How to manage health care providers more efficiently? - An empirical study of local level reforms in Hungary

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“That any sane nation, being observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.” G.B. Shaw

Abstract

In recent years one of the most struggling questions in Hungary was how to restructure the health care system. Although the system level reforms failed, the regional and city level governance innovations prevailed. Due to budget restrictions the local governments were facing severe financial problems, which highly influenced the healthcare sector. In several cities the local governments responded to the challenges by making the governance of the health care providers’ uniform. A more comprehensive and cost-effective model was implemented in order to control the city companies and to support their operations. In major cities, the health care providers were integrated into holding companies in order to develop a uniform governance system. The centralization of the management tasks provided an effective framework for controlling the subsidiary companies. The restructuring was successful not only financially, but generated significant benefits for the owners and subsidiaries as well. The study examines the effects of the corporate restructuring through the analysis of the merger of two health care providers in Debrecen. The empirical study highlights not only the results of the restructuring, but also illustrates the challenges of the entire process.

1 Introduction

Efficiency, effectiveness, goals, impacts, responsibilities – the key notions of performance-oriented thinking and management -, that are mainly applied by private sector organizations to improve their activities. Viewed in a historic perspective, efficiency has always been an expectation for the operation of public service organizations, and even in Max Weber’s definition of bureaucracy rationality and efficiency are the most important elements. Public management has long been based on the ideology of efficiency, however this cannot be the ultimate goal of an organization, since it only deals with the question of how things are happening, while ignoring why.

Nowadays, efficiency has been replaced by performance, which beside efficiency embraces the ultimate goals and impacts of a particular organization too. In the last 15 years, both the philosophy and the tools of management, successfully applied in the business sector, have increasingly spread among public organizations.
Our research aims to describe and analyze the process of the strategic renewal of two health care service providers, the adaptation of business-like organizational and management methods. The aim of the study is to evaluate the process of strategic renewal, and analyze the factors influencing the outcomes.

1.1 Literature Review

Over the 1980’s there was a significant shift in the public sector of Western European countries and the U.S. towards management methods. The New Public Management (NPM), according to the original notion, was a framework responding the challenges of the economic recession and tax revolts. However, due to the significant results achieved by the NPM methods nowadays it is seen more like a general solution to increase efficiency. (Pollitt, van Thiel, & Homborg, 2007)

The more focus on new public management methods and the growing role of nonprofit sector increased the attention on reengineering public service providers. In Western countries the public and nonprofit organizations applied different management tools to enhance the efficiency. The adaptations of different strategic supported by several management tools, like the Balanced Scorecard concept (Kaplan & Norton, The Balanced Scorecard. Translating Strategy into Action., 1996), business process reengineering (Hammer & Champy, 1993), management control systems, performance measurement and evaluation methods (e.g. (Voelker, Rakich, & French, 2001); (Quinlivan, 2000); (Elefalk, 2001)).

As in the past decades the cost of the health care system has increased drastically, the NPM methods came into focus triggering a widespread debate started on how to enhance the efficiency of health care organizations. Some scholars argue that macro-level solutions could have long term impact on the providers, while others prefer micro level measures. Although many scholars approve the importance of macro-level approaches, there is no clearly defined path to pursue. In many developed countries health care systems have followed a clear decentralization trend (Crivelli, Leive, & T., 2010), while number of European countries (e.g. Nordic countries) – due the rising costs – employed centralization strategies in order to sustain the systems financially. (Saltman, 2008)

Although the macro level strategies differ significantly, scholars agree on that in micro level reforms could have positive impact on the performance. (Saltman, Bankauskaite, & Vrangbæk, 2007). It should be also added that there is a widespread debate on the level of coordination. While in the U.S., in Great Britain the merger of hospitals considered as key element of new public management reforms, many scholars highly question whether the mergers lead to more efficient structures (Kitchener & Gask, 2003). As Kitchener and other scholars illustrate mergers fail to deliver the expected outcomes:

- cost savings were much lower than anticipated;
- co-operation between the units remained weak;
- enhance in synergy was therefore partial.

By underlining the importance of Fulop (Fulop, Protopsaltis, King, Allen, Hutchings, & Normand, 2004) and Choi (Choi & Bommels, 2009) results – that the outcomes of the merger are context dependent – our aim is to analyze the factors influencing the outcomes. Our hypothesis is that professional planning together with supportive environment would foster efficient transition. As change management theorists also highlight the change process goes through a series of phases. In order to achieve the anticipated results both the
organizational and the behavioral elements are to be analyzed. (Kotter & Schlesinger, 1979) As Beer and Nohria argue (Beer & N., 2000.), to obviate the fail of the changes a combined – focusing on the economic incentives and the cultural capabilities – strategy is to be implemented.

2 Hungarian health care system

After the political changes the current structure of the health care system was introduced in Hungary. As part of the first generation reforms during the political changes the Hungarian centralized Semashko model was transformed into a decentralized insurance based one. While under the former state-socialist model providers faced soft budget constrains – instead of performance based financing they received a fixed annual budget highly influenced by individual political bargaining power (Bodnár, Dankó, Drótos, Kiss, Molnár, & Révész, 2006) – the new model aimed to focus more on the performance.

2.1 The structure of the Hungarian health care system

The introduced system is based on the contractual relationship between the National Health Insurance Fund (NHIF) – established in 1993 – and the providers (Ferguson & Irvine, 2003). The National Health Insurance Fund (NHIF) is one of the key entities in financing the system. The NHIF has a determined budget which is distributed among the providers upon the principles set by the Ministry of National Resources. Theoretically, the NHIF operates as a procurer, however due to the deficiencies of the system the control function of NHIF is rather weak.

The NHIF incomes rely on the compulsory contribution of the insurers. It should be noted that the system is based on the notion of solidarity (Goglio, 2005), practically the NHIF covers all the treatments for the whole population regardless of the contribution (Orosz & Burns, 2000). The universal coverage itself partially explains the underfinanced structure, as only 37 percent of the population is employed; basically the treatment of the majority of the population is not covered.

On the providers’ side three levels can be identified:

- Primary care;
- Secondary general care;
- Secondary specialized care.

The primary care is based on the services provided by general practitioners (GPs) and dentists. These practices directly contract with the NHIF, thereof operate as private practices. The outpatient primary care on the other hand is provided by the municipalities. Although the local governments are legally bonded to provide primary care for the inhabitants, the outpatient primary care is an arbitrarily service.

The secondary general care includes policlinics and hospitals providing basic range of services. These hospitals are run by either municipalities or by counties. More specialized work is conducted in national institutes and in clinical departments of medical universities. It should be taken into consideration that legally there is no clear distinction between specialized clinics and local hospitals. Due to the underfinanced structure, specialized clinics often provide basic treatments in order to co-finance other services. In this respect specialized clinics compete with general hospitals.
The Hungarian health care system struggles with serious deficiencies; the current social insurance-based system is not sustainable either in short term, or in longer run. The total health spending in Hungary accounted for 7.3% of GDP, which is relatively low compared to the OECD average 9%. At the meantime the health status of the Hungarian population is one of the poorest among the OECD member states (OECD, 2008). In addition the deficiencies can be just partially explained by the underfinanced system, the efficiency is also strongly questionable;

- The country has the lowest life expectancy among the OECD countries. More detailed analysis also shows significant deficiencies. In Hungary the proportion of smokers is far higher than the OECD average, the alcohol consumption is the highest among the observed countries, and in addition the obesity rate is almost the double of the OECD average. (OECD, 2010)
- The infant mortality, one of the most important indicators measuring the efficiency of the health system, is also above the OECD average. (UNICEF, 2008)
- Although the number of the hospital beds was reduced drastically over the past decades, the hospitalization rate is still above the OECD average. The large number of acute-care beds along with the easy access to the hospitals artificially overemphasizes the role of the expensive acute care. In addition the acute care is one of the most inefficient elements of the health care system, basically the structure of incentives is inadequate, while providers' spending are uncontrolled. (Goglio, 2005)
- In Hungary about one third of total health expenditure is spent on drugs, while the OECD average is around 15% (OECD, 2008). Although there were significant attempts to cut back on pharmaceutical spending, the high expenditure remained a major policy concern. (Goglio, 2005)
- The inefficient system is also marked with uncontrolled patient paths. The coordination between the health care providers is ad hoc; therefore neither the patient path is controlled, nor is the providers' efficiency monitored.

Life expectancy at birth and total expenditure on health, % of GDP in OECD countries
Although the Hungarian health care system struggles with several deficiencies, no comprehensive reforms have been successfully implemented since the political changes of the 1990’s. Almost all the government attempted to implement structural reforms, however – due to fiscal restrictions and because of public resistance – the implementation failed.

The failure of the reforms led to the current situation, where not only the providers are underfinanced, but also the Health Insurance Fund is in deficit. Thus, other external sources are needed to finance the treatments. As in Hungary the private sectors participation is minimal due to policy restrictions, the providers are to self-finance their services. Thereof the also underfinanced local governments are to highly contribute to the health care budget. The local governments by taking a more defined role in co-financing aimed to control more and more providers spending and make their operations transparent.

From this perspective a bottom-up wave of reforms started, the local and county governments became the engine of enhancing the efficiency of the providers. It should be also noted that the local level reforms were based on rather spontaneous and isolated measures; no comprehensive governmental policy was strengthening the effects.

3 Case description

In order underline the statement that the management methods implemented during the change process influence the success of the merger we analyze the example of the integration of two Hungarian health care providers in Northern Hungary, in Hajdú-Bihar County.

Hajdú-Bihar County is one of the most underdeveloped regions in Hungary. Although the difficult financial situation the county reaches the country average in several health care indicators, such as the morbidity rate, life expectancy, infant mortality etc. (Bekesi, Wyss, & Goschler, 2010).
In 2008 the county and the local government decided to merge the local hospital and outpatient care institute in order to stabilize the financial situation of the providers and rationalize their operation. The merger included only the local providers; the university hospital remained intact because of political reasons.

3.1 Background – pre-integration phase

Before the establishment of the health care concern in Hajdú-Bihar County the local hospital (Kenezy Hospital) and the outpatient care institute (Outpatient Care Centre) operated as independent corporations (not as institutions) and the asset management duties were separated from the health care providers into two – dedicated – asset management companies.

From a historical perspective the merger had important premises; both providers changed their legal form from institution to corporation. The change in the legal form had significant impact on the mergers from the following aspects;

- The asset management had been separated from the companies. Two asset management companies were founded for facility management.
- The corporation as a legal form – in Hungary – is a more management focused organization providing flexible environment for the management (supple employment, financing, bookkeeping etc. tasks (incl. personal performance management and motivation)).
- During the process of legal form changing the organizations were reorganized. Their structures were significantly simplified and at the meantime were transformed into more performance based ones.

Concerning the external factors the stable and supportive political environment was also crucial when implementing the changes. Although on national level there were significant changes in the political arena, on local level the political background remained constant. In addition the local political elite supported the integration.
At the meantime the economic situation posed significant challenges to the providers. Due to the changing financial legislation the hospital’s situation became even more critical; thereof a more emphasized local contribution was needed.

### 3.1.1 Drivers of change

The merger was inspired by the success of the integration of public utility companies in Debrecen. This integration also reinforced and strengthened the initiation to merge the local health care providers.

The Municipality of Debrecen reorganized its public utility companies in 2000. The municipality established a holding company to integrate the local heating, water, transportation, housing etc. companies. Nowadays the Asset Management Co., Debrecen holds the shares of local airport and media firms as well, and it is one of the strongest and dynamically developing corporations in East-Hungary. During the first years of 2000 the holding managed to stabilize the financial situation of its subsidiaries. Before the integration they had been highly indebted and from year to year they demanded a significant amount of subsidy from local government. However, after establishing the holding – which is responsible for strategic and financial governance of the subsidiaries – a significant profit was made (without governmental aid) while service level increased.

The functions of the parent company and the internal shared services inspired health care integration. The central treasury, the cash pool, the joint procurements managed by professional teams, the aggregated contracts and framework agreements, the unified, transparent and well-regulated financial processes and IT systems, the effective group control (management control systems), the strategy-oriented and harmonized investments among the subsidiaries proved to be important instruments to increase efficiency, exploit benefits from economics of scale and scope and to put the whole group into a prosperous track.
Basically most of the management methods can be interpreted and adopted in health care sector organizational changes. On the grounds of public utility concern’s auspicious experiences City of Debrecen and Hajdú-Bihar County aimed to evaluate the relevance of integrated governance regarding their health care portfolio. Therefore they prepared feasibility study on the merger and integration of hospital, outpatient care provider and asset management companies.

The study made by the management consultants of IFUA Horváth & Partners (who thereafter assisted the whole integration work as well), analyzed the possible forms of unified governance:

1. merger into one organization (the legal independence of preceding companies ceases);
2. operative holding – or in German: Stammhauskonzern (one company owns and leads the remainders, and besides concern management it keeps operative functions as well);
3. concern with a separated holding company (the group of firms governed by a dedicated and separated holding company).

After the in-depth evaluation of the possible advantages and disadvantages regarding each above-mentioned forms of governance, the local governments decided to found a new holding company in the spring of 2008: Health Care Holding Co. of Local Governments, Debrecen and to transfer the business shares of the hospital, the outpatient care provider and the asset management firms to the holding company. The main reasons for choosing this governance model were the following ones:

- the new holding organization may concentrate on the strategic issues and the management of the group, the subsidiaries on the main medical processes;
- different kinds of duties and tasks, strategic and operative management are clearly separated;
- holding can make objective decisions – without partiality, and it is not burdened with operative medical problems (e.g. in the times of planned extensions);
- the performance of the firms can be presented with no distortion, all participants of the group have their own balance sheet, profit and loss account, transfer pricing system creates transparent internal charges (compared to merging all companies into one big organization);
- the shares of the owners (and the changes in the ownership structure) can be easily managed.

In case of a separated holding the expenses are higher than of a single company, however in the long run the model seemed to be the most appropriate for implementing the planned strategy and fulfill the professional requirements of the local governments. For financial reasons the holding also offers a more flexible structure.

The integration was also rational from a regional perspective; most of the development potentials at the level of the individual organizations had already been exploited (during the transformation from institution into corporation). To reach further significant improvements in the quality of health care services – a goal set by the local governments - the harmonization of the different professional levels was also in focus.
The sphere of activities (and the groups of patients) of the Hospital and the Outpatient Care Center partly overlapped, they covered lots of medical services from primary to secondary (and in some field: tertiary) care in the county. Together they could achieve medical and financial synergies and become a stronger player on the local health care market – in comparison to the main competitors: the local university clinic and other public or private service providers.

3.2 Integration phase

Organizing and launching the new concern took more than half year (from summer, 2008 until the first months of 2009). A complex organizational design and development project was conducted during this period, with several sub-teams (responsible for legal, organizational, medical, infrastructural topics etc.).

After the municipalities’ decision first of all a detailed analysis of the current situation of future subsidiaries was needed (in summer 2008) concerning organizational, management, internal / external capacities used at main and support processes, lists of contracts, types of procurements, ICT systems and movable / immovable assets. Building upon the results of the analysis, a comprehensive organizational and operational vision had been elaborated answering emerging questions regarding:

- the new corporate governance system,
- necessary functions of the holding company,
- suitable level and form of centralization,
- framework of central financial system;
- supporting software (medical, ERP and related programs).

Detailed schedule helped to keep interconnected deadlines during the integration project, to ease risks and organizational resistance and to make the main organizational changes transparent for the governments, politicians.

The integration phase was directed by a well-prepared organizational / operational strategy. However, the management missed to develop market strategy.

At this stage, the integration was conducted as a business process reengineering project and carried most of the typical characteristics of BPR initiations, e.g. radical and extensive changes in processes over functions and organizational units, with high risks, cultural and structural modifications.

Before the integration the future subsidiaries had been audited and their assets evaluated. The holding company (operating as a joint-stock company) gained 100% of the shares of the Kenézy Hospital, HOC and asset management companies. The official corporate documents and regulations were modified according to the new governance model. Several legal pitfalls came up and had to be resolved – the integration initiation in local health care system was as novel in Hungary as the concern of utility companies previously, at the millennium. Therefore a unique legal framework had to be implemented.
From January, 2009 the holding runs centralized financial management and administration, central technical support and service management and other administration. Additionally new internal professional functions (e.g. management control, internal audit, quality management, marketing-PR, HR and legal activities) developed in the holding compared. At the same time the rationalization of the subsidiaries proceeded. After the restructuring the subsidiaries could focus on the main activities as the directorates of the holding provided them the background services. Thanks to this model the efficiency within the group could increase, the economics of scope were exploited, while the supporting functions were managed professionally.

For January 2009 the fundamental organizational and financial regulations were modified. Centralization of background activities went hand in hand with the cut-back. But layoffs remained on a moderate level, as far as the firms had already been streamlined. At the same time implementing new processes needed a longer time. Another factor, the economic turmoil also highly influenced the speed of the implementation. To sustain the political support it was crucial not to cut back on human costs radically. The political elite highlighted that it could not be a goal to increase rashly the unemployment and extend remarkably the local resistance.

As mentioned above, in order operate the new model adequately, internal organizational and financial regulations had to be modified. Furthermore a comprehensive transfer pricing system had been elaborated which covers all the internal service deliveries, performance flows and the appropriate settlements. The service map within the concern is diverse (a lot of different background activities from holding to subsidiaries, rental and technical support from asset management firms to remainders, rental for outsiders, e.g. GP-s, other health care providers). Transfer pricing model and documentation system was to follow legal regulations to fulfill owners’ and managements’ expectations concerning the financial results, liquidity and internal resource optimization.

In 2009 several other actions and arrangements stabilized the operation of the health care group and promoted the finding and utilization of possible synergies. By creating a cash-pool system the current accounts within the group became unified. The cash-pool seemed to be an efficient tool for:
• managing and maximizing return on current assets,
• operating (virtual) internal credit market,
• getting better financial conditions,
• lowering interest payments to the bank for credit liabilities,
• increasing the amount of interests paid by the bank.

The hospital has the far highest external revenue within the group, but it is seriously underfinanced – due to central governmental decisions. The minister of health drastically reduced the number of centrally financed beds of Kenézy Hospital in 2007: from 1317 to 844, and cut back the maximal performance limit of the institution. Therefore the effective liquidity management was essential for survival.

The five firms of health care concern in summer 2009 became a registered “VAT group”. From then on the internal payments within the group became settled without obligation to pay value added tax. To understand the significance of this system we have to set out that the human medical services are VAT-free in Hungary. In line with this rule the hospital and outpatient care provider are not able to reclaim VAT after their procurements needed for medical services. At the same time most of support processes and background activities are provided by holding directorates to health care subsidiaries. Before the tax-group system obligation to pay VAT arose in the holding because of the services supplied to the subsidiaries but – on the other side – the hospital and outpatient care provider were not able to reclaim this amount of money. Nowadays the new system – beyond cash-pool – assists liquidity management significantly. The switch to the new system went hand in hand with the special modifications in bookkeeping and financial processes.

The main goal of the establishment of the concern was to improve the health care services of the region. The improvement of medical controlling together with the working out of group level management control systems – and the results of planning and reporting activities – fostered considerably the harmonization of outpatient services within the group.

The support of the medical controlling staff was essential to maximize state revenues (exploit performance limits) and to optimize internal resources. The group applied standard medical controlling methods, e.g. tracks regularly the margins of departments and tried to extend management competences of middle-level managers (heads of departments) and enhanced the responsibility they take.

The whole financial process from the first moment when new demand arises within the group through the contracting, execution, task monitoring, verification of financial documents up to paying to the supplier became well-regulated, strictly documented and permanently controlled by budget-holders. Budget-holders became responsible – in a horizontal aspect – for specific areas in the concern, e.g. medical stocks, other (non-medical) materials, outsourced technical services, personal costs. Moreover the financial directorate of the holding paid attention on solid business planning, systematic reporting and on decision supporting.

The above-mentioned methods and systems resulted in modern, streamlined management and operation in this case. In the Hungarian health care sector – and in the public sector as well – this model became an outstanding example of enhancing the efficiency of providers by the modification of the governance model, the levels of decisions and the extent of centralization.
Beyond the former description it is worth to emphasize some further characteristics of the integration phase. Firstly: all directors and managers of the holding – had management, medical and legal competencies – had worked previously as managers for years at the hospital, outpatient care provider or asset management firms. Therefore managers had extensive knowledge on the organizations and by having a very similar background could co-operate well at critical points.

The owners – the municipalities – supported the management team. Four of senior executives of the concern were elected by local governments to the board of directors of holding, and no further – outsider – directors were appointed. For that reason executives had enough potential to manage effectively the process of change, to break down any kind of organizational resistance. Other important characteristic is that all of the directors were – in “personal union” – executives of subsidiaries as well.

However it should be emphasized that during the transformation the mayors of Debrecen and Hajdú-Bihar County – as members of the general assembly of the holding – took part in making critical decisions, e.g. starting the integration process or approving values of apports and shares.

3.2.1 Results
The new model of the health care concern brought significant gains and had auspicious effects.

In 2009, thanks to the above-mentioned measures the concern realized the following savings compared with the preceding year:

- cash-pool system: 122 000 €
- VAT group: 471 000 €
- headcount reduction: 704 000 €
- centralized procurements: 283 000 €
- centralized IT systems: 77 000 €
- further fields: 218 000 €
Total: 1 875 000 €

To count final balances we have to take into account the costs and expenditures of the transformation process.

- legal fees: 22 000 €
- auditor fees: 6 000 €
- IT costs: 46 000 €
- further consulting expenses: 78 000 €
- infrastructural costs: 59 000 €
- further costs: 37 000 €
Total: 248 000 €

According to the previous numbers the final financial balance of the integration is – without any doubt – positive: the savings are much higher, than the expenses (the calculated difference is 1 627 000 €).

Beside the economic gains significant non-financial effects took place:
• Simpler and more transparent governance structure. The local governments as owners formulate expectations concerning the portfolio, communicate towards the holding company that is responsible to specify detailed goals for subsidiaries.
• Persistent and intensive management control and risk management is guaranteed over subsidiaries.
• The operation became controlled. Throughout the unified planning and reporting system the medical and financial performances could be compared.
• The model provided an appropriate framework for further mergers, enlargement of the concern or integration of other health care providers – or owners of health care providers (municipalities from the region). The special management know-how seemed also crucial for further expansion – and has solid value per se.
• The quality of care increased as the surplus resources, savings (came from the new model) were used to modernize health care infrastructure. The quality improvement implied positive effects towards local citizens, patients – and indirectly towards local governments and governing politicians.
• Despite the constrained financial circumstances of the Kenézy Hospital and the Outpatient Care Centre, the service level of the medical processes never falls below the line—thanks to the new model.
• The inspections of different kinds of authorities have never found (critical) deficiencies, legal or operational problems in the group.

However – similarly to other concerns—in some cases certain subsidiaries had to accept higher maintenance or administration cost than they had before the integration – because of the group level optimization. It should be highlighted on the other hand that on concern level the gains were much higher than the losses.

The integration process was an intensive period for the managers and employees (directly involved in the merger and in the restructuring). The employees faced with serious challenges, managed special risks, and solved organizational and human problems. These obligations exceeded far their normal working tasks and duties – and could be remunerated only partly.

It should be also noted that during the changes the top management failed to involve the mid-level managers. For that reason the top management had to deal with more operational tasks that were desired. Another deficiency that somehow constrained the development was the lack of a comprehensive, long term strategy. The vision and the goals were clarified, however the top management failed to formulate a strategic framework describing the operation of the concern.

These deficiencies at some level hampered the changes, but thanks to the strong leadership could not influence the overall process.

3.3 Post integration phase – Current challenges
From 2010 – after the main integration phase – the concern concentrated on the following issues:

• Refining the collaboration within the group, improving processes among the holding and its subsidiaries.
• Development of information systems and technology supporting administrative procedures or technical duties (e.g. using textiles with RFID).
• Starting new projects:
  o modernization of the medical infrastructure: buildings, rooms, devices, related ICT systems – e.g. mammography centre, ED, outpatient care services, central and ambulant operating rooms, ICU, radiology;
  o training of physicians and other employees;
  o implementation up-to-date treatment methods (e.g. one day surgeries, complex rehabilitation, screening and prevention).

Most of these projects were subsidized by the development programs of the European Union and co-financed by the group, however in some cases all costs were covered by internal financial resources (usually from savings).

By summarizing it should be noted that the more efficient and optimized operational model cannot answer alone to the financial challenges. The financial system of the Hungarian health care sector was modified several times last years. Nowadays – under a new government – reform initiations emerge.

In longer run it is a fundamental question to clarify the responsibility of local governments in the health care services. The health care group and its owners – the local governments of Hajdú-Bihar Conty and City of Debrecen – suffer from the inconsistencies of the current system.

Last but not least the current age(ing) of the medical devices and infrastructure is a heavy constraint in the daily operation of the Kenézy Hospital and the Outpatient Care Centre. The modernization of some activities from year to year cannot substitute the amortization. In addition, the standard revenues for patient care from the State to the service providers do not cover the expenses. Moreover most of the buildings are out-of-date, and are not suitable for the up-to-date medical methods.

In 2010 and 2011 the management of the health care group devoted their attention to the following strategic actions – beyond the above-mentioned priorities (e.g. modern medical methods: one-day surgery, rehabilitation or development of infrastructure and personal skills, knowledge):

• possibilities in medical tourism – attract foreign patients, increasing the ratio and value of fee-for-services in the portfolio of the group;
• medical services beyond – or over – the frontiers, enhancing the collaboration with foreign (primarily with Romanian) partners;
• participation in clusters, partnership with non-medical organizations;
• regional cooperation, extension of the current group, integration of further health care providers.

The last strategic action is essential for the long term sustainability of the concern. It had to set out that by this time – 2 years after the beginning of merger – the possible advantages from integrated background processes and unified management have already been exploited. If the concern seeks to reach a higher level of integration and reach further professional and financial gains they are to extend the portfolio.
To summarize, the example of Debrecen highlights that by a professionally engineered change process implemented in a supporting environment the integration of different health care providers could enhance the level of efficiency. The Debrecen model was an inspiring example for other local governments in Hungary. As other local governments strive with the same challenges in Hungary as Debrecen had, the Debrecen holding became a model for restructuring health care on local level. Many municipalities have already implemented similar structures and currently there is a high possibility that Budapest would also follow the model. Last year, after the municipal elections the newly appointed political leadership highly supported to integrate the twelve municipality owned hospitals, however due to political reasons the process have been suspended.

4 Conclusion

The integration of Debrecen’s health care providers highlights how on local level new public management based reforms relying on BPR methodology could be successfully implemented. By creating a comprehensive structure fitting to the local needs and in a supporting environment, the goals of the integration (eg. cost savings and improved synergy) could be achieved. The case study also refers to the challenges identified by several NPM scholars questioning the efficiency brought by the integration (Kitchener, 2003; Choi, 2009). As argued, several factors influence the outcome of the implementation, according to our case study the success of the integration highly depends on:

- external factors (political environment; financial environment; juridical background; competitors and etc.);
- internal factors (management; organizational culture; „deep structures” and etc.).

In order to manage the integration efficiently these factors are to be considered when planning the merger process. Although the external factors highly induce the outcomes, organizations usually have little influence on them. From this respect it is reasonable to launch mergers only in positive external climate. In addition detailed planning and the careful implementation is also crucial to achieve the anticipated results. In our understanding a clear methodological approach is to be followed that combines top-down and bottom up elements.

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**TOP-DOWN approach:**
- Adapting process model
- Identification of process capacities
- Comparison of selected process with best practice companies
- Identification of potential for optimisation
- Reconciliation of the scope of further analysis and setting objectives

**Team-based approach:**
- Development of precise integration measures
- Evaluation and implementation-oriented elaboration of these measures
- Adoption of an implementation roadmap for the selected measures/projects

**Ensuring sustainability:**
- Elaboration of a personnel concept
- Establishing a measure-related controlling including tracking of the achievement of objectives
- Ensuring sustainable implementation success

The first phase is typically a preparation period, during which the process model is developed based on the analysis of the external environment and the internal competences. The decision
on the model is typically made by the top management to ensure the applicability. However during the second and the third phase a team-based approach is needed in order to involve the critical stakeholders. To ensure sustainability the timing is also crucial for the different measures. Before implementing complex and painful measures it is advisable to define quick wins in short run. In order to ensure the sustainability a project team should be created that continuously monitor the schedule and the entire process.

References


