CASE CODE 23

23. PARC TAULI CONSORTIUM HOSPITAL (C)

"We don't get breathing time to sit back and consolidate. The pace of work and change has yet not slowed down despite over five years having passed since the consortium was formed," said Sra. Mastrich, Director (Technical), the staff support to the Director General, who was closely involved in the process of merger and integration throughout the five years period. "Today we are a little better placed," she continued, "but a lot more is yet to be done. It is one damn project after another. The la Salut building, which is quite old, has to be erased and a new building is to be constructed, as the old building is almost becoming unfit for operations now. The maintenance people get six to seven complaints daily from failure of power to failure of water supply. The building, besides accommodating over 150 beds also accommodates many offices. The new building, apart from accommodating all this, will also have at least a major part, if not total, of the Clinica In;antil operations (paediatrics) shifted here, which is almost two kilometres from the main complex. The problem we are struggling with is how to effect the decision, what do we do with the existing occupants, in the intervening period." Her words only described the pace of hectic activities which were quite visible to any stranger visiting PATCH, with construction work going on almost in all the direction as if a turnkey project was nearing completion.

"Why this whistling," asked a surprised case writer from her. She smiled, "The staff is protesting for the revision of the salary structure to have parity with the staff of the NHS run hospitals that were somewhat better. You might know that though we are a referral hospital for the NHS, we are ourselves not a NHS hospital. The NHS hospitals are under the control of the national government, while we are a public hospital paid by the NHS, but under private management. The decision is not in our hands. The agitation has almost paralysed over fifty hospitals in the state. We are lucky. The staff has decided to protest but not let the services be crippled, as they believe the patients are not responsible for it. They protest during the recess and as soon as the tea break is over they come back to their usual duties." Sure it happened.

PATCH was formed as a Consortium Hospital under an agreement on December 31, 1986, through merger of four independent hospitals, two of them owned and run by the municipality of Sabadell, and one each by a mutual funds company and a savings bank in Sabadell, a town close to Olympic '92 site, Barcelona. PATCH (A) case gives the historical setting detailed background of the merger agreement. PATCH (B) describes the excitement, pains and turmoil through which the organisation passed in a period of about five years. This case describes the achievements, setbacks and the way they looked at the future.

Summing up the experiences of the last five years period a doctor said, "We have undergone almost a metamorphosis. There were four small hospitals, some specialised and some general ones, run more like private clinics. With the formation of the Consortium, overnight we became a

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Case prepared by Prof. Krishna Kumar, Visiting Professor, under Euro-India Cooperation & Exchange Programme (1991-92), and Dr. Marvel Peiro, Associate Professor, Escuela Superior de Administration i Direction de Empresas (ESADE), Barcelona, Spain. *Data has been disguised wherever necessary.

big, public hospital. The doctors were the supremo in the earlier set up, each feeling like a king with his own empire. The consortium brought with it a new structure which limited the almost absolute freedom enjoyed by them thus far. The crisis of 1989 also had a strong under-current of the professionals' reluctance to accept a supervisory i.e., management level. The change in the Norms of Admission, was as much a shock to some clients as to some doctors. The new philosophy for the functioning of the hospital was far too radical for few of them to adapt. In a way the crisis can be said to be the real turning point for the hospital. It settled the issue of basic philosophy for management of the hospital once and for all. The legitimacy of the governing council as the supreme body was clearly established which was necessary for the functioning of any organisation. Once these issues were settled, the ground was ready for some fruitful plans to be implemented for the future of the Consortia."

A new management ideology announced by the Governing Council was very emphatic, clear, and categorical (see exhibit 5). It was given wide publicity to reach every member of the hospital and client system. The following were the main thrust points:

- the Consortium is a non-profit making, public service institution.
- patients are the key players (under no circumstances may the interests of the organisation or the professionals be detrimental to the patients),
- optimum quality of care is to be the individual and collective aim of all the professionals in the institution,
- care is to be based on inter-disciplinary work.

The consultative mode of the resolution of the crisis, carried out in a conducive climate, brought out the difficulties the staff and doctors were facing in the transformation process. They expressed that the directors were introducing the changes at too fast a pace, which they were finding difficult to cope with, especially because often they neither knew the reason for the changes nor the mechanism to cope with it.

The crisis also impressed upon the management the need for being more participative. The management then switched over to a visibly democratic style of functioning. Symbolic of :t was the fact that the Technical Commission and the Commission for Medical Care now had elected representatives instead of nominated ones.

The management of the hospital also realised the importance and need of being `more transparent' in functioning and initiated conscious efforts to improve upon the communication with people which later became an aspect of serious concern for them. "We realise how difficult it is," said a director. "In the past we thought we are communicating everything, but now we realise that we were at the most only informing," he carried on. "We are taking as much care as possible now. To aid the communication process a monthly bulletin was introduced. But over a period of time we realised that it was not effective, as many people didn't seem to even read them. We realised that it looked like a management organ. People did not follow it. To improve upon the system the staff was encouraged to bring out the bulletin themselves, writing all that they felt was required and would be of use and interest to them, with management keeping them regularly informed about the developments' and proposed change in policies, procedures, new projects etc. It looks this arrangement would turn out to be a better one as more people, from doctor to kitchen staff, appear to be reading the bulletin with interest now."

The new management style was also made an integral part of the new ideology of the management that was later brought out as a policy document duly approved by the governing council and widely circulated (see exhibit 5).

The Reorganisation

Once the crisis was resolved, the introduction of changes became more easy and fast paced. The new management ideology was reflected in a new organisation structure of PATCH that was formally introduced in October, 1991 (see exhibit 6).. The new organisation structure highlighted the patient care as the hub of functioning of the hospital, with all other services playing the supporting role.

The new Executive Committee comprised:

- Director General*
- Director, Patient Area
- Director, Economics & Technical Area
- Director, Labour Relations
- Manager

Two other management committees were also created with the following composition:

(a) Committee for Patient Care:

- Director, Patient• Care*
- Director, Medical Services
- Director, Nursing Services
- Director, Prog. Health
- Director, Admissions
- Director, Client Attention
- Director, Social Health Services

(b) Economics and Technical Management Committee

- Director, Economics & Technical*
- Director, Administration
- Director, Security and Maintenance
- Director, Hotel Services
- Head, Management Control
- Subdirector, Computers & Finance
- Subdirector, Personnel Administration
- Subdirector, Information
- Head. Client Attention

* denotes Chairperson

Introduction of Perspective Planning

In the year 1989 the management of PATCH started thinking of introducing a formal planning system. Towards this a Director (Planning) was appointed to undertake detailed analysis of various medical services provided which would help in shaping the strategies for each of the areas and the future of the hospital as a whole. A time bound programme was drawn for the purpose following a planning model (see exhibit 7). The analysis carried out was observed to be very valuable for designing/ modifying the action strategies.

The analysis undertaken for the planning purpose also led to improved clarity of vision. The realisation gradually dawned that it was not the treatment of a particular disease that needed to be attended, but the total patient care, involving even the socio-psychological milieu in which the patient finds himself. The technical aspect was only as important (not meaningless) as the social and psychological dimensions of the patient care, a lesson learnt from the experience of managing the Old Persons Home. The focus of organisation thus shifted from the disease to the patient which finally found description in the new ideology of the hospital.

Looking Back

By 1991, the Consortium had stabilised, the operations steadied (see exhibit 8) and the storm settled down. The facilities were restructured to a large extent and the management was looking for further consolidation of the operations and shaping the organisation as per the new ideology announced formally. "We can now look forward to brighter days ahead," said a doctor, "as we are more clear today of what we are doing, where we are heading. This clarity is very valuable."

"It was a hard process with high personnel and human costs," was another opinion. "A meaningful number of people left or had to leave the institution at different stages of integration process, including a large number, fourteen to be precise, of medical chiefs, as they could not reorient themselves to the changed demands, particularly to the concept of a public service hospital. They could not change their past practices and behaviour and could not respond adequately to the demands of bringing improvements in their area of operations. Many staff members who were involved in the implementation process had to spend long hours, overstretching themselves at high personal costs. At times we wonder whether this much human cost is imperative in any merger process."

"All this was worthwhile," was yet another view expressed. "The sacrifices made by so many people are fetching fruits in terms of the role this hospital is playing in catering to the health care services in Sabadell. It has assumed a recognition as a great hospital. For instance, the hospital has been selected as a referral hospital for Barcelona Olympics. It has made good technical and scientific progress and improvement in the formation of professional staff and has now been recognised as a medical college hospital by the Autonomous University of Barcelona."

"To a large extent all this can be attributed to the choice of good people for important positions by the governing council of the Consortium," one staff member said, "who faced the realities firmly and with a sense of dedication. Indeed the sincerety of purpose towards the people has been a significant factor, in my view," he carried on. "There were occasions for softer options, but they were not acceptable to them at the cost of the organisation. The staff appreciates today the transparent management here, which is generally not seen at other hospitals around."

"The will power to innovate and improve and the feeling of our own hospital can be felt by everyone," was yet another view. "Indeed it has been one of the reasons of the problems of change that we face continuously. But, the participation of all in the process reduces the difficulties today. For instance, in the development of the Directive Plan introduced formally in 1991-92, over 2000 people at various levels participated in the discussion at different stages. It becomes easy to understand and prepare ourselves for the change."

"Looking at the future we find today we have two options open to us," said the present Director General, "to be a local hospital and have stability or more importantly to be a vanguard hospital, becoming a model for other hospitals in Spain and understanding the persons with respect and humanity — becoming a

kind of statesman hospital. The two alternatives involve enormous soul searching before a final decision is taken," he concluded.

EXHIBIT-5

IDEOLOGY OF THE "CONSORCI HOSPITALARI PARC TAULI" (a summary)*

1. AIM

The aim of the Institution is to provide integrated and personalised health care to its assigned population in response to need.

2. THE PARADIGM

People working in the "Consorci" should know, accept, adopt and support the objectives of the paradigm, based on the following elements:

1. Institutional model 2. Health Care Model 3.Education and Research 4. Internal relations

2.1 Institutional Model

The statutes of the "Consorci" define it as a NON-PROFITMAKING-PUBLIC-SERVICE providing its assigned population with equal care for all of it with equity of access and open information systems and open to all other services in the community.

The "Consorci" is open to training and research activities in all areas related to the health care system.

2.2 The Health Care Model

The guidelines for the health care model are:

- PATIENTS ARE THE KEY PLAYERS. The aim of health care is to respond appropriately to the needs of the patients. This requires an effective communication system with all available services in its ambit. Under no circumstances may the interests of the organisation or the professionals be detrimental to those of the patients.
- QUALITY OF CARE has different specifications for acute and chronic care. The elements defining these two areas are:
- Acute health care focuses on fast and accurate diagnosis, application of efficient, effective and the least aggressive therapy, taking into consideration the quality of the patient's life, his need to be informed as well as the need for objective evaluation of the results.
- Quality of social/chronic care is defined as the assessment of the patient's prognosis and compliance with individualised cart programme developed by the team and directed towards promotion of autonomy, social integration, overcoming shortcomings, adaptable procedures, comfort and general well-being. The promotion of quality of life and respecting the dignity t f the patient is at the forefront of the paradigm.
- Optimum quality of care is to be the individual and collective aim of all Professionals in the Institution.
- Technical committees are seen as the best way to establish a policy fostering quality since they provide a way for constructive participation o" all professionals.
- The Governing body and the management team guarantee permanent suppo't to the

policy of quality health care.

- COMPREHENSI' g AND PERSONALIZED CARE is necessary to meet personal needs, in all circumstances taking into account not only the biological but also the social, psychosocial and cultural element:
- INFORMATION AND COMMUNICATION WITH THE PATIENT. The identification of personal problems and the understanding of patients is required for effective communication. Interpersonal communication allows emotions and anxieties to be expressed and suffering t educed, increasing patients confidence in the Institution and its staff and improving behaviour positive to the patients' wellbeing. Communication with patients and relatives should be built on the criteria of viability, validity, efficiency and adaptability.
- CARE BASED ON INTERDISCIPLINARY WORK. Health care goes beyond the responsibility of any individual. All professionals are involved in health care and work on an interdisciplinary bases. -
- CARE IS A PERSONAL AND INSTITUTIONAL RESPONSIBILITY. Health care is made up of a set of actions and decisions by numerous professionals and it should be understood as an Institutional function with ethical and legal responsibilities beyond those of the individuals involved. It reaches all levels in the institutions.
- TRAINING, EDUCATION AND RESEARCH. Health care is in permanent need of training programmes and continuing education. Education and research ought to be guided by the objectives of the Health Care Model.

2.3 Education & Research

The "Consorci" is associated with the University through educational and research programmes based directly on the improvement of the quality of care and open to all areas directly or indirectly related to the Health Systems.

Education and training are integral parts of the paradigm. Their aim is to teach, update and/or perfect professional knowledge and techniques and to promote the personal competence needed to guarantee quality of care.

Research is a fundamental element for the progress of the health care system. Research contributes to improvements in the health prospectus of the population, incorporates the scientific method in the habits of professionals and permits the Institution to relate to 'national and international reference groups.

2.4 Internal Relations

The "Consorci" seeks to make work humane and promote professionalism through individualized support of staff. Suitable policies of encouragement and motivation S help individual development.

The staff is the most valued asset of the Institution, consequently, the Institution has to be receptive to and supportive of its people. A Labour Relations Policy favourable to employees within the budget limits i; eagerly sought.

3. THE MANAGEMENT MODEL

The Management Model defines the structure of the information, communication, evaluation and decision making coherent with the Institutional Model.

The design of a management model that is really effective requires adaptations to the real situation of the Institution at all times, bearing in mind the adopted strategies, the existing conditions, the resources available arid the objectives to be achieved.

The characteristics that conceptually define the Management Model to be developed in the "Consorci¨ are:

— *Participation.* Seeks the co-responsibility of all professionals.
– *Clarity.* Based on an information system open to everybody with an understandable, descriptive and objective language. *Matrix Organisation.* Each person is in direct line of hierarchy, and at the same time is closely related to other people of other hierarchical lines. The management uses structure to promote integration of services into operational matrix units to meet the needs of the patients, avoiding at all times that any organisational elements becomes an end in itself.
– Harmonious, coherent, effective and efficient. The information system, which lies at the basis of Management is to be developed on "key factors¨ relevant to the Institutional model at each organisation level. The information system is to be aimed at obtaining useful information for evaluation and decision making. It is necessary to make a critical analysis of information which is difficult to measure but highly relevant and that which is easy to measure but of little relevance. A system is to be designed based on what is needed, not on what is available.

3.1 Information Policy

Information policy in support of Management must be consistent with the Model itself, discriminatory and selective, as well as oriented towards the objectives of the Institution. The critical success factors to be developed are:

— Quality of services.
– Response to the Health and Social needs of assigned population.
– Effective and efficient use of resources.
– Integration and coordination with the other available Social-Health care services.
– Qualification and satisfaction of personnel.
– Integration of education and research into the daily work. The final aim of the key factors is to help the design of the information and communication systems needed to provide relevant information to decision making at all levels.

** The Governing Council approved this document on March 26, 1990. By doing so a process of debate and reflection that lasted nearly four years was completed.*

EXHIBIT
Oraganisation Structure Effective from 1991

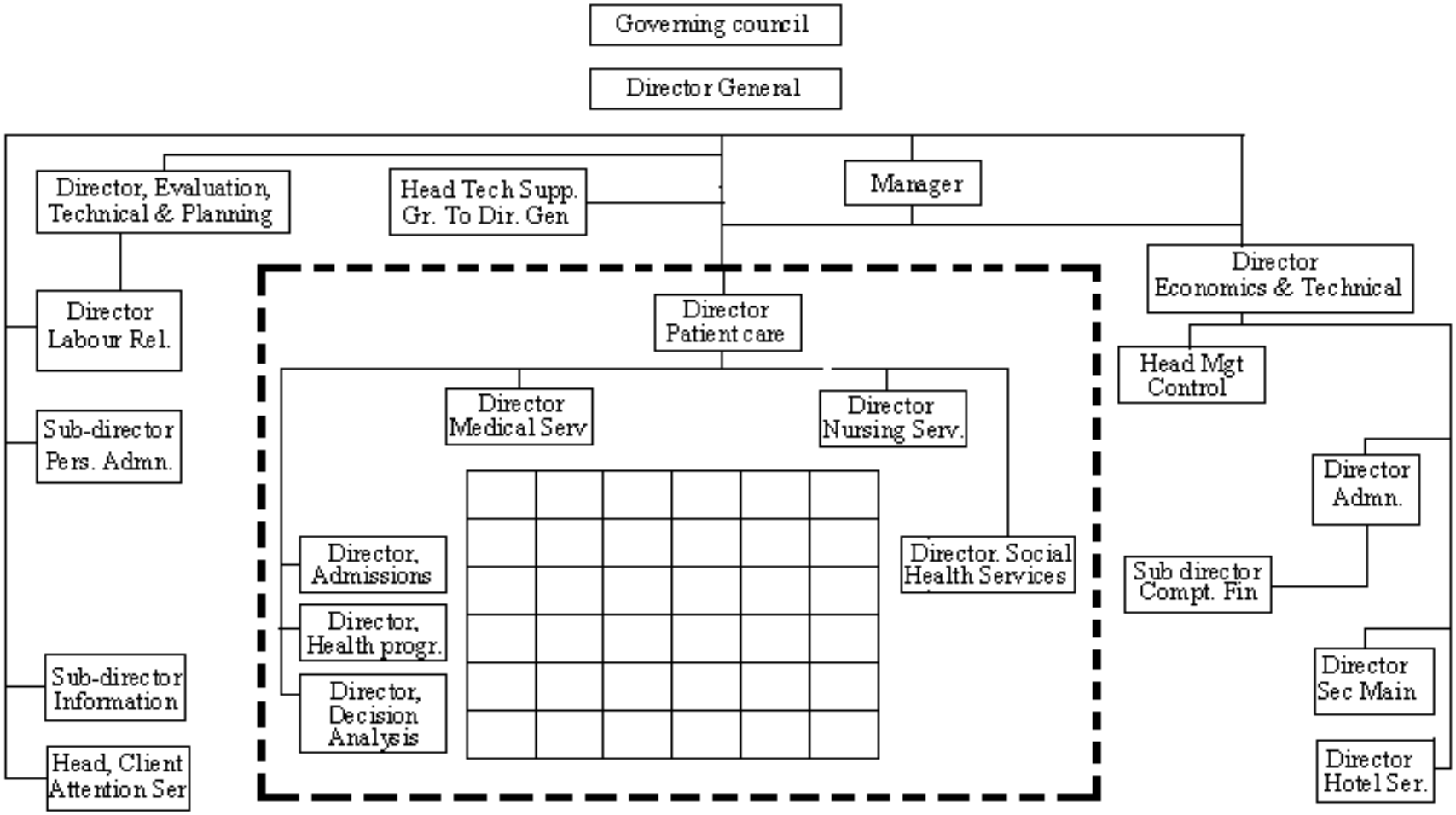

EXHIBIT-7 (A)

SUMMARY OF THE FIREST PHASE OF THE PERSPECTIVE PLANNING PROCESS

Parameters		Months of 1990									Months of 1991										
CAI's	Dates	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
COT	09/04 - 22/06																					
MPE	06/06 - 11/07																					
CPE	12/06 - 16/07																					
MED	19/09 -07/																					
SUR	20/09 - 07/11																					
G&O	31/01 - 09/04																					
PAT	2 7/05- 12/07																					

SHC	25/04 - 26/09																					
DHS	19/06 - 26/11																					

EXHIBIT 7 (B)
SUMMARY OF THE FIRST PHASE OF THE DIRECTIVE PLANNING PROCESS

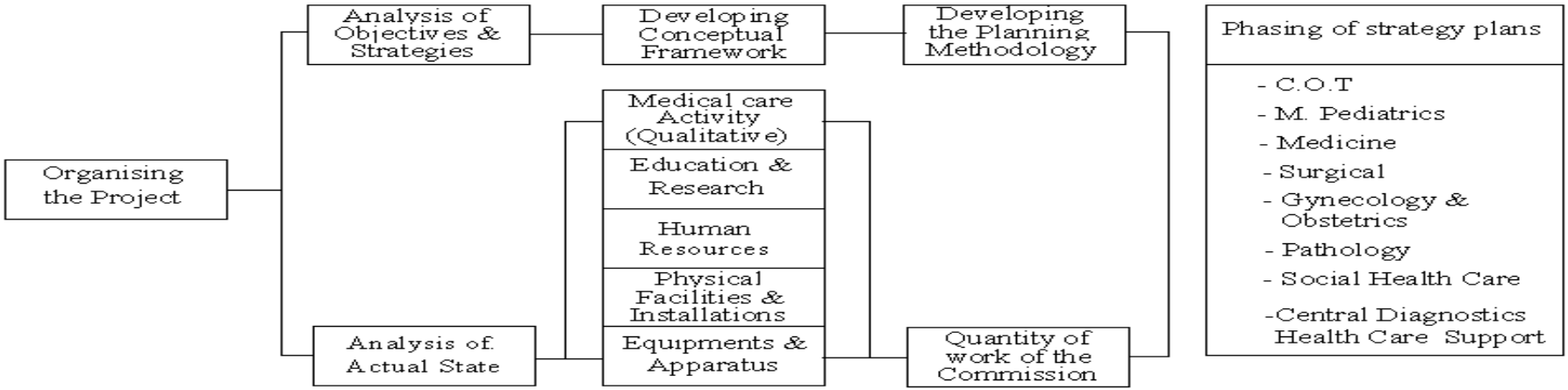

EXHIBIT – 7(C)

NUMBER OF PEOPLE WHO PARTICIPAND IN DEVELOPING THE STRATEGIES

Parameters	Area, Service and homogeneity of the composition of the Assessment teams									
	COT	MPE	CPE	MED	SUR	G&O	PAT	SHC	DHS	Total
No. of Meetings	17	20	10	33	20	23	29	22	17	191
No. of Persons	66	76	48	201	116	139	207	133	181	1167
No. of Persons Invited	205	244	151	669	401	356	507	442	372	3346
No. of Persons Who Attended	183	197	115	549	348	317	407	311	318	2745
Participation %	89.3	80.7	76.2	82.1	86.8	89.0	80.3	70.4	85.7	82.0
Hours Spent in Meeting	50.8	48.8	24.8	4.8	40.6	45.5	55.7	48.2	34.3	423.5
Total Hours Spent	519.4	473.1	298.6	1184.6	798.2	618.6	764.3	737.5	661.7	6066.0

EXHIBIT- 8 (A)

INCOME AND EXPENDITURE ACCOUNT FOR 1987-91

Thousands of Pesetas)

Expenditure	1987	1988	1989	1990	1991
Consumables	662,075	736,944	915,757	1,346,064	1,573,722
Expenses on Personnel	2680,932	3320,640	384,072	4,573,83	5,462,364
Financial Charge	17,508	68,654	61,567	44,476	49449
Taxes	368	826	1,014	2,274	4,804
External Services	526,926	566,359	480,294	439,819	566,019
Porterage & Carriage	7,506	5,694	5,953		
Sundry Expenses	69,111	72,445	87,166		
Amortizations	63,883	94,128	127,794	152,814	231,698
Provisions for Insolvency	15,600	20,000	17,000	20,000	132,000
Total Expenditure	4,043,909	4,885,670	5,520,617	6,579,270	8,020,056
Income	1987	1988	1989	1990	1991
Charges of Services	3,867,458	4,713,702	5,318,447	6,358,537	7,755,706
Incidental Income	16,917	35,213	43,804	40,177	44,43
Financiers	6,285	4,316	2,877	8,645	7,446
Subsidy received	71,294	75,927	61,248	77,585	101,674
Other Income (amortization of subsidies received)			44,500	83,204	107,204
Total	3,961,954	4,829,158	5,470,876	6,568,148	8,016,453
Net Surplus (Deficit)	-81,955	-56,512	-49,741	-11,122	-3,603

EXHIBIT – 8 (B)
ACTIVITIES OF THE HOSPITAL DURING 1987-91

	Gynaecology Obstetrics Services					Pediatric (General & Surgical) Services					Intensive Care Services					Total				
	1987	1988	1989	1990	1991	1987	1988	1989	1990	1991	1987	1988	1989	1990	1991	1987	1988	1989	1990	1991
1	20071	16418	15780	15189	15640	38459	40241	35904	29657	23550	0	0	458	525	1386	181065	188594	186943	185962	178660
2	3543	3175	3285	3302	3400	5637	5888	5442	5492	4710			149	103	105	194007	21205	22357	24151	23508
3	5.6649	5.1710	4.8036	4.5999	4.6	6.8226	6.8344	6.5975	5.4000	5	0	0	3.0738	5.0970	13.2	9.3298	8.8938	8.3617	7.6999	7.5999
4	555	1072	1365	1300	1403	4426	5392	4793	5234	5540						9818	15436	21256	226499	27841
5	8748	8073	8451	9540	10400	26518	28272	25962	26723	27574						87531	94091	96015	102933	104102
6	9303	9145	9815	10840	11803	30944	33669	30755	31957	33114	0	0	0			97349	109527	117271	129432	131943
7	8354	9981	9404	9396	10492	60577	71603	72767	68747	69948			305			155084	172234	175630	172542	176797
8																648	648	642		
9																76.5%	79.7%	79.0%		
10		75.15%	73.6	76.7			66.5%	55.1	58				95.9						61.1	63.6
11		26.2	26	26.2			5.0%	4.4	4.05										8.3	8.1

EXHIBIT 8 (C)
Analysis of the Resources Generated during 1987, 1988 and 1989

	Surplus Category	1987	%	1988	%	1989	%	Total	%
1	Income from Medical Care and Services	3938752	145.9	4789629	138.6	5379695	135.7	14108076	139.4
	Less								
2	Sanitary and Supplies	-1071600	-39.7	-120100	-34.8	-1292400	-32.6	-3566100	-35.2
3	Other Expenditures	-213300	-7.9	-210300	-6.1	-216200	-5.5	-639800	-6.3
	Gross Surplus	2677054	99.1	3416758	98.9	3917776	98.8	10011588	98.9
4	Other Incomes	23202	0.9	39529	1.1	46681	1.2	109412	1.1
	Net Income	2700256	100%	3456287	100%	3964457	100%	10121000	100%
5	Salaries etc.	2149900	79.6	2676700	77.43082300	77.7	3082300	7908900	78.1
6	Contribution to Social Security	527100	19.5	632800	18.3	739000	18.6	1898900	18.8
7	Taxes & Rates	368	0.0	826	0.0	1	0.0	1195	0.0

8	Interest on Loans	17508	0.6	68654	2.0	61500	1.6	147662	1.5
9	Ploughed Back	5380	0.2	77307	2.2	81656	2.1	164343	1.6

EXHIBIT – 8 (D)
BALANCE SHEET FOR 1987-88

Assets	1987	1988	1989	1990
Fixed Assets	1,999,727	2,313,211	2,685,390	2,926,513
Current Assets	125,252	134,677	154,987	202,197
Financial Assets	21,236	132,934	9,110	143,324
Debtors	1,054,714	1,146,463	1,800,551	154,587
Loss from Operations Usuaries	-81,955	-56,512	-49,741	-11,122
Total Assets	3,282,884	3,783,797	4,699,779	4,663,180

Liabilities	1987	1988	1989	1990
Social Fund	2,021,114	2,102,724	2,360,382	2,286,142
Capital Subsidy	70,000	159,500	350,500	678,836
Long term Loans	--	151,386	14,266	131,901
Short term Loans	1,191,770	1,370,187	1,846,631	125,952
Provisions				851,397
Creditors				589,704
Loss written off				-752
Total Liabilities	3,382,684	3,783,797	4,699,779	4,663,180

Variance Analysis of the Operation for 1987-1989

Costs	1987	1988	1989
Actual Cost of Operations	4,043,909	4,885,670	5,520,617
Budgeted Cost of Operations	4,026,228	4,862,155	5,547,503
Variance	-17,681	-23,515	+26,886
	-0.44 %	-0.48	+0.48 %
Income	1987	1988	1989
Actual Income	3,961,954	4,829,158	5,470,876
Budgeted Income	4,026,228	4,862,155	5,547,503
Variance	-64,274	-32,997	-76,627
	-1.9 %	-0.67 %	-1.38 %