Workshop on Hospital Governance

Purpose of the Meeting
To investigate the role of hospital advisory boards versus that of a Governing Board, which might be the ideal way to manage central hospitals in the future.

Objectives
- Present various scenarios on hospital governance, lessons from CEOs who are running hospitals in South Africa, international perspective from Belgium and Australia.
- Use evidence to come to a position on the way forward for the National Department of Health (NDOH)

Day 1 - Session 1 Management of Central Hospitals by the NDOH

Position of Central Hospitals and their Challenges
The opening session identified a set of key challenges posed by the government’s call to nationalize central hospitals. Central hospitals are hospitals that are linked to academic schools and are used for the purpose of developing experiential training for medical doctors and affiliated professions. South Africa has ten such hospitals located in five (5) out of nine provinces namely, Gauteng, Western Cape, Eastern Cape, KwaZulu-Natal, and Free State.

According to Dr T Fisher (Presentation 1), failure to decentralise operational decision making to the level where decisions are better informed has been linked to under-management of central hospitals. This problem has been linked to poor management and governance at provincial level with allegations of lack of efficiency, bureaucracy and poor planning. Not effectively implementing delegations was seriously obstructing the CEOs role of managing central hospitals.

Nationalizing centralized hospitals (centralization) implies that control and operational business of these hospitals is handled by National government, in this case the National Department of Health. In future, this also means that funding for these hospitals and how it is allocated will be left to the National Department and no longer in the hands of provincial departments. Provincial departments have been blamed for often overlooking the needs of central hospitals and using funds meant for central hospital in other non-related areas. When national government seizes control of central hospitals, the oversight role as well as support for hospital CEOs will be delegated to provincial governments.

Comments from the floor highlighted the need for government to look at having centralized tertiary hospitals so that these can serve patients from all over South Africa. This would then require government to define the service package of central Hospitals, for example use categories such as T1|T2|T3 to define
how the highly specialized services are packaged and spread across the country. The scenario at the moment is that patients from other provinces are refused treatment; something that should not be allowed to continue. There was general agreement that equitable access to healthcare was critical to all patients.

**Hospital Management Reforms**

According to Mr Mothoagae (Presentation 2), the issue of hospital reform had been discussed previously and an effort to address hereditary challenges facing hospitals at the time, led to the initiation of a Health System Project (HSP) in 1995. The final report concluded that over-centralization leads to systematic underdevelopment of management skills and operational systems in areas such as personnel, financial and labour relations management. The project developed a strategy for implementing the National Policy on Decentralization of Central Hospitals. The policy set out to:

- Delegate substantial powers over personnel, finances, procurement, and other critical management functions to hospital management;
- A shift in the role of Provincial Health Administration from its current executive /administrative line management role, to one whose main functions are to set guidelines and broad policy, as well as providing critical support for hospital management;
- The establishment of representative, accountable Hospital Boards as statutory bodies, with clearly defined and important governance powers;
- Development of modern, efficient management structures and systems;
- The recruitment, development and retention of skilled and motivated hospital managers.

The Health System proposed implementation strategies for decentralisation to take effect. Some of the strategies included, core package of essential measures to be met for centralization to take effect; criteria for decentralised status; implementation timetable on behalf of provincial departments.

Decentralisation of hospital management policy was implemented concurrently with the establishment of the District Health System (DHS). The main policy priority of the Department was that primary health care (PHC) and the DHS were seen as a critical step to achieving universal health care coverage. At this time many proponents of DHS argued for a move away from the hospital centric health system to a comprehensive PHC based on the DHS. During this period resources and focus were shifted from hospitals towards PHC. These conflicting priorities derailed the momentum to implement the policy on decentralisation of hospital management.

Consequent to the latter, the department of health established an interdepartmental Task Team on Decentralisation of Hospital Management. In 1999, the Task team presented its report before the MINMEC and PHRC. The report recommended for (1) preparation at National, provincial and hospital level; (2) hospital application for decentralized status; (3) provincial assessments for decentralised status; (4) if hospital meets the required criteria then a charter of interdepartmental delegation is conferred upon the hospital and key management posts. The Task Team also recommended a set of criteria for determining decentralisation process. The criteria included amongst others service delivery plans;
strategic plan and evidence of capacity to implement; capacity to manage human resources and human resource development and other relevant planning tools.

The current Task Team has the responsibility of proposing a method for the department to continue with the implementation of the nationalisation of central hospitals. More importantly, the Task team is required to look at investigating the role of hospital advisory boards versus those of a governing board, which might be the ideal way to manage central hospitals in the future.

Session 2: Legislative Framework for Management of Central Hospitals in South Africa

Setting the Context on Intergovernmental Relations in South Africa
As presented by Prof L Mathebula (Presentation 3) Intergovernmental Relations (IGR) refers to relationships that arise between different governments or between organs of state from different governments in the conduct of their affairs (IGR Framework Act, Act 13 of 2005). IGR operate in a variety of combinations (vertical, diagonal and horizontal; in fact 360°) of interactions and transactions conducted by government officials (elected and/or appointed) and between and amongst spheres of governments and organs of State. The framework for such relations and their accompanying hierarchic order is defined in constitutions and national legislation. Intergovernmental relations are defined through constitutions, legislations, inter-sphere agreements and contracts, legislated and/or assigned mandates, cross-border agreements and other legally binding instruments. IGR occur through the flow of information as generated and exchanged by elected and appointed government officials.

Legal Opinion on the Policy to Centralise the Management and Control of Central Hospitals

The Brief: following the NHC resolution, wanted to find out if it is legal to “take over the management and control of public central hospitals”

Dr Mathebula argued that the legal opinion by the State Law Advisor on management of central hospitals failed to address the issue of organs of state, instead it focussed on the intervention than on governance issues. The opinion should have been guided by the prescripts of the IGR Act and associated legislation. It is important therefore for government to correctly frame the argument on centralisation. Ideally government should focus on broader definitions and avoid using judgemental tone e.g. “poor management”. Additionally, there is a need to seek a determination from the constitutional court with respect to policy intent and perhaps ‘force’ a court determined amendment. The demarcation board data will be crucial in supporting the need for ensuring equitable access to tertiary health services (affordability trend definition).

Discussions

On the question of which governance option was best between SANRAL and PALAMA, the response was that PALAMA is a state department with a Director-General and therefore not the best option. SANRAL on the other hand is an agent of government. The governance model at SANRAL includes a board and CEO where the board is the accounting authority. SANRAL is funded through grants (non-toll
business area) from the central government. Similar to SANRAL other agencies also have a revenue generation model. There are more than 300 state owned entities in South Africa; the Task team can look at best practice models from amongst these.

With respect to funding, the discussants looked at options, implications and input from the Finance and Fiscal Commission. An aspirational approach towards governance of national assets allows for constructive discussions. By using governance as a nation–building exercise and toning down the language, national government would be in a better position to engage with all affected parties. A look at policies for the Academic Health Complexes might provide useful guidance on how this can be improved. Discussants noticed government’s intention to improve the health system, however taking over management and control was too harsh. They noted that it was important therefore to have a 5-10 year evolution in improving hospital governance. Additionally, the 20 years of the current government’s experience in hospital management should be able to inform the NHI debate going forward.

The National Health Act, specifically section 41, needs to be proclaimed by the president. In light of the gaps in promulgation of section 41, there is a need look at the powers of the hospital advisory boards and revise accordingly. A question that should be asked is whether advisory or a governance board would be a better option for hospital management. Additionally there is a need to look at the White Paper on the transformation of health system, the Chapter on hospital.

**Way Forward**

**[Action Point]**: Under the Legal Framework: conduct an analysis of the policies, legislation and come up with a matrix and synthesize the evidence.

**Session 3: Governance and Accountability**

**Models of Governance of Central Hospitals**
The CEOs from Charlotte Maxeke Hospital, Inkosi Albert Luthuli Hospital, Universitas Hospital and Kalafong Hospital presented key issues that they face, these are summarized in table 1 below:

**Table 1 Key Issues Affecting Central Hospitals**

<table>
<thead>
<tr>
<th>Key Issues at Central Hospitals</th>
<th>Charlotte Maxeke - GP</th>
<th>Nkosi Albert Luthuli - KZN</th>
<th>Universitas – Free State</th>
<th>Kalafong - GP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Service</strong></td>
<td>No regional hospital in the province</td>
<td>There is no district hospital near this hospital, general lack of district hospital beds</td>
<td>Lacks specialist services</td>
<td>Demand for specialists in the hospitals</td>
</tr>
<tr>
<td><strong>Referral systems</strong></td>
<td>Referral system not managed appropriately at the hospital</td>
<td>Specialized services are provided but often misunderstood</td>
<td>Orthopedics, ophthalmology are referred to other hospitals</td>
<td>Weak district health system referrals</td>
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<tr>
<td>Funding</td>
<td>All central hospitals in the province underfunded</td>
<td>Hospital is running accordingly</td>
<td>Resources are a challenge in the province and hospital</td>
<td>Previously disadvantaged hospitals remain underfunded</td>
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<td>Delegation</td>
<td>Role clarification challenges between PDOH &amp; NDOH</td>
<td>Issues of autonomy at certain tertiary hospitals</td>
<td>Lack of support from other provinces</td>
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<tr>
<td>Governance</td>
<td>Conflicting views at provincial and hospital levels</td>
<td>There are governance issues in the hospital</td>
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<tr>
<td>Role of Boards</td>
<td>Advisory boards not providing positive contribution</td>
<td></td>
<td>Role of the board would be effective if members were experienced and skilled</td>
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<tr>
<td>Human Resource Constraints</td>
<td>Appointment of registrars a challenge</td>
<td></td>
<td>No medical officers, registrars trained at Kimberly hospital in the Northern Cape</td>
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</table>
International Experience from Belgium with regard to Autonomization of Central Hospitals

Background to the Management of Central Hospitals in Belgium:

Previously the country’s hospitals were governed by religious organizations and the funding was provided for by the government. Types of Hospitals in Belgium consist of the following:

- General Hospitals (> 150 beds, Emergency, D&N, Divisions of IM, GS, radiology, etc.)
- Specialised Hospitals (revalidation, geriatric)
- Psychiatric Hospitals
- University Hospitals (only 7)

Hospitals are owned by legal entities mostly private, rarely city council or regional government; owners are not governing the Hospitals. The country’s view is that hospitals must be governed by own board of governors. Exploitation of Hospitals is ruled by federal law (regularly adapted) and is geared by Federal Ministry of Health and Social Affairs by following means:

1. closed financial system (honoraria, cost of hospitalisation, infrastructure)
2. accreditation following positive audit on predefined criteria (5 years)
3. Programming of type of beds and care programmes according to societal needs (since 1982 no new beds allowed)
4. Hospitals have to comply to set rules or risk to be penalised
5. Pressure is up to collaborate and make strategic plans

The budget for the hospitals is a fixed amount from government which is distributed to all hospitals. Prominent hurdles exist with regard to hospital funding which include financial pressure to increase clinical performance to the detriment of time and budget for academic task in hospitals. Challenges along integration especially in multi-government structures still exist. Different statutes apply in university or hospital appointments.

Governance of University Hospitals in a network – Australia

In the past hospitals in Australia were managed by organizations through finance and knowledge. The hospitals were funded centrally and when funding was exhausted hospitals had to manage without funding. This presented challenges with regard to funding priority areas in the hospitals. Through evolution, the university hospitals were managed through the appointment of CEOs and several categories, clinical boards were also established to govern the hospitals. Organizational reforms gradually led to autonomy and clinical focus. Currently, the default is that state health director generals appoint hospital CEOs. This gives closer control. The alternative is that state ministers appoint boards, and the board appoints the CEO.
Professional divisions of medicine, nursing and corporate are giving way to clinical divisions of critical care, surgery, medicine, psychiatry, maternal and child, cancer, etc. Academically active clinician managers have become the ideal divisional head, but not the norm. Commonwealth and state governments split public hospital funding around 50:50. The mechanism of providing a fund is shifting from historical and function based budgets toward activity based funding using diagnosis related groups (DRGs).

The Commonwealth has just uncapped its share, and will now pay for increased activity. This is supplemented by earning benefits for treating private patients. Universities, quite separate entities from the hospitals receive funds per head for an agreed number of student placements, and compete for research funding.

Summary of Day 1 Discussions
The Task Team reviewed the current status taking into consideration the brief to discuss and establish which model could be utilized in taking over the management of central hospitals. In addition to the discussion and way forward already for session 1, the Task Team recommended that:

- a reform programme be developed while requesting funding from the National Treasury through the Minister of Health, easy wins have already been identified
- Consider establishing executive advisory boards with experienced members
- Definition of roles is important to ensure appropriate governance.
- Revisit the governance framework
- There are strategic opportunities and challenges for intergovernmental relations. A policy framework for the intergovernmental relations is therefore required
- Competencies and utilizing other models.

Day 2 Session 1: Hospital CEO Competencies

Leadership Competencies
Background information regarding the identification of CEOs is a critical component in health leadership development. In creating autonomy on governance of central hospitals, executives should demonstrate measurable outcomes and effectiveness.

Academic Competencies for Leadership in Hospitals:

Comprehensive framework of national/ provincial/ district/ local government leadership competencies. For hospitals, the job roles and responsibilities informing competencies for CEOs; Line Managers and Hospital Boards. Academic qualifications should include but not limited to Health (Clinical); Business; Public Administration and extensive public health experience and Competencies.

Competencies

The qualifications above should be combined to enable management of the hospitals according to the following areas:

- Competency Clusters
CEOs pointed out that financial management was really not a top competency. This is due to the fact that CEOs do not have full delegation of authority. The Task Team will look at including other competencies at a later stage; in the meantime CEOs will be required to advise the Task Team on trainable competencies.

Assessment of CEO candidates should look at the following:

- The skill set should be aligned to experience
- Competencies
- Character
- Cunning nature or ability
- Patronage
- Framework
- Knowledge
- Attributes

Competency Assessments for CEOs should be conducted to ensure appropriate placements. Hospital Boards and CEOs should have open communication lines to build trust amongst themselves and their employees.

Discussion

It was proposed that fully autonomous hospitals should be developed without being taken over by the National Department of Health. There is a need to look at an ideal environment that would allow for autonomy and that a suitable CEO for management should be identified. Competencies should be included as part of the competency framework which include skills, knowledge, attributes, roles of the board, etc. Hospitals may be governed by the Hospital Boards.

Session 2: Scenarios for Governance of Central Hospitals

Table 2 provides a comparison of the models for hospital governance as per brief to the Task team.

<table>
<thead>
<tr>
<th>Current Model</th>
<th>Autonomy Model</th>
<th>National Control Model</th>
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<tbody>
<tr>
<td>Hospital managed by provincial departments of health (PDOH), funding allocated and managed by the provincial department</td>
<td>Central hospitals will be autonomous either while reporting to the NDOH or PDOH</td>
<td>Central hospitals report to the NDOH</td>
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</table>

Table 2 Comparison of Hospital Governance Models
<table>
<thead>
<tr>
<th>Under PDOH coordinated system management i.e. integrated hospital service delivery</th>
<th>No protection of research and development and teaching</th>
<th>Potential to increase balance between teaching on research &amp; development</th>
<th>Potential fragmentation of the system</th>
<th>Improved access and equity to tertiary services</th>
<th>Disruption to continuum of care</th>
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<tbody>
<tr>
<td>Familiarity across the board</td>
<td>Promotes inequitable access</td>
<td>Enhances hospital management decision making</td>
<td>Potential fiduciary lapses</td>
<td>Streamlined resourcing</td>
<td>Rationalization and practicalities</td>
</tr>
<tr>
<td>Central procurement</td>
<td>Management &amp; control challenges</td>
<td>Integrated hospital planning, resource allocation and budgeting</td>
<td>Weakened central coordination of national policy</td>
<td>Centralized management</td>
<td>Lack of capacity in the NDOH</td>
</tr>
<tr>
<td>Clear roles and delegation</td>
<td>Role of boards</td>
<td>Defined governing of boards</td>
<td>Recruitment pool for board and hospital management – rogue boards</td>
<td>Single principal for easy monitoring</td>
<td>Impact on strategic role of the NDOH</td>
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<tr>
<td>Local economic development</td>
<td>Red tape renders inefficiency</td>
<td>Competition amongst hospitals</td>
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**Proposal for the Model to be implemented**
The Task Team proposed that the Autonomy and National Control Models should be combined for implementation in management of central hospitals.

**Closure**
The Chairperson thanked all in attendance and adjourned the meeting at 16:00 on day 2.
## Annexure 1 - List of Attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation and Affiliation</th>
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<tbody>
<tr>
<td>1. Prof M Jacobs:</td>
<td>Chairperson for the Academy for Health</td>
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<tr>
<td>2. Dr. I Funani</td>
<td>HLSP – Technical Lead</td>
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<tr>
<td>3. Dr. T Fisher</td>
<td>Chief Director Tertiary Services, Policy and Planning and</td>
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<tr>
<td>4. Dr. T Lekalakala</td>
<td>Hospital Management</td>
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<tr>
<td>5. Prof Paul Mio Dugdale</td>
<td>Australia</td>
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<tr>
<td>6. Dr. Ben Van Camp</td>
<td>Belgium</td>
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<tr>
<td>7. Prof Lucky Mathebula</td>
<td>Intergovernmental Relations Researcher</td>
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<tr>
<td>8. Gladys Bogoshi</td>
<td>CEO Charlotte Maxeke Hospital</td>
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<tr>
<td>9. Ms. Edwin Mabuela</td>
<td>Assistant Director, NDOH Hospital Management</td>
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<tr>
<td>10. Ms. Keneilwe Modise</td>
<td>Hospital Management</td>
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<tr>
<td>11. Sibularo Gailela</td>
<td>CEO Universitas Hospital</td>
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<tr>
<td>12. Mogale Mothoagae</td>
<td>CEO Kalafong Hospital</td>
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Annexure 2

Work plan for hospital governance

The table below depicts the terms of reference and lead people that will be responsible for the various work streams.

<table>
<thead>
<tr>
<th>Work Streams</th>
<th>Terms of reference</th>
<th>Average time frame</th>
<th>Responsibilities</th>
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</table>
| Governance and Management | • Governance and Management structures  
• Relationship between the accounting officer, the management and the accounting authority  
• Define the powers, role, functions, competences and composition and/or constitution of the accounting authority structure;  
• Define the powers, role, functions, competences and composition and/or constitution of the accounting authority officer and management team;  
• Defining and concretising the service package of central hospitals;  
• Tried and tested administrative arrangement;  
• Performance monitoring; | 12 months | Dr. Zungu and Dr. Mazizi (there will be sublead) |
| Legislation and policy  | • Policy and regulatory audits, including legislation, in order to develop scenarios;  
• Development of a legislative framework which may include promulgation of a Hospital Act;  
• Stakeholder engagement  
  o Build consensus and political endorsement;  
  o Defining the framework | 3-18 months | Professor Mathebula |
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<tr>
<td></td>
<td>o Developing stakeholder engagement mechanisms</td>
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<td></td>
<td>o Creating fit for purpose stakeholder directories; etc.</td>
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<td></td>
<td>• Conceptual frame work for hospital autonomy;</td>
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<td>•</td>
<td></td>
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<tr>
<td>Resourcing</td>
<td>• Financing;</td>
<td>12 months</td>
<td>Dr. W Chitha</td>
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<tr>
<td></td>
<td>• Infrastructure and health technology</td>
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<td></td>
<td>• Human Resource</td>
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<td>Research;</td>
<td>• Short term package to review literature</td>
<td>18 months</td>
<td>Short term technical Assistance</td>
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<td></td>
<td>• Benchmarking options</td>
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