and managed as part of an area-based service structure</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital funding (current expenditure)</td>
<td>Payment by occasion of service from public funds</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payment by occasion of service from insurance funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practice funding</td>
<td>Capitation-based system from public funds</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payment by occasion of service from public funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payment by occasion of service from insurance funds</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct payment from patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The private company running the primary and secondary care services in the Netherlands “NHBO Medisch” does not use the funds for the purpose of the hospital. In Portugal, private health care is provided under the control of a public service administration.

Figure 6: Descriptors Comparison between 5 different types of European Hospitals

Success Stories are not limited to the major European countries compared in the previous table. The following two figures present social solidarity hospitals good practices from Greece (Figures 7 Swedish member of the European Parliament Mikael Gustafsson visiting 8).
5. Discussion – Why are the WHO Recommendations Rarely Practiced?

Several Reasons have been advanced by board members and Health professionals that we interviewed:
1) Assigning Lawyers or Non-Business experienced professionals to the Board as administrators (including Medical doctors) with little MANAGEMENT experience is a recipe for failure.

2) Political Motivated assignments of administrators not based on PERFORMANCE offer no Guarantee especially when MOTIVATION / DEDICATION to the Health Mission is not validated by Patients and Hospital Staff.

3) Applying Best practices involves a commitment to A QUALITY CULTURE and BEING LEGALLY AND FINANCIALLY ACCOUNTABLE.

4) TRANSPARENCY means encouraging being SCRUTINIZED and ACCOUNTABLE by Patients/Investors and the General Public.

5) Applying BEST PRACTICES is a Balancing Act to deliver Value for Investors, Patients, Society (within Budget while increasing throughput and Guaranteeing Quality of Health services FOR ALL).

**One Possible Solution:** The Trustee Toolbox [www.mhhp.com](http://www.mhhp.com) suggests doing the following:

8. Why Should Boards Regularly Do a Self-Assessment? (US Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are required to conduct an annual board self-assessment. JCAHO Standard) LD.4.5 requires hospital leadership to:

9. Set measurable objectives for improving hospital performance;

10. Gather information to assess their effectiveness in improving hospital performance;

11. Use pre-established, objective process criteria to assess their effectiveness in improving hospital performance;

12. Draw conclusions based on their findings and develop and implement improvement in their activities; and

13. Evaluate their performance to support sustained improvement.

15. How should the Assessment be Used to Improve Governing Performance?

16. What are the Costs of Board Under-Performance?

Examples of reports for management to evaluate hospital performance from the Trustee Toolbox can be seen in Figures 9 & 10 Below.
While Diagram 9 exposes possible causes to a problem, Diagram 10 gives a snapshot of leadership attitudes. These are all good but involve a significant time investment on the part of the board. One possible reliable solution and accepted methodology for accessing the current situation can be found in the next section.
6. SMMM tool based on the Data Envelopment Methodology as a possible means to evaluate board performance?

The Balanced Scorecard Institute (www.balancedscorecard.org) created the Strategic Management Maturity Model (SMMM) for busy managers who need a quick assessment of their organization performance. The tool allows to monitor progress in improving maturity of strategic management, and to allow benchmarking across organizations, or departments and in order to identify best practices.

There are 8 slides with 5 options each corresponding to the Eight Dimensions of Strategic Management (Figures 11-18 below for each dimension): 1) Leadership, 2) Culture and values, 3) Strategic thinking and planning, 4) Alignment, 5) Performance measurement, 6) Performance management, 7) Process improvement, 8) Sustainability of strategic management (each slide ranks 1-5 for a maximum total of 8 to 40 points) and the Results are explained in Figures 19-21.

![Figure 11: Leadership - Dimension 1 of 8](http://epublishing.ekt.gr)
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)
Figure 12: Culture and values - Dimension 2 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)

Figure 13: Strategic thinking and planning - Dimension 3 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)
Figure 14: Alignment - Dimension 4 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)

Figure 15: Performance measurement - Dimension 5 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)
Figure 16: Performance management - Dimension 6 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)

Figure 17: Process improvement - Dimension 7 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)
Figure 18: Sustainability of strategic management - Dimension 8 of 8
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)

Figure 19: Results - Score
Source: The Balanced Scorecard Institute (www.balancedscorecard.org)
7. Conclusion

Recent national reports from Australia, Scotland and the United States have examined how external mechanisms for performance measurement contribute to internal development and public accountability. The common conclusions are that:

1) Voluntary and statutory agencies should be actively coordinated for consistency and reciprocity.
2) Consumers should be prominently involved.
3) National programs should be comparable internationally.
4) The standards, processes and results of external assessments should be transparent and freely accessible to the public.

The Greek economic crisis exposes needs and priorities that should be exploited in the future.

The experience and performance of social Solidarity hospitals across Europe and Greece should help create better value for money hospitals. The authors believe that the future health systems across Europe should be socially just and inclusive. This will require that the system becomes more patient friendly and that Hospital Boards performance should be often monitored with audits and evaluated with tools like the SMMM Tool, to ensure financial and health value performance for the money invested. Hence Hospital CEOs / should by preference be a good administrator with extensive Business Management Experience while caring for the Health mission of generations of patients.

**Bibliography**


Uwe E. Reinhardt U.E. (2010) The Economics of For-Profit and Not-For-Profit Hospitals, Nonprofit hospitals owe society community benefits in exchange for their tax exemption, but what is a fair amount? *Health Affairs*. 19(6), pp56-82

**Websites**


Trustee Toolbox [www.mhlp.com](http://www.mhlp.com) (accessed 12 March 2016)

The Balanced Scorecard Institute, 2010, ‘‘the Strategic Management Maturity Model (SMMM)’’, [www.balancedscorecard.org](http://www.balancedscorecard.org) (accessed 10 April 2016)