Author's response to reviews

Title: Implementation of Hospital Governing Boards: Views from the Field

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Version: 3
Date: 23 December 2013

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December 23, 2013

Dear Dr. Morrey,

Thank you very much for your review of our manuscript #1460864269581470, “Implementation of Hospital Governing Boards: Views from the Field.” We have revised the paper based on the reviewers’ comments, which we appreciate. Enclosed is an itemized list of each of the comments from the reviewers and our response to each.

We believe the revised version of our paper is stronger based on the reviewers’ suggestions and look forward to your continued review.

If you have any questions, please let me know at elizabeth.bradley@yale.edu or 203.499-7351.

Sincerely,

Elizabeth H. Bradley, PhD
Professor of Public Health
Director, Global Health Initiative
Referee 1 Comments and Responses

Comment #1
It might be good to have an introductory section on the general context of Ethiopia – reformist government with strong party discipline (which may mean party members have more authority than others), very underfunded facilities, while relative strong state apparatus there are still limits to authority to regional and district administrators.

Response
We agree with the reviewer that this would be helpful and have added the following to the background, as recommended (P. 5).

The Ethiopian government has been reforming the health sector for more than fifteen years, as guided by the Health Sector Development Program (HSDP). The nation faced many challenges in this endeavor including poorly funded facilities, shortages of clinical staff and limited access to services for rural communities. The vast majority of hospitals in Ethiopia have been funded and managed by the state, either through federal or regional health bureaus. The government has now focused on the decentralization of decision making from the federal level to the regional, zonal, and district levels, allowing for efficient mobilization of resources. A major element of this decentralization reform has been the establishment of governing boards, which reflect hospital and community leadership and are charged with strategic planning, budget approval, and performance management responsibilities.

Comment #2
While I like the use of qualitative and quantitative studies, here they seem disjointed rather than complementing each other. Many quoted statements seem to come from only boards that are not well functioning and not from those that were. Is this a selection bias for the boards selected for interviews or just lack of reporting qualitative results from good boards?

Response
We appreciate this comment and understand how the qualitative and quantitative studies may have seemed disjointed. The reviewer is correct that the quotes highlight the ways in which governing boards are not functioning well. This was purposeful. We did not set out to conduct a full qualitative study of governing boards but rather to allow for an open-ended question in the survey to probe for areas that were problematic, from the perspective of survey respondents. We have clarified the study design, the survey tool and specifically the open-ended question in the revised manuscript as follows.

(P. 6) Study design specifies this as a cross-sectional, quantitative study

We conducted a cross-sectional study using quantitative data from a national survey of government hospital governing boards in Ethiopia during 2011 linked with hospital performance data from the Ethiopian national performance management system.
Survey instrument clarified as including 36 closed-ended and 1 open-ended item

The study team developed a 36-question survey instrument to ascertain the functioning of Ethiopian hospital governing boards. Closed-ended survey items were developed through a rigorous, 6-month process, which included in-depth analysis of literature, convening of stakeholders, and review of policy documents in which intended functions of the governing boards were described. In addition, we included 1 open-ended item at the end of the survey, “Please share any other comments or concerns you have in relation to the functioning of your governing board.” In practice, the discussions focused on challenges and concerns.

The survey included 3 domains of governing board functioning: (1) board structure, (2) board roles and responsibilities and (3) board training and orientation practices. The board structure domain included questions about the number of members, level of gender and community representation, members’ professional experience, meeting frequency, length, content and compensation. The board roles and responsibilities domain required respondents to describe what concrete actions were taken, with a focus on the review of specific clinical services and the monitoring of overall performance and what documents were created to outline roles and responsibilities (bylaws, terms of reference). The board training and orientation domain asked about the presence of orientation manuals and programs for new members, board self-evaluation and additional training needed by board members.

Comment #3
In general, I am skeptical of these selected quotes and would prefer some more systematic reporting of qualitative data – how many of those interviews give consistent responses, and what are the characteristics of the boards or members that respond with interesting additional information that is not in the quantitative study? If this cannot be done in a more systematic way, I would take out the qualitative results entirely because they add little to what the quantitative show and seem biased.

Response
We understand the reviewer’s concerns, and we appreciate the opportunity to systematically expand the analysis and use all the qualitative data we have from the single open-ended question on the survey. We have expanded the results (Pp. 12-15) and the discussion (P. 17) substantially to reflect these data (Pp. 24-27).

ADDITION TO THE RESULTS (Pp. 12-15):
Themes from open-ended responses about concerns in governing board functioning

A total of 80 individuals (87% of respondents) provided responses to the open-ended question. Several areas of concern regarding the implementation and current functioning of hospital governing boards emerged from these open-ended responses. Recurrent themes included: 1) unclear authority of the governing boards, 2) inadequate
commitment and limited incentives for members to meet as a governing board, 3) ineffective communication and collaboration between the governing board and the regional health bureau, 4) unmet training needs of governing board members, and 5) inadequate representation from community, district, and zonal levels (as opposed to regional level) on the governing board (See Figure 1 for larger set of quotations).

Unclear authority of the governing boards

More than 15 respondents indicated that they were concerned about the unclear authority of the hospital governing board. Some articulated boundary problems with the hospital management (being unclear about what was under the authority of the hospital management versus the governing board) and other respondents highlighted the boundary problems with the regional health bureaus (confusion over what was within the jurisdiction of the governing board versus what was the responsibility of the regional health bureau). The ambiguity in authority was apparent in statements about decisions concerning financial incentives for the staff, handling ethical issues, drug procurement, corrective action for employees, CEO supervision, and overall budgeting for the hospital. Quotations that illustrate ambiguity between the governing board and hospital management and the ambiguity between the governing board and the RHB include the following.

*It would be good if the role and responsibility of GB and hospital management had clear demarcation (from one respondent)....even though hospital employees have ethical problems, the governing board could not take action because its role has not been clearly stated (from a second respondent).*

*It would be better if the CEO could report directly to the governing board instead of the regional health bureau (from one respondent)....Sometimes the regional economy and development bureau interfere with budgeting, which was a board responsibility (from a second respondent)....The GB has no autonomy; decisions made by the governing board have been violated by the RHB (from another respondent).*

Inadequate commitment and limited incentives for governing board members

A second issue described by respondents was lack of commitment of board members to meet regularly and to attend meetings. Respondents suggested the incentives were insufficient. In some cases, chairs were overcommitted to more than one board; in other cases, members were high-level government officials from the zonal or regional levels, who were too busy to prioritize their governing board responsibilities. Community members also were described as sometimes too busy as well with their private businesses to commit to attending hospital board meetings, and respondents highlighted the lack of financial incentives for board members being a detriment to the functioning of the board. For instance, respondents stated the following:
In our zone, one person chairs three hospitals, which is inconvenient for the chair because he does not have enough time to get to know all information about the hospitals (one respondent)... Most of the governing board members are high government officials [and] they do not [dedicate] enough time to the governing board (a second respondent)... Community representatives have not attended meeting as needed because they have private businesses (another respondent)... [The GB is not performing well due to] inadequate of payment (another respondent).

Ineffective communication and collaboration with RHB

In addition to ambiguity about the governing board versus the RHB roles, lack of communication and collaboration between the entities was also described as limiting board functioning. Although this concern was less frequently noted, respondents expressed that the relationships could be more effective in some cases.

[There is] no relationship between GB and the RHB; hospital data have exclusively been reported to the RHB (rather than to the GB and then to the RHB (one respondent)... The GB reports to the RHB, so the RHB [should] work closely with the GB, follow challenges of the GB, solve financial and human resource problems (a second respondent).

Unmet training needs of governing board members

A central concern for respondent was the lack of training and orientation for governing board members. Respondents believed that often board members did not have the needed background or training to be effective in the position. The following illustrative statements highlight this theme.

Training should be given to GB members before they start work as GB members (on respondent)... If GB members have received training on project designing... effective management style... how to give incentive to hospital staffs and retain them, [they would do a better job] (a second respondent)... There should be an orientation program for new governing board members and all additional training should be provided on site, [rather] than outside of the district (another respondent).

Inadequate representation from community, district, and zonal levels

Several respondents described concerns about insufficient representation of the community or more local levels of government on the hospital governing board. The majority of respondents who identified this issue stated more community representation was needed, although some also thought greater diversity across
districts was required, particularly for hospitals that served people from multiple districts. Overall, the sense of those concerned was that the governing board did not have adequate representation from the communities the hospital served and still depended too much on leadership from the regional levels of government. Respondents stated:

It would be better if the GB composition comprised more community representatives (one respondent)...It would be better if the GB members were nominated from the district [more local] administration than from zonal administration (a second respondent)...The current GB comprises members from the same district administration, so it would be better if the composition could from different districts [that the hospital serves] (another respondent)

ADDITION TO THE DISCUSSION (Pp. 15-18)
(P. 16) We additionally identified a set of challenges as perceived by governing board chairs responding to an open-ended question. These focused on role definition and ambiguity in authority of the governing board, which in some cases seemed to risk eclipsing the roles and authority of hospital management and in other cases were limited by inadequate authority over financial and human resource decisions still under the jurisdiction of regional authorities. The finding highlights the central challenge in decentralization efforts, which is coming to terms with the roles and responsibilities – both on paper and in practice – of new governance structures between the regional government and the communities that hospitals serve. In Ethiopia, the reform efforts have progressed substantially to create governing boards and, in so doing, improve hospital management and patient experience; however, qualitative data suggest that the issues of governing board member selection, training, and motivation, as well as clarity in responsibility persist in some cases and will require ongoing attention to reinforce the vision of decentralization.

(P. 18) ...Last, the open-ended data attained were helpful but we were unable to have in-depth qualitative interviews of both the successes and challenges encountered with establishing and managing governing boards. Such a study would provide added depth to the understanding of this largely quantitative analysis.

Comment #4
I know it is seldom done in these empirical studies, but it would be good to have a paragraph about the logic or theory of why the authors expected good governing boards to have an effect on performance. It is only when we get to the results that some explanation for this comes out on empirical findings of more developed countries rather than the logic of why we would expect it.

Response
We agree with the review that this would be helpful and have added the following the background (See underlined text, which is new) (P. 5). With the existing citations in the
background showing the link between governing boards and performance (McDonagh, 2006; Collins et al., 1999), we believe this will be sufficient but we defer to the editor if more detail is preferred. We recognize space limitations.

We hypothesized that hospitals with higher functioning governing boards would have better performance, as measured by better adherence to the Ethiopian Hospital Reform Implementation Guidelines (EHRIG) and more positive patient experience. This is based on the concept that governing boards are local entities that can hold hospitals accountable for performance, can support strategic thinking to promote alignment between services and community needs, and can help advocate with the ministry for financial resources needed for hospitals.

Comment #5
The description of the findings in the abstract is surprisingly more complete than in the “discussion” section which brushes over the findings without discussing their implications in more detail.

Response
We do not repeat the results in detail in the discussion because they are described fully in the results and the tables, and we are sensitive to the space limitations of the journal. To address the reviewer’s concern, we have added the following, concerning implications of the findings, to the discussion (Pp. 15-17).

...In particular, our findings suggest that strengthening governing boards to perform essential financial and operational responsibilities may result in improved hospital performance. Additionally, the findings highlight some of the ongoing concerns that may be experienced by countries seeking to decentralize including needs for reinforcing clear distinctions between roles of regional government, governing boards, and hospital management and supporting board members with sufficient training and incentives to engage in governance activities.

...We additionally identified a set of challenges as perceived by governing board chairs responding to an open-ended question. These focused on role definition and ambiguity in authority of the governing board, which in some cases seemed to risk eclipsing the roles and authority of hospital management and in other cases were limited by inadequate authority over financial and human resource decisions still under the jurisdiction of regional authorities. These findings highlight the central challenge in decentralization efforts, which is coming to terms with the roles and responsibilities – both on paper and in practice – of new governance structures between the regional government and the communities that hospitals serve. In Ethiopia, the reform efforts have progressed substantially to create governing boards and, in so doing, improve hospital management and patient experience; however, qualitative data suggest that the issues of governing board member selection, training, and motivation, as well as clarity in responsibility persist in some cases and will require ongoing attention to reinforce the vision of decentralization.
Comment #6
P. 11: How many were “designees” rather than the Chairperson?

Response
We have added the following to P. 11 of the revised manuscript.
Of the 92, 79 respondents (89%) were board chair persons, and 13 (14%) were designees.

Comment #7
P. 4: Describe the composition of the “study team” and how they did the interviews (e.g., one asking questions and the other filling in the questionnaire, length of time for average interview, what they did if there was conflicting information).

Response
We have added the following to the manuscript to provide greater detail about the study team and the interviewers (Pp. 7-8), as requested.

The study team was multidisciplinary and consisted of academicians from universities in Ethiopia and the US, non-governmental organizations with knowledge in governance and hospital operations, and physicians, nurses, and individuals with hospital management experience in Ethiopia. Twelve interviewers traveled throughout Ethiopia, each independently conducting 1-hour face-to-face interviews with board Chairpersons or their designees. Challenges faced in interviewing were scheduling meetings with senior government officials and completing all survey questions when respondents were unsure of the correct response. To address these challenges, interviewers were persistent with follow up to officials and left responses blank if respondents did not know the answer. The survey also offered “I don’t know” as an optional response as appropriate.

Comment #7
Pp. 10-11: Could you do an analysis of the performance data for all hospitals including those without boards? It might be interesting to add to the analysis the performance of hospitals without boards to see if boards overall have a positive effect. For instance: “The average EHRIG score was 58.1% of the standards being met (P. 11); how does this compare to all hospitals which reported an EHRIG score?

Response
We agree with the reviewer that this information would be helpful; however, we did not survey hospitals without governing boards, as it was a government mandate for hospitals to establish boards. Only 16 government hospitals, in the smaller regions, had not established governing boards by the time of the study, and their performance would differ markedly for a host of reasons. Hence, we did not think this would be a strong comparison. We have added the following to the revised manuscript (P. 6).
Only 16 of the government hospitals, all in smaller, more rural regions of Ethiopia, had not established governing boards at the time of the study; all hospitals with governing boards were contacted for the survey.

Comment #8
P. 11: Do you have at least a range of payments for board members?

Response
We have added the following to P. 11 of the revised manuscript.

The payment ranged from 0 USD to 25 USD per meeting.

Comment #9
P. 15: The first paragraph of the discussion unnecessarily repeats earlier justification for the study.

Response
Thank you for highlighting this repetition; we have deleted the duplicative sentences.
Referee 2 Comments and Responses

Comment #1
P. 6: Can you provide more detail on the structure and mission of the hospital boards? Who sits on these, how many members in general and what is their overall remit? This is relevant for external validity of these findings to other areas. Perhaps some of these details could also be added to Table 2 (could be “Structure and Activities of ...”).

Response
Thank you for the opportunity to highlight additional details about the hospital governing board structure. We have added the following to P. 6.

Hospital governing boards have 5-7 members (government and community representatives), are required to consider gender and community representation in recruitment of new members, and exist to better mobilize resources, enhance community participation, and improve hospital performance. Board members are selected by the Federal Ministry of Health and Regional Health Bureaus as appropriate, serve 3-5 year terms, and focus on financial and operational oversight of hospitals, as per the Ethiopian Hospital Reform Implementation Guidelines (Federal Ministry of Health, 2010) and legislation in 9 regional health bureaus and 2 city administrations.

Comment #2
P. 9: The administration of the patient survey is unclear. Are these continuously used in hospitals for all discharges or were they administered for this study? Please provide more detail on sample sizes and response rates per facility.

Response
The data are captured at the hospital level for each hospital and reported to the Federal Ministry of Health as part of their routine hospital performance monitoring system; hence patient-level data were not available for analysis, and response rates are not reported by hospital are not reported; however, in our previous work, response rates for such surveys are generally above 95%. We have revised the manuscript with the following sentence (P. 9)

Patient experience is routinely measured by the Federal Ministry of Health using validated surveys, which have been previously described (Webster et al., 2011); hospital-level data were available for this study.

Comment #3
P. 10: How is the multivariable model constructed? What is the outcome: mean patient score (this would give an n=49) or are individual patient scores modeled with a fixed effect for hospital, which would give a larger n? Please provide the n in the results and the table.

Response
Thank you for the opportunity to expand on the multivariable modeling method, which included only hospital-level data. Patient-level data were not available; hence we could not expand the sample size and use fixed effects. We have added the following to the revised manuscript to clarify our approach (P. 10).

P. 10 (Methods) Hospital performance data on 2 indicators (the percent of EHRIG standards met and patient experience) were measured at the hospital level as part of the Federal Ministry of Health national hospital monitoring and performance improvement system. No patient-level data were available.

Comment #4
P. 106: Further on the above point, assuming individual level outcomes, patient characteristics might be confounders in this relationship between board governance and patient satisfaction. Basic patient characteristics were unavailable from the survey according to the paper by Webster et al. Also, were there other variables available, such as the number of doctors/nurses, urban or rural setting?

Response
The reviewer is correct that patient characteristics were unavailable; however we did have data on time since the hospital board was implemented, hospital location by region, and type of hospital (primary, secondary, and tertiary), which aligns largely with rural, semi-urban, and urban. None of these factors added significantly to the fit of the multivariable model. The following addresses these points.

In both models, time since the governing board was implemented, region in which the hospital was located, and number of hospital beds were not significant and were therefore dropped from the final models presented. Hospital type was associated with performance (with primary compared with secondary and tertiary hospitals having worse performance on both outcomes).
References


