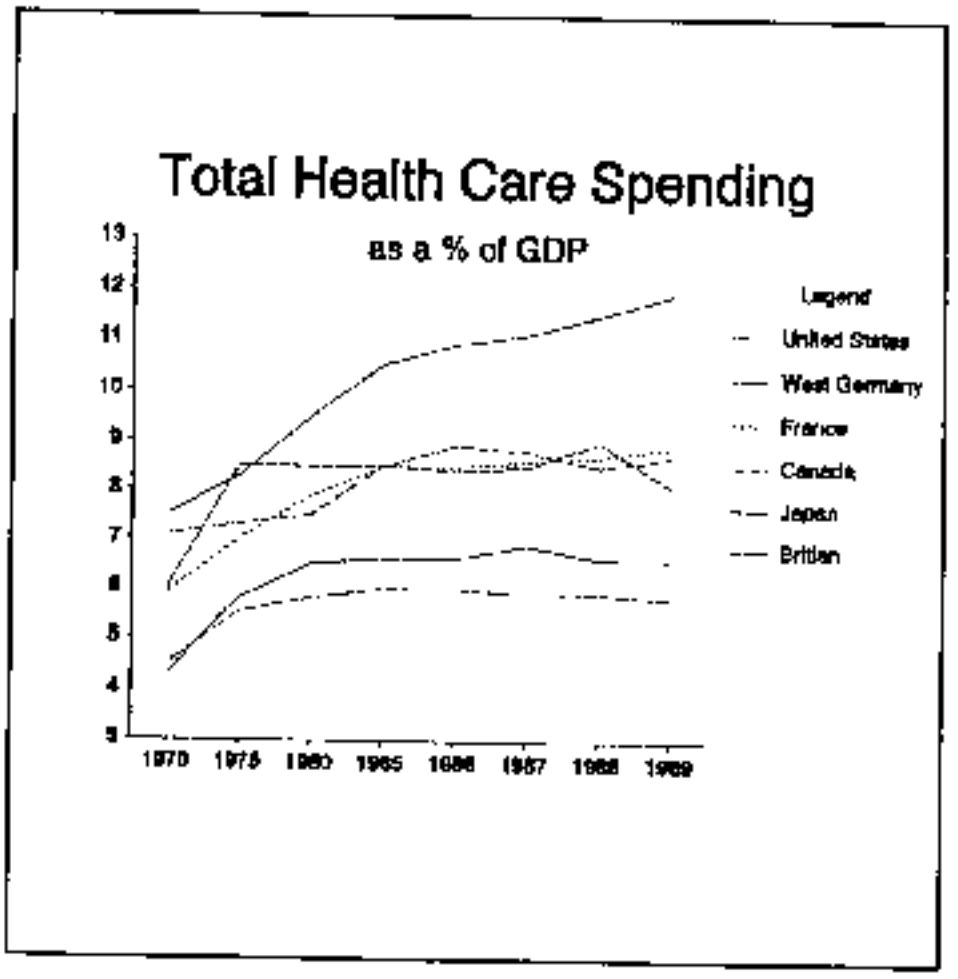
'SELF-GOVERNING HOSPITALS - IN A PUBLICALLY FUNDED SYSTEM'

As you might imagine, it is a great pleasure for me, having been born in Leeds, and having spent most of my career working at the General Infirmary, to be invited back to the Nuffield Centre to talk about the role of self-governing hospitals in a government-funded system. This is the model we enjoy in Canada, and the model being pursued through the current reforms in the U.K. to create self-governing hospital trusts.

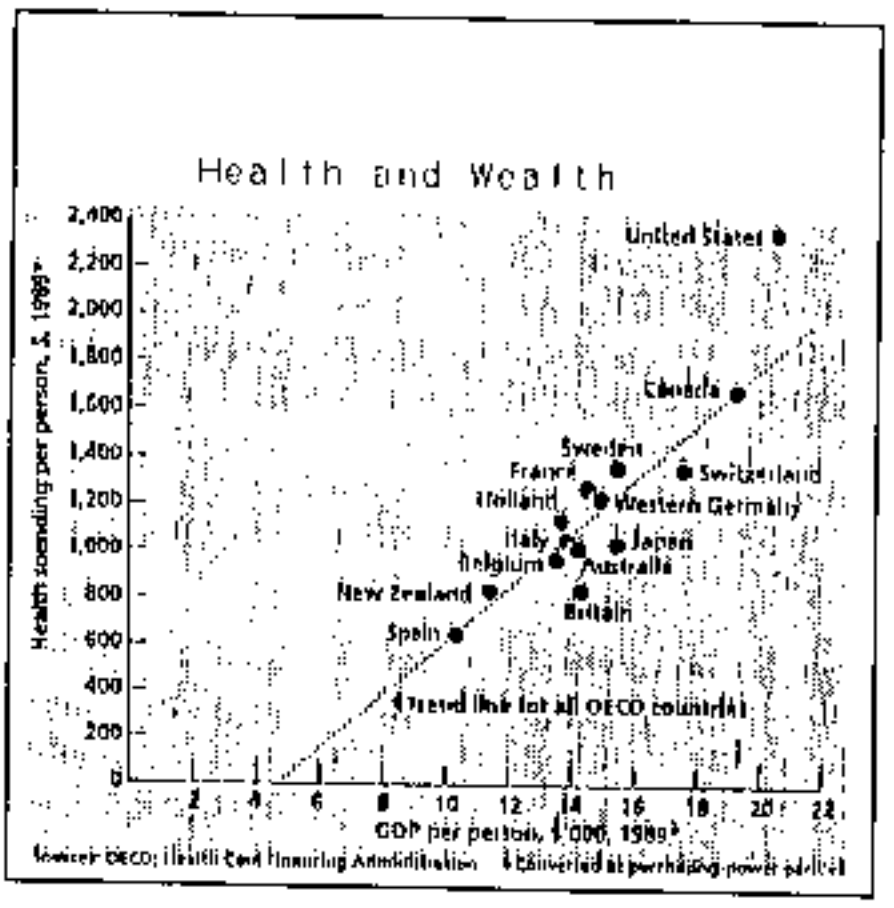
You might understand my enthusiasm for this subject if I explained to you a little bit the situation of my departure from England. I left in October 1974 shortly after the first reorganization. Prior to reorganization, I had been the Assistant Secretary to the Board for the United Leeds Hospitals and the Deputy House Governor of the General Infirmary of Leeds. In working in a teaching hospital, I had always enjoyed limited freedom and flexibility that you got from the fact that we were semi-autonomous Board of Governors. With the 1974 reorganization, the General Infirmary at Leeds suddenly became part of the multi-level system. Our direct relationship with the Ministry was replaced by a multi-tier system, part of the Leeds Area Health Authority Western District (T). As you might imagine, going to work each day for the Leeds Area Health Authority Western District (T) was hardly something that stirred my heart and sent blood coursing through my veins. I lost any sense of commitment to the organization or belief that anything I could do was really going to have any impact. The reason why I have so enjoyed my experience in Ontario and why it pleases me to see this shift going on in the current system in the U.K. is that I believe that it is important to have hospitals as cohesive purposeful reorganizations with which their staff can strongly identify. This ensures that corporate values are in place that drive the organization in a coordinated fashion to deliver exemplary care and service.

Having made clear my biases from the beginning, I will get into the substance of my presentation.

I want to start by talking about the international scene and then gradually bring it down to the hospital level. For those of you not familiar, the first graph shows Canada relative to the other industrialized nations with regard to the percentage of G.D.P. spent on health. As you can see, Canada, after putting on a little bit of an early spurt, tends to cluster around the majority of the other industrialized nations and has recently been showing some slight improvements. Three countries are outliers, the United States way up, and then Japan and the United Kingdom way down. While we understand some of the problems as to why the United Kingdom is somewhat lower, Japan remains a mystery to many of us, partly because they seem to have different accounting procedures and different admitting practices.

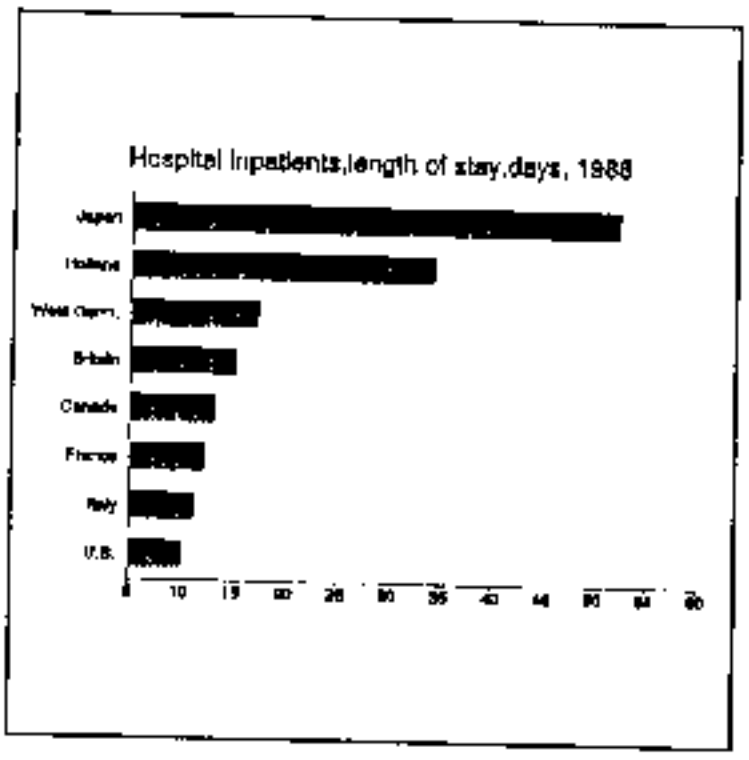


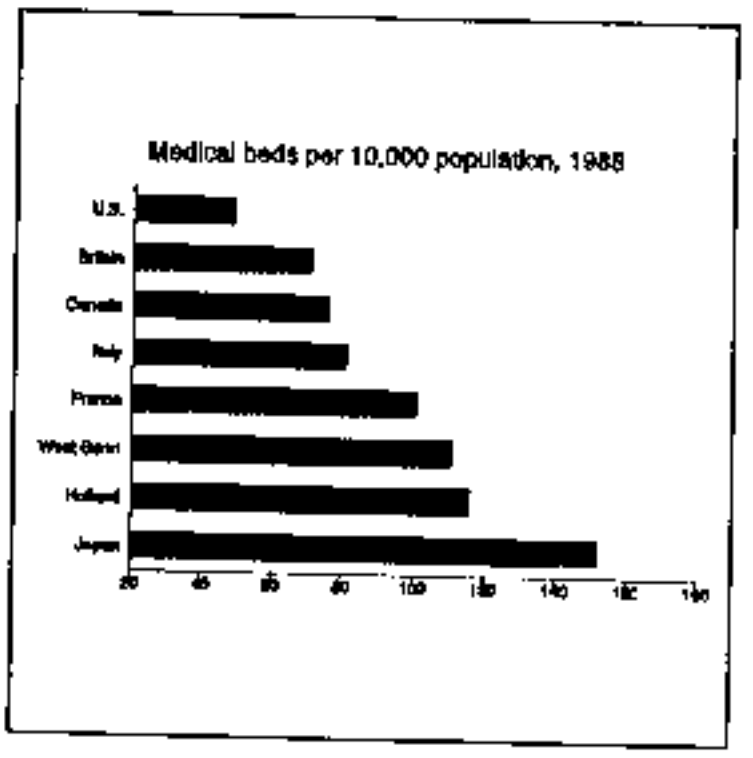
What is important is to tie those costs back to wealth. As we keep hearing these days we cannot improve health care services without improving the wealth of the nation. By looking at how those two particular parameters correlate, you can see on this second graph, that Canada is right on the line in terms of the slope. This suggests that the amount spent on health relative to the wealth of our nation is appropriate when measured against other countries.

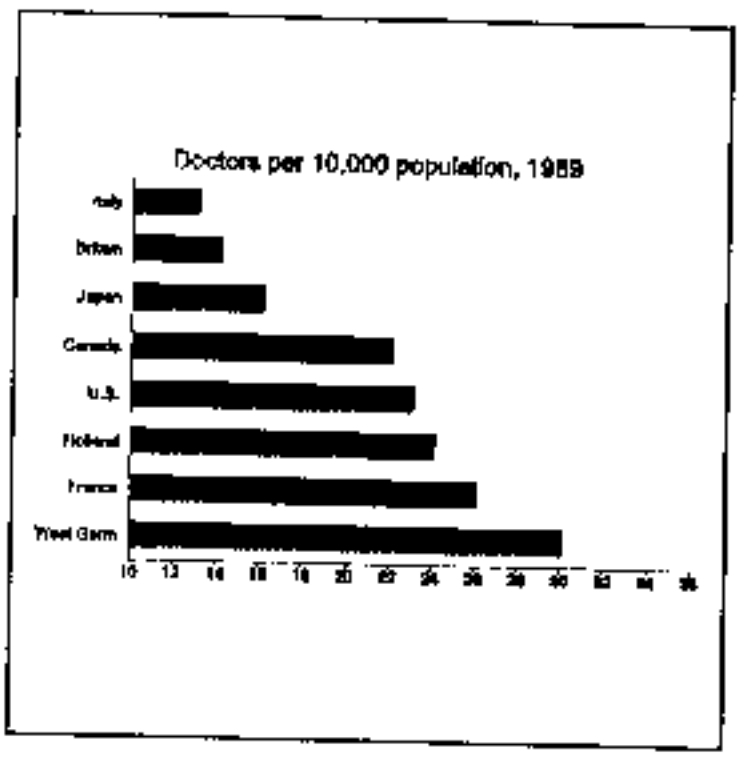


Again you can see a number of other countries that are off the line. Either they are spending much too little relative to their wealth, or spending far too much.

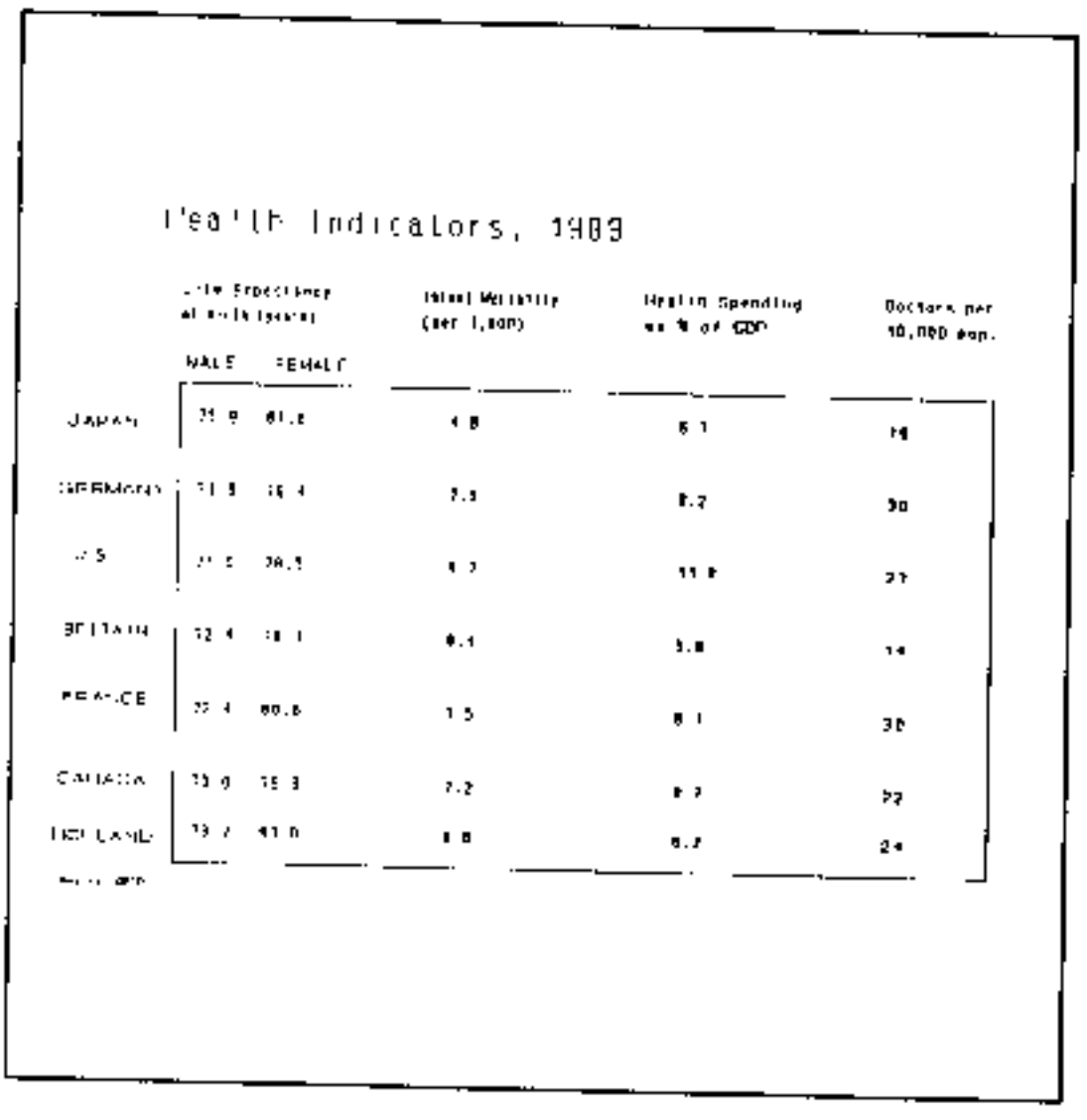
The next three graphs looks at length of stay, the number of beds per 1000 and the number of physicians per head of population. You will see again that Canada performs well among industrialized nations.







The graph below demonstrates some of the measures of health and again shows Canada's performance relative to life expectancy, infant mortality rate, and life expectancy. It would suggest that we do have a well-performing system when we look at ourselves in comparison to other industrialized nations.

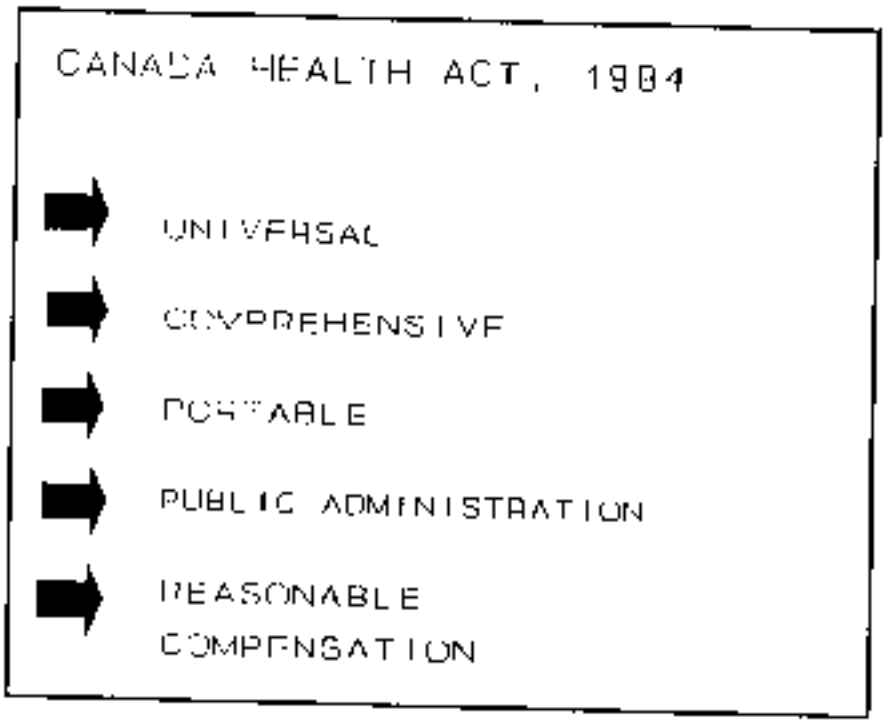


This data, however, is not an excuse for complacency as there are other jurisdictions which show a better record. There are opportunities to improve, both the financial effectiveness and the overall quality of our system.

Canada Level

Having flaunted Canada's position within the international situation, I want to spend a little time talking about the Canadian Healthcare System. One of the misconceptions with regard to health care in Canada is that there is such a thing as a Canadian system. In fact, health care in Canada is a provincial responsibility, and the role of the Federal Government is purely that of standard setting and funding. Through the Canada Health Act, they have

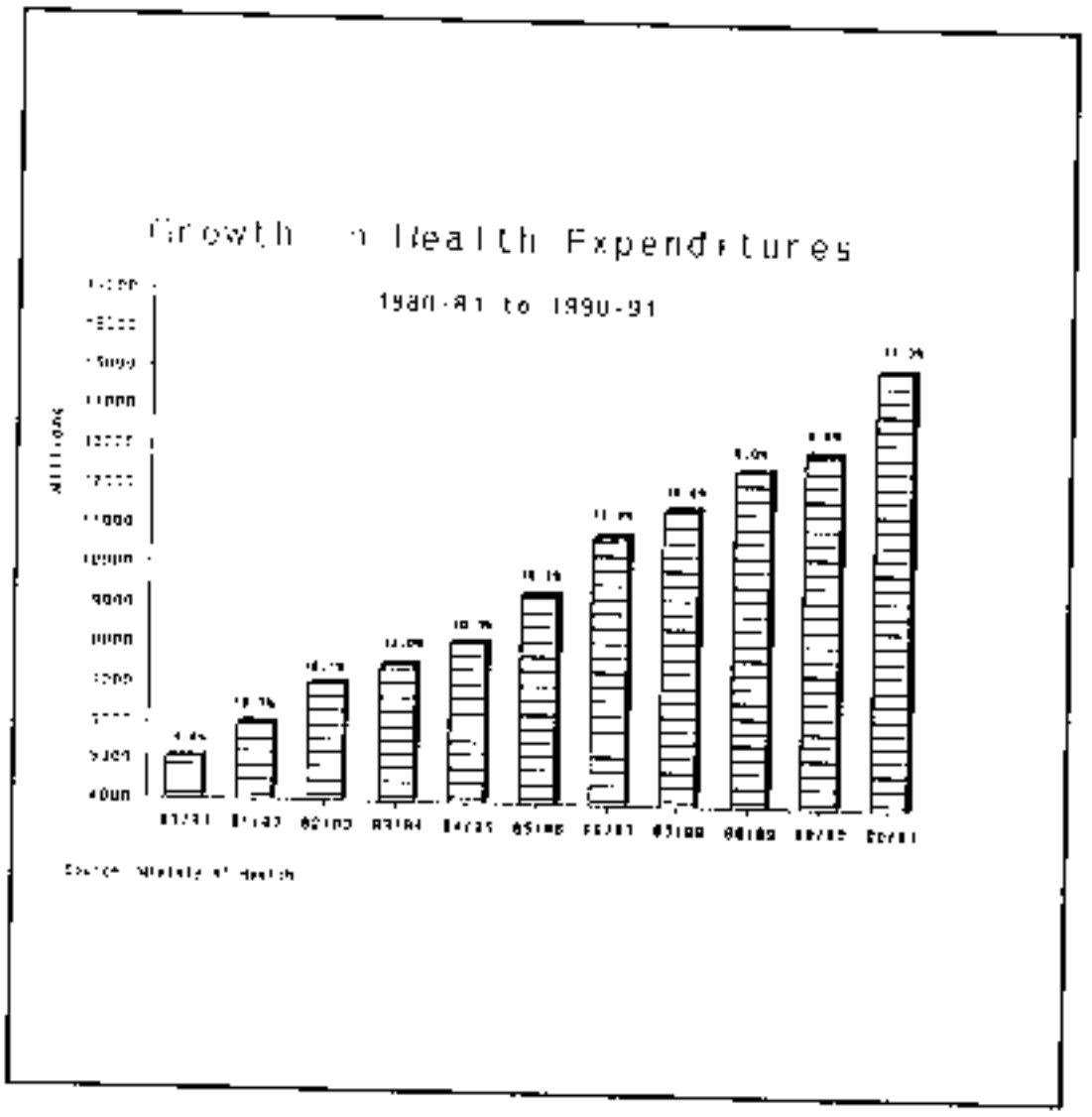
established a number of key principles that have to be followed in order for the Federal Government to share in the cost of the provincial programs. However, once these principles are met, the nature of the system, how it is organized and how it is delivered is entirely the responsibility of each Provincial Government. The principles that are in the 1984 Canada Health Act are shown here.



Firstly, the system has to be universal, that is, it extends throughout the population of the province being served. Secondly, the system has to be comprehensive, in that it has to offer a full range of health services under the plan. Thirdly, the health benefits have to be portable so that a resident of a particular province is covered for their healthcare needs when they travel between provinces and also outside of the province. Fourthly, the system has to be publicly administered, i.e. there is no private insurance allowed in Canada. This is probably one of the major factors that has determined the nature of the system we now enjoy. I should explain that it is possible to insure for so-called extended healthcare services, i.e. the cost of private and semiprivate accommodation, pharmaceuticals, other aids and devices which are not covered under the government plan. However, the healthcare services provided by the province cannot be insured for under any third party insurance scheme. What this has done is ensure there is only one level of service in Canada. We do not have the system as in the U.K., where there is a publicly funded system and a parallel private system.

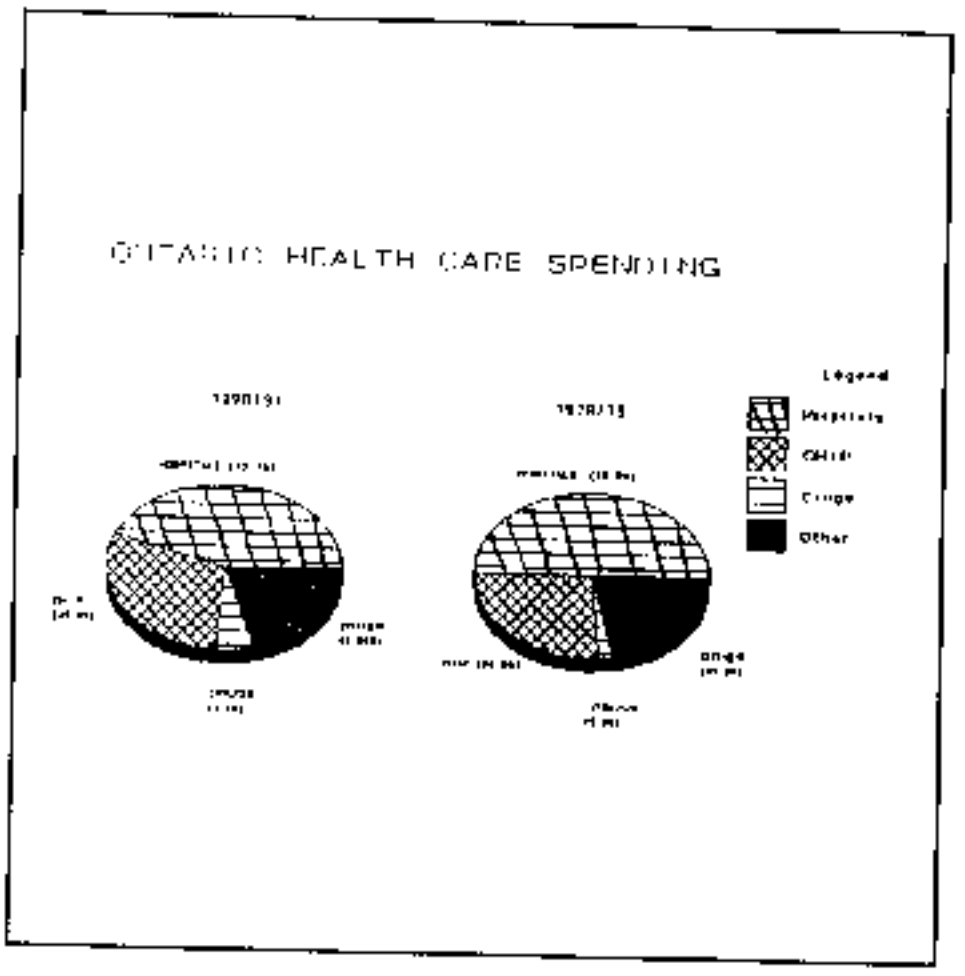
This means that all members of society depend on the same public system, the most influential and members of the higher socio-economic classes are as dependent on the Ontario Healthcare System as are the poor, unemployed etc. As a consequence, whenever there is a problem in the system, those with influence and access to the media ensure that this does not go undiscussed. Governments therefore are very sensitive to the needs of the system and to ensuring that it is responsive.

The Canadian system costs in excess of $50 billion and I should explain that when talking in terms of numbers, in Canada, as in the rest of North America, a billion is one thousand million which is not the larger value of the term billion in the U.K.



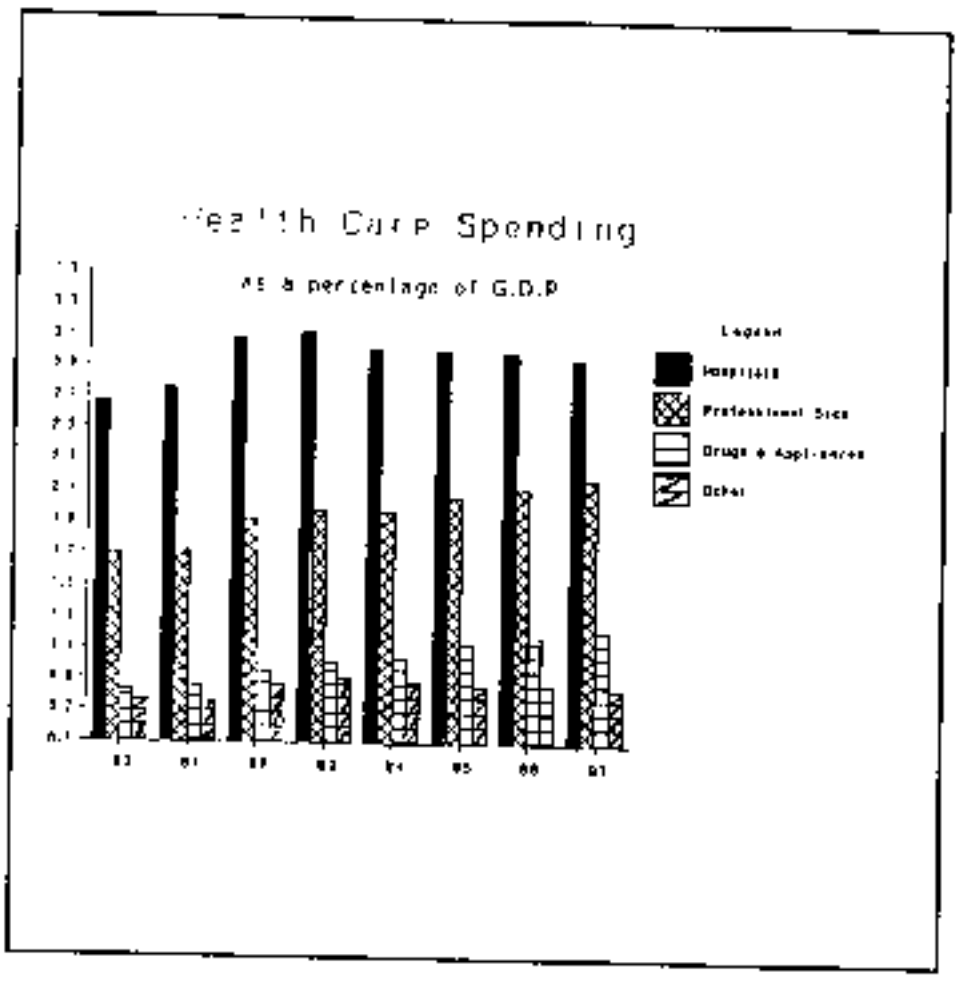
I would now like to move to the provincial level where as I said, healthcare is organised and delivered. You can see the Government of Ontario's problem when we look at the graph above. Notwithstanding the fact that health care expenditure has retained its relativity to

wealth as a cost to the province. The year-over-year increase in dollars being spent on health increased at an average of 12 per cent. This is a major concern for us all and is the province's most difficult financial problem.

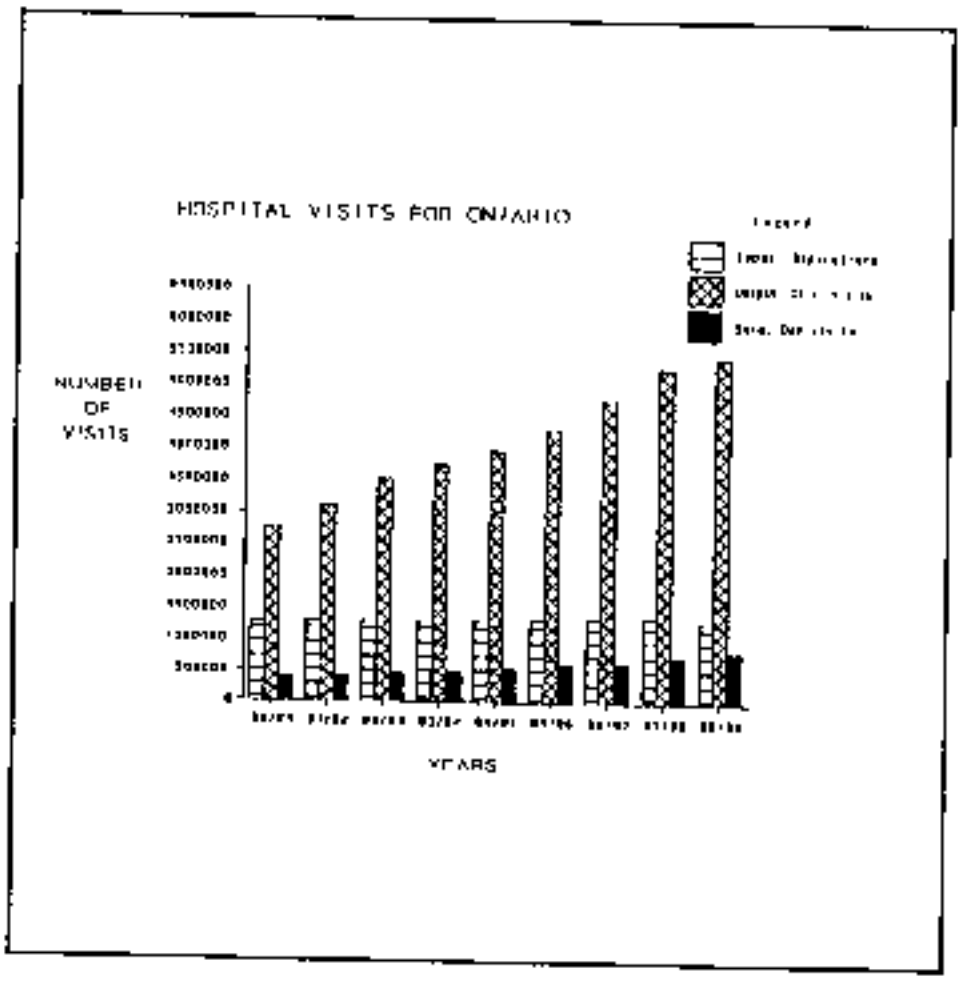


What is important is to understand where that money is going. You will see from this pie chart above that hospital expenditure has diminished in their share of the province's health care dollars. We were consuming some 50 per cent of that dollar just over 10 years ago and it is 43 per cent of that dollar today, so that relative to the other components of the health care pie, we have been doing fairly well.

This is further amplified on this next graph which shows Ontario hospital expenditure as a percentage of G.D.P., which despite the initial blip has been relatively stable and in fact is going down. The real increases are in the percentage of G.D.P. being spent on professional services. This is predominantly physicians and other practitioners fees. There are similar increases in the drugs and devices column which includes pharmaceuticals, orthotics and prosthetics devices. These are the growing component in the cost of our health care system.

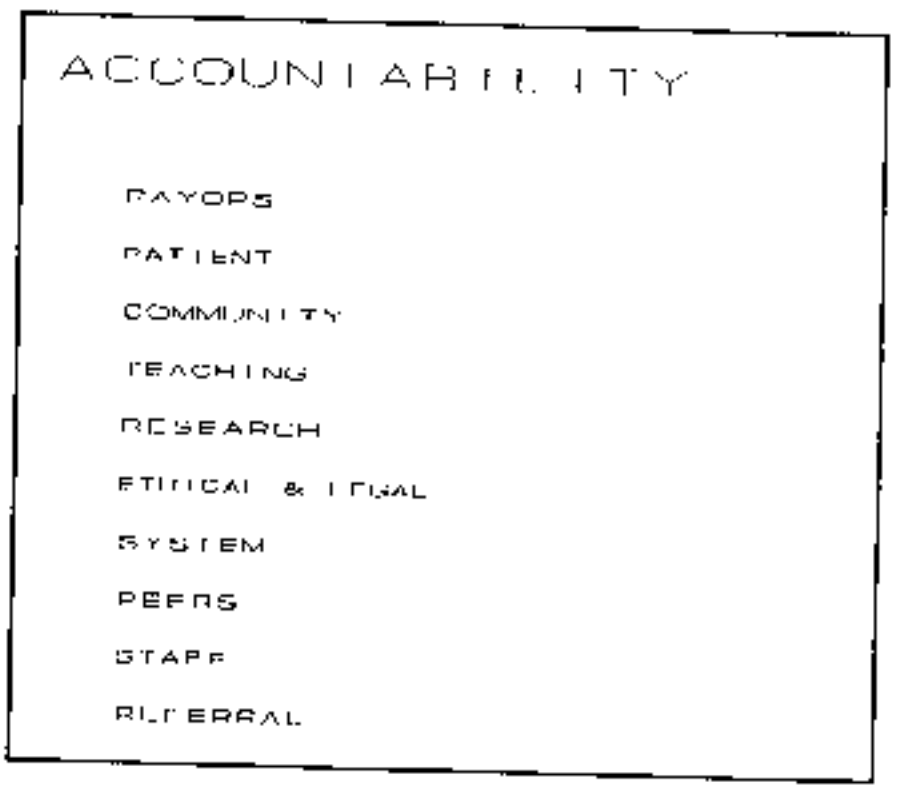


What I am trying to demonstrate is that from a hospital's perspective we believe that we've done a relatively good job at holding the lid on our expenditures. This is particularly significant in relation to our activities. For not only have we been keeping control from a dollar perspective, but during that same period the volume of what we do has increased dramatically. In this chart, you will see inpatient activity is unchanged notwithstanding the increase in the demands of the population. This was achieved by providing more and more care on an ambulatory and community basis. The above graph shows that the amount of outpatient visits and treatments and ambulatory care and surgery has more than doubled over the last ten years. Particularly from academic



hospitals, there is much we can do and are doing in the research and development area. Through base support and attracting research oriented companies in the pharmaceutical and medical device industry thus enables us to use our hospital's research capabilities to create wealth.

Having dealt with the world scene, Canada and Ontario, I am going to talk more specifically about our hospitals, how they operate, why they are such complex organizations, and why a self-governing status is so important to their effectiveness. Peter Drucker has written about hospitals as the most complex organizations that exist. The complexity has many dimensions. The first is due to the fact that we are accountable to so many different parties, agencies, etc. Here is a list of the sort of accountabilities that I feel that most hospitals have as organization. Financially we are accountable to government for the operating revenue that they provide, and similarly to any other insurance company or payment agency.



We are accountable to our patients, as our clients/customers, and should be directed by their needs and requirements.

We are accountable to the various communities that we serve and have to demonstrate that we are responsive to their needs.

As academic hospitals we have educational accountabilities. Sunnybrook for example, has 1400 students. We are also a major research organization. Again speaking from the Sunnybrook perspective, we have over $10 million dollars of peer reviewed research going on every year.

We also have major ethical and legal accountabilities, whether this is through government because of regulation and legislation, or just as part of the health care system in ensuring that we live up to the highest ethical standards.

We are also accountable to the system as a whole. That is a very important responsibility. We have to recognize that we work within a system. One of the major criticisms hospitals currently enjoy is that they are somewhat autonomous and self-interested. Part of the problem, I believe, is that nature abhors a vacuum and as such hospitals fill the vacuum which is created by the lack of definitive strategies for hospitals within the health system. In many ways, their competitiveness and independence is more due to the lack of an integrated framework within which they function.

We are also accountable to our peer hospitals. One of the things which certainly attracted me to work in Ontario was the degree to which hospitals are autonomous and the freedom I enjoy to make changes. However, through such systems as accreditation I am accountable for my organization's performance. We have to be open and willing to allow our peers in to assess how we are performing and demonstrate we are doing an effective job and using our resources well.

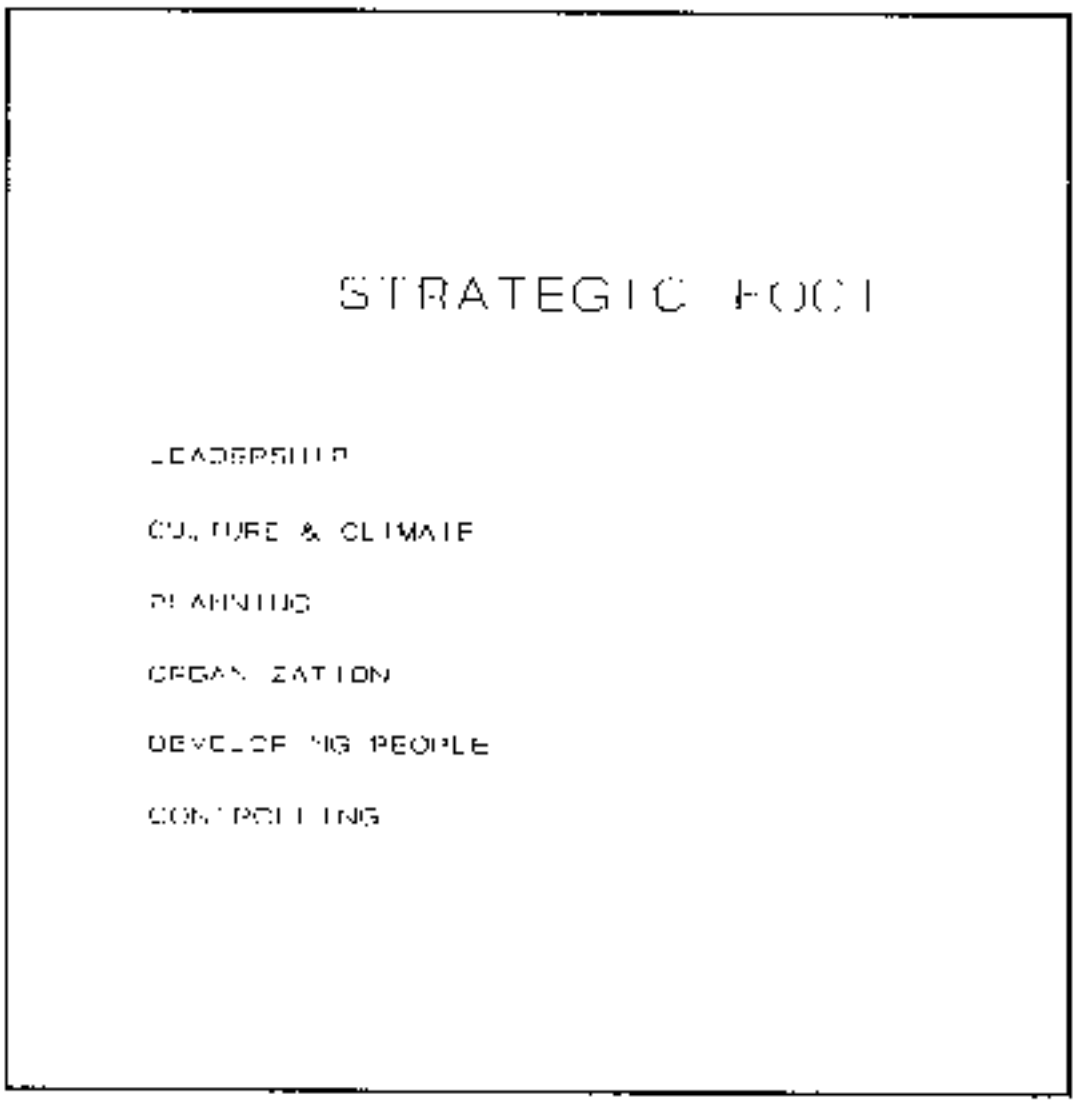
We are also accountable to our staff. As many of you are aware, hospitals are predominantly people, that is what we consist of: 75 per cent of our budgets are spent on people. How those people behave and interact and how we manage to excite them and enjoy their commitment to our organizations, is the measure of our success as organizations.

Finally we depend on referrals from other organizations or other professionals and we have to demonstrate that we effectively deal with the clients and customers they send and provide appropriate feedback for what we do.

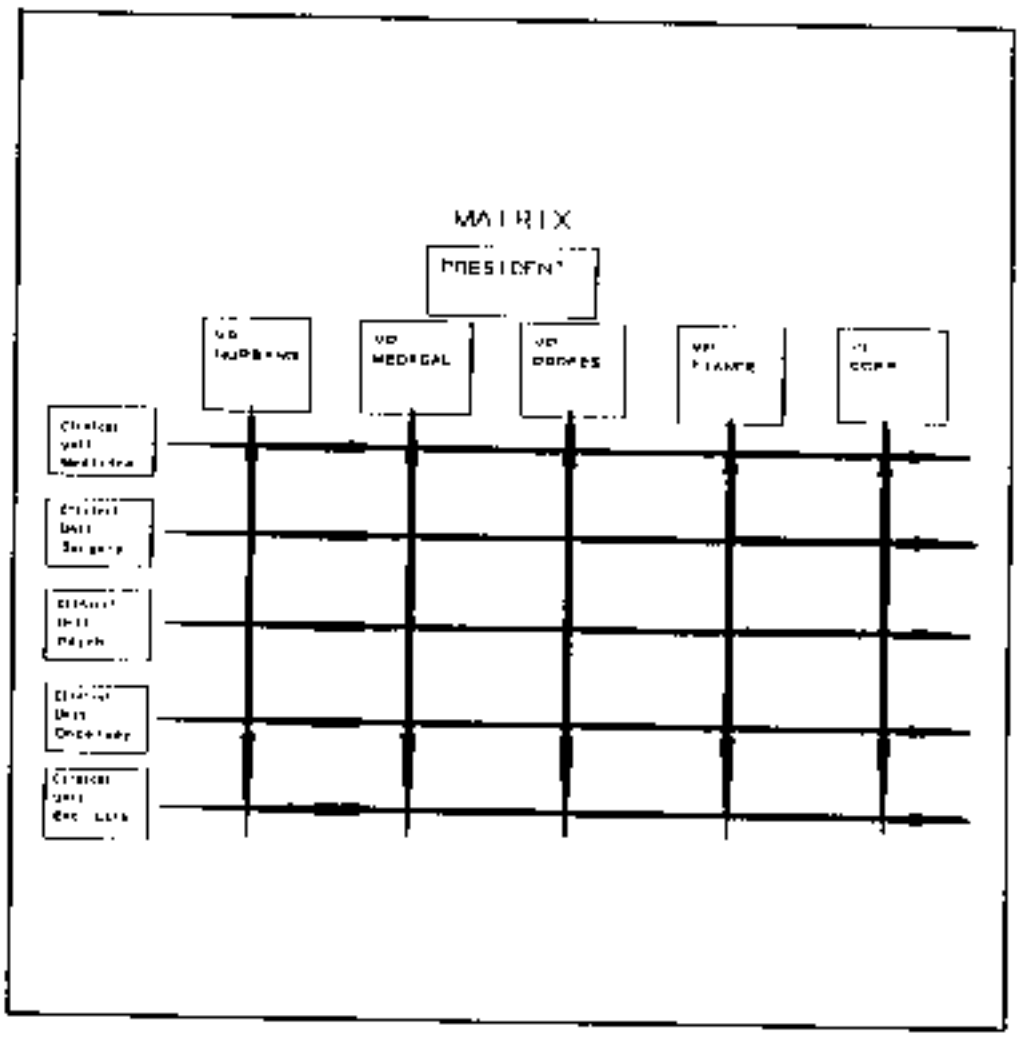
Each of the previously mentioned accountabilities has a unique dimension to it. Some are

contradictory and one of the reasons why hospitals need to be free is to balance those accountabilities. When I left the United Kingdom which was a government-operated system, the only accountability appeared to be to government. We had lost our sense of accountability to the patient and the client. In my view, the overriding need for self-governing hospitals in England is the recognition that if there are to be healthy hospitals, they have to be relatively free to meet and balance the many demands of accountability upon them and not be seen to be just accountable in one single direction.

The second dimension of the complexity we face as organizations, is similar to that faced by all organizations, whatever business they are in. This particular chart below details the components of an organization that, if managed well, create a healthy well run entity.



The next diagram is an example of a matrix organization. I think we have to spend more time on the horizontal dimension. We have to show that the main focus of our organization is the patient, the client. In fact the majority of problems I face as President of Sunnybrook are concerned about where the system breaks down in the interface between different departments, divisions, professionals. How we process patients through and provide a smooth interaction with those many departments is the challenge. This is what determines a successful outcome. We have therefore to look at our organizations and focus them on what we want to achieve as outcomes than the somewhat self-interested needs of the different professions and disciplines who typically find comfort in herding together in great numbers.

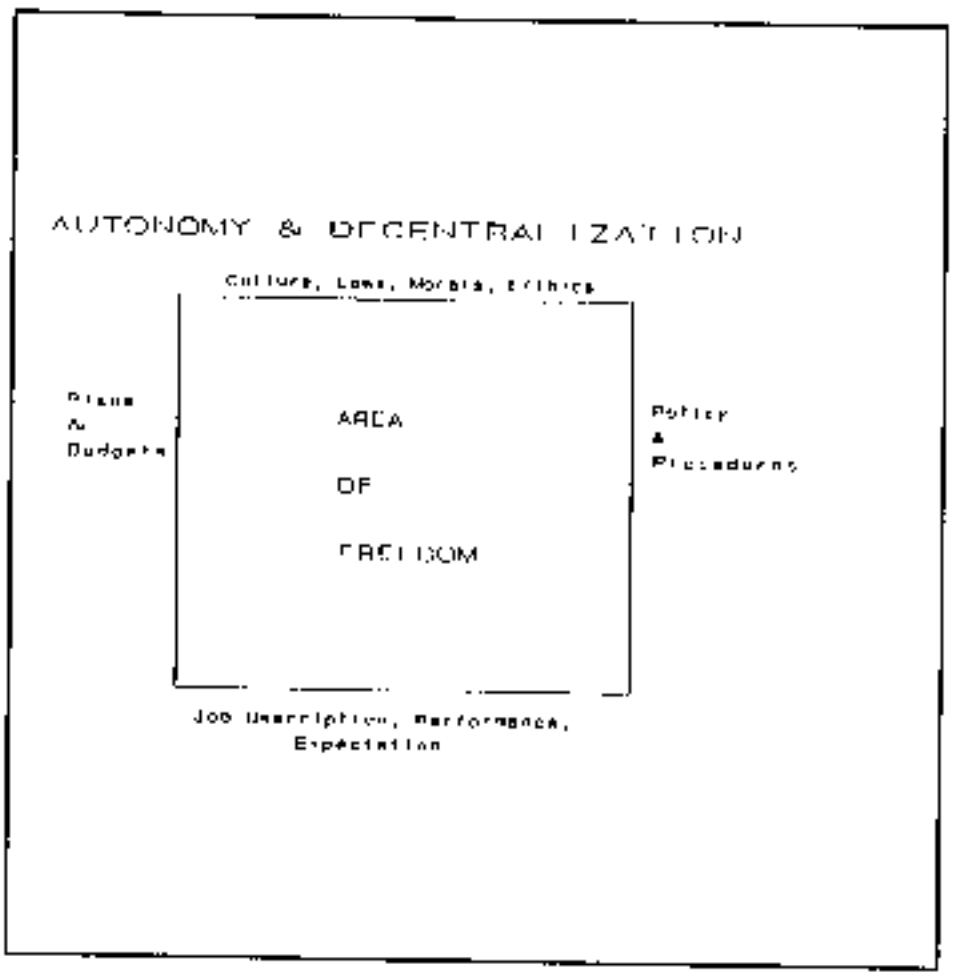


In addition to organizing, we have to develop our people. Again, we are a people-dependent industry, we have to focus on ensuring our personnel are excited by our organizations and in working for us. We have to find ways to identify and ensure that they have opportunities to develop to their full potential. Conversely we have to find ways of helping the people who no longer fit in our organizations to find other avenues and careers which best suit them.

The last component is controlling and monitoring. Hospitals have been very slow off the ground at providing the type of information they need to effectively control and monitor their performance. This is a major responsibility, a very expensive responsibility. Potentially

hospitals should be spending 2 to 3 per cent of their budgets on this activity. That is a significant number of dollars being spent on the needs of information. Without it, however, we cannot manage effectively and be accountable for the effective use of our resources.

Finally none of these points work independently, they are all interdependent. Leadership brings together all the points. The development of people is obviously crucial and part of the overall culture and climate of the organization. How people develop affects the organizational structure. How we monitor peoples effectiveness affects how we develop them. Each of the points interrelates to the others and has to be looked upon again as a balanced whole. The health of our hospitals as organizations comes from how well we are able to integrate those respective points.



The final part of my presentation is to talk about the freedom we need to maintain our hospitals as healthy organizations. I made reference to the fact that the autonomy of our organizations is a crucial component of their ongoing success. People like myself, are stimulated by the challenge and the opportunity to make a difference. We can only make a difference if we have an area of freedom within which we work. That does not mean as organizations we want total autonomy and that we are going to work as anarchists just doing what we wish. We do need a framework but a framework that leaves a large enough space for us to determine how we are best able to do our jobs. The framework, as shown above, is formed by the fact that there are external cultural influences, there are legal requirements, and there are external moral and ethical boundaries put upon

us as organizations.

Similarly, there are policies and procedures that are determined externally.

There are also external planning systems that will influence what we do as part of a health care system, and budgets that we will have to live within and be committed to.

Finally there are performance specifications and descriptions of what we should do as organizations and as individuals.

Bearing these limitations in mind, there still has to be a large enough area of freedom to provide our organizations with exciting opportunities. This similarly applies to the governance of our organizations. We are only going to attract Directors to our Boards if they feel they have some freedom to make a difference. It is to my mind the ethos of healthy organizations that they have the freedom to pursue the strategic foci I talked about.

Having created the area of freedom for the organizations, it is my challenge to provide an area of freedom for each of the departments and employees of my organization. Thereby they are challenged and they are free to make a difference in their own areas.

I have tried to outline to my mind the fundamental components and benefits of a self-governing system for hospitals. As I have stated, it is not a problem-free model, particularly with regard to how the system is planned and integrated. However, these deficits can be overcome and are greatly outweighed by the benefits that come from a system which truly focuses on the patient. I have often used an analogy that I believe the fundamental differences between the U.K., the U.S.A. and the Canadian systems are as follows. If you looked from afar at the U.K. system, you would determine that the major customer is in fact government. Because of the hierarchial bureaucratic nature of the structure, it forces those involved in the management of the system and delivery of the system to be constantly

worried about the reaction of the next level of the bureaucracy to their actions. In the U.S. system, I perceive the fundamental customer of the hospitals to be the physician. My involvement in professional activities lead me to believe that the concern of most U.S. hospitals is how do they market their services to physicians, which will then result in the physicians referring patients and business. What I like to believe is that the Canadian system believes its customer is the patient. This is because I believe we are sufficiently autonomous not to be constantly looking over our shoulders at government, and can truly design our services to meet the needs of the patient and where appropriate, act as patient's advocate. Our system is not perfect but I do believe Canadian hospitals have provided a service which is now universally recognised as the best in the world and is so supported by the public that it receives an approval rating that is not met by any other service or individual in the country. I hope the Self Governing Trust initiative will lead to similar levels of customer satisfaction in the UK.

On a personal note, I will close by saying that I get a lot of satisfaction from my job. This comes from the sense that I am able to create the sort of organization that I feel will best deliver the care and services we are funded to provide. I have the freedom that constantly provides me with new and unique challenges to extend myself and my capabilities to their fullest extent.

Thank you very much.