WORLD HEALTH ORGANIZATION
Regional Office for the Eastern Mediterranean
ORGANISATION MONDIALE DE LA SANTE
Bureau régional de la Méditerranée orientale

منظمة الصحة العالمية
المكتب الإقليمي لشرق المتوسط

Regional Committee for the Eastern Mediterranean

EM/RC56/5
August 2009

Fifty-sixth Session

Original: English

Agenda item 6 (c)

Technical paper

Improving hospital performance in the Eastern Mediterranean Region

Globally and regionally, hospitals absorb around 50%–70% of total government health expenditure, employ a large workforce and make extensive use of sophisticated biomedical technology. Improvement of hospital performance as part of improving overall health system performance is high on the reform agenda of countries in the Region. This paper raises awareness of the gaps in hospital performance in the Region and of the crucial roles of clinical governance and leadership and management in improving hospital performance.

A draft resolution is attached for consideration by the Regional Committee.

Contents

Executive summary

Hospitals are important and costly components of the health system worldwide. Globally and regionally, hospitals absorb around 50%–70% of total government health expenditure, employ a large workforce and make extensive use of sophisticated biomedical technology. WHO and the International Hospital Federation undertook a comprehensive global study of hospital performance during 2001–2002. The study identified the major challenges affecting hospital performance as the disconnect between hospitals and the national health system; chronic underfunding in low-middle and low-income countries, concomitant with underfunding of the health system in general; and predominance of the curative orientation of hospitals and minimal involvement in preventive and promotive care to the catchment communities. The absence of a culture of costing and cost analysis was a feature in many public hospitals and hospital managers in most countries lacked competencies and skills in this area.

In the Eastern Mediterranean Region, weak management of hospitals has been emphasized as one of the causes of low hospital performance, especially in lower-middle and low-income countries. Poor management of human resources has also been noted to be widespread with an absence of incentive and reward systems and comprehensive appraisal systems. Improvement of hospital performance as part of improving overall health system performance is high on the reform agenda of countries in the Region. Many countries have developed programmes to strengthen hospital managerial skills and to introduce modern procedures in hospital management, including hospital autonomy, to provide greater flexibility in management, improve information systems and increase hospital efficiency.

Clinical governance was introduced in hospitals in developed countries to bridge the gap between clinical and managerial cultures and bring together the often separate tasks of management and quality assurance, including hospital public health involvement. It is based on the principle that those responsible for enhancing the quality of care must also be able to influence the use of resources. Clinical governance has not yet been introduced in any hospitals in the Region. However, all countries of the Region have been engaged at some time in some aspects of clinical governance, which will facilitate introduction of the concept.

Based on the perceived needs of countries in the field of hospitals, WHO has produced a number of focused publications and policy papers on hospitals and has developed several tools that can be used to improve performance through strengthening hospital management, assessing and improving quality, patient safety and accreditation. WHO has also strengthened support to countries by building support networks, establishing collaborating centres and establishing interactive websites.

The objective of this paper is to raise awareness of the gaps in hospital performance in the Region and of the crucial roles of clinical governance and leadership and management in improving hospital performance. It is critical for Member States to improve hospital performance if patients in the 21st century are to receive cost-effective and quality services. This can be achieved through: cost analysis and containment in regard to hospital financing; strengthening leadership and management in hospitals; introduction of clinical governance; and use of the performance assessment tool for quality improvement in hospitals.

1. Introduction

Hospitals are important and costly components of the health system worldwide. Globally and regionally hospitals absorb around 50%–70% of total government health expenditure, employ a large workforce and make extensive use of sophisticated biomedical technology. Besides treating patients, hospitals play important roles in teaching, research, health system support and employment of health professionals [1]. Hospitals range from small 30 bed rural settings supervised by general physicians, to district and secondary hospitals, to highly sophisticated tertiary hospitals with advanced medical specialities, high technology equipment and well known for teaching of health personnel. Rules of performance apply variably to them all [2]. Hospital performance can be looked at in two contexts: within the context of the overall goals of the health system, i.e. ensuring high quality and equitable health services that are responsive to public expectations and fairness in the way people pay for health services; and as a subsystem encompassing responsiveness to patients, clinical efficiency, effectiveness, quality and safety [3].

As institutions, hospitals increasingly face external and internal challenges. Externally, this includes evolving epidemiological and demographic scenarios, changing patterns of disease and ageing populations. Internally, hospitals face substantial challenges, such as increasing complexity and specialization, the introduction of new medical technologies and pharmaceuticals, rising public and political expectations and new financing mechanisms. These challenges require management and leadership of the highest calibre [2].

The relationship between the hospital and other health care services varies considerably. At one end of the spectrum, typically in rural areas of middle- and low-income countries, the hospital has a central role in the delivery of all types of health care, often with administrative responsibility for outlying facilities. At the other end of the spectrum, the United Kingdom, for example, has transferred budgets for purchasing hospital care to groups of primary care physicians, thus potentially giving them more power over hospitals [1].

In the late 1980s, it became clear that poor performance and declining health outcomes were caused not only by under-funding, but also by inadequate management of health care resources [3]. Recently, weak management of hospitals has been emphasized as one of the causes of low hospital performance in the Eastern Mediterranean Region, especially in lower-middle and low-income countries [4]. There is a long history in all countries of the Region with regard to building up hospital managerial skills and introducing up-to-date procedures, practices and quality programmes. Many countries, to reduce costs and improve management and accountability have tried hospital autonomy[1] and have adopted contracting out of clinical and non-clinical services. The data collected by hospital systems in the Region are mostly quantitative in nature and usually focus on productivity indicators related to curative and rehabilitative services. They do not capture qualitative data, such as information on the needs and expectations of the population, which would enable managers to address performance improvement.

In the past decade, new strategies have been developed at global level and used to address performance improvement. These include assessment of hospital performance against a set of indicators, to help hospitals become more responsive to community needs [5]. The new concept of clinical governance is a major innovation, first developed in the United Kingdom in 1998. It was introduced as a set of activities that bring together the often separate tasks of management and quality assurance. Clinical governance is defined as *a framework through which national*

[1] Hospital autonomy: degree of autonomy (decision rights) hospitals retain in relation to their owner, organized purchasers, the government and consumers. In the context of hospitals, critical decision rights include control over input mix and level, outputs and scope of activities, financial management, clinical and non-clinical administration, strategic management (formulation of institutional objectives), market strategy and sales [4].

health system organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish [6,7].

Despite the large share of the health budget devoted to hospitals, and in contrast to the growing body of research on primary care, there has been relatively little research on hospital performance. Hospitals are usually assessed in relation to the production of curative services without measuring their contribution to support for primary health care, public health services, research in health and training of health professionals. Nevertheless, during the past decade more attention has been dedicated to hospital performance and many organizations interested in hospitals have started to produce focused publications and policy papers and to develop more tools to help in strengthening hospital performance [2].

In 2000 WHO proposed a health system framework proposal that was well accepted by Member States and, based on their input, revised in 2007 [8,9] Health stakeholders are becoming more and more interested in health systems and in streamlining hospital services as part of the health system [10]. Improvement of hospital performance as part of improving overall health system performance is high on the reform agenda of countries in the Region. Many countries have developed programmes to strengthen hospital managerial skills and to introduce modern procedures in hospital management, including hospital autonomy, to provide greater flexibility in management, improve information systems and increase hospital efficiency.

The objective of this paper is to raise awareness of the gaps in hospital performance in the Region and of the crucial roles of clinical governance and leadership and management in improving hospital performance. The paper describes the current situation and presents validated evidence-based tools and recommendations to address these issues.

2. Global situation

Until the Second World War, hospitals[2] were largely run as independent charitable and religious institutions. After the war, hospitals became the focus for the development of modern health systems in many countries, and particularly in the industrialized economies. The growth of hospitals was supported by the development of health and biomedical technology, particularly antiseptic techniques, more effective anaesthesia and surgical knowledge [2].

The issue of hospital efficiency and performance dominated the policy debate in many countries during the last two decades of the 20th century. One important dimension of that debate was focused on cost recovery in order to reduce government involvement in financing public hospitals [11]. Health professionals were expected to become more cost-sensitive, and a culture of costing and cost analysis was promoted in many public and private hospitals. Costing, coupled with epidemiological information on causes of discharge, led to the adoption of the concept of diagnostic related groups[3] as a refined mechanism for reimbursement [2].

Globally, the number of hospitals beds per population in a country has traditionally been used as the indicator of quality of health care. However, evidence has shown that decreases in morbidity and mortality are influenced more by public health preventive and promotive actions and better hospital management rather than mere numbers of beds. Three major developments have

[2] Residential establishment equipped with inpatient facilities for 24-hour medical and nursing care, diagnosis, treatment and rehabilitation of the sick and injured, usually for both medical and surgical conditions, and staffed with at least one physician. The hospital may also provide outpatient, preventive and promotive services.

[3] Diagnostic related groups: a way of categorizing patients according to diagnosis and intensity of resources required, usually for the period of one hospital stay [8].

influenced hospital care in recent decades: the transfer of long-stay psychiatric patients to community settings; the increasing provision of nursing care for the elderly outside hospitals; and the restructuring of acute care, with more ambulatory treatment and rehabilitation outside hospital. These changes have resulted in a decrease in the number of acute hospital beds and a decreasing average length of stay. Admissions have risen, reflecting the more efficient management of patients, new technologies and financial incentives to reduce length of stay. The number of acute care beds in European Union countries actually fell from 41 beds per 10 000 population in 1990 to 34 in 1999 [12].

One of the most powerful factors shaping change in hospitals has been increasing medical specialization. Health care workers are increasingly required to acquire new competences in order to perform their tasks. They also have to keep up to date with new developments in information technology. In the future, technological advances will require an even more specialized workforce. There is also a trend towards strengthening nursing as an independent health profession, and some European countries have introduced various types of nurse practitioner. Overall, the role of multidisciplinary teamwork is increasing, which will require new skills, new attitudes to collaboration and new mechanisms to ensure continuity of care [3].

Hospital organization and management underwent major transformations during the 1980s. Management models were borrowed from the private sector. These aimed at making managers more accountable, flattening previously hierarchical management structures, promoting competition to produce greater efficiency, linking inputs to results and setting performance indicators against which to assess staff compliance and productivity. Management information systems were strengthened by using information technology and the international classification of diseases (ICD) [2].

Hospital autonomy was promoted in lower and middle-income countries, but concerns were raised that such reforms represented a first step towards privatization of publicly owned hospitals. The models on which current experiences are based did not emphasize the role of the Ministry of Health in regulation, evaluation and ensuring equitable access [13]. It is evident from evaluation studies carried out in Africa, Asia and Latin America [14,15] that well designed autonomy and improved governance are generally associated with better performance. Failures were attributed to lack of clearly defined mission, inefficient decision-making and management systems, and insufficient motivation of personnel [16,17].

The concept of clinical governance is based on the premise that those responsible for enhancing the quality of care must also be able to influence the use of resources. It requires hospitals to integrate financial control, service performance and clinical quality, the latter encompassing activities such as improving information systems, instituting professional development and developing peer review systems [18]. The clinical governance elements are: education and training, clinical audit, clinical effectiveness, openness of performance results to public scrutiny, research and development, and risk management to the patient, the practitioner and to the organization.

In order to understand the drivers of hospital performance better and to assess the factors influencing it, WHO and the International Hospital Federation undertook a comprehensive global study on hospital performance during 2001–2002. The results were published in 2008 [19]. The study chose at least two countries from each of the six WHO regions totalling 20 countries. From the Eastern Mediterranean Region it included: Egypt, Cyprus (now in the European Region), Lebanon, Morocco and Syrian Arab Republic. The objective was to review the role of hospitals within the health system and their capacity to meet the population’s needs. The study observed that while there are huge differences between countries, there is considerable commonality

between countries regarding factors which affect the performance of hospitals. In most of the countries studied, hospitals tend to be run as a separate system with very little connection with the national health system.

The study concluded that chronic under-funding and poor management in most middle and lower-income countries led to decay and neglect of public hospitals. The effect was greatest at the district level, resulting in the diversion of patients to the tertiary level. Most hospitals deliver overwhelmingly curative services, and hospital involvement in providing preventive and promotive care to the catchment communities is minimal. Their role in education and training of health workers is limited, with most using conventional methods. With regard to human resources management in hospitals, in most countries the study found that poor management of human resources is widespread with incentive and reward systems absent. Systemic appraisal systems exist in very few countries, while a few countries lack even job descriptions and skills specifications. Low morale, underpayment and inequities in availability and distribution of human resources have created problems in recruiting and retaining competent staff. [19].

3. Regional situation[4]

Hospitals in the Region are quite diverse in their size, functions and ownership. A large proportion of hospitals are owned by government and provide free or subsidized hospital care. Nevertheless, there is increasing dependency on user fees to cover hospital budgets in the public sector, consequently reducing access to hospital services by the poor. To address the resultant inequity and to increase efficiency, transparency and cost containment, almost all countries are introducing some reforms.

The supply of private hospitals, usually of small to medium size, has grown in all the countries as a consequence of active and passive privatization policies. Private hospital beds range from 80% of the total beds in Lebanon, to 43% in Jordan and Yemen to 8% in Sudan and 6% in Iraq.[5] This proliferation of the private sector is not accompanied, in lower middle and low-income countries, by a parallel development of regulatory systems. Concentration of public, and especially private, hospitals in the capital and other big cities has exacerbated inequity in distribution of care in many countries.

Most countries of the Region do not have hospital strategies and plans[6] in relation to the health system as a whole. Hospitals provide largely curative and rehabilitation services and their involvement in preventive and promotive activities is low to moderate, with great variation between hospitals and countries. Where hospitals support primary health care, that support is largely confined to training, developing management protocols and referral.

The number of beds per 10 000 population ranges from 37 beds (Lebanon 37 and Libyan Arab