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Improving Health Care Management at the Top

Sharon Roberts
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BUSINESS EXPERT PRESS

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How Balanced Boardrooms Can Lead to Organizational Success

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BUSINESS EXPERT PRESS

Improving Health Care Management at the Top: How Balanced Boardrooms Can Lead to Organizational Success

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Abstract

In this book we explore the influence of gender on organizational performance in the health care sector. The authors argue that gender diversity of boards improves health care organizational performance when compared to homogeneous boards. The theoretical framework used was developed from conducting literature reviews of scholarly academic journal articles on gender, boards, and organizational performance as well as performing an in-depth study of the performance of health care organizations in Ontario, Canada. Research results suggest that effective boards and their composition were dependent on their female-to-male ratio to realize administrative efficiencies. Publicly funded, nonprofit, 126 acute care hospitals located in Ontario, Canada, were chosen as the health care sector for this research. Limitations of this study are in the complexity of the health care industry, competing internal and external priorities, and funding constraints. Nevertheless, this book is original work and relevant for use by boards to examine the complementary mix of gender as a predictor of organizational performance.

Keywords

board, diversity, gender, health care, organizational performance, upper echelons

Contents

Abstract .... *v*
Chapter 1: Gender diversity may be the answer to performance 1
1.1: Significance of this book 1
1.2: Connecting the dots 2
Chapter 2: Background—What theory reveals 5
2.1: Upper Echelons Theory 6
2.2: Hospital board influence 11
2.3: Hospital board diversity 11
Chapter 3: The Canadian Local Health Integration Network (LHIN) – Business case 13
3.1: Background 14
3.2: Health spending in Canada 15
3.3: Efficiency and quality measures 16
Chapter 4: Health Care Executive Management Composition—The Good, the Bad, and the Ugly 21
4.1: Board composition 21
4.2: Board qualifications 25
4.3: Board social responsibility 26
Chapter 5: Hospital Performance—A taboo to overcome 27
5.1: Critical, resource management 27
5.2: Implications of board diversity 28
5.3: Effectiveness of females on organizational performance 28
Chapter 6: Dominance—By whom? 33
6.1: Board gender distribution 33
6.2: Efficiency levels across Local Health Integration Network 34
6.3: Organizational performance 35
6.4: Best Performing LHIN 35

Bibliography *37*
Index *53*

CHAPTER 1

Gender diversity may be the answer to performance

In Chapter 1, we argue that gender diversity may be the answer to improving organizational performance. We further argue that gender diversity on corporation's boards (especially in health care organizations) has a direct link to performance.

Breaking the gender barrier of all-male boards continues to be a topic of interest in the media and government. With so many women in management advancing their educational qualifications, research across industries and countries show a low representation of women in top decision-making roles. Although an obvious lack of women corporate directors in Canada is prevalent, 50 percent of the workforce consists of women making decisions on the frontline.

1.1 Significance of this book

Industry studies on upper echelons are primarily related to high-tech, computer, banking, electronics, semiconductor, furniture, finance, food, and airline industries. However, many studies limit their initial sample to a specific industry situation such as the type of investments involved.

We develop an awareness of the prevalence of male boards in Ontario hospitals and its consequence. Furthermore, we strive to provide information that could create new management processes, thus improving organizational survival of the Ontario health care sector.

Our findings are not unique to country or industry because underrepresentation of women in the upper echelons of many organizations is affecting global economies. The intellectual segregation is preferential tendency toward men accessing leadership roles.

We provide evidence that improved organizational performance in hospitals located in Ontario, Canada, is the consequence of gender diversity on boards.

Use of this information could benefit top management future appointments to the upper echelons in health care. However, the debate on the lack of female representation on health care boards has attracted more journal articles since Hambrick and Mason's Upper Echelons Theory (UET) research in 1984. To date, more than 140 publications and 37 articles on female board appointments have followed since this first publication.

In addition, this information might benefit human resources in forecasting the hiring of board members, improving succession planning, and ensuring talented management.

The government could use the predictive model generated from data analysis of organizational performance to forecast allocation of resources in Ontario hospitals.

However, research specific to diversity, gender, and hospitals is limited, which makes this book the first to illustrate the link between gender diversity of boards and organizational performance in hospitals.

The benefit to the health care system is to bring purposefully gender diversity to hospital boards in Ontario. Further, organizational survival in a changing health care environment could be affected by engaging a dialog in response to the negligible change in hospital performance during the period of 2007 to 2011.

1.2 Connecting the dots

In the health care sector accountability, hospital performance is subject to a range of factors like service, quality, and efficiency of delivery. With the regulatory standardization of patient care practices, the stability in hospital performance does not imply only efficiency in the provision of services. Management researchers have viewed successful upper echelons or top management teams (TMTs) as multidisciplinary, heterogeneous, and diverse.

For consistency, upper echelons explored in this book are at the board level. The board is identified as the strategic decision-making team comprised of the upper echelons in organizations. Nonvoting

members of the board are included as board members if identified on hospital board listings as contributors to the strategic decision-making process. The diversity of opinion, knowledge, and background allows a thorough discussion of performance potential, which helps minimize groupthink, reduce individual influence of team members, restrict the generation gap, and encourage assessment of alternatives.

Members of the Canadian government are considering legislating corporate boards by requiring them to appoint more female members, similar to the practice now in place in several European countries.

In 2014, the gender diversity of 126 acute care hospital boards in Ontario, Canada, comprised 60 percent males. Some hospital boards had all-male members or had at least three female members, but no board was comprised of all-female members.

In the health care industry, the cost of provisioning quality patient care continues to increase. A distinctive niche exists in health care for unified leadership because of the industry's size, complexity, differing incentives, and scarcity of resources. Administrative inefficiencies persist in the health care industry. As it relates to hospital board composition and organizational performance, a connection exists with the diversity of the board in decision making to the efficient management of hospital expenses. Managing hospital costs in a time of change, reduced funding, and rising health care costs demands a new model of corporate governance and board composition.

The main sources of data we used are from the Canadian Institute of Health Information (CIHI), and Canadian hospital websites. The sources are reliable secondary sources, therefore reducing biases by not attempting to combine primary and secondary data.

Further, organizational performance is determined by efficiency as a quality measure of health care, indicating hospital effectiveness in maximizing the best outcome using fewer resources.

The efficiency indicator for finance and human resources is the Administrative Services as a Percentage of Total Expense (ASEPTE).

We used the variable gender to identify group heterogeneity of hospital boards grouped by the Local Health Integration Networks (LHINs) and the efficiency indicator ASEPTE to show regional organizational performance.

CHAPTER 2

Background—What theory reveals

Research involving Upper Echelons Theory (UET) in business has provided executives with a novel approach to improving corporate efficiency. Interestingly, unexpected patterns in data revealed valuable information for organizations regardless of the industry. However, researchers have had mixed and inconclusive results to support UET. Primarily, causal factors from mixed sample populations skewed the results. Furthermore, subtle changes to the original interpretation of the UET altered the fundamental scope of application. As an example, sampling multiple industries and hierarchies as singular entities led to results that assumed the need of other variables or theory for consideration.

Hambrick encouraged researchers to examine the *black box* or psychological behaviors of the upper echelons in strategic decision making. Strategic decision making requires interactive relationships of individuals to enhancing the exchange of information and risk taking at a cognitive level. The difficulty in studying this phenomenon is limited access and openness of individuals that could introduce research bias leading to unreliable findings.

Empirical evidence in research has yet to provide results that are usable. The link between cognitive and demographic diversity may be plausible in complementing each other.

Complementing theories such as agency, social identity, behavioral and evolutionary have introduced a holistic approach to studying board's diversity, composition, dynamics, structure, and roles. In addition, contingency, resource dependence, stewardship, stakeholder, and board power theories have traditionally been used as different types of theoretical frameworks. The above-mentioned theories have a relational component that is driven by individual's experiences and socialization. See Figure 2.1, representing the research theoretical framework that complements UET.

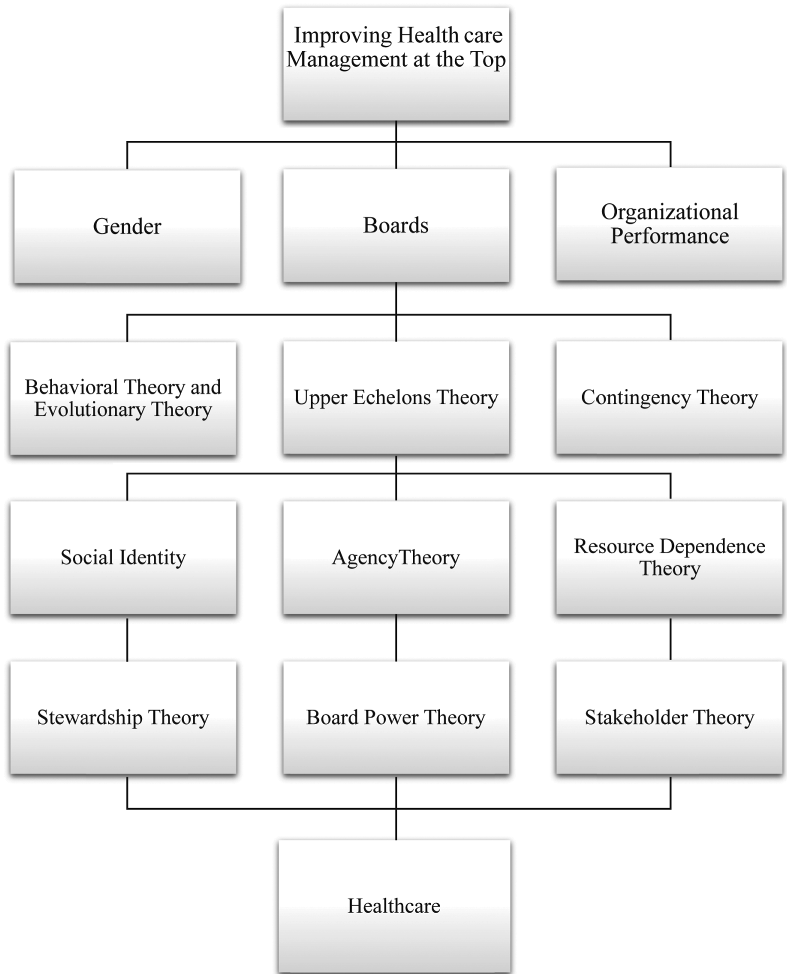

Figure 2.1 Research theoretical framework and scope

2.1 Upper echelons theory

In this section, we explore various aspects of UET as it relates to women having an important role on corporate boards.

We also present a summary of UET and some results of recent business research on this topic concerning the health care sector.

Hambrick and Mason suggested that UET for top management teams could predict organizational outcomes such as strategic choices and performance levels. In turbulent environments, a challenge for up-

per echelons is to develop new management processes. A strategic performance level such as organizational survival could benefit from team heterogeneity.

Upper echelons research is multileveled and involves individuals, teams, organizations, and their environments. However, research in UET lacked multilevel theory and proper methodology, resulting in studies that focused on a single industry, did not use multiple data sources skewing results, did not have clear definitions of variables used and interpreted results independently. Consequently, a match between theory, measurement, and statistical analysis essential in research on multiple levels was absent.

The upper echelon characteristics are independent variables as causes of strategic choices that lead to organizational performance. The basis of UET propositions is that dependent variables are strategic choices for performance levels. Gender, an independent variable, male or female, when applied to UET removes research bias.

Hambrick and Mason developed 21 propositions characterizing UET's dependent variables that correlated with the independent variables of age, functional track, career experiences, formal education, socioeconomic background, financial position, and group heterogeneity.

Propositions related to age are as follows:

1. Firms with young managers will be more inclined to pursue risky strategies than those firms with more mature managers. They further indicate that specific forms of risk include unrelated diversification, product innovation, and fiscal leverage.
2. Firms with younger managers will experience greater growth and variability in profitability from industry average than will firms with more mature managers.

Functional track propositions are as follows:

3. A positive association exists between the degree of output-function experience of top managers and the extent to which the firm emphasizes outputs in its strategy; specifically, indicators of an output emphasis include product innovation, related diversification, advertising, and forward integration.

4. A positive association exists between the degree of throughput-function experience of top managers and the extent to which the firm emphasizes throughput in its strategy, which includes indicators of output like automation, plant and equipment, and backward integration.
5. The degree of output-function experience of top managers will be positively associated with growth.
6. In stable, commodity-like industries, throughput-function experience will be positively associated with profitability.
7. In turbulent, differentiable industries, output-function experience will be positively associated with profitability.

Hayes and Abernathy (1980) suggested adding the following:

8. The degree of peripheral-function experience of top managers will be positively related to the degree of unrelated diversification in the firm.
9. The extent of peripheral-function experience of top managers will be positively related to administrative complexity, which includes formal planning systems, coordination devices, budgeting, and incentive compensation schemes.

Career experience proposition hypotheses are as follows:

10. Years of inside service by top managers will be negatively related to strategic choices involving new terrains like product innovation or unrelated diversification.
11. For an organization in a stable environment, years of inside service will be positively associated with profitability and growth.
12. For an organization facing a severe environmental discontinuity, years of inside service will be negatively associated with profitability and growth.

Propositions related to formal education are as follows:

13. The amount, but not the type, of formal education of a management team will be positively associated with innovation.
14. There is no relationship between the amount of formal management education of top managers and the average performance (ei-

ther in terms of profitability or growth) of their firms. However, firms whose managers have had little formal management education will show greater variation from industry performance averages than will firms whose managers are highly educated in management.

15. Firms whose top managers have had substantial formal management education will be more complex administratively than will firms whose managers have had less such training.

Propositions related to socioeconomic background are as follows:

16. Firms whose top managers come disproportionately from lower socioeconomic groups will tend to pursue strategies of acquisition and unrelated diversification.
17. Furthermore, such firms will experience greater growth and profit variability than will firms whose top managers come from higher socioeconomic groups.

Propositions related to financial position are as follows:

18. Corporate profitability is not related to the percent of shares owned by top managers, but is positively related to the percent of the total income that top managers derive from the firm through salaries, options, dividends, and other benefits.

Group heterogeneity propositions are as follows:

19. Homogeneous top management teams will make strategic decisions more quickly than will heterogeneous teams.
20. In stable environments team, homogeneity will be positively associated with profitability.
21. In turbulent, especially discontinuous environments, team heterogeneity will be positively associated with profitability.

In summary, three distinct propositions were related to group heterogeneity:

1. Homogenous top management teams will make strategic decisions more quickly than will *heterogeneous* teams.

2. In stable environments, team *homogeneity* will be positively associated with profitability.
3. In turbulent, especially discontinuous, environments, team *heterogeneity* will be positively associated with profitability.

Organizational survival, a strategic performance level, is a challenge for upper echelons to develop new management processes.

In the health care environment with the current situational condition, boards are predominantly male and hospital performance shows minimal efficiencies. Although several efficiency initiatives are occurring in hospitals such as Lean Processes[1], greening[2], hiring freeze, salary freeze, pay for performance, waste management, and wait-times management, those initiatives are focused on reducing spending and differentiating hospitals based on the patient's experience.

The health care leadership of the future is in crisis. New paradigms are influencing the recognition for changes to board composition and diversity.

Women have been on the frontline of health care for more than 375 years in Canada since the first hospital opened in Quebec to present. UET rationalizes the assimilation of females on male-dominant boards because of the benefits of differing perspectives and additional associations.

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[1] **Lean Processes**
Womack and Jones recommend that managers and executives embarked on lean transformations think about three fundamental business issues that should guide the transformation of the *entire organization:*

- Purpose: What customer problems will the enterprise solve to achieve its own purpose of prospering?
- Process: How will the organization assess each major value stream to make sure each step is valuable, capable, available, adequate, flexible, and that all the steps are linked by flow, pull, and leveling?
- People: How can the organization insure that every important process has someone responsible for continually evaluating that value stream in terms of business purpose and lean process? How can everyone touching the value stream be actively engaged in operating it correctly and continually improving it? (Source: Lean Enterprise Institute—www.lean.org/WhatsLean/)

[2] **Greening** is the process of transforming artifacts such as a space, a lifestyle, or a brand image into a more environmentally friendly version (i.e., *greening your home* or *greening your office*). The act of greening involves incorporating *green* products and processes into one's environment, such as the home, workplace, and general lifestyle. (Soucre: Wikipedia https://en.wikipedia.org/wiki/Greening)

2.2 Hospital board influence

In this section, we argue that the expected performance of hospitals in Canada is to provide quality health care that is equitable and affordable.

Board accountability, mandated by government, is changing the landscape of hospital services with an emphasis on customer service.

The Ontario Ministry of Health and Long-term Care (MOHLTC) requires transparency of public hospitals. Transparency enables the public to access pertinent information from annual reports, strategic plans, financial statements, wait times, and others to choose where to receive patient care.

Nevertheless, boards are transitory, and hospital system characteristics are historical. Candidates who meet board qualifications with required knowledge and skills could change the effectiveness of hospital performance. However, hospital boards are regulated under the *Public Hospitals Act* that comprises best practices for hospital governance, including board composition. In 2004, the MOHLTC-funded report *Hospital Governance Accountability in Ontario*, commissioned by the Ontario Health Association (OHA), assessed hospital governance across the province. The results show that the competency levels in technology and legal skills are underrepresented by 70 percent and 50 percent of respondents respectively.

2.3 Hospital board diversity

The Hôtel-Dieu de Québec, located in Montréal, Quebec, was the first and oldest hospital in Canada, established in 1639; this hospital is run by an order of nuns, the Religious Augustines Hospitalières of St. Joseph. However, decision making was by the priesthood. Historically, hospital boards were predominantly male.

More than 375 years later, males dominate the running of hospital boards in Ontario. This is a conundrum, because we observe the dominant presence of females in daily hospital operations, at the frontline of patient care, and on senior management teams in hospitals located in Toronto. Although a lack of female corporate directors in Canada exists, women are managing to break the gender barrier of all-male boards of directors.

The results from a study of 193 Canadian firms of the *Financial Post Directory of Directors* for 2004 indicated that women appointed to all-male boards between 1996 and 2004 have specialized knowledge and skills. They have firm-specific knowledge either as insiders or as support specialists with a specific expertise in areas such as finance or legal. Diversity is a near-universal value in the corporate world, but the upper tiers of management remain stubbornly homogeneous.

Ibrahim, Angelidis, and Howard (2011) suggested in their empirical study of board of directors with or without health care background the composition of hospital boards with members having a health care background are less likely interested in strategic issues. However, expertise in financial fiduciary, legal, and regulatory requirements are not gender-based, rather they represent the necessary skills for effective decision making in the current environment.

Although board composition has remained stagnant, board member development needs to focus on diversifying its members' expertise and skills. Specifically, board members having various perspectives to complex environmental challenges encourage more efficient participation in processes related to strategic decision-making (Ford-Eickhoff, Plowman, & McDaniel Jr., 2011).

CHAPTER 3

The Canadian Local Health Integration Network—Business case

In Chapter 3, we introduce the reader to the Canadian Local Health Integration Network (LHIN). We include several specific examples illustrating the present status of the health care sector in the LHIN.

Ontario health care expenditure has grown to the excess of 46 percent of the provincial budget. The MOHLTC introduced 14 LHINs in an attempt to enhance health performance strategy and system integration with measurement and accountability. Geographically the LHINs comprise 150 hospital corporations located on more than 200 sites. The 126 acute care hospitals are the sources of primary care that form integrated health service plans with local health service providers.

The 14 LHINs represent health authorities responsible for the administration of health care services in the province of Ontario, Canada. LHINs' region number and names are listed as follows:

1. Erie St. Clair LHIN
2. South West LHIN
3. Waterloo Wellington LHIN
4. Hamilton Niagara Haldimand Brant LHIN
5. Central West LHIN
6. Mississauga Halton LHIN
7. Toronto Central LHIN
8. Central LHIN
9. Central East LHIN
10. South East LHIN
11. Champlain LHIN

12. North Simcoe Muskoka LHIN
13. North East LHIN
14. North West LHIN

The MOHLTC accountability agreements managed by the LHINs at the local level include improving the coordination and integration of services within the local health system. In addition, to increasing access to key health care service; improving patient-centeredness, patient safety, and quality of health services; increasing sustainability, and equity of the health system.

See Table 3.1 for the number of local health service providers by LHIN in 2014.

Table 3.1 Number of local health service providers by LHIN in 2014

Region		Number of Local Health Service Providers	Number of Acute Care Hospitals
1	Erie St. Clair LHIN	12	5
2	South West LHIN	37	19
3	Waterloo Wellington LHIN	11	6
4	Hamilton Niagara Haldimand Brant LHIN	26	9
5	Central West LHIN	5	2
6	Mississauga Halton LHIN	8	3
7	Toronto Central LHIN	25	7
8	Central LHIN	15	6
9	Central East LHIN	18	8
10	South East LHIN	14	6
11	Champlain LHIN	26	16
12	North Simcoe Muskoka LHIN	10	5
13	North East LHIN	36	22
14	North West LHIN	18	12

3.1 Background

In 2007, the MOHLTC transitioned hospitals accountability under the *Local Health Integration Act*. Responsibility of the 14 LHINs is to prioritize, plan, and fund health care services including hospitals.

LHINs comprise of a comprehensive spectrum of the Canadian health care sectors because they cover a wide variety of health services, including those offered by hospitals, long-term care homes, and community care access centers.

In addition, LHINs cover health service providers in community support service agencies, mental health and addiction agencies, and community health centers. The LHINs provide governance and opportunities to explore why some regions thrive and are more efficient than others. See Figure 3.1 for the regional locations of the Ontario LHIN.

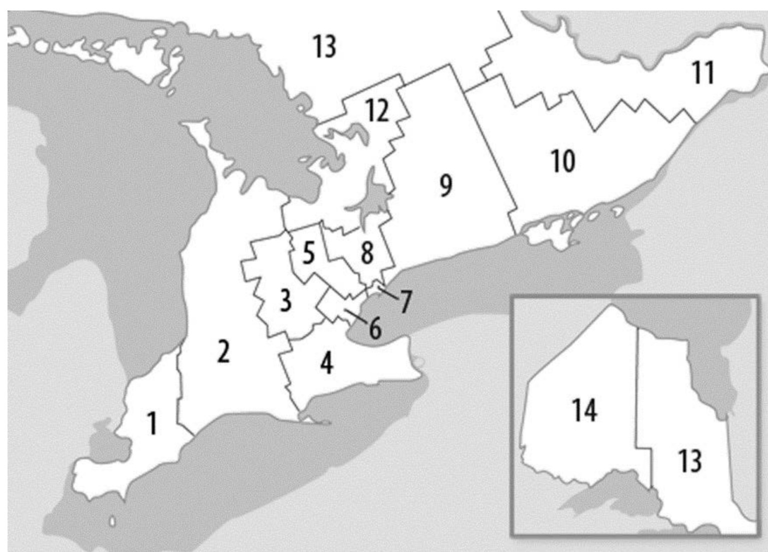

Figure 3.1 Regional locations of the Ontario Local Health Integration Network (LHIN). Source www.lhins.on.ca

3.2 Health spending in Canada

According to the Canadian Institute of Health Information (CIHI), in 2013 health spending in Canada reached $211 billion or $5,988 per person. This represented 11.2 percent of Canada's gross domestic product (GDP), down from 11.3 percent in 2012, 11.4 percent in 2011, and 11.6 percent in 2010 and 2009. Of the $211 billion, 60 percent of total health spending is directed to hospitals, drugs, and physicians. Hospitals account of total health spending decreased from 45 percent in 1975 to approximately 30 percent in the early 2000s.

Hospital spending related to compensation for the workforce is more than 60 percent of total expenditures. Consequently, improving public services, while containing costs, has become a priority for hospitals. Government expectations are that hospitals achieve better patient outcomes with fewer resources while containing costs.

In 2011, the Ontario Ministry of Health and Long-Term Care (MOHLTC) legislated a new Hospital System Funding Reform (HSFR) based on volumes of procedures.

The change in funding model and shift of care to Alternate Levels of Care (ALC) that are less expensive could affect the viability of services and levels of care in hospitals.

An imbalance in service provision could further affect sustainability of health services and result in hospital closures, mergers, or acquisitions.

A potential redistribution of health service provision could influence the following:

- Organizations' capacity to manage strategic change processes and expose risks in organizational performance.
- Financial viability, because 5 percent of Ontarians account for 66 percent of health care expenditure in Ontario.

3.3 Efficiency and quality measures

The definition of organizational performance correlates the measure of financial performance with the quality of care and patient satisfaction within a fiscal year. Besides, hospital performance will vary and could be dependent on changes in the hospital environment such as the use of LEAN Processes on administrative services to improve patient wait times. In this section, information relevant to hospital performance is reported in the LHIN regional values.

CIHI website provides downloadable data of the Canadian Hospital Report Project (CHRP), which is accessible to the public.[1]

[1] **CIHI**: Health Care in **Canada**—How is the system performing?

The *CHRP 2013 Health System Characteristics—Hospital-Level Export Report* is a summary of health system characteristics of indicator rates at the national, provincial, hospital, and region-specific.

The efficiency quality measure includes the indicator of Administrative Service Expense as a Percentage of Total Expense (ASEPTE). This indicator is a measure of the legal entity's total expenses spent in administrative departments such as finance and human resources. However, CIHI has qualified data exclusions of outliers from the calculation of all averages and that data is only of acute care hospitals that participate in CHRP.

The numerator includes all expenses associated with the administrative, finance, human resources, and communication functional centers. The denominator includes all expenses net of recoveries. The formula for calculation is 100 × (numerator/denominator). A high percentage indicates that administrative costs are a large portion of the region's hospital expenses; a low percentage indicates that administrative costs are a small portion of a region's hospital expenses.

Region 6, Mississauga Halton LHIN, has consistently maintained low ASEPTE averages and in the range between the average provincial and Canadian values. In comparison, Regions 13 and 14 North East and North West LHINs respectively had the highest ASEPTE values. Most significantly, apart from the Mississauga Halton LHIN, the remaining LHINs have yet to achieve the ASEPTE provincial or Canadian average values.

See Table 3.2 for the ASEPTE average values by LHIN from 2007 to 2011.

See Figure 3.2 for the ASEPTE average values by LHIN from 2007 to 2011.

Table 3.2 ASEPTE average values by LHIN from 2007 to 2011

	Region	ASEPTE Avg. Value 2007~2008	ASEPTE Avg. Value 2008~2009	ASEPTE Avg. Value 2009~2010	ASEPTE Avg. Value 2010~2011
1	Erie St. Clair LHIN	6.61	6.44	6.26	6.05
2	South West LHIN	7.04	6.74	7.10	6.74
3	Waterloo Wellington LHIN	6.65	6.52	6.77	6.59
4	Hamilton Niagara Haldimand Brant LHIN	6.91	6.88	6.79	6.95
5	Central West LHIN	5.63	5.89	5.82	6.58
6	Mississauga Halton LHIN	5.57	5.67	5.71	5.39
7	Toronto Central LHIN	6.27	5.83	6.20	6.10
8	Central LHIN	7.12	6.84	6.69	6.40
9	Central East LHIN	7.01	7.21	7.16	6.87
10	South East LHIN	6.62	7.11	6.47	6.36
11	Champlain LHIN	7.74	7.59	7.36	7.55
12	North Simcoe Muskoka LHIN	6.24	6.43	7.12	7.34
13	North East LHIN	9.00	9.14	8.99	8.45
14	North West LHIN	9.66	9.94	9.25	8.79
	Sum	98.07	98.21	97.69	96.16
	Average	7.00	7.02	6.98	6.87
	Average Provincial Value	5.97	5.84	5.92	5.75
	Average Canadian Value	5.16	4.94	4.88	4.62

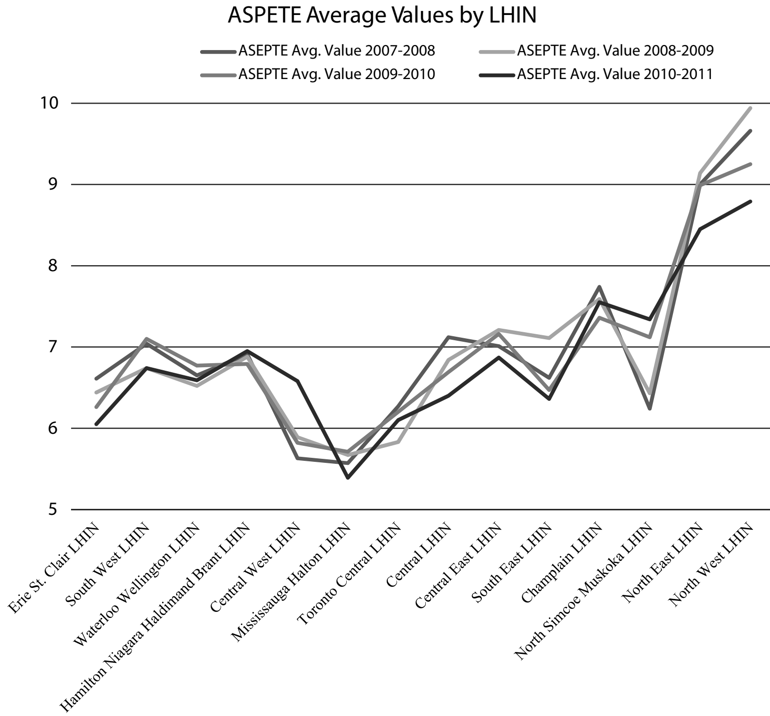

***Figure 3.2* ASEPTE average values by LHIN from 2007 to 2011**

CHAPTER 4

Health Care Executive Management Composition—The Good, the Bad, and the Ugly

In Chapter 4, we explore the specificity of board composition in LHINs' 126 acute care hospitals.

Boards are transitory, and hospital system characteristics are historical.

Subsequent research could have different results as the number of board members and their gender could change. In addition, hospital performance will vary and could be dependent on changes in the hospital environment such as use of LEAN Processes on administrative services.

We identify the board as the strategic decision-making team comprised of the upper echelons in organizations. Nonvoting members of the board are included if identified on hospital board listings as contributors to the strategic decision-making process.

4.1 Board composition

Researchers have confirmed that diversity on boards provide better governance, experience, and opinions. Women who lacked corporate board experience could be appointed as nonexecutive directors. However, talented corporate women are leaving their positions to start their own businesses. Because of changing goals such as work–life balance, male-dominated boards are increasing and fewer role models exist for women in the ranks. These transitions are felt across North America and the UK.

In 2014, the total number of hospital board positions in Ontario was 2,138. The average number of hospital board positions filled by males and females was respectively 11 and 7. The average hospital board size was 18.

North East LHIN had the highest number of board positions—313. Central West LHIN had the lowest number of board positions—34. Toronto Central LHIN had the highest average number of males on hospital boards—17. North West LHIN had the lowest average number of males on hospital boards—six.

See Figure 4.1 for the total hospital board positions by LHIN in 2014.

See Figure 4.2 for distribution of hospital board gender by LHIN in 2014.

See Table 4.1 for the average board size by LHIN in 2014.

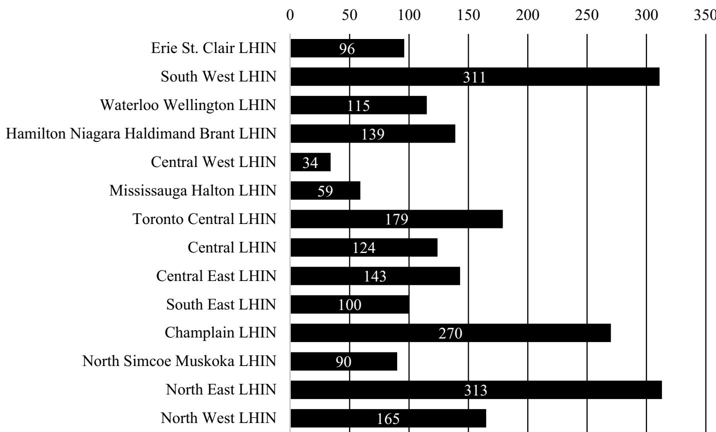

Figure 4.1 Total hospital board positions by LHIN in 2014

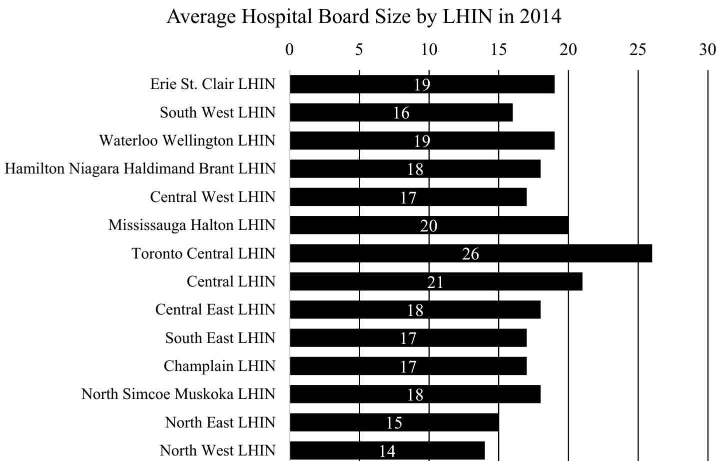

Figure 4.2 Distribution of hospital board gender by LHIN in 2014

Table 4.1 Average hospital board size by LHIN in 2014

Region		Total Board Positions	Average Number of Males	Average Number of Females	Average Board Size
1	Erie St. Clair LHIN	96	12	7	19
2	South West LHIN	311	9	7	16
3	Waterloo Wellington LHIN	115	12	7	19
4	Hamilton Niagara Haldimand Brant LHIN	139	10	7	18
5	Central West LHIN	34	11	6	17
6	Mississauga Halton LHIN	59	13	7	20
7	Toronto Central LHIN	179	17	8	26
8	Central LHIN	124	14	7	21
9	Central East LHIN	143	11	7	18
10	South East LHIN	100	11	6	17
11	Champlain LHIN	270	10	7	17
12	North Simcoe Muskoka LHIN	90	11	7	18
13	North East LHIN	313	8	7	15
14	North West LHIN	165	6	7	14
	Total	2,138			
	Average	153	11	7	18

The total number of hospital LHIN board members was 1,265 males and 861 females, with 12 positions vacant.

- South West LHIN had the highest number of male board members—174.
- North East had the highest number of female board members—141.
- Central West LHIN had the lowest ratio of male-to-female board members—22:12.
- North West LHIN had the highest percentage of females—52 percent.

See Table 4.2 for the number of males and females on hospital boards by LHIN in 2014.

See Figure 4.3 for the distribution of hospital boards.

Table 4.2 Number of males and females on hospital boards by LHIN in 2014

Region		Males		Females		Vacancies	
1	Erie St. Clair LHIN	59	61%	37	39%		0%
2	South West LHIN	174	56%	135	43%	2	1%
3	Waterloo Wellington LHIN	73	63%	42	37%		0%
4	Hamilton Niagara Haldimand Brant LHIN	82	59%	57	41%		0%
5	Central West LHIN	22	65%	12	35%		0%
6	Mississauga Halton LHIN	39	66%	20	34%		0%
7	Toronto Central LHIN	121	68%	58	32%		0%
8	Central LHIN	84	68%	40	32%		0%
9	Central East LHIN	88	62%	52	36%	3	2%
10	South East LHIN	65	65%	35	35%		0%
11	Champlain LHIN	158	59%	112	41%		0%
12	North Simcoe Muskoka LHIN	55	61%	35	39%		0%
13	North East LHIN	169	54%	141	45%	3	1%
14	North West LHIN	76	46%	85	52%	4	2%
	Total	1,265	59%	861	40%	12	1%
	Average	90		62		3	

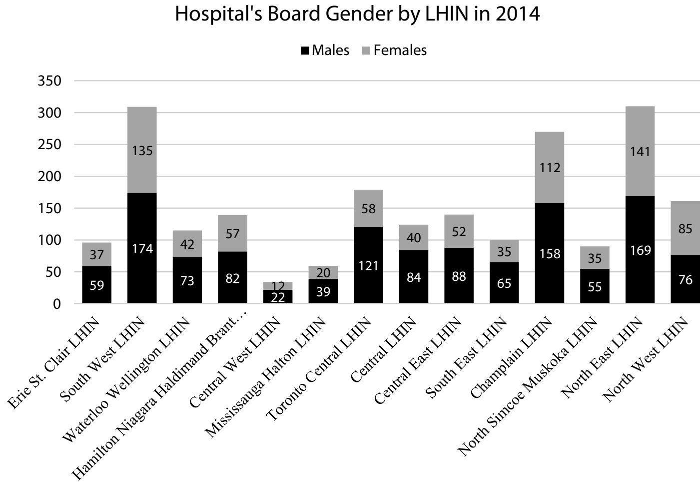

Figure 4.3 Distribution of hospital's board gender by LHIN in 2014.

4.2 Board qualifications

Controversial discussions are prevalent regarding the number of women to men on boards in support for gender diversity in the boardroom. Legislation by several countries such as Norway, Sweden, and Germany to enact mandatory female representation on boards is up to 40 percent. Compliance by Norwegian companies was achieved in 2008.

The EU has proposed similar targets by 2020 for listed companies. However, regulating gender parity in the boardroom ignores the lack of evidence to support a significant difference in organizational performance. The scarcity of evidence and empirical studies to support gender quotas are inconclusive.

In Australia, compliance and reporting by corporations included gender diversity, age, ethical, and cultural backgrounds. In South Africa, the limited resources and skills shortages affect all industries regardless of gender diversity. Quota legislation to fill 30 to 40 percent of board positions with women could lead to inexperienced and underqualified females assuming decision-making roles.

The underrepresentation of women on corporate boards is receiving attention from several governments. According to Catalyst (2013), in the U.S., of the 46.9 percent women in the workforce, only 14.4 percent of top executive roles are held by women. The Status of Women

Canada (see www.swc-cfc.gc.ca/fun-fin/index-eng.html) reported that of 48 percent women in the workforce, only 15.9 percent were represented on corporate boards. Qualifications are not the limiting factor because women are earning more university degrees than men. [see www.aei.org/publication/stunning-college-degree-gap-women-have-earned-almost-10-million-more-college-degrees-than-men-since-1982/]

4.3 Board social responsibility

Research reveals that increased number of women in TMTs indicates higher corporate earnings. However, underrepresentation of half of the population is not translating into better management culture, meeting the needs of both men and women at work. Although diversity is a desirable goal for the customers and community that organizations serve, a visual demonstration of support is necessary to attract top female talent.

The debate on gender diversity is not limited to the lack of women on boards but illustrates the reasons for barriers that prevent women from achieving board appointments. In particular, the old boys' club and a closed network are gatekeeping board positions for friends and relatives. Moral value and equal opportunity for women in the boardroom may appear to be a better argument than for gender diversity. Nevertheless, the intellectual segregation is discriminatory because of preferential tendency toward men accessing leadership roles.

Other factors such as stress, working 20 hours a day, child care, work–life balance, conflict, failure, and workplace harassment are common complaints from women. Regardless, the aspirations of women are self-defeating with interests fading as they climb the corporate ladder. Women may be the most significant barrier in attaining board appointments because of their high expectations in contributing to improving organizational performance.

Although the beliefs of board members are socially reproduced through interactions, their relationships and functional conditioning could negatively affect decision making. A longer tenure in upper echelons follows more persistent strategies. International experience increases social performance, whereas tenure diversity increases tolerance, environmental awareness, and risk adversity.

CHAPTER 5

Hospital performance–A taboo to overcome

In Chapter 5, we engage the reader in a dialogue regarding hospital performance—What works, what does not, and what is irrelevant.

We use real examples based on data retrieved from the Canadian Institute of Health Information (CIHI), hospital websites, and anecdotal references.

5.1 Critical resource management

Critical resource management comprises women who have specialized knowledge and skills that could break the gender barrier. Researchers have discovered that female candidates have idealized vision of boards.[1] Their intuition, moral values, and common sense counter an innate censorship to conform.

Internal barriers and stereotypical tendencies are limitations imposed by the lack of self-confidence in women. Women adopting male attitudes are less likeable, and less helpful to other women climbing the ranks. If boards can ensure that three or more women are represented, it is predicted that female candidates will follow.

Interestingly, several measures to promote gender diversity relate to flexible work models, parental leave, virtual mobility, policies to penalize for sexual harassment, and mentoring programs. Other incentives include child care support, networking, goal setting, career transitioning, and campaigns.

In the health care industry, privacy and transparency are double-edged swords. Because of their public status board members' income and personal lives are public knowledge. This exposure enables self-

[1] See www.slideshare.net/VivianedeBeaufort/3-de-beaufortsummers-5

promotion for which some women are not comfortable with. Several debilitating emotional states can disenfranchise a women's legitimacy on the board. Organizations' need to support women to attain and sustain their presence on a board is necessary to enable and maintain their contribution to the organization.

5.2 Implications of board diversity

A consistent message in support of board diversity is in the expectation of its stronger financial performance and the ability to attract and retain top talent, innovation, insight, and efficiencies with improved board effectiveness. However, some women continue to experience the need for a claim for legitimacy in male-dominant boards. Opposing leadership styles of change by females and of conquest by males introduces conflict. The board environment demands courageous conversations to enable transparency that some men or women are not comfortable with.

Integrating long-term vision of the organization is an essential trait to master. Women may choose not to conform, resist peer pressure, and seek to improve their version of a directorship. The implications could develop into either further conflict or, hopefully, meaningful change.

5.3 Effectiveness of females on organizational performance

In 2010 to2011, the lowest ASEPTE average value (5.39) was that of Mississauga Halton LHIN compared to other regions. The ASEPTE average value for Ontario was 5.75 and Canada, 4.62.

Mississauga Halton is the only LHIN with ASEPTE average values that consistently lie within the provincial and Canadian range; it achieved the lowest values across Ontario since 2007. Based on the above, we conclude that provincial and Canadian ASEPTE values are unrealistic, that waste exists across LHINs and in hospitals, and that technology is not readily available across the LHIN system.

Further, the variation in the levels of efficiency across LHINs had a linear regression of how ASEPTE average values were affected by males and females.

In 2010 to 2011, $p > 0.05$, r^2 = 0.168 for males is not significant and $p < 0.05$, r^2 = 0.399 for females is significant. This means that a critical mass of more than 30 percent of females on hospital boards is associated with higher levels of efficiency. The R square, r^2, value is 39.9 percent of variance of the average number of females on hospital boards and explained by ASEPTE average values for 2010 to 2011.

The Central West LHIN ASEPTE average value of 6.58 in 2010 to 2011 showed the most significant increase in ASEPTE value of 86 percent from 2009 to 2010, and the least number of females, suggesting male-dominant hospital boards had a negative influence on organizational performance.

However, North East LHIN ASEPTE average value of 8.45 in 2010 to 2011had the most significant decrease in value of 94 percent from 2009 to 2010, and the most number of female hospital board members of 141. Also, North West LHIN ASEPTE average value of 8.79 in 2010 to 2011 had a significant decrease in value of 95 percent from 2009 to 2011, and the next highest number of female hospital board members of 85, suggesting female-dominant boards have a positive influence on organizational performance.

See Table 5.1 for the hospital's board gender and ASEPTE average values by LHIN from 2007 to 2011.

See Figure 5.1 for the hospital's board gender and ASEPTE average values by LHIN from 2007 to 2011.

Table 5.1 Hospital's board gender and ASEPTE average values by LHIN from 2007 to 2011

		Total Board Positions			ASEPTE Average Value			
Region		Males	Females	Vacancies	2007~2008	2008~2009	2009~2010	2010~2011
1	Erie St. Clair LHIN	59	37		6.61	6.44	6.26	6.05
2	South West LHIN	174	135	2	7.04	6.74	7.10	6.74
3	Waterloo Wellington LHIN	73	42		6.65	6.52	6.77	6.59
4	Hamilton Niagara Haldimand Brant LHIN	82	57		6.91	6.88	6.79	6.95
5	Central West LHIN	22	12		5.63	5.89	5.82	6.58
6	Mississauga Halton LHIN	39	20		5.57	5.67	5.71	5.39
7	Toronto Central LHIN	121	58		6.27	5.83	6.20	6.10
8	Central LHIN	84	40		7.12	6.84	6.69	6.40
9	Central East LHIN	88	52	3	7.01	7.21	7.16	6.87
10	South East LHIN	65	35		6.62	7.11	6.47	6.36
11	Champlain LHIN	158	112		7.74	7.59	7.36	7.55
12	North Simcoe Muskoka LHIN	55	35		6.24	6.43	7.12	7.34
13	North East LHIN	169	141	3	9.00	9.14	8.99	8.45
14	North West LHIN	76	85	4	9.66	9.94	9.25	8.79
	Average Values	90	62	3	7.00	7.02	6.98	6.87
	Average Provincial Value				5.97	5.84	5.92	5.75
	Average Canadian Value				5.16	4.94	4.88	4.62

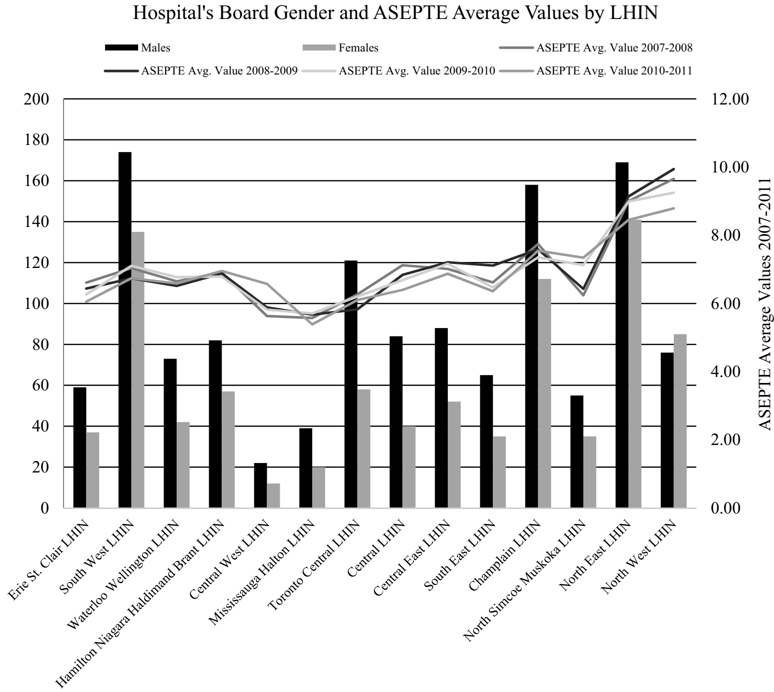

Figure 5.1 Hospital's board gender and ASEPTE average values by LHIN from 2007 to 2011

CHAPTER 6

Dominance—By whom?

In Chapter 6, we argue that the dominant presence of women in daily hospital operations and at the frontline of patient care surpasses their representation on the senior management teams in hospitals located in Ontario.

However, a critical mass of more than 30 percent of women in the boardroom is associated with higher hospital performance by achieving better outcomes with fewer resources and improving public services while containing costs.

6.1 Board gender distribution

The average number of women on hospital boards throughout the LHIN is seven. Although more than three women are represented on boards in Ontario hospitals, the gender distribution appears to be consistent throughout the province with an average of 60 percent males to 40 percent females.

See Figure 6.1 for the average hospital board gender by LHIN in 2014.

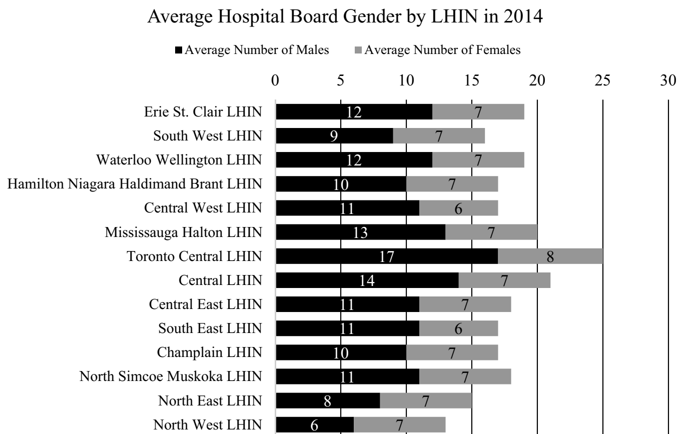

Figure 6.1 Average hospital board gender by LHIN in 2014

6.2 Efficiency levels across Local Health Integration Network

The time series analysis is a predictive model that trends ASEPTE values from 2007 to 2017. Four of the 14 LHINs, Waterloo Wellington, Hamilton Niagara Haldimand Brant, Central West, and North Simcoe Muskoka, showed a projection of increased inefficiencies to 2017 with a positive trend line, which suggested increasing costs and inefficient operations. Negative trend lines are shown in 71 percent of LHINs. A negative trend line suggested reduction in costs and efficient operations.

See Figure 6.2 for the time series analysis of ASEPTE average values from 2007 to 2017.

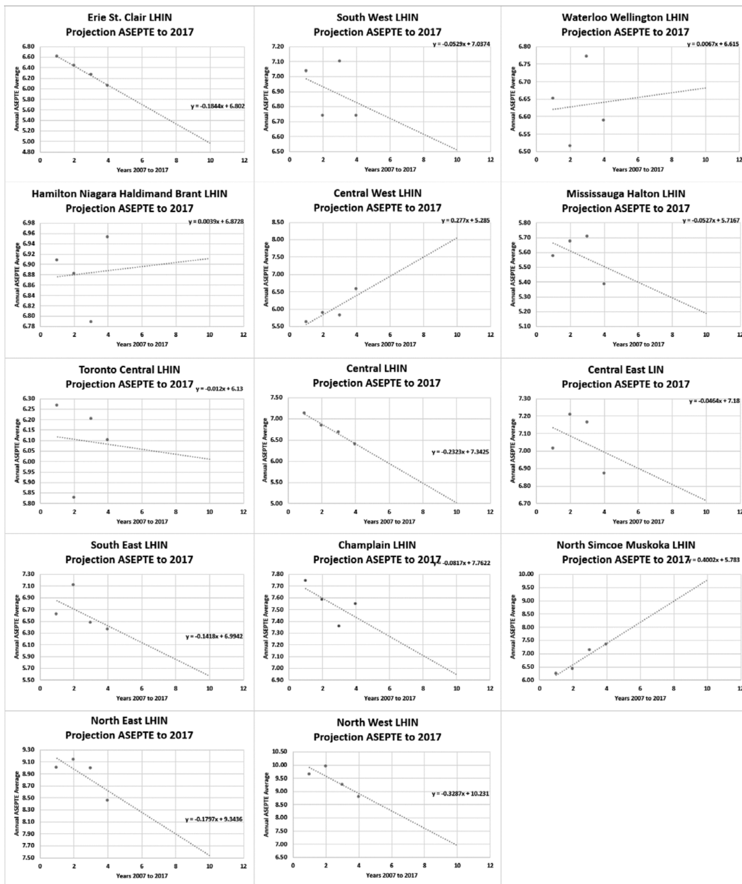

Figure 6.2 The chart is a time series analysis of ASEPTE average values from 2007 to 2017—a predictive model of LHIN performance

6.3 Organizational performance

The targets set for quality measures may appear unrealistic or inefficiencies in the health care system exist. However, no significant movement exists to drastically reduce ASEPTE average values in 2010 to 2011 or to close the gap between LHIN performance and provincial and Canadian values.

Of the 126 acute care Ontario hospitals, 22 or 18 percent are positively trending in ASEPTE average values and are in close geographical proximity to each other. The hospitals are in highly populated communities and operate in LHINs region 3, 4, 5, and 12. In addition, several hospitals are major hubs that offer a variety services in areas of general teaching, 100 to 200 beds, cancer care, and rehabilitation. Other services include diagnostic and therapeutic care and specialized care. Loss of any service would be significant and could have a major effect on patient care in Ontario.

Some patients are traveling more than two hours to receive care from out of town rather than at their community hospitals. The MOHLTC and LHINs have an opportunity to normalize and course correct the imbalance in LHINs 3, 4, 5, and 12.

For the 82 percent of hospitals that are improving their trending negatively ASEPTE values, capacity to reach their annual targets is an indicator that change is slow and may take years or not at all. The MOHLTC has the opportunity to address the shortcomings by reassessing their strategic-based measurement goals with the LHINs.

Last, learning from Mississauga Halton LHIN of what they are doing right could be a model to follow.

6.4 Best performing LHIN

Mississauga Halton LHIN of the Trillium Health Partners and Halton Health Care Services comprises six hospitals:

Trillium Health Partners:

1. Credit Valley Hospital
2. Mississauga Hospital
3. Queensway General Hospital

Halton Health Care Services:

4. Georgetown Hospital
5. Milton District Hospital
6. Oakville-Trafalgar Memorial Hospital

Credit Valley Hospital

According to the Trillium Health Partners website[1], before the merging of the Trillium Health Centre and the Credit Valley Hospital, it had one of the lowest ASEPTE value in the province (4.70), signifying a high level of efficiency. Further, the annual report for 2010 to 2011 showed the hospital contributed to a financial surplus of $7.9 million, which reflected efficient management of administrative costs and use of operational dollars. The ASEPTE values for Halton Health Care Services were 5.08 and Trillium Health Centre were 6.38.

Founded in 1970s, The Credit Valley Hospital located in Mississauga, Ontario, is a regional center of excellence in clinical genetics, renal, maternal–child care, and oncology. Core clinical programs include general internal medicine, perinatal surgery, emergency, mental health, rehabilitation, obstetrics and gynecology, pediatric, and cardiac services.

Several female board members were appointed as part of the board's extensive discovery, due diligence, and strategic decision-making processes. Some female board members had attained distinguished careers as presidents or CEOs of their own companies and organizations. Further, they had knowledge and skills that included board experience, banking, human resources, service industry, consulting, information technology, quality, and organizational performance. CIHI acknowledged the amalgamation of the Credit Valley Hospital with the Trillium Health Partners showed better performance rates than previous.

[1] http://trilliumhealthpartners.ca/

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Index

Administrative service expense as a percentage of total expense (ASEPTE), 3, 17
  average values by LHIN, 18–20, 28–31
Agency theory, 5–6
Alternate levels of care (ALC), 16

Behavioural and evolutionary theory, 5–6
Black box, 5
Board, 2–3, 21
  average size of, by LHIN, 23
  composition of, 21–25
  distribution of gender by LHIN, 22, 24, 25, 30–31
  diversity on, 11–12
  gender distribution on, 33
  implications of diversity on, 28
  influence of, 11
  qualifications, 25–26
  social responsibility, 26
Board power theory, 5–6

Canada
  gross domestic product (GDP), 15
  health spending in, 15–16
Canadian hospital report project (CHRP), 16–17
Canadian institute of health information (CIHI), 3, 15, 27
Contingency theory, 5–6
Credit valley hospital, 36–37
  ASEPTE values in, 36
Critical resource management, 27–28

Diversity, 3
  in gender, 1
  on hospital board, 11–12
  implications on board, 28

Gender, 7
  on boards, 2
  diversity, 1
Greening, 10
Group heterogeneity, 9–10
  propositions to, 10

Halton health care services, 36
Health care
  industry, 3, 27–28
  management composition of, 21–26
  system, 2
Homogeneous top management teams, 9, 10
Hospital governance accountability, 11
Hospital system funding reform (HSFR), 16

Intellectual segregation, 1

Lean processes, 10, 16, 21
Local health integration act, 14
Local health integration network (LHIN), 3, 13–20
  with ASEPTE average values, 28–31
  average size of board by, 23
  best performing, 36–37
  of board gender by, 22, 24, 25, 34
  health service by, 14
  regional locations of Ontario, 15

Ministry of health and long-term care (MOHLTC), 11, 14, 16, 35

Ontario health association (OHA), 11
Ontario health care sector, 1
Organizational performance, 1, 2, 16, 34–35
  effectiveness of females on, 28–29
Organizational survival, 10

Propositions, in UET
- age, related to, 7
- basis of, 7
- career experience, 8
- financial position, related to, 9
- formal education, related to, 9
- functional track, 7–8
- group heterogeneity, 9–11
- peripheral-function experience, 8
- socioeconomic, related to, 9

Resource dependence theory, 5–6

Social Identity theory, 5–6
Stakeholder theory, 5–6
Stewardship theory, 5–6

Top management teams (TMTs), 2
Trillium health partners, 36

Upper echelons, 1, 2, 7
- psychological behaviors of, 13

Upper echelons theory (UET), 2, 5, 6–11
- career experience proposition, 8
- functional track propositions, 7–8
- group heterogeneity propositions, 9–11
- peripheral-function experience, 8
- propositions. *See* Propositions, in UET
- research theoretical framework, 6

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Improving Health Care Management at the Top

Sharon Roberts • Milan Frankl

In this book the authors explore the influence of gender on organizational performance in the health care sector. They argue that gender diversity of boards improves health care organizational performance when compared to homogeneous boards. The theoretical framework used was developed from conducting literature reviews of scholarly academic journal articles on gender, boards, and organizational performance as well as performing an in depth study of the performance of health care organizations in Ontario, Canada.

Research results suggest that effective boards and their composition were dependent on their female to male ratio to realize administrative efficiencies. Publicly funded, nonprofit, 126 acute care hospitals located in Ontario, Canada, were chosen as the health care sector for this research. Limitations of this study are in the complexity of the health care industry, competing internal and external priorities, and funding constraints. Nevertheless, this book is original work and relevant for use by boards to examine the complementary mix of gender as a predictor of organizational performance.

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