Global Hospital Management Survey – China

Management in Healthcare Report

GHMS-China
Global Hospital Management Survey

WMS
World Management Survey

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EXECUTIVE SUMMARY

The Global Hospital Management Survey – China (GHMS-China) seeks to identify, measure, and compare differences in management practices across hospitals within China and in countries around the world.

Our GHMS-China pilot study conducted in November 2013 measured the state of management practices in 20 of China's largest public hospitals. This GHMS-China report details the findings of the pilot study with respect to management practices in hospitals and lays the foundation for future areas of inquiry. We hope this report will serve as a valuable guide for a subsequent full study that will survey a greater number and variety of Chinese healthcare institutions in the future.

Major important findings include:

- Quality of management practices in interviewed public hospitals is slightly below average. However, the overall management score is higher than expected for a developing country like China.
- Public hospitals in China scored the highest in standardization and scored the lowest in talent management.
- While performance and target management scores were average, management practices associated with autonomy were low.

Low management scores are most likely due to:

- Low levels of autonomy for hospital managers, hospital department directors, and specialty leaders.
- Absence of formal processes for continuous improvement.
- Lack of formal accountability mechanisms for managing individual performance.
- Subpar employee welfare and benefits, including a lack of incentives.

The findings of this study have significant implications for policy makers and hospitals. These implications are further discussed in the final section of this report.

GHMS - CHINA

Project Background

China's leaders are currently overseeing large-scale and ambitious reforms of the country's healthcare system. The reforms, which have accelerated in implementation since 2009, focus on five key areas: health insurance access, essential medicine provision, primary care delivery, public health service expansion and public hospital reform.

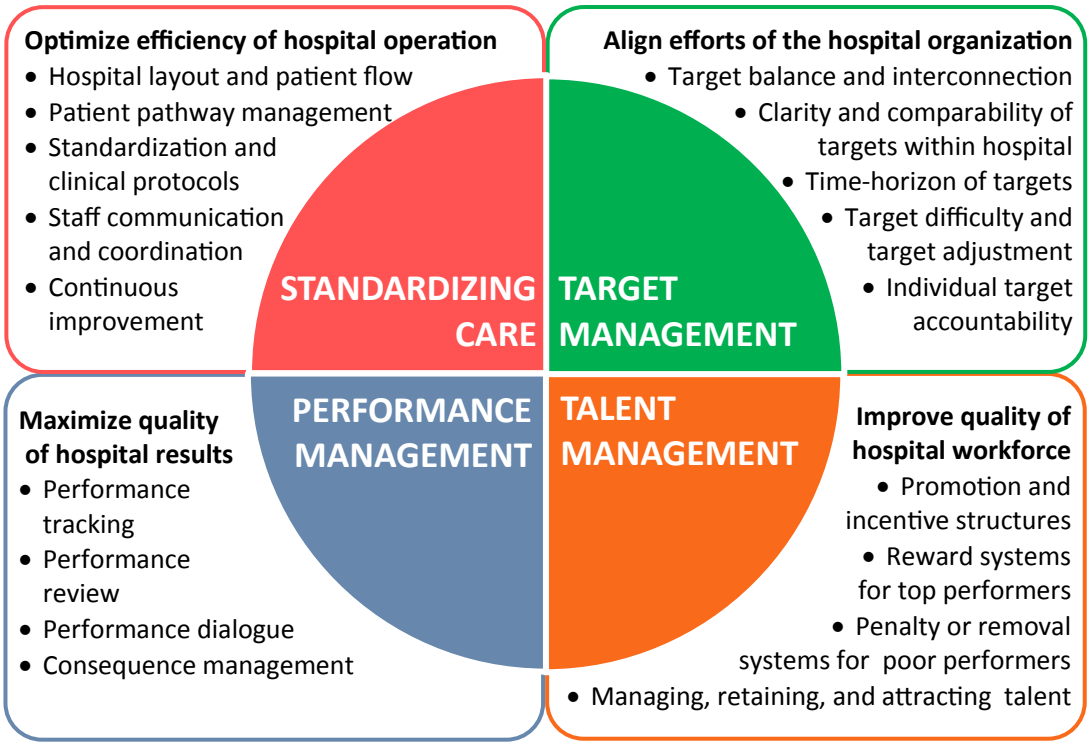
Public hospital reform in China remains the next major, but uncertain step. Chinese policymakers have offered up a number of bold policy ideas that will require effective management and cooperation within both local governments and healthcare organizations if they are to bear fruit. However, transparent, widespread, and reliable means of evaluating Chinese hospitals do not currently exist.

Initiated and currently directed by the China Center for Health Economics Research (CCHER) at Peking University, the Global Hospital Management Survey – China (GHMS-China) Project seeks to remedy this deficiency by implementing the World Management Survey (WMS) in China to collect data on management practices in Chinese hospitals.

The Management Practice Interview Guide, a globally validated survey instrument originally developed by the WMS team, includes questions on 21 different management practices across four major management domains: operation/standardization, monitoring, targeting, and incentives (Bloom et al, 2011, McConnell et al, 2013). The current project seeks to adapt the WMS methodology and the Management Practice Interview Guide to the Chinese context.

In November 2013, CCHER completed a pilot study with 20 general public hospitals, located in 12 provinces and 2 municipalities across China. We completed 39 in-depth interviews with clinical staff and discussed 21 different management practices which are divided into four areas: standardizing care, performance management, target management and talent management. Interviewees were mainly based in the Cardiology department, and included directors of departments, physicians, nurses, and other healthcare staff.

In order to examine management practices, GHMS-China research analysts conducted interviews with hospital managers, including specialty directors, physicians, and nurses, for an average of 60 minutes to discuss four key areas of hospital management:



Data were also collected on the organizational structure of each hospital, examining several aspects of hospital autonomy and hierarchy structure:

AUTONOMY

For Hospital Managers:
- Hiring and firing decisions
- Addition of new bed space
- Maximum capital expenditure without required authorization
- Department budgeting and strategic investment autonomy

For Staff:
- Clinical pathway decisions
- Performance targets

HIERARCHY STRUCTURE

Identifying Hospital Structure:
- Number of organizational layers above and below hospital managers
- Span of control for each hospital manager
- Who is each person reporting to (or accountable to)?

Our Analysts:

Interviews in the pilot study were conducted by students recruited from a variety of the best universities and academic departments in China, including:

- Peking University Guanghua School of Management
- Peking University National School of Development
- Peking University Health Science Center
- Beijing Foreign Studies University
- Renmin University School of Economics
- Central University of Finance and Economics

Our research analysts scored responses to questions for each management practice on a scale of 1 to 5, where 1 is the worst practice, 3 is the average, and 5 is the best. The survey instrument we created had a standardized scoring rubric for these grades of management.

INTERVIEWER

- Given no information about the interviewees
- 2 analysts per interview: interviewer & listener
- Analysts are trained to recognize and score management practices consistently

INTERVIEW

- Prepared open-ended survey questions
- Standardized training and scoring rubric
- Designed to encourage the use of examples when discussing management practices

INTERVIEWEE

- Given no information about the interviewers
- Ensured anonymity and confidentiality
- Informed that the interview is academic and educational, not for evaluation

The GHMS-China study examines the quality of hospital management in China using a survey instrument adopted from the WMS. The WMS evaluates management practices within industries and across countries using a standardized, double-blind interview process (Bloom, 2012).

This process allows for the control of many sources of bias and has led to more accurate estimates of management performance for hospitals in the United States, the United Kingdom, and many other countries.

BEFORE INTERVIEW

- Arranged telephone interviews with double-blind controls to minimize bias
- Standardized Chinese survey instrument, translated from WMS
- Academic emphasis, rather than evaluative, to encourage honesty

DURING INTERVIEW

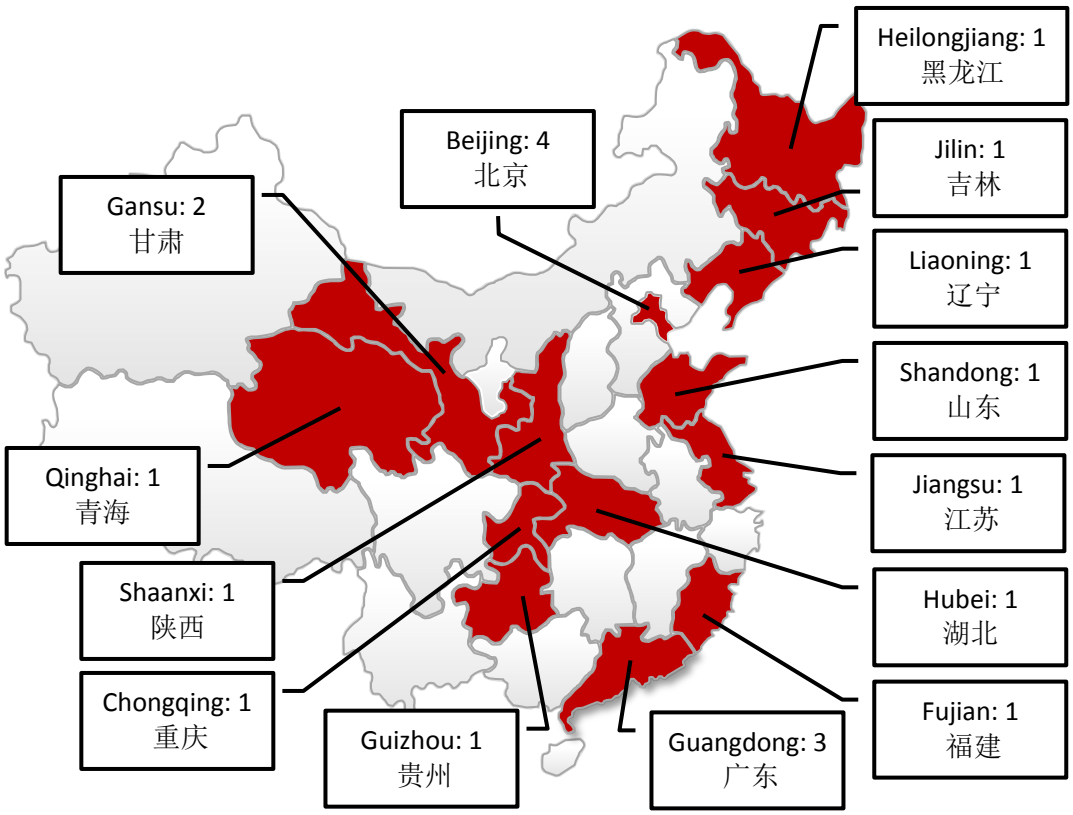
- Each interview has two analysts listening for double-scoring
- Observed all aspects of the interview process, including time, length, and demographics
- Individual analysts also tracked and monitored for potential errors

AFTER INTERVIEW

- Records from interviewers and double-scorers are compared, with each interview undergoing back-scoring for accuracy
- Measurement errors are controlled for during regression analyses
- Results are cross-checked with external datasets

Hospital Selection

In November 2013, GHMS-China analysts interviewed hospital staff in 20 Level 3 general public hospitals across 12 provinces (Heilongjiang, Jilin, Liaoning, Shandong, Jiangsu, Fujian, Guangdong, Hubei, Shanxi, Guizhou, Gansu, Qinghai) and 2 municipalities (Beijing, Chongqing) in China.



All of the hospitals in our pilot study are Level 3 hospitals. The Ministry of Health classifies hospitals into three different levels, each sub-divided into several grades, based on hospital size, equipment, and operation.

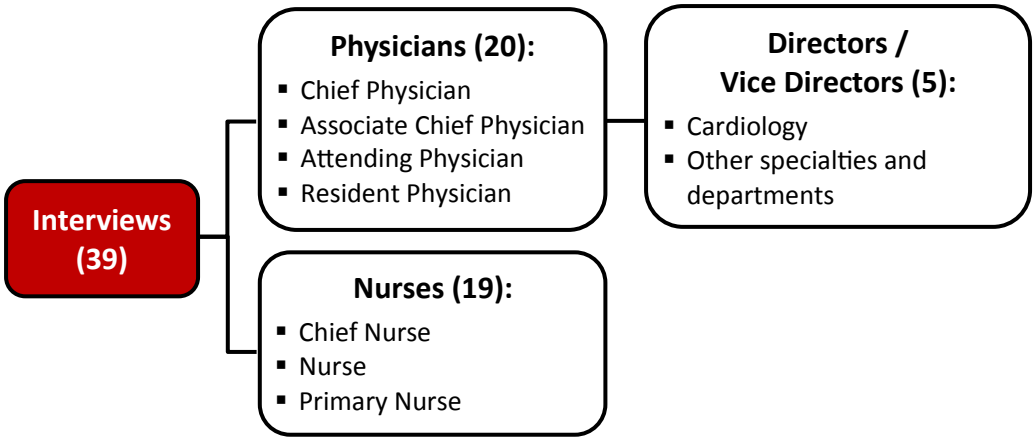
Hospital	Beds	Size	Personnel
Level 3	≥ 500	≥ 60 square meters per bed	≥ 1.04 doctors per bed ≥ 0.4 nurses per bed
Level 2	100-499	≥ 45 square meters per bed	≥ 0.88 doctors per bed ≥ 0.4 nurses per bed
Level 1	20-99	≥ 45 square meters per bed	≥ 0.7 doctors per bed ≥ 3 doctors, 5 nurses total

SOURCE: China Health Statistics Yearbook, 2008; Ministry of Health

Interview Selection

The GHMS-China study focused on interviews with managers, doctors, and nurses in specialty departments in Level 3 hospitals. Although most interviews were targeted towards Cardiology departments, interviews from other specialties and departments – ranging from neurosurgery to orthopedics to endocrinology – were also included in this study.

Out of 39 interviews, 20 were conducted with physicians and 19 conducted with nurses. Because most – if not all – management positions in Chinese public hospitals are filled by a physician, 5 interviews were also conducted at a department director or vice-director level.



Managers had an average of 5.6 years of working experience in their current positions and 13.9 years of working experience in their hospitals. The longest tenure at any hospital among our interviewees was 30 years and no manager had been in their current post for more than 13 years.

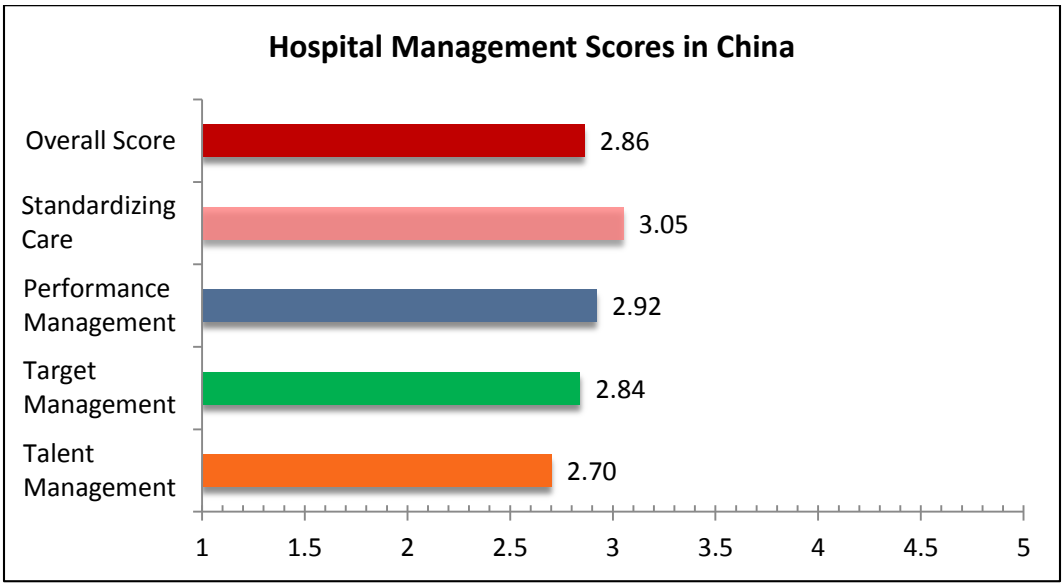
Hierarchy and Titled Positions in the Chinese Hospital System

Chinese	Pinyin	English	Academic Title
科主任	kē zhǔ rèn	Director	*(administrative title only)*
副科主任	fù kē zhǔ rèn	Vice-Director	*(administrative title only)*
主任医师	zhǔ rèn yī shī	Chief Physician	Professor
副主任医师	fù zhǔ rèn yī shī	Associate Chief Physician	Associate Professor
主治医师	zhǔ zhì yī shī	Attending Physician	Lecturer
住院医	zhù yuàn yī	Resident Physician	Teaching Assistant
护士长	hù shì zhǎng	Chief Nurse	*(administrative title only)*
护士	hù shì	Nurse	Technician
护师	hù shī	Primary Nurse	Primary Technician

SOURCE: Ministry of Health; Accessible at http://www.bimt.com.cn/Policy.aspx

Overall Hospital Management Score

Based on GHMS-China pilot study results, overall average management score across large public hospitals in China was **2.86** on the 1-5 WMS management score. The score of 2.86 suggests that the current state of hospital management for Chinese hospitals is slightly below a standard average score of 3.



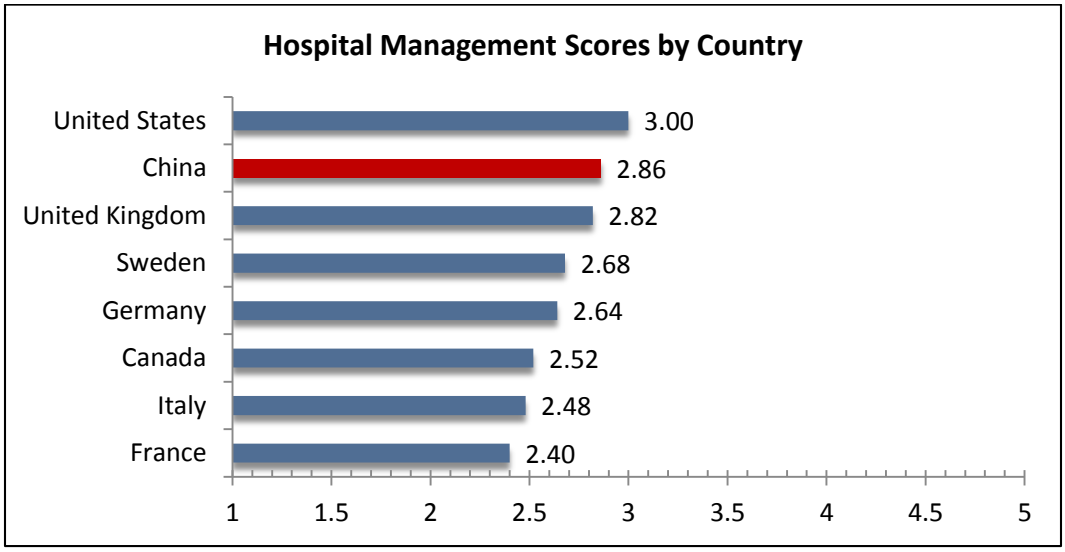
According to the breakdown of hospital management scores based on area of management, Chinese hospitals showed particular strength in their standardization/operations management and acute weakness in their talent management.

It is important to note that all of the 20 hospitals participating in the pilot study were Level 3 general hospitals, the highest classification given by the Ministry of Health for all public hospitals. Therefore, these results may overestimate the state of management for all hospitals in China.

However, the quantity and novelty of data collected from each of the 39 interviews of these hospitals is considerable enough to provide a brief, but precise assessment on the current state of management in China's public hospitals and can provide key insight into a future nationwide full study.

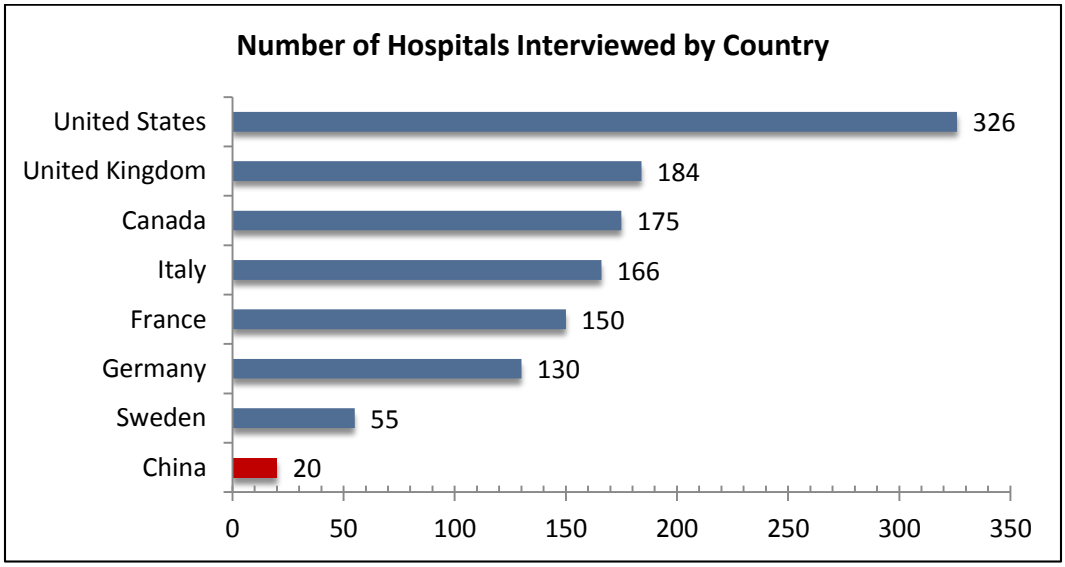
International Comparisons

When compared to results from identical hospital management studies performed in other countries, China's average hospital management score is quite surprising. Despite appearing to be below average, a score of 2.86 is relatively high internationally, above that of the United Kingdom and second only to that of the United States.



SOURCE: Management in Healthcare: Why Good Practice Really Matters, 2010

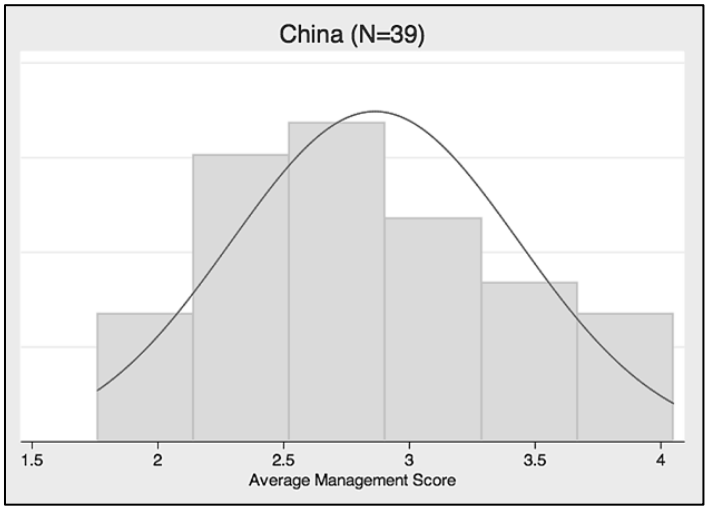
A key caveat lies in both the hospital selection and number of hospitals participating in the GHMS-China pilot study. Although there was fairly wide geographic coverage, the pilot study only included Level 3 hospitals, which are the highest classification of public hospitals in China and are typically located in large metropolitan areas.

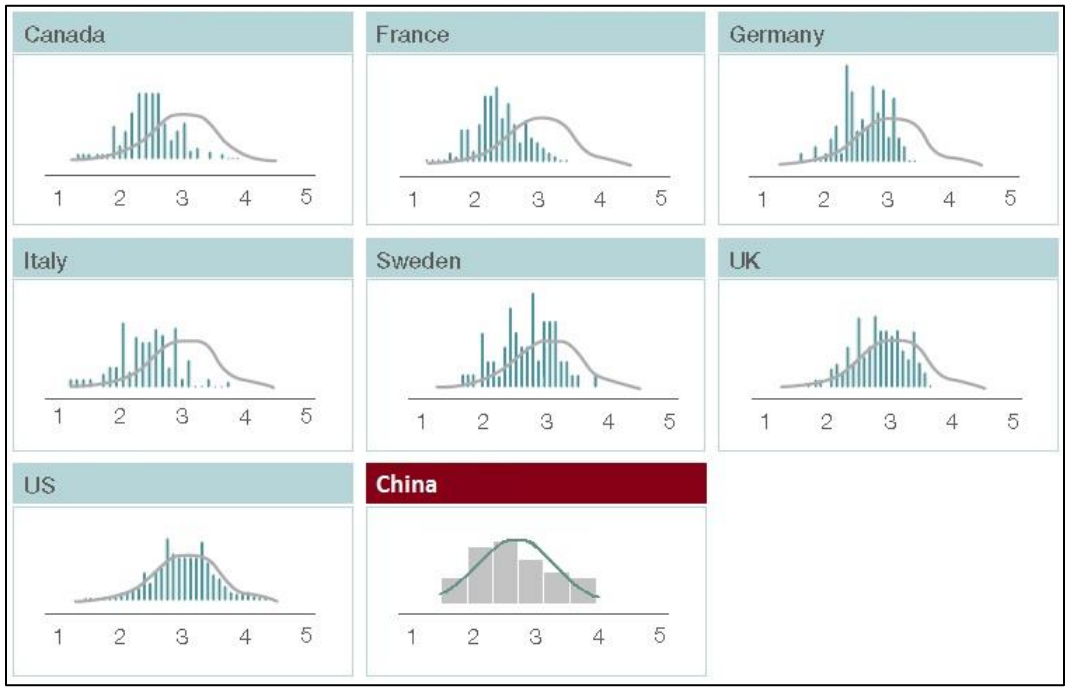


SOURCE: Management in Healthcare: Why Good Practice Really Matters, 2010

Additionally, the number of hospitals interviewed in the GHMS-China pilot study is substantially lower than that of the studies in the other countries. This means that the scores from our pilot study are more likely to vary more significantly and be an under-representative sample of the true management scores for all hospitals in China.

Fortunately, the distribution of scores collected in our pilot study appear to be near-normal and similar to the distribution of scores in other countries, demonstrating that our model in China is consistent with that of the other international studies.



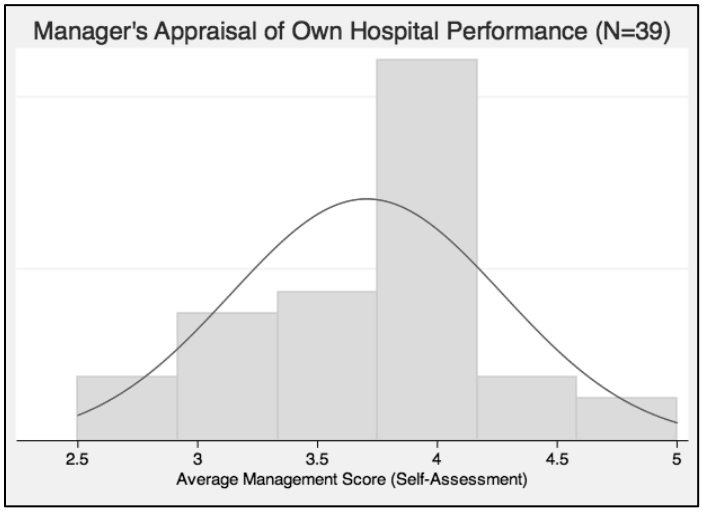


ADAPTED FROM: Management in Healthcare: Why Good Practice Really Matters, 2010

Factors for Variation

Variation based on Manager Self-Assessment

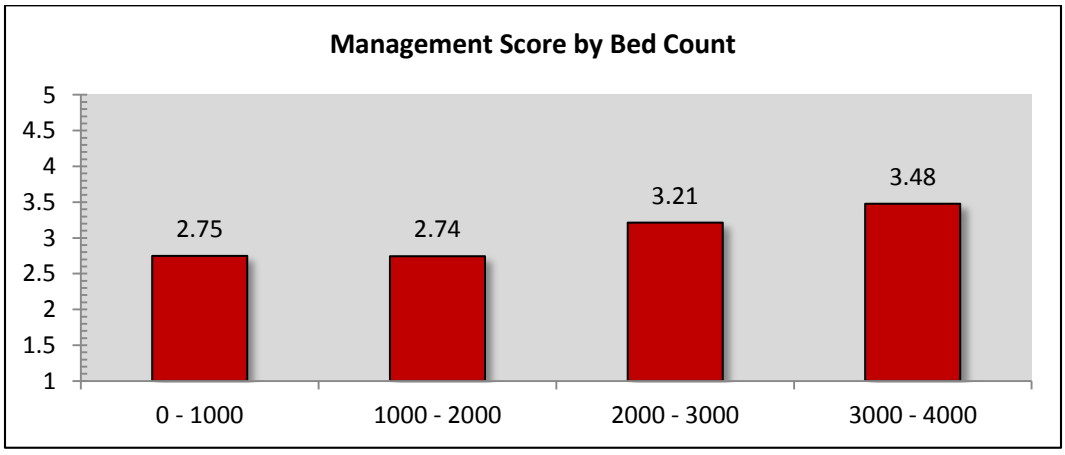
At the end of every interview, we asked hospital managers to rate their own hospitals on a scale from 1 to 10, not factoring in their own performance. Below is the distribution of the means of these responses, after having been converted to a 5-point scale:



Self-assessed scores averaged out to 3.75 – nearly one full-point above our objective scoring measurements. This indicates that a majority of the interviewees perceive their hospitals as above average and will generally over-score their own hospital's management practices.

Variation based on Hospital Size

There appears to be an association between hospital-size, measured by bed count, and average hospital management performance in China.



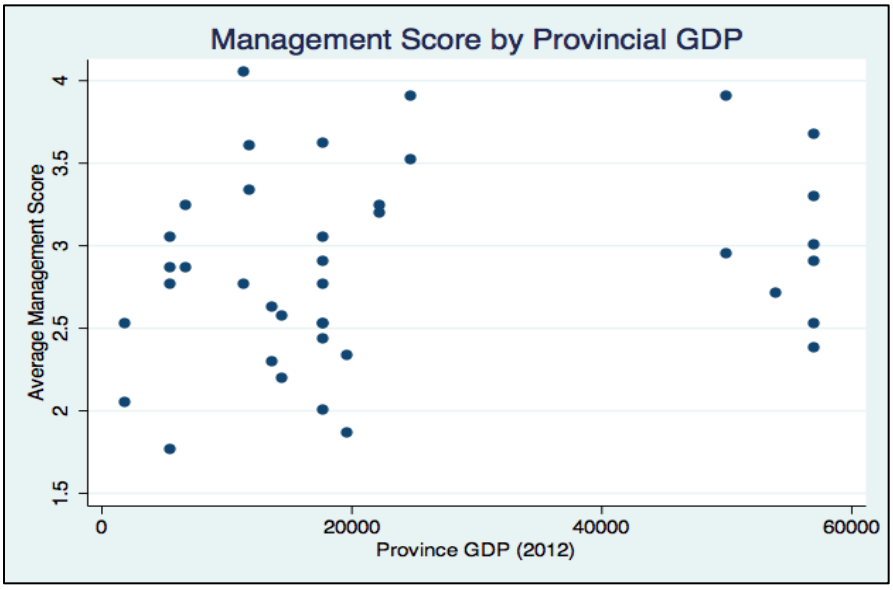
Management practices appear to be better in larger hospitals than smaller. Better managed hospitals in China are more capable of growing, and large scale hospitals are more attractive for talents and are more capable of growing and attracting top talent.

However, this variation is not significant among interviewed hospitals. One reason for this is because all the public hospitals selected in our pilot study were Level 3 hospitals, which are required to have at least 500 beds according to Ministry of Health, resulting in no significant difference in size among the hospitals interviewed.

Variation based on Provincial GDP

Our pilot study was carried out in 12 provinces and 2 municipalities, which included China's most prosperous autonomous regions: the capital city (Beijing), Eastern coast (Jiangsu, Fujian and Guangdong), as well as some of the China's least developed areas – the West (Qinghai, Gansu, Guizhou).

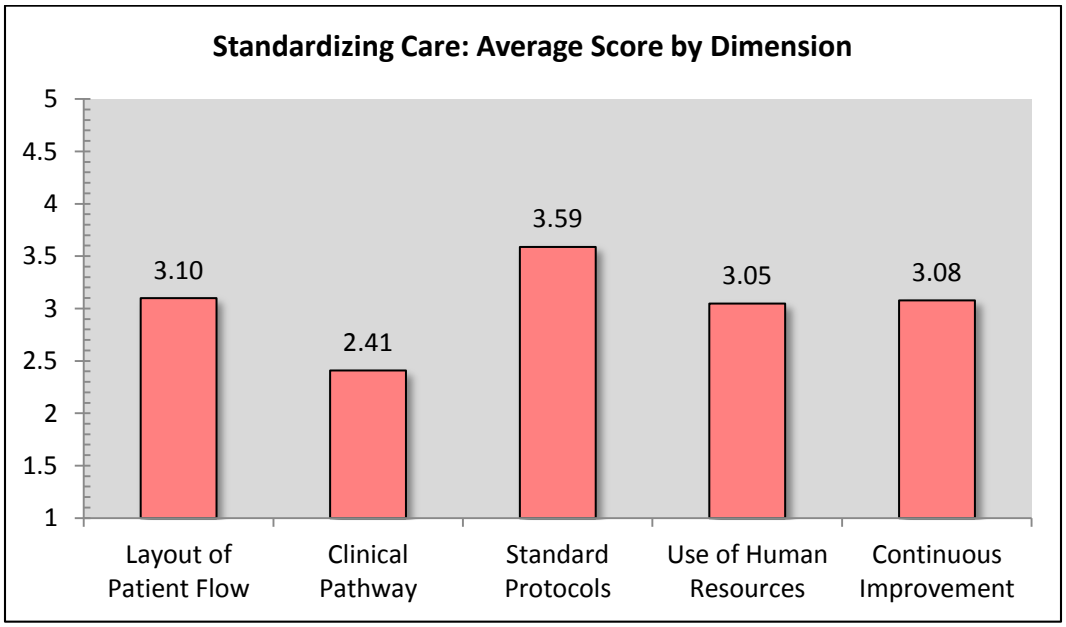
Since hospital budgets rely partially on subsidies given out at the provincial level, we expected to see an association between provincial GDP and our hospitals' average management score. This was, indeed, the case:



SOURCE: China's Bureau of Statistics Report, 2012

Standardizing Care

Five dimensions of management practices were used to measure the standardization of care and operation in Chinese hospitals: hospital layout, patient pathway, clinical protocols, use of human resources, and continuous improvement.

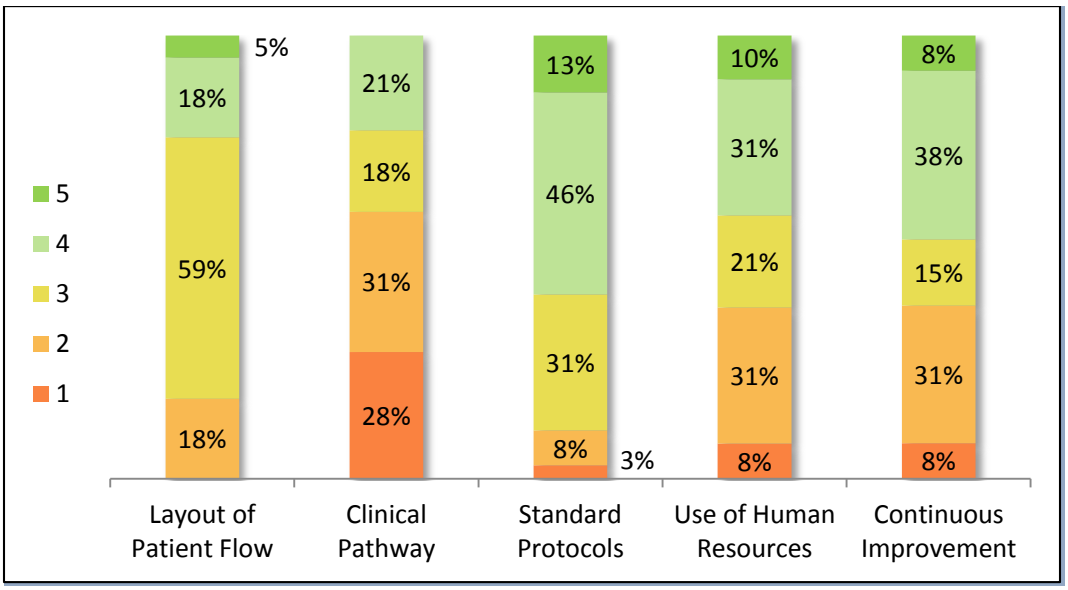


Although Chinese hospitals scored the highest in standardizing care out of the four areas of management, scores for patient pathway management were the lowest across all 21 management practices.

One possible reason is that China's Ministry of Health has only recently started implementing a pilot clinical pathway platform since 2009, with many changes being imposed upon hospitals that will rarely challenge or change pathways from department or individual clinician input. Hospital managers indicated that oftentimes these clinical pathways were either hard to follow or difficult to implement in practice.

On the other hand, Chinese hospitals scored the highest (3.59) in creating and following standardized protocols. Additionally, practices in patient flow optimization, use of human resources, and continuous improvement all had an average score of 3, indicating that hospitals have some processes available for improving management in these dimensions.

Scoring Breakdown for Each Management Dimension:



- **Layout of Patient Flow:** More than half (59%) of Chinese hospitals had an average score of 3 for this management practice, indicating that there are processes in place for optimizing hospital layouts, but that these processes are not regularly challenged or improved.

- **Clinical Pathway:** More than half (59%) of Chinese hospitals scored below average, due to responses that indicated that control of clinical pathway is centralized within the Ministry of Health.

- **Standard Protocols:** 89% of Chinese hospitals scored average or above, suggesting that there is a strong emphasis on the standardization and monitoring of clinical procedures among Chinese hospitals.

- **Use of Human Resources:** There is a large gap in scoring, with 41% of hospitals scoring above average and 39% of hospitals scoring below average. Chinese hospitals either have systems for effective human resource deployment or do not employ such processes.

- **Continuous Improvement:** There is also a large gap in scoring, with 46% of hospitals scoring above average and 39% of hospitals scoring below average. Differences in scoring are indications of whether or not a hospital had regular processes in place for staff to expose and resolve problems before they occur.

Key Insights:

- Senior staff should actively monitor layout of patient flow and implement protocols with appropriate regularity.
- Allocation of work and improvement processes need to have more clinician involvement to create more incentives for better performance.
- The Ministry of Health should provide hospitals with training programs on workplace optimization and clinical pathway implementation.
- Hospitals need more autonomy from the Ministry of Health on clinical pathway management.

Details of general management practices for each **Standardizing Care** dimension are summarized as follows:

Layout of Patient Flow

Layout of hospitals:

- Chinese hospitals have numerous layout requirements built into each grading evaluation. While standardized across hospitals in the same level, hospital layouts are typically not challenged beyond Ministry of Health regulations.
- Many Chinese hospitals have service centers or escort services available to guide patients during busy hours.

Typical patient flow:

Registration → Outpatient clinics/Specialty clinics → Examination → Payment → Pharmacy

Clinical Pathway

- Many Chinese hospitals have not implemented clinical pathways across the hospital and pathways may only be available for one or two patient groups.
- Most clinical pathways are imposed top-down from the Ministry of Health. Hospitals have little incentive, opportunity, or capability to implement changes.

Standard Protocols

- Standardized protocols for each hospital are typically available to staff on websites, bulletin boards, or in printed manuals.
- Monitoring is limited to inspection of patient records and ward rounds; many managers claimed that they could not know if all staff followed the protocols regularly.
- Responsibilities for monitoring and inspection are limited to the Directors of Specialties and Chief Nurses.

Use of Human Resources

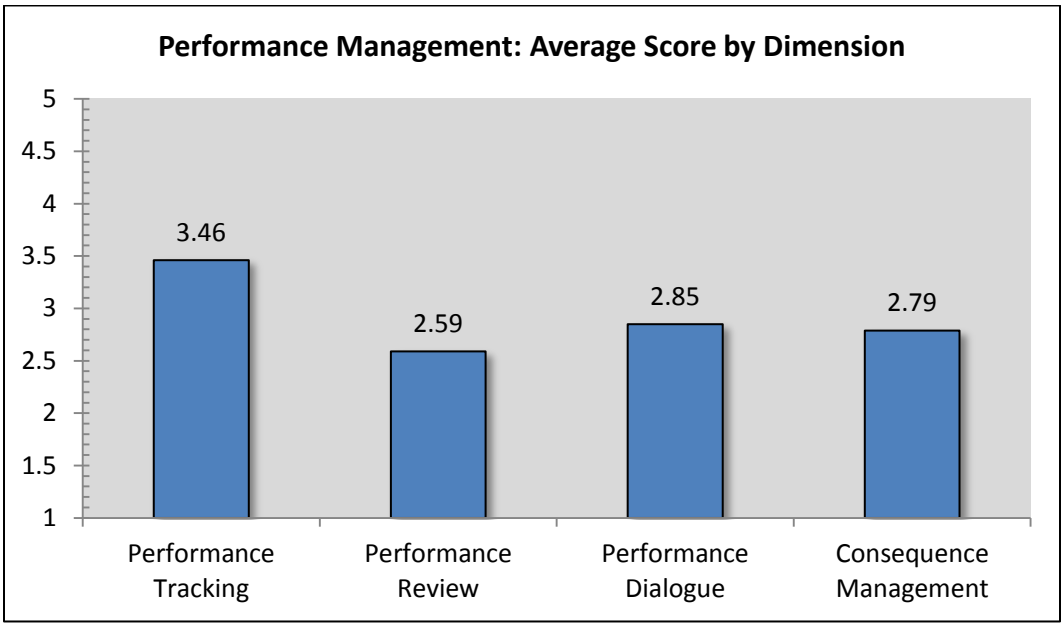
- Physicians are not moved across specialties or departments due to boundaries between professions
- Hospitals mostly rely on allocating work between nurses based on specialty, capability, and personal characteristics.
- High-scoring hospitals utilized emergency nurse teams that could be transferred from less busy to busy areas.

Continuous Improvement

- In high-scoring hospitals, Directors of departments would hold regular quality improvement meetings with clinicians every month to discuss problems and solutions.
- For most hospitals, Chief Nurses are required to monitor and inspect nurses at least 3 times a day, by checking patient records and conducting ward rounds.
- In high-scoring hospitals, patients would fill out a satisfaction survey or be interviewed via telephone after discharge

Performance Management

Four dimensions of management practices were used in order to measure performance management in Chinese hospitals: performance tracking, review, dialogue, and consequence management.

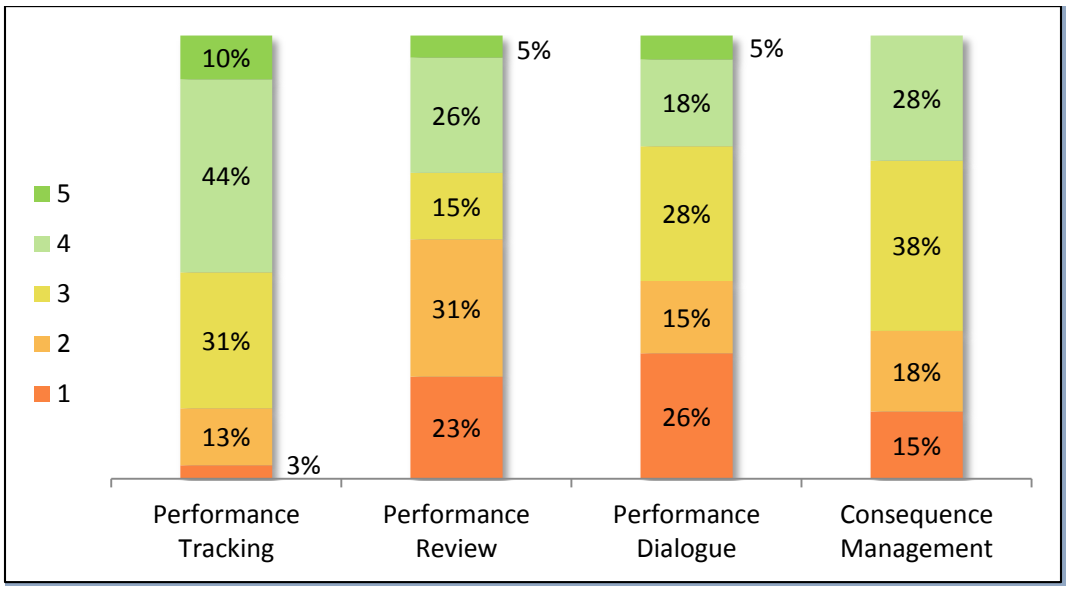


Among the four performance dimensions measured in our study, Chinese hospitals had the highest average score (3.46) in performance tracking. This relatively higher score may be due to hospitals being required to track and report specific performance indicators to the Ministry of Health. Because these indicators were critical for hospital evaluation, nearly every Level 3 hospital we interviewed had senior staff directly responsible for performance tracking, with departmental and individual performance available for staff to see.

Despite this above average score in performance tracking, however, there was little indication that Chinese hospitals reviewed or tracked performance indicators beyond government requirements. Accordingly, Chinese hospital scores for performance reviews were the lowest (2.59) among the four dimensions.

Scores for performance dialogue (2.85) and consequence management (2.79) were also below average, as Chinese hospitals managers mostly relied on informal and irregular processes to manage both performance conversations and performance plans, with little to no formal processes available for accountability.

Scoring Breakdown for Each Management Dimension:



Percentage of each score for each dimension is showed above.

- **Performance Tracking:** Over 85% of Chinese hospitals scored an average or above in performance tracking, indicating that hospital managers place unique emphasis on the measurement and tracking of performance and quality indicators in China.

- **Performance Review:** Over half (54%) of Chinese hospitals scored below average, due to hospitals lacking regular review meetings or conversations about performance indicators.

- **Performance Dialogue:** 26% of Chinese hospitals had the lowest management score of 1 while another 28% had an average score of 3. This gap in scores is caused by hospitals either having adequate review meetings or not having review meetings at all.

- **Consequence Management:** Although no hospital had the best score of 5, approximately 66% of Chinese hospitals scored at least average in consequence management. Higher scores were due to many hospitals managers being capable of using penalty or retraining processes to manage problems or procedural failures.

Details of management practices for each **Performance Management** dimension are summarized as follows:

Performance Tracking

- Most performance indicators are tracked every month, including outpatient quantity, surgical quantity, average length of stay, bed turnover rate, academic publications, etc.
- While hospital managers have access to performance data, many hospitals have separate Information/Medical Service Departments to oversee data collection and tracking
- Performance results are very openly communicated to all staff in a hospital, either through informal meetings, bulletin boards postings, and/or website postings.

Performance Review

- Performance indicators are rarely reviewed and/or changed beyond Ministry of Health requirements.
- Only senior hospital staff can review indicators; however, they do so occasionally, with results informally communicated to staff and not inclusive of all staff groups.

Performance Dialogue

- In many hospitals, no formal review conversations are held either between senior staff or within departments.
- Conversations that do occur are informal, and are often in response to problems related to performance evaluations that arise during hospital operations.
- Hospital managers complained about lack of autonomy within their specialties or departments, due to pressure from external administrative departments

Consequence Management

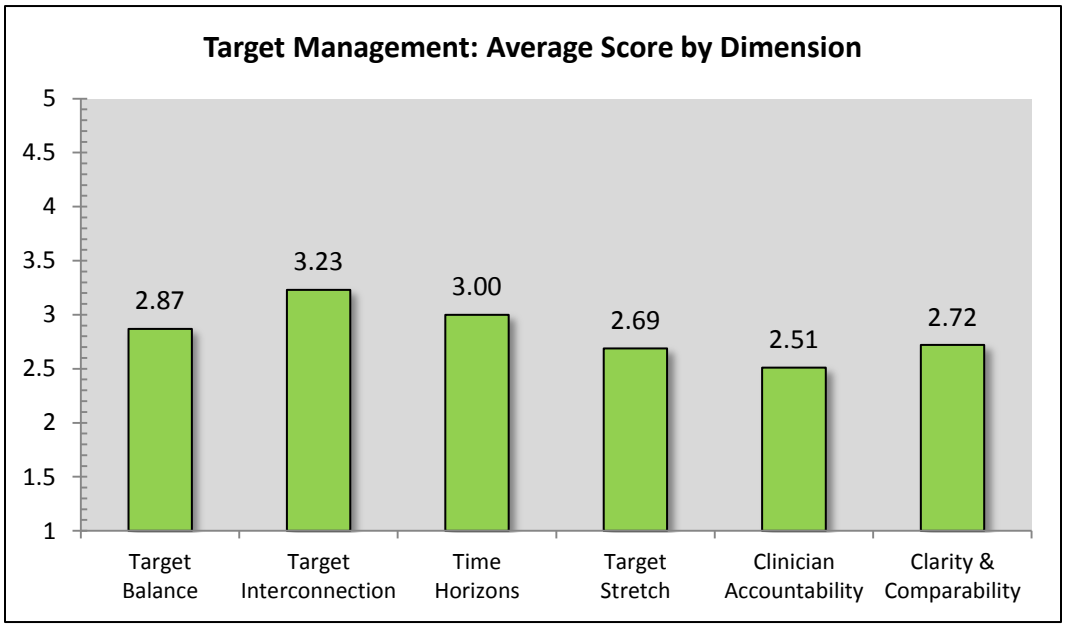
- Although processes for exposing problems were rare, hospital managers claimed to be able to resolve minor problems within one to two days of exposure.
- Failure to respond or achieve agreed tasks would typically result in reduced bonuses within one or two months.
- High-scoring hospitals employ a separate Medical Service department to oversee implementation of tasks every month.
- Failures in cost-control are rarely identified or addressed.

Key Insights:

- Although hospitals continuously track performance or quality indicators required by the Ministry of Health and beyond, senior staffs need to be more active in performance management.
- Formal processes, such as regular meetings to review performance indicators, are needed to identify hidden problem, address root causes, and define clear follow-up steps.

Target Management

Six dimensions of management practices were used in order to measure target management in Chinese hospitals: target balance, target inter-connection, time horizons, target stretch, individual accountability, and target clarity and comparability.



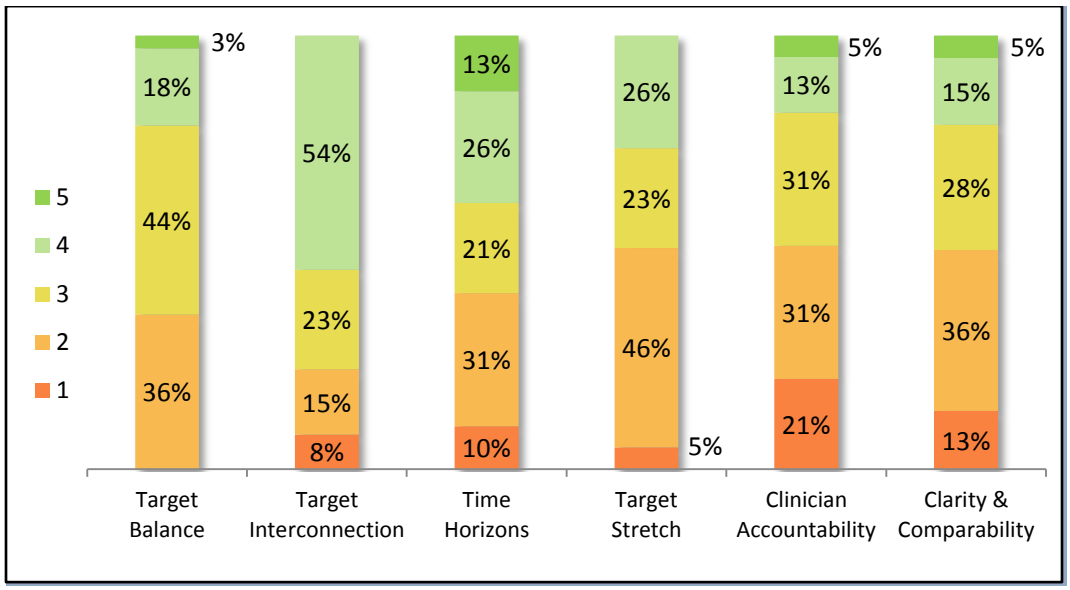
On average, Chinese hospitals scored average or below average in all dimensions of target management, except for target interconnection, where Chinese hospital managers scored above average in linking targets to hospital performance and cascading targets to certain staff groups.

Chinese hospitals scored average in time horizons, with staff indicating that there are short and long-term targets, but they are set independently of each other and not communicated regularly to all staff.

Chinese hospitals perform worst in the target stretch (2.69) and clinician accountability (2.51) dimensions of target management, mostly because there is a lack of leadership roles and accountability among clinicians for the delivery of individual goals. Clinicians passively accomplish goals and often have no input on revising targets that are too difficult for them.

Target balance, and clarity and comparability of target are slightly below average, showing that goals do cover some aspects of management but are not balanced, and individual targets are not well defined.

Scoring Breakdown for Each Management Dimension:



- **Target Balance:** Although none of the Chinese hospitals interviewed scored a 1 for the target balance dimension, this may be due to our sample only including Level 3 hospitals, which have stringent reporting requirements from the Ministry of Health. 44% of Chinese hospitals had balanced sets of targets, scoring a 3, and 36% of Chinese hospitals did not have financial balance or cost control targets, scoring a 2.

- **Target Interconnection:** Over half (54%) of Chinese hospitals scored above average. Targets are managed well down hospital organizations, with hospital leaders cascading goals down to specific staff groups.

- **Time Horizons:** Chinese hospitals scored variably in this dimension, with scores distributed among scores of 2, 3, and 4, showing variation between hospitals in terms of setting long-term and short-term targets.

- **Target Stretch:** Over half (51%) of Chinese hospitals scored below average in the target stretch dimension. Although targets may cascade down, clinicians complained about the difficulty of their targets and the inability of clinical staff to provide input when setting targets.

- **Clinician Accountability:** Over half (52%) of hospitals scored below average, due to a lack of accountability beyond clinical quality. There were no formal leadership roles among clinicians to deliver targets.

- **Clarity & Comparability:** Nearly half (49%) of hospitals scored below average, due to measures being complex and not clearly understood.

Key Insights:

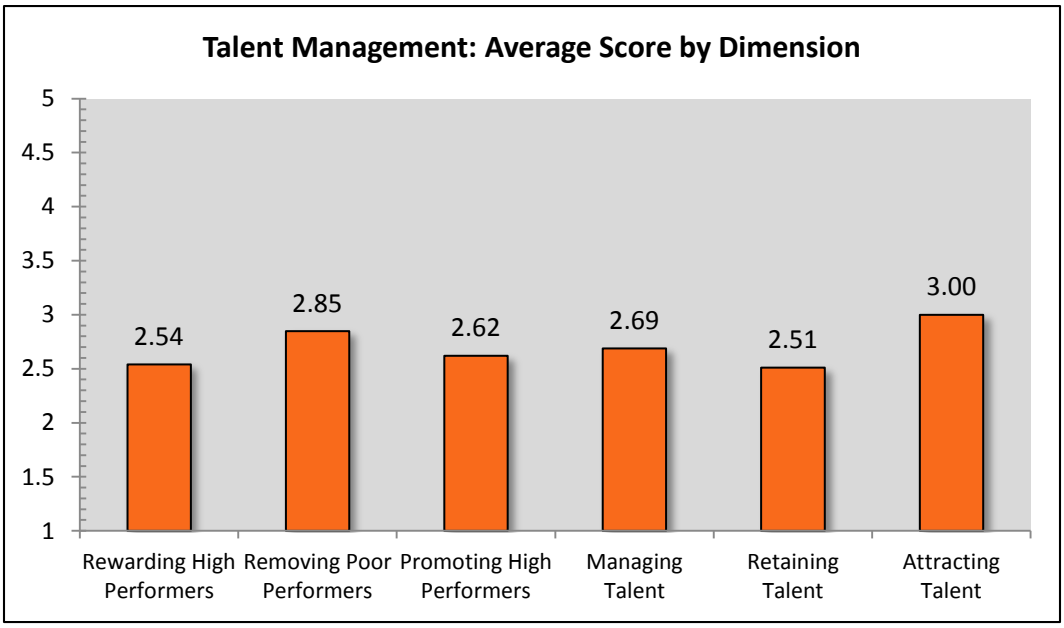
- Goals should cover a balanced set of targets, including quality, waiting time, operational efficiency, and financial balance.
- Clinicians should be more actively involved in the target setting process, in order to prevent difficulty in target stretch and improve target clarity.
- More formal processes are needed to improve target communication and comparability between hospital departments.

Details of management practices for each **Target Management** dimension are summarized as follows:

Target Balance	▪ Goals only focus on medical quality and research, including improvement in clinical technology, accomplishment of clinical tasks, research and innovation. ▪ Goals are usually set to meet Ministry of Health requirements ▪ Goals only extend to senior staff; many clinicians claim that they do not clearly know hospital's goals only individual tasks.
Target Inter-connection	▪ Hospital goals are discussed by hospital leaders and cascaded down to department Directors by weekly meetings, which are then informally cascaded down to specific staff. ▪ Department Directors will typically assign individual targets to clinicians without clear communication of hospital goals.
Time Horizons	▪ Long-term and short-term goals are set independently, with most long-term goals set without specific plans or benchmarks. ▪ Short-term goals (≤ 1 year) are limited to Ministry of Health reporting requirements, accomplishments in clinical tasks, improvements in quality, and research goals. ▪ Long-term goals (3-5 years) are limited to hospital expansions, improving reputation, or meeting evaluation goals.
Target Stretch	▪ Clinicians expressed frustration with targets, claiming that most hospital targets are difficult to reach. ▪ There are no opportunities for clinicians to be actively involved in setting targets; therefore, little clinical input is available.
Clinician Accountability	▪ Clinical performance is considered the main part of the job, with accountability focused on clinical quality. ▪ Most hospitals did not have cost-saving requirements or accountability procedures for clinicians. ▪ For poor performance, bonus reduction is generally a widely accepted practice across all hospitals in China.
Clarity & Comparability	▪ For high scoring hospitals, all hospital staff are able to check their individual performance via website or hospital offices. ▪ Interviewees complained that many target measures were complex and not easily understood.

Talent Management

Six dimensions of management practices were used in order to measure talent management in Chinese hospitals: rewarding high performers, removing poor performers, promoting high performers, managing talent, retaining talent, and attracting talent.



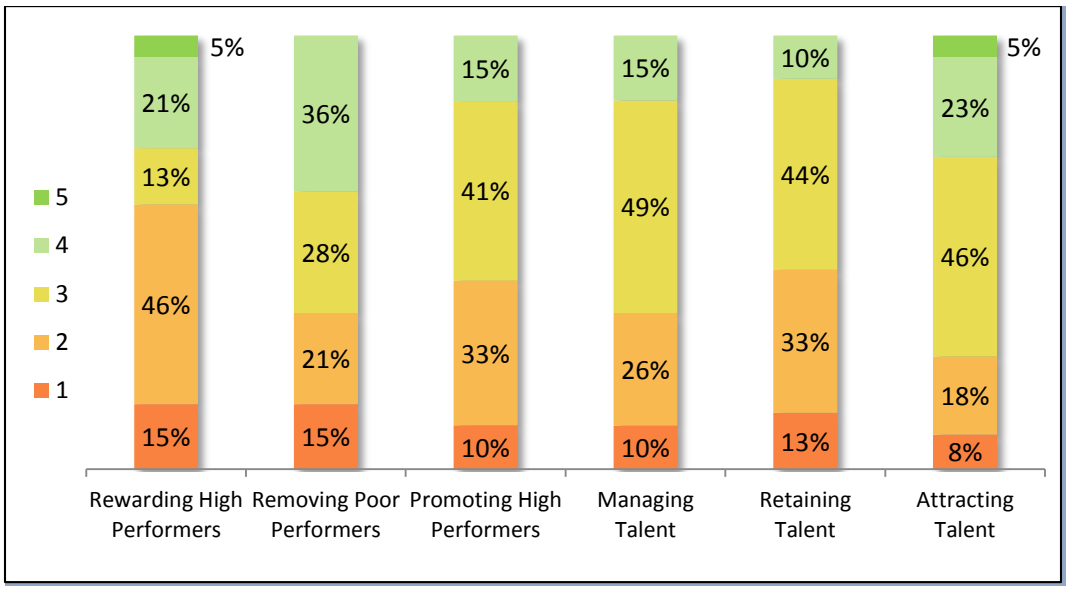
Scores for talent management, in general, were the lowest among the four key areas of hospital management studied. Not surprisingly, scores for each dimension in talent management are below average.

Attracting talent was the only dimension to reach an average score, indicating that Chinese hospitals do not have unique advantage or value proposition. Most Level 3 hospitals interviewed were able to attract talent by relying on their reputation and academic influence, rather than by providing competitive benefits or welfare.

The lowest scoring dimension was retaining talent. Most Chinese hospital managers do not have mechanisms in place to keep talented clinicians, and often have no ability to retain clinicians that leave.

Although many hospitals have strong financial incentive systems in place to manage performance, the value of talent management is not well understood in Chinese hospitals. Managers should be provided with more training and stronger incentives in human resource management.

Scoring Breakdown for Each Management Dimension:



- **Rewarding High Performers:** Over half (61%) of Chinese hospitals scored below average on this dimension. Although there are reward systems, clinician bonuses are largely based on position and workload rather than quality and individual performance.

- **Removing Poor Performers:** Chinese hospitals had varied scores in this dimension, with most hospitals only able to move underperformers to less critical roles, rather than directly fire them.

- **Promoting High Performers:** 41% of Chinese hospitals scored average and 41% scored below average in this dimension. Most hospitals rely on tenure and years of service as the basis of promotions, but there are some with mechanisms to include consideration of performance.

- **Managing Talent:** Almost half (49%) of Chinese hospitals interviewed scored average in this dimension. Most hospital managers recognized the importance of managing talent, but no processes are in place to incentivize or motivate managers to improve talent management.

- **Retaining Talent:** Chinese hospitals do not have formal processes in place to keep top talent and managers rely on informal conversations. Score differences are based on perceived hospital efforts to keep talent.

- **Attracting Talent:** 46% of Chinese hospitals scored average in this dimension. Most clinicians claimed that their value proposition is comparable to those offered by other hospitals,

The details of management practices for each **Talent Management** dimension are summarized as follows:

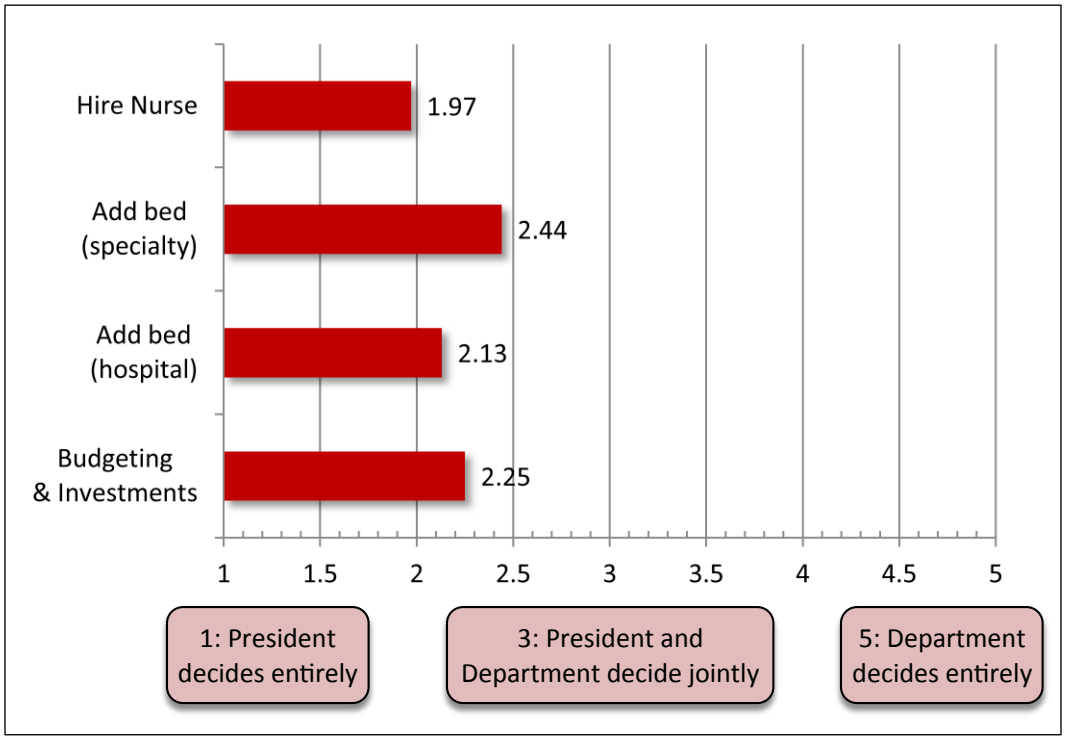
Rewarding High Performers	▪ Clinician salaries are comprised of basic pay and bonuses. ▪ Bonuses depend on a clinician's hospital position and academic title, but generally are based on workload rather than quality or individual performance. ▪ Non-financial incentives include training opportunities and academic research opportunities, but are informally awarded.
Removing Poor Performers	▪ Due to Ministry of Health grading requirements and workload pressure, hospitals are actually incentivized against removing hospital staff. ▪ Poor performers are moved to less critical roles or re-trained. ▪ Clinicians are considered full-time and permanent, with firing procedures difficult if not impossible.
Promoting High Performers	▪ Tenure is a basic requirement for promotion candidates, with hospital committees then considering clinical performance, workloads, educational background, and research experience. ▪ High-scoring hospitals had self-selecting promotion processes, where any clinician can apply for a promotion at a given time, provided they believed their performance to be adequate.
Managing Talent	▪ Hospital managers are not held accountable for or evaluated on attracting, retaining, or developing staff. ▪ Opportunities for studying abroad and other seminar training processes are available but processed informally.
Retaining Talent	▪ Hospital managers have few measures to persuade talent to stay, with most relying on informal negotiations. ▪ Major reasons for leaving include: heavy workloads, low salary, high pressure, lack of concern for clinicians, and insufficient welfare or benefits.
Attracting Talent	▪ Because of the importance of Ministry of Health grades, most hospitals compete only in terms of grade evaluations. ▪ Hospitals only need to rely on their grading, reputation, and academic influence to attract top clinicians. Higher level and grade hospitals have intrinsically higher value to clinicians.

Key Insights:

- Out of all hospital management areas, talent management requires the most improvement and emphasis.
- Reward and promotion systems should rely less on tenure and more on individual clinician performance.
- Hospital managers should be incentivized or held more accountable for their talent management.
- Hospital grades currently play too significant of a role in the ability of hospitals to attract talent.

Autonomy and Hierarchy Structures

In addition to the above management questions, the GHMS-China pilot study also collected information about hospital autonomy and hierarchy structures. To measure this, we asked questions about who in the hospital had the authority to make decisions on the following four dimensions: hiring nurses, adding beds in a department, adding beds in the hospital, and budget setting and investment.

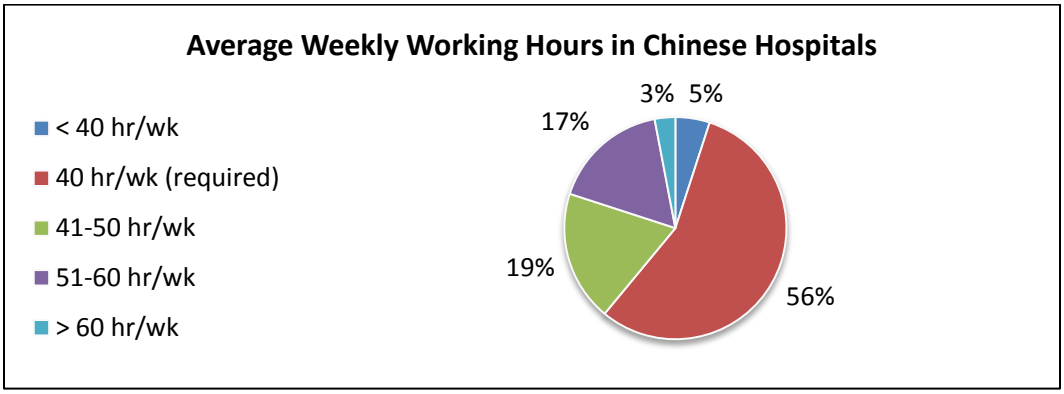


When it comes to decision-making in Chinese hospitals, the top has all the power and the bottom almost none. Hospital presidents make almost all personnel and strategic decisions, oftentimes without consulting departments. Departments may have constrained autonomy when it comes to managing personnel and bed space but they have almost no authority to add personnel or beds when needed.

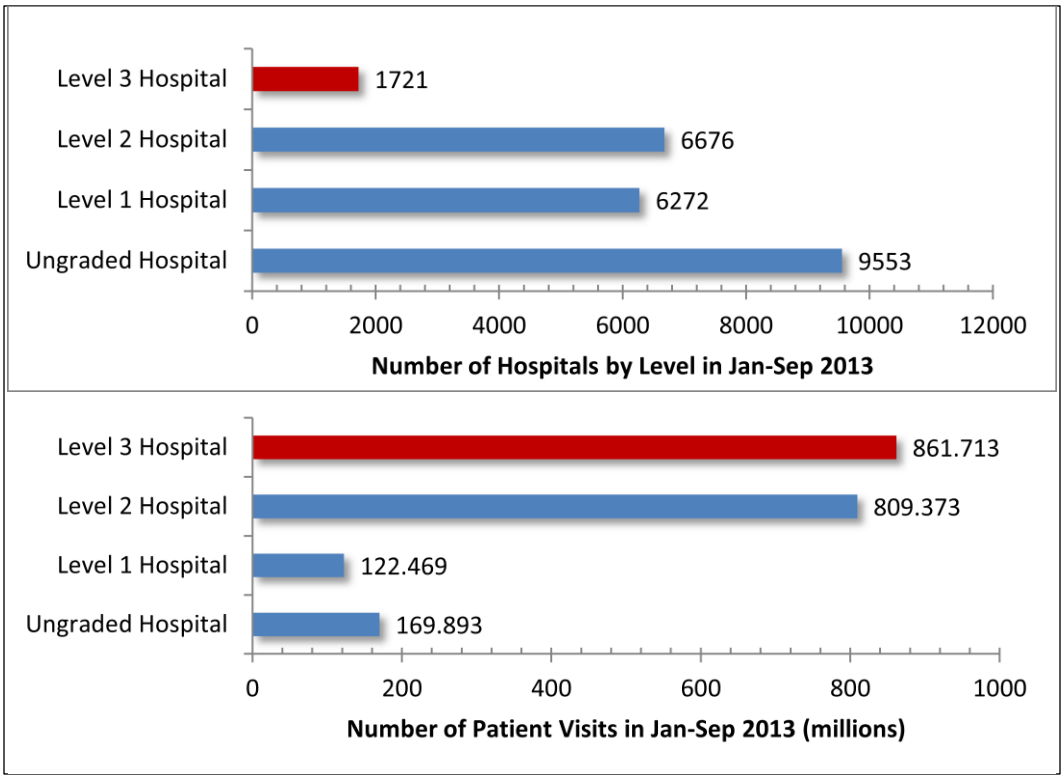
When we asked managers what was the largest capital investment that they could make without first consulting their presidents, 32 of our 39 managers—roughly 82 percent—responded with "none" or "zero." To our surprise, answers did not change much across different, even higher level, positions: our highest-ranking manager said that he could only invest up to 50,000 RMB (less than USD $10,000) without consulting his president.

Workload and Incentives

During our interviews with hospital managers, heavy workload was a major source of complaint across all hospitals. Clinicians in China are required to work 40 hours a week, with 56% of interviewed clinicians meeting this requirement. However, 39% of clinicians claimed that their average weekly working hours exceeded 40 hours, reaching as high as 80 hours a week:



The high average of weekly working hours could be due to the unbalanced distribution of hospitals and patient visits in China. Hospitals rated Level 3 by the Ministry of Health receive a disproportionately larger number of patient visits than hospitals that are Level 2 or Level 1:



SOURCE: National Health and Family Planning Commission, 2013

Memorable Quotes:

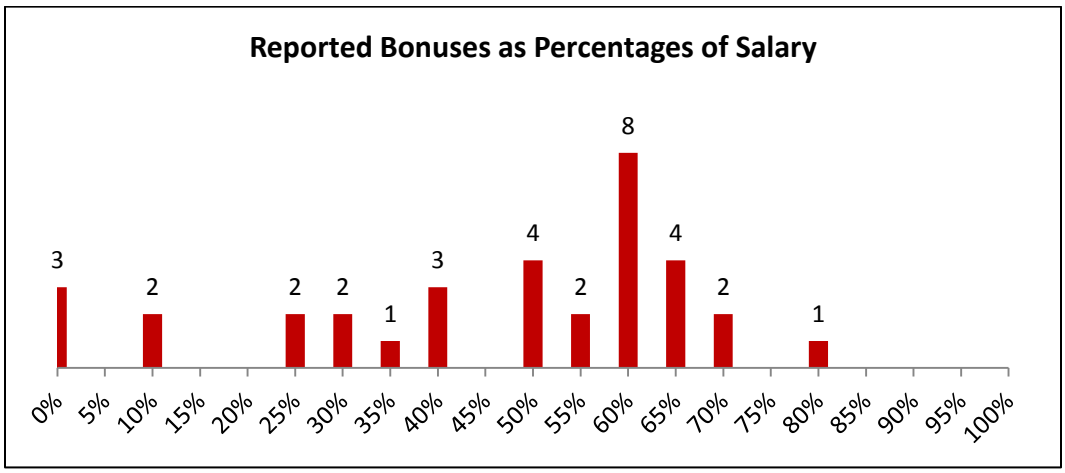
Exposing problems

Analyst: "How do problems with patients typically get exposed?"

Manager: "Through arguments."

Despite the high number of patients, there are few financial incentives in place for physicians and nurses to accommodate this workload. A recent 2013 survey of 5,900 physicians done by McKinsey in China found that the average Chinese physician makes between $5,640 and $15,000 a year.

In our interviews with Level 3 hospitals, monthly bonuses paid to nurses and physicians make up nearly 45% of their reported salaries on average. Bonuses accounted for at least half of 21 managers' salaries and only 5 managers reported bonuses constituting less than a quarter of their pay:



However, almost every manager that we talked to told us that everyone in their department received the same bonus—and oftentimes the same salary—regardless of their own personal performance. This is still the standard practice in most Chinese hospitals where bonuses are rewarded every month from surplus revenue at the department level.

RECOMMENDATIONS

Based on results from our GHMS-China study, we have compiled a list of recommendations to policy makers and hospital managers for improving management practices in public hospitals.

Hospital Managers

More efforts needed on talent management

- Individual performance needs to be emphasized more strongly than position and tenure in reward systems. Bonus structures should better reflect a clinician's individual performance and should be set based on individual performance indicators.
- Hospital managers should be more incentivized or held accountable for managing talent in their clinicians. Managers should also be given more tools for developing their staff or more rewards for performance.
- Hospital managers should have procedures for offering additional professional development opportunities to more staff groups.
- Hospitals should offer competitive benefits beyond hospital grade and reputation. A unique employee value proposition is essential for hospitals to build their talent pools.

Higher levels of autonomy needed

- Directors should have more autonomy to manage their departments, including firing and hiring, addition of beds, and budget setting and investment.
- For target management, hospital managers need to give clinicians more autonomy to set individual targets. The process for developing hospital goals process needs to extend to more staff groups so that goals would be more reasonable and aligned.

Review and adjust hospital operations with appropriate regularity

- Because of their important role as healthcare providers for the public, hospitals should adjust operations based on patient demand. Patient flow and hospital layouts should be optimized for and motivated by patients, rather than for evaluation requirements.
- Hospital managers should have more processes available to allow them to independently monitor and improve operation process regularly.

Actively review and improve performance indicators

- Instead of passively tracking performance, hospital managers should review indicators upon the basis of their staffs' individual performances to ensure that measurement indicators are meaningful.
- Individual performance indicators should be emphasized so that clinicians' performances can be formally tracked and accountable.

Health Policymakers

Higher levels of autonomy are needed for public hospitals

- One major goal of the State Council's 12th Five-Year Plan of Health Reform and the 2013 Third Plenary Session is the acceleration and systematic reform of public hospital internal governance structures. Our findings show that hospital leaders still have limited autonomy to manage hospital operations.
- The Ministry of Health and related healthcare system administrative departments should give hospitals higher levels of autonomy in managing hospital operation, including clinical performance, financial budgeting, and human resource management. Responsibilities for public hospitals and Ministry of Health need to be more clearly defined.

Workload and salary reform for nurses and physicians are needed

- Human resource management, especially compensation systems for overtime work, in public hospitals need to be updated. Policy makers should have more processes in place to re-evaluate the labor value of nurses and physicians in China and adjust current salary systems to be more applicable for the current workload of the healthcare industry.
- Additionally, bonuses and reward systems should be tied more strongly to individual performance indicators rather than position and tenure.

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