

WHO RUNS THIS PLACE? AN ANALYSIS OF THE LEADERSHIP OF PUBLIC HOSPITALS IN SOUTH AFRICA.

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ABSTRACT

The South African press frequently publishes articles which highlight the weakness and insufficiency of healthcare delivery. Anecdotal evidence suggests that poor leadership is partly to blame for poor service delivery. This study was designed to evaluate leadership in Healthcare. To do so, we formulated a best practice effective leader and measured South African hospital leadership against this prototype.

This study derived a competence framework from available literature identifying the desirable characteristics of hospital leadership. This included academic qualifications, personal characteristics and functional competencies.

A pilot study was conducted which evaluated the academic qualifications of management against hospital performance as measured by the South African Department of Health. Hospitals were categorised as either poor (or not-improving) and good (or improving). Making use of a limited national audit and press coverage, deductions were made about the performance of hospitals in relationship to the profile of the Chief Executive Officer (CEO) of the institution.

We found that the global best practice models are roughly followed in South Africa, however at relatively lower qualification levels. We found that all the best run hospitals in South Africa are clinician led, but equally, so are all the worst hospitals.

This paper presents a useful insight into the sort of leadership in South African hospitals, chiefly summarising existing qualifications and experience. This paper questions the current recruitment policy for hospitals which preferentially hires clinicians and asks questions about management qualifications which remain inadequately explored.

Key words: Hospital Management, South Africa, Leadership Competence, Online data trolling

INTRODUCTION

Hospitals are complex technological systems, which involves people, machinery, information, medical supplies, medication, services, complex human resources and a broad spectrum of clients. To unify the management of such a system requires astute and insightful leadership that is au fait with modern management techniques as well as the technological means to do so. Managing this kind of technology well, may lead to improved health outcomes and significantly reducing cost. This paper examines leadership in public hospitals in South Africa.

BACKGROUND

Quality of Hospitals

From May 2011 to May 2012 the Health Systems Trust (HST), funded by the National Department of Health (NDoH) conducted a baseline audit of all South African hospitals and clinics. The audit measured the facilities against six criteria, as seen in Figure 1. Data collected was measured using the National Core Standards quality assessment framework and is an indication of the functionality of a facility (Health Systems Trust, 2012).

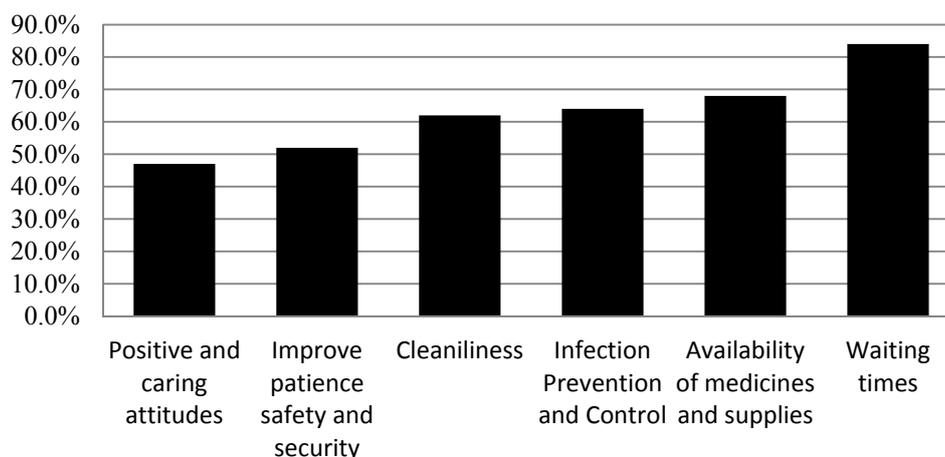


Figure 1: Average hospital compliance rate on the different criteria (Health Systems Trust, 2012)

On average, hospitals performed poorly in positive and caring attitudes, and performed relatively well on waiting times. The NDoH published a national summary report on the audit, but did not publish full results of the individual hospital ratings except for the three worst and the three best performing institutions in each category (Mapumulo, 2014).

The major shortcoming of the report is that it does not present an overall result per hospital, showing only performance of a single criterion.

It should be noted that only one of the 394 hospitals audited in 2011/2012 met the National Health Standards. Even though some hospitals excellence in one area, this does not suggest that they are performing well overall.

Standards and competence sets

The National Department of Health in partnership with the Development Bank of Southern Africa (DBSA) developed the so-called “ten point plan”. This is a list of projects that are aimed at tackling areas of improvement in the health system. Amongst the ten priorities, is that of “*strengthening health care system management*” (South African National Department of Health, 2010).

Leading on from this, the DBSA conducted in depth research of the profile of CEOs in the nine provinces, and published a suite of nine reports outlining the characteristics of health leadership in

South Africa (Development Bank of South Africa, 2011). As a result of this study, a comprehensive as-is state was created, and renewed recruitment policies were proposed.

World best practice in hospital leadership

Traditionally, hospitals have been led by clinicians. In recent years, that tradition has changed. In the United States and the United Kingdom, more Hospital CEOs are non-clinicians (Goodall, 2011). Of the 6 500 hospitals in USA, a mere 235 are led by clinicians (Gunderman and Kanter, 2009). There has been an increase in the debate of who should run hospitals, Clinicians or managerial experts? The United States of America and the United Kingdom have invested in this field of research. Yet there has not been conclusive evidence to determine the appropriate qualifications required of a hospital CEO. The problem lies in developing accurate hospital performance measurement criteria and cross referencing these to the qualities of the hospital CEOs (Goodall, 2011).

South African Hospital Leadership

The management structure (as can be seen in Figure 2) of the South African healthcare system is very steep. This is evident in the fact that there are four levels of leadership above hospital CEOs slowing down decision and reducing their autonomy (Holdt and Murphy, 2007). Many of the traditional functional roles of CEOs are housed within the administrative chain above the CEO, this may include finance, Human Resources and strategic matters. In the strictest sense, the CEO's role is often reduced to managing the day to day running of a hospital.

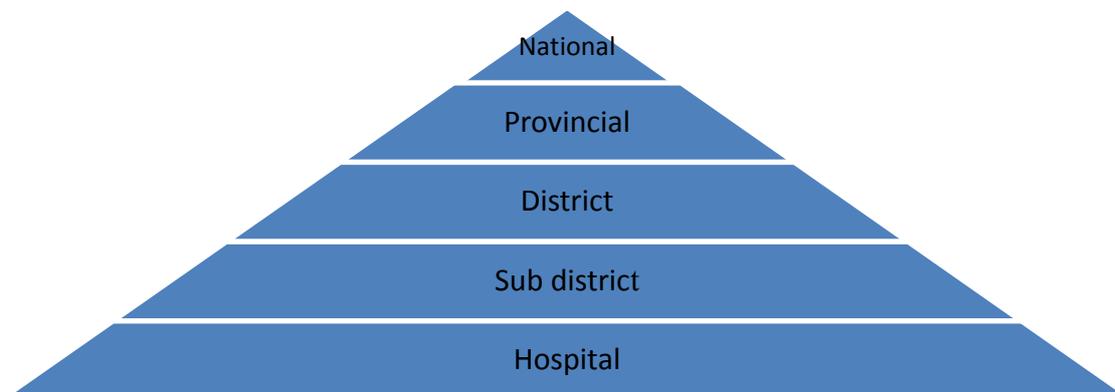


Figure 2: Hierarchical structure of public healthcare management

Recruitment criteria

The department of health advertised 122 hospital CEO positions in 2012. This followed on from the DBSA study (Development Bank of South Africa, 2011) which showed that most CEOs do not have the appropriate qualifications and experience to run their hospitals. A total of 102 of the 122 vacancies were filled by January 2013. The replaced CEOs were horizontally shifted to provincial and national departments (Makholwa, 2013a).

The minimum qualification and experience of a hospital CEO were defined as (National Department of Health, 2011):

- I. A degree or advanced diploma in health is a prerequisite, and a management qualification is an added advantage.

II. Minimum experience of five years in management in the health sector.

The minister of health, Dr Aaron Motsoaledi, emphasised that CEOs should have a health background as a prerequisite because the NDoH conjecture that the health sector is better managed by members of the health profession (Medical Chronicle, 2013).

After appointment, the hospital CEO attends an academy for leadership and management in healthcare. The academy offers a platform to discuss the challenges a hospital CEO is most likely to face, and offers effective methodologies to overcome those challenges (Bateman, 2013).

METHOD

This research was a case control study. Retrospective data were gathered on hospitals and their CEOs. The research objectively measures the competence of public hospital CEOs by relating their characteristics (with a focus on qualifications) to the performance of the hospital they run.

Data were collected on each South African hospital CEO using the following data sources:

- Discussions with Provincial health departments (Biographic and other information on CEOs.
- Provincial departments of health websites ¹(names and basic information of CEOs)
- LinkedIn (Qualifications and experience of the CEOs)
- Google search (For any notable characteristic of the CEO)
- Health Profession Council of South Africa (HPCSA) website (Clinical qualifications of CEOs)
- Hospital websites (For any further information)

From these websites, a list of all the hospitals in the province, the hospital classification and the names of the CEOs were found. This process was time consuming and data in the public domain could not always be validated yet, wherever practical, data were triangulated from various sources. One limitation was that not all CEOs had a publically accessible profile.

We assumed that Information sourced from the health department websites was accurate and up to date. Table 1 gives the total number of hospitals that were investigated, as per classification and province.

Table 1: Number of hospitals where CEO characteristics were investigated

Hospital classification	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
District Hospitals	65	13	11	44	27		17	15	11	
Regional Hospitals	0	4	9	11	5		1	1	5	
Tertiary and Central Hospitals	0	2	7	4	1		1	0	3	
Specialised	1	1	6	11	0		1	1	9	

¹ This information was available for: Gauteng, Limpopo, KwaZulu-Natal and Freestate. Eastern Cape and Mpumalanga's health websites were not functional for the duration of this study. Northern Cape and Northwest provinces are yet to set up an independent health website

Hospital classification	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
Hospitals										
Classification unclear	3	0	0	2	0			4		
Total	69	20	33	72	33	33	20	21	28	329

Of the 329 hospitals investigated, CEO data were found for 212. Four provinces (LP; GP; FS; KZN) had all the names of their hospital CEOs. The response rate in the remaining provinces is shown in Table 2.

Table 2: Results from the individual hospital search

Province	No. of hospitals investigated	No. of respective CEOs acquired
Western Cape	28	17
Northern Cape	20	6
Eastern Cape	69	9
Mpumalanga	33	14
North West	21	9

Detailed research was conducted on each CEO, to understand personal characteristics in the four key areas as set out in Table 3.

Table 3: Areas of investigation of each CEO (Development Bank of South Africa, 2011)

Demographics	Qualification	Experience	Other Information
1. Gender 2. Acting CEO versus permanent appointment	1. Highest qualification 2. Field of study and the sub field of study of the highest qualification. 3. Institution where qualification was attained 4. Overall qualification mix 5. Clinical qualification	1. Duration of occupancy in the CEO position 2. Experience in healthcare 3. Experience in non-healthcare	1. Notable achievements of the CEO 2. Evident leadership skills

Hospital performance.

Data were collected to create a simple performance measure for hospitals. This approach was favoured because no single universal South African public hospital ranking system exists. Audit results from the 2011/2012 national healthcare facility baseline audit² (Health Systems Trust, 2012) were used together with the rate of negative media reports of each hospital as a triangulation mechanism. This led to a small sample of hospitals with rated performance.

Using these findings, hospitals were classified as either “good/improving” or “poor/non-improving”. The characteristics of hospital CEOs in good/improving hospitals were compared to those in poor/non-improving hospitals.

To understand the current performance of hospitals, two major sources of data were used. These were the results from the 2011/2012 healthcare facility baseline audit and reports in the media that were deemed negative.

Where data from the healthcare facility baseline audit were available³, these were taken as a datum, and the change in negative reporting was interpreted as the diversion from this baseline.

An increase in the number of negative reports was interpreted to mean a decrease in hospital performance whilst a decrease in the number of negative reports meant an increase in hospital performance.

In addition to comparison to the datum established by the national audit, the annual frequency of negative media reports was also evaluated before and after CEO appointments. This was done for all hospitals for which full CEO detail is available.

This gave a simple measure of whether hospitals have improved in performance. The consistency of media reports will be negligibly affected since more than a 100 CEOs were appointed recently (2013), therefore negative media reports will be investigated for a short time frame.

Sixty percent (60%) of the hospitals are run by CEOs who were appointed in 2013 or later, hence CEOs that were appointed according to the revised minimum requirements for hospital managers set out by the department of health. Concerns should then arise, if CEOs appointed according to the new standards are not providing notable hospital improvement, is the appointment policy for hospital managers moving in the right direction?

Overall, we interpreted our data as follows:

- i. Hospitals that had an increase or no change in the number of negative reports after appointment of CEO can be classified as non-improving hospitals.
- ii. Hospitals that recorded a decrease in the number of negative reports after appointment of CEO can be said to be improving in performance.
- iii. A hospital identified as a top hospital in one of the six criteria used in the 2011/2012 audit, and has kept the number of negative reports before and after the audit constant can still be classified as a top performing hospital in that criterion. To maintain the level of service at that high standard does require good managerial characteristics.

² The full results of this audit were not published.

³ Investigations were only conducted on hospitals (from the audit) on which CEO details were available

- iv. A hospital identified as poor performing in the audit, and has recorded a constant amount of negative reports before and after the audit, can be considered to still be a poor performing hospital.

RESULTS

Characteristics of hospital CEOs

Results on each area of focus is summarised below. It should be noted that the results presented below are not conclusive due to the limited sample however we are confident that they have highlighted trends.

We found that 27 % of hospital-CEOs are acting in this role. In most such cases, the acting CEO was internally recruited from the leadership of that particular hospital, and that their previous role (e.g. clinical manager) was still being fulfilled by them.

An analysis of experience prior to appointment showed that the majority of the CEOs do not have non-healthcare working experience, with only four found to have management backgrounds other than in healthcare.

Qualifications

We were able to gain information related to the qualifications of 78 CEOs. The HPCSA records the clinical qualifications attained, but does not record other qualifications that might have been obtained in other fields. It was found that CEOs who had a degree or diploma as their highest qualification had obtained that qualification in the field of health.

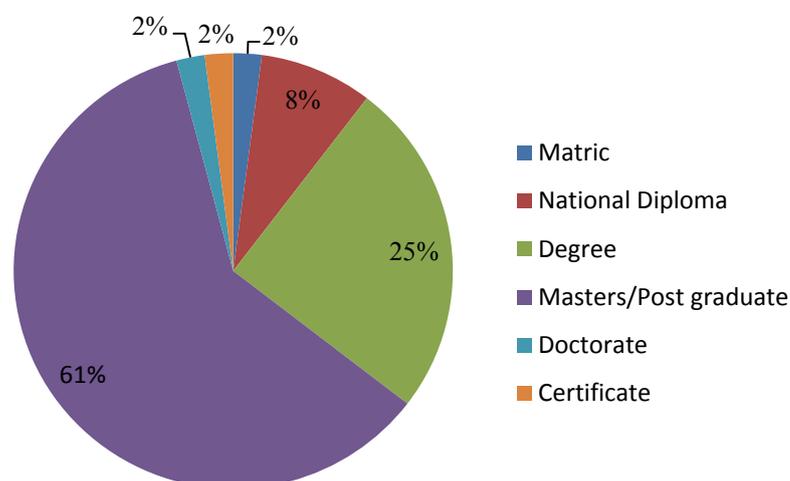


Figure 3: CEOs highest qualification (n =48)

The most common highest qualification from our sample is a masters or post graduate degree (61 %), this compares favourably to an older study which found this number to be only 39 % (Development Bank of South Africa, 2011).

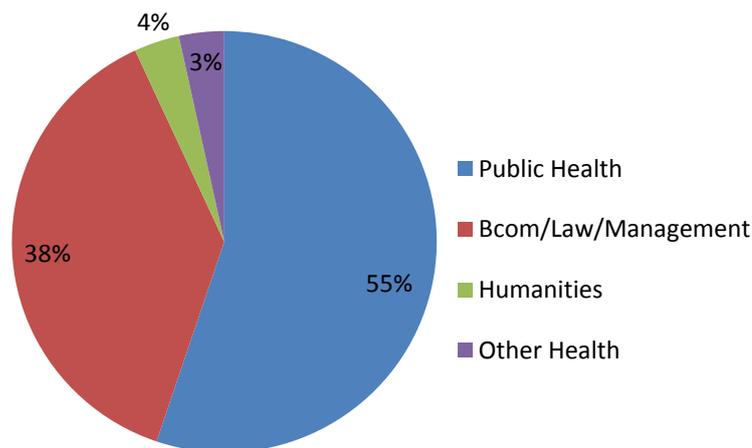


Figure 4: Masters/post graduate/doctoral field of study (n=29)

Of those with post-graduate qualifications, 55% were obtained in the field of public health, 38% in the field of commerce, law and management, and 4% were in humanities. The field of commerce, law and management includes governance; management; business sciences; accounting and law.

Figure 5 shows the qualification mix of hospital CEOs, which not only shows the highest qualification, but all qualifications in combination.

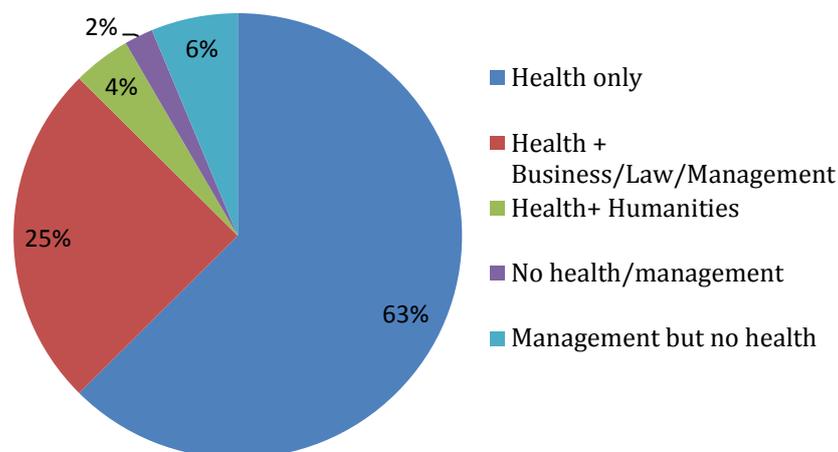


Figure 5: Qualification mix of hospital CEOs (n=48)

It can be seen that 92% of CEOs have at least a health qualification, compared to 87 % in 2011 (Development Bank of South Africa, 2011). Thirty-one percent (31%) of CEOs have a Business/Law or Management qualification, compared to the 19%, whilst those with neither a health nor management qualification have decreased from 4% to 2%.

Figure 6 shows the clinical qualifications of those hospital CEOs who are registered with the HPCSA.

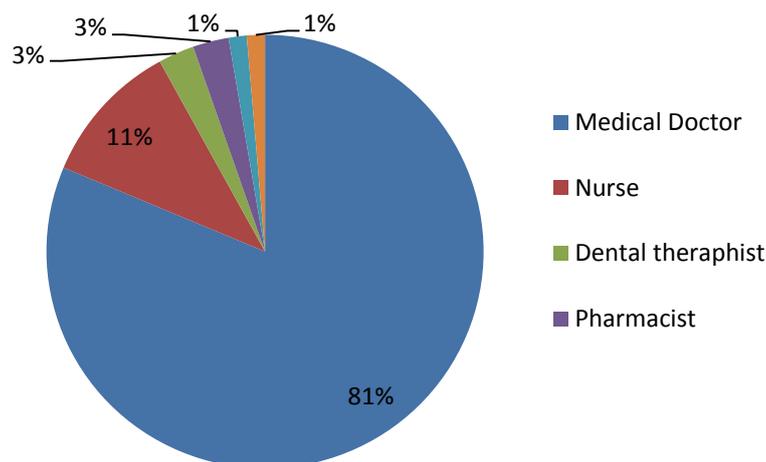


Figure 6: Clinical qualification of CEOs (n =75)

Medical doctors were found to contribute 81%, followed by nursing on 11%.

Experience

The duration of tenure of a CEO was found for 52 hospitals. The results from this investigation give the minimum number of years the CEO has been in that position. This was because of the occasional absence of media articles acknowledging the CEO appointments, and the absence of clarity on LinkedIn. In such cases, we investigated the first press coverage of the individual in that role. Figure 7 shows a breakdown of CEO tenures.

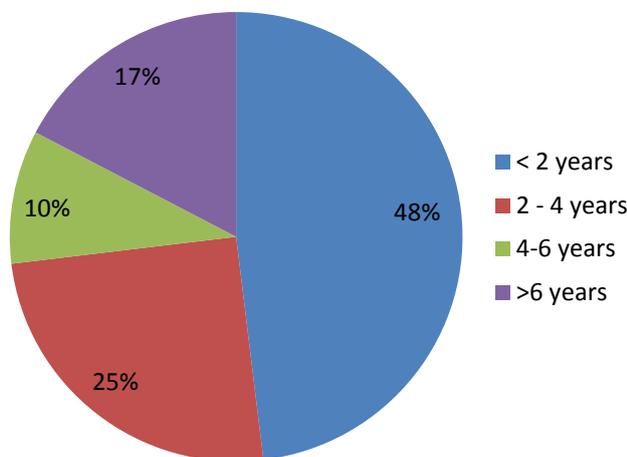


Figure 7: Duration of CEO tenure (n=52)

Of the CEOs, 48% were appointed less than two years ago; 25% have been in the CEO position for two to four years; 10 % for four to six years; while 17% have been in the CEO position they are currently in for more than six years. This grouping is due to the fact that the new employment criteria for CEOs were introduced in 2012; 122 CEO posts were advertised to displace CEOs that were deemed incompetent due to the DBSA report (Makholwa, 2013b). CEOs that were appointed in this time frame have been appointed in accordance to the revised minimum requirements policy for a hospital CEO. Whilst those employed between 2010 and 2012 may have been employed in response to the results of the national healthcare facility baseline audit.

HOSPITAL PERFORMANCE

Our analysis was able to compare several institutions to the benchmark that had been set in the national audit. Table 4 shows an example of institutions that had not improved since the audit, based on media coverage.

Table 4: Hospitals that decreased in performance since the 2011/2012 audit

Hospital	Result from 2011/2012 audit	Number of negative reports in 2010/2011	Number of negative reports in 2013/2014
Tshwaragano Hospital	2nd worst infection control (30%)	0	2
WF Knobel Hospital	3rd dirtiest hospital	0	1

We found that 75% of the hospitals had an increase or no change in the rate of negative media reports. This suggests that the majority of hospitals are not improving in performance or may be deteriorating. Figure shows a sample of how the rate of negative reports has changed following CEO appointments.

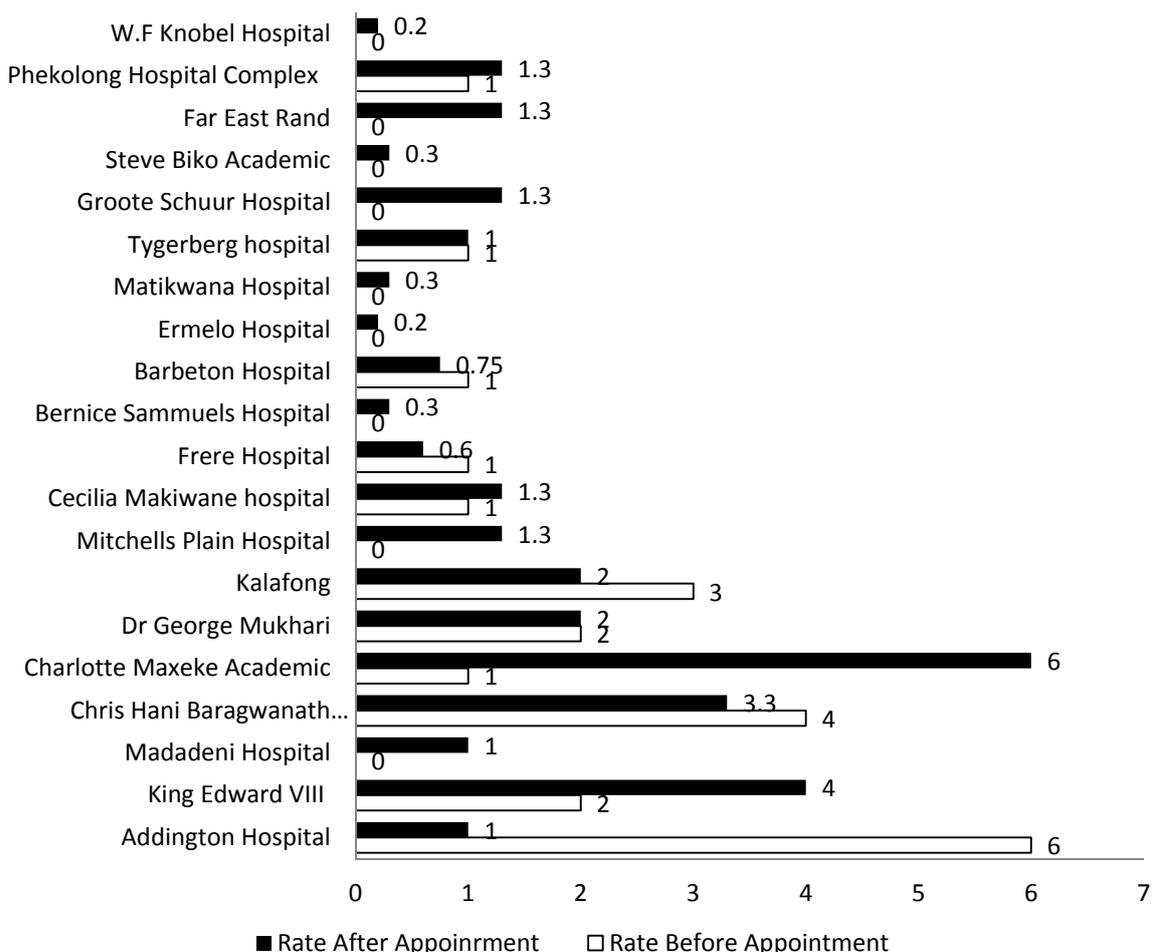


Figure 8: Rate of negative reports before and after CEO appointment for the different hospitals

ANALYSIS

Relationship between hospital performance and characteristics of CEOs

Highest qualification

Figure 9 compares the highest qualification of hospital CEOs in poor/non-improving hospitals to those in good/improving hospitals.

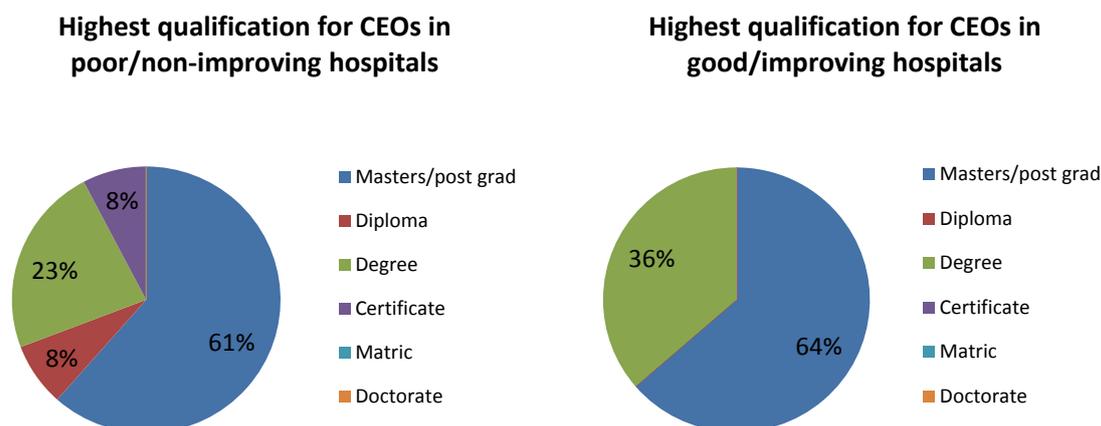


Figure 9: Highest qualification of CEOs in poor/non improving and good/improving hospitals

The highest qualification for CEOs in both poor and good performing hospitals was investigated. It was found that for good/improving hospitals, 100% of the CEOs at least had a degree as their highest qualification. For poor/non-improving hospitals, 16% of CEOs had a certificate or diploma as their highest qualification. Results from the investigation also showed that a similar percentage of CEOs from both poor and good performing hospitals had a masters or post graduate qualification. Further analysis was then conducted to determine if there is a difference in the field of study for the masters/postgraduate qualification.

Field of study for post graduate qualification

Figure 10 shows the field of study for a masters/post graduate degree for poor/non improving hospitals and for good/improving hospitals.

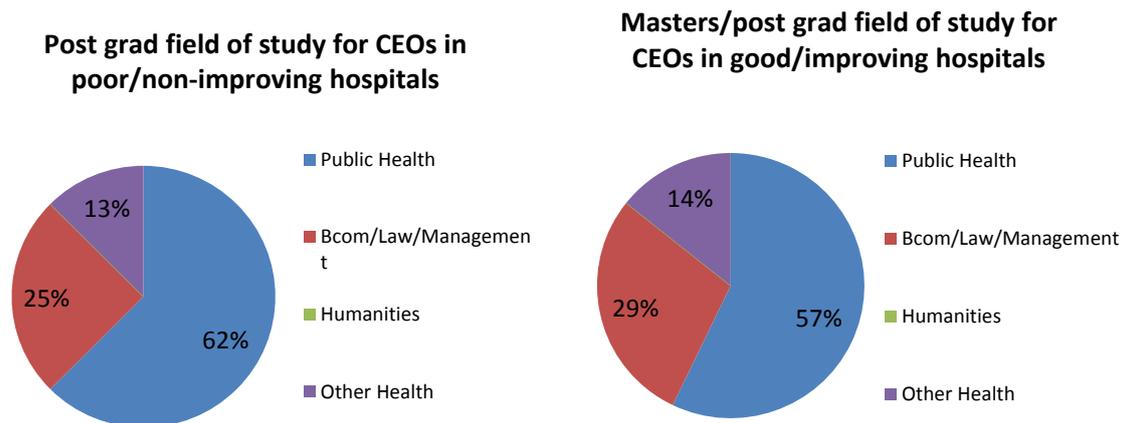


Figure 10: Post graduate degree for poor/non improving hospitals and for good/improving hospitals.

CEOs from good/improving hospitals are slightly more qualified in management for their masters/post graduate qualification than CEOs from poor/non-improving hospitals. Public health is the leading higher qualification in both poor and good performing hospitals.

All qualifications that CEOs attained (not just their highest qualification) were then analysed to determine the qualification mix of the CEOs.

Qualification mix of hospital CEOs

Figure 11 compares the qualification mix of hospital CEOs in poor/non-improving hospitals to those in good/improving hospitals.

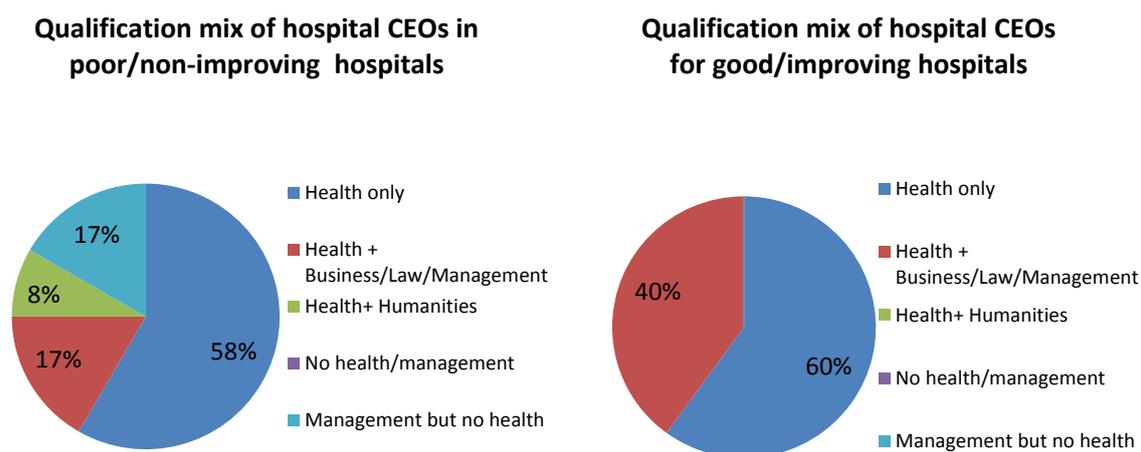


Figure 11: Qualification mix of hospital CEOs in poor/non-improving hospitals to those in good/improving hospitals

100% of CEOs in good/improving hospitals had at least a health qualification, with 40% having a health and a management qualification. For poor/ non-improving hospital CEOs, 83% at least had a health qualification. Only 17% had both health and management qualifications. It was also found that 17% of CEOs from poor/non-improving hospitals only have a management qualification. The management qualifications ranged from certificates in management to masters in management.

Seeing that the majority of CEOs are in health, an investigation of the clinical qualification for CEOs from both poor and good hospitals was investigated.

Clinical qualification

Figure 12 compares the clinical qualification of hospital CEOs in poor/non-improving hospitals to those in good/improving hospitals

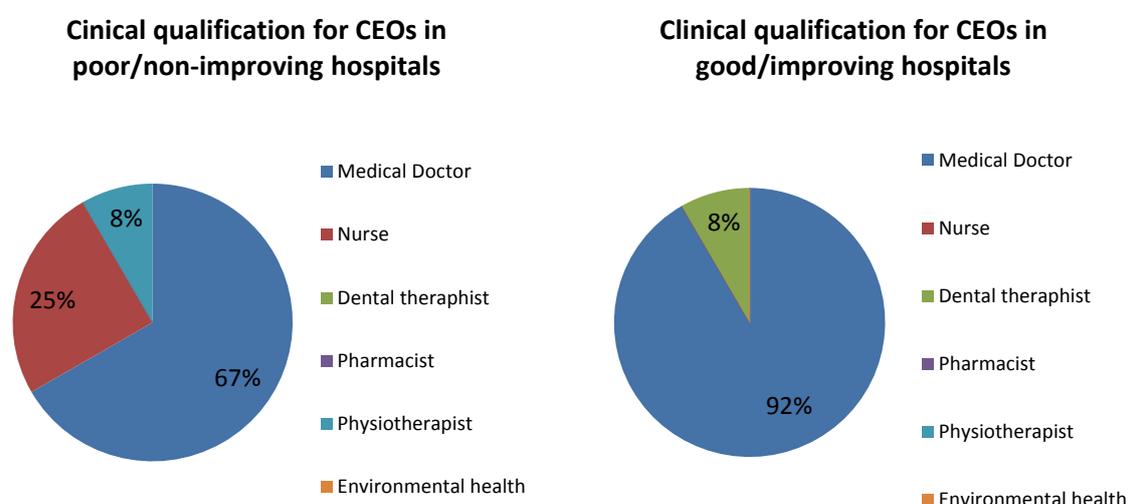


Figure 12: compares the clinical qualification of hospital CEOs in poor/non-improving hospitals to those in good/improving hospitals

92% of CEOs in good/improving hospitals are medical doctors, while poor/non improving hospitals have 67% of CEOs as medical doctors. It was also found that 25% of CEOs in poor/non-improving hospitals have a nursing qualification. This data therefore suggests that medical doctors are performing better in this position compared to other clinical qualifications, for example, nursing.

Duration in CEO position

Figure 13 compares duration of appointment of CEO from the two classifications.

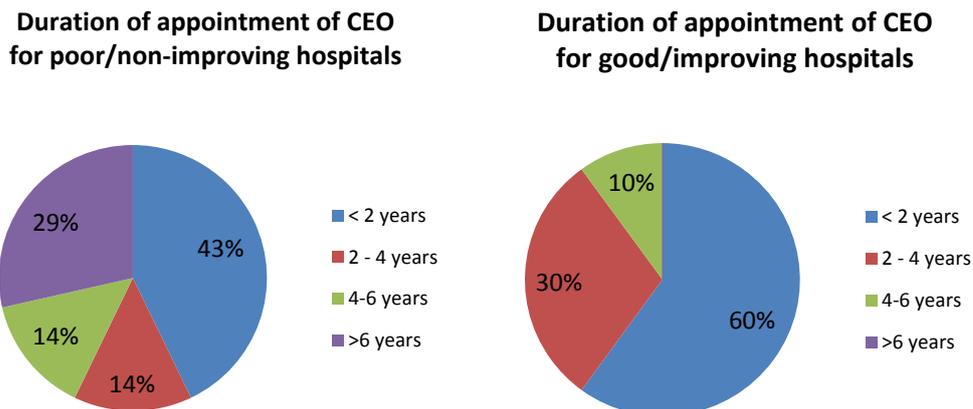


Figure 13: Duration of appointment of CEO from the two classifications

Sixty percent of hospital CEOs in good/improving hospitals were appointed less than two years ago, therefore appointed according to the national standards of minimum requirements set out by the NDoH after the DBSA study. Since this percentage is considerably higher than the 43% in poor/non improving hospitals, it can be said that the introduced standards are bringing about a slight improvement in the performance of hospitals. 0% of hospital CEOs in good/improving hospitals have been running the hospital for more than 6 years, while 29% of CEOs in poor/non-improving hospitals have been running the hospitals for more than 6 years. This suggests that recruitment standards of hospital CEOs from 2008 and before were not working well, and that there has been a slight improvement in the competence of CEOs appointed according to the revised standards implemented from 2012.

To investigate the success rate of CEOs appointed according to the new standards the following data was compiled. Figure 14 shows the success rate of CEOs appointed according to the revised CEO appointment policy.

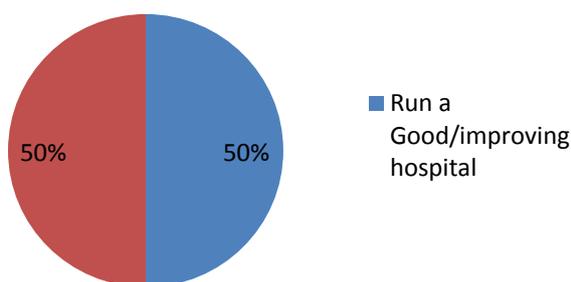


Figure 14: Success rate of CEOs appointed according to current CEO recruitment standards

Of the hospitals that were rated in performance, it was found that 12 CEOs were appointed less than two years ago, hence appointed according to the new appointment standards. Given that a little over 100 CEOs have been appointed according to these standards, 12 is arguably a good random sample. It was found that from the sample, 50% of the CEOs were running good/improving hospitals, and 50% running poor/non-improving hospitals.

DISCUSSION

Perhaps the most unexpected result from this study was that virtually all characteristics that were measured were poor predictors for hospital improvement, to the extent where variation is usually attributable to randomness.

One of the stronger predictors of hospital improvement is the duration of tenure of an executive. This is interpreted in part as the success of the new recruitment baselines as introduced in 2012, which promote clinician leadership and the attainment of higher qualifications.

It is striking that the better hospitals are disproportionately led by CEOs who have taken up their post in the last two years. Although this seems to support the new hiring policy, there is also evidence that an equal number of new appointees run poor hospitals.

The same is true for further qualifications, which are often seen as useful in preparing individuals for hospital CEO roles, however our data suggests that postgraduate qualifications have a minor impact on the quality of leadership and that they are a poor predictor for success.

Although the majority of postgraduate qualifications are in public health, our data suggest that this is not effective at preparing individuals for hospital leadership, which is yet again unexpected.

To fully explain the much better success rate of new appointees, we would propose a longitudinal follow up study to investigate complacency and neglect.

The focus on clinical leadership seems justified from our data sample, which shows that all hospitals run by nurses and physiotherapists are classified as poor/not improving. Our data further show that all hospitals run by dentists are deemed good/improving, whilst medical doctors are proportionally far better represented in running good hospitals than bad.

There is some evidence to support the new selection criteria for CEOs as proposed by the DBSA (Development Bank of South Africa, 2011) Key amongst it is the focus on clinician leadership, which contrasts with US best practice.

We do believe that the selection criteria need to be refined, possibly by considering the competence of non-clinician hospital CEOs in the USA (Gunderman and Kanter, 2009) and to review the course material of the compulsory leadership academy for hospital CEOs. The academy and public healthcare courses are not providing notable improvement in the leadership skills of South African public hospital CEOs.

CONCLUSION

The performance of hospitals was simplistically generated. It was found that better performing hospitals are more likely to be run by CEOs who possess:

- i. A higher level of qualification,
- ii. A qualification mix of healthcare and management,
- iii. Clinical qualifications as medical doctors,
- iv. A more recent appointment in line with the new selection policy.

It was however found that the success rate of CEOs appointed according to the new policy have a success rate of 50%. The appointment policy is resulting in slight improvements in some hospitals, but the low success rate is an area of concern.

The competence of hospital CEOs may be improved in two ways:

- i. Abandon clinician leadership and adopt an American model of management experts running hospitals.
- ii. Maintain clinician leadership, but strengthen their leadership skills, specifically by strengthening public health courses and the academy of leadership and management.

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