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FAMILY-OWNED HOSPITALS IN LEBANON: STATE OF ART, CHALLENGES, AND PERFORMANCE

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ABSTRACT

It is often widespread that family-owned hospitals are 'not good enough'. Family businesses provide a critical infrastructure for economic activity and wealth creation.
The purpose of this study was to assess the extent of truth of this cliché. The art of management of family-owned hospitals in Lebanon, their challenges, and their performance were assessed. It was posited that family and business-oriented decisions emerge in areas like board of directors, human resources (HR), and strategic processes. Areas where only family members take decisions were dug into, and with respect to what decisions are made was sought to be known. The study was built on a sample of 64 family-owned hospitals in Lebanon. The response rate was 62.5%. To go beyond and give a clearer image, a specific case study based on in-depth analysis of the audit reports of 5 of the family-owned hospitals that we were able to reach was carried out. Family-owned hospitals were not as bad as the public implies about them. Most hospitals preserved their "family factor" and displayed "emotional attachment" to their businesses. "Family control" factor was also obvious throughout the study, with an important side note of the newer generation's belief of "business-first" management style. Family-owned businesses realized the importance of emotional intelligence in retaining their employees and making them feel part of the family, however a professional HR management system lacked. Our findings highlighted that family firms can achieve successful business results by using a combination of family and business orientation in their decision-making and management styles.

INTRODUCTION

Family-owned businesses in Lebanon have experienced immense growth over the past five years. Many of these family-owned businesses have enlarged their businesses' affairs and employed more people; 46% of family-owned firms have experienced steady growth over the past five years and 21% of them achieved a rise in annual revenues between 6 and 20%. These firms secure 14,000 jobs annually, representing 12% of the entire workforce in the industrial sector. Family-owned businesses are 6% more profitable than non-family-owned businesses, and the market value for these businesses are usually 10% higher. The reason behind this is due to the fact that people tend to take care of their own businesses, in comparison with employees working for a public company for example. Regretfully, passing along the legacy does not necessarily ensure continued success for the family enterprise. Over 70% of family businesses do succeed in the second generation, however only half of these make it to the third[1].
Administratively, Lebanon is divided into six provinces. Based on the living household survey 2007, accounting for death and birth as reported to MOPH, and adding Palestinians living in camps and displaced Syrians, the total estimated population of Lebanon is around 5,643,634. Lebanon is an upper-middle income country based on the World Bank 2014 criteria. The GDP growth has slowed considerably in the past few years [2].

In 1998, Lebanon spent 12.4% of its GDP on health which was considered the most among other countries in the Eastern Mediterranean Region. The Lebanese healthcare system can be qualified as an atypical system. It shares elements from other healthcare systems; however the combination of these elements defines its peculiarity [3].

It has been reported that close to 60% of private hospitals were established during the war years. This expansion has been mortared through the financing of medical care by the public funding agencies, mainly the MOPH [4].

The Lebanese system is controlled by the private sector which is responsible for 90% of all total services according to the WHO. Lack of regulation of the private sector drove the industry to have an oversupply of private hospitals clustered in one area. The hospital sector suffers from distortions at different levels, including uneven geographical distribution of hospitals, overpopulation of inefficient small-size hospitals, limited supply of public beds, and low occupancy rates. According to a technical study done by BEMO [5], there is a total of 163 hospitals contracting with the MOPH, 84.66% of the hospitals are private hospitals. The highest concentration of hospitals is attributed to Mount-Lebanon with 37.4% of the total number of hospitals while the lowest number of hospitals available is in Nabatiyeh at 6.75%.

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~37% of hospitals in Lebanon are family-owned [6].

MATERIALS AND METHODS

The purpose of the study is to explore the art of management, challenges, and performance of family-owned hospitals according to Donabedian's model (structure, process, and outcomes). It focuses on their primary goals, strategic process, HR management styles, and governance.

Research and Design

The research consists of a quantitative study; one anonymous survey questionnaire that consisted of 23 questions was developed based on the aforementioned literature and purposes of the study was distributed (20 questions were close-ended; some with a list of choices, others with a scale of applicability and 3 questions were open-ended with a target to learn about the outcomes of the hospitals), as well as a case study of audit reports, which was linked to results obtained from the questionnaire. Participants were assured that their data will be used for purposes of the study only and treated confidentially.

Participants

Participants were owners or people in key positions referred to by the owners of family-owned hospitals in all regions of Lebanon. A sample of 64 family-owned hospitals was reached in order to ensure the representativeness of our sample, of which 40 hospitals (62.5%) positively responded to participate.

Case Study

While conducting the process of filling in/interviewing of the questionnaires, it was noted that a big number of hospitals did not answer the open ended questions. This was statistically proven (55% gave No Answer to these questions in the survey). Self-survey assumption for perfection was also noticed. This pushed us into the process of verification using the case study.

The case study was based on audit reports of 5 family-owned hospitals that we could reach, ensuring very high confidentiality and that the hospitals remain anonymous.

The audit reports were studied in-depth to analyze the opportunities for improvement given to the hospital. The opportunities for improvement were categorized into the following big titles: Quality, Policy Procedure, Safety Structure, Processes, Outcome Indicator's Transparency & Inter-operability, HR, Management, and GB.

Then, they were linked to answers 6 questions of our survey (question numbers: 6, 7, 10, 11, 13, &20). This way, a verification process was performed as well as a clearer image of the outcomes was revealed.

Statistical Analysis

Regarding the questionnaire, statistical analysis was performed using *SPSS*, the statistical package.

Since responses to questions concerning outcomes were continuous variables, and our independent variables were categorical, and since the sample size of respondents to questions related to outcomes was <20 (18 hospitals to be exact), we chose the Non-Parametric Mann Whitney U-test for binary variables and Non-Parametric Kruskal Wallis Test for categorical variables with more than 2 levels (as in our questionnaire) in order to analyze responses. $P<0.05$ was the cut-off for statistical significance.

The sample size of responsive hospitals is 40. Because the effects are harder to detect in this smaller samples, and especially because the questionnaire included questions with a scale ranging from 1 (least important) to 5 (most important) and from 1 (not applicable) to 5 (strongly applicable), we merged the options of the scale: 1 (least important), 2 (neutral), 3 (most important) and 1 (not applicable), 2 (narrowly/barely applicable), 3 (strongly applicable), etc. This was the simplest way to boost the statistical power of the tests.

RESULTS

Questionnaire

Decisions in family-owned hospitals according to respondents' answers are taken mainly with respect to the organization's interest, 75%. 17.5% of respondents said both the organization and the owner's interest are taken into consideration while making decisions. 5% stated that decisions are made with respect to the owner's interest only, and 2.5% said that political influence is also considered (Figure 1).

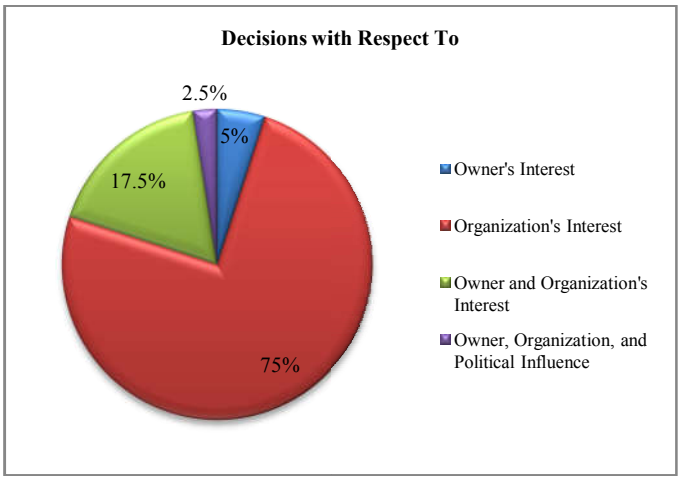

Figure 1 Agency Vs. Stewardship Theory

Decision makers in family-owned hospitals consider various aspects when taking a decision. When asked about their primary goals when making decisions, respondents answered as follows; 82.5% of them stated that good family reputation among internal and external stakeholders was regarded extremely important and 80% of them that family member emotional attachment to the business. Family control of the business was extremely important for 75% of the respondents and 70% of them regarded family social bonds with the community as extremely important. Profit maximization was considered a primary goal when making decisions for 70% of the respondents, and 67.5% of them also regarded family succession to top leadership positions as extremely important. 50% of respondents regarded family wealth creation an extremely important goal, and 40% of themsaid income to support the family was a primary goal. A relatively large percentage, 42.5%, of the respondents regarded maximizing firm value for future sale as least important when making decisions, and majority of the respondents, 65%, said that political ambitions did not exist whereby only 17.5% of them regarded this goal of high importance in their decision-making process (Figure 2).

It was notable that the bigger percentage of respondents said their strategic process was aligned with business aims more than family aims (Figure 3).

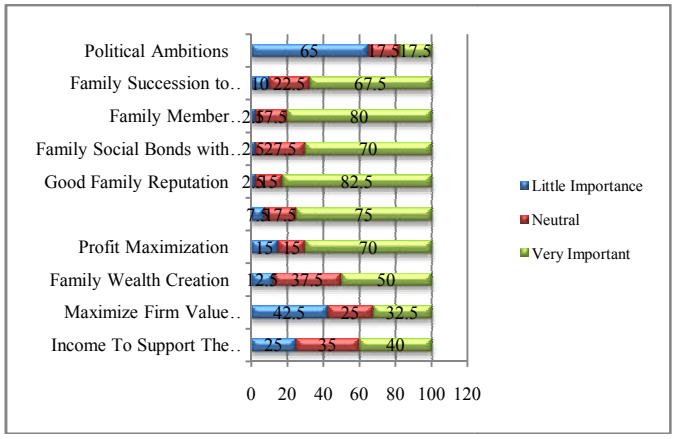

Figure 2 Primary Goals when Making Decisions

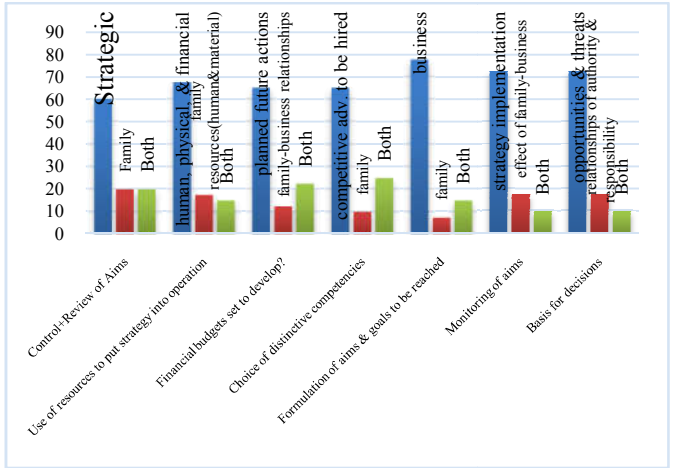

Figure 3 Strategic Process

When asked about characteristics of HR and their style of management in the hospital, 90% of the respondents said that evaluation and performance of employees is linked to quantifiable results, 52.5% said that evaluation and performance of employees based on their behavior is widely used and 47.5% said that it was barely used. 77.5% of respondents said that criteria for promotion depended on knowledge, experience and skills; 72.5% of the respondents said that promoting employees based on length of their service is barely used, 22.5% of them said that this was widely used, and 5% said that this was not used at all as a criterion. 70% of respondents said that they barely had ample freedom in decision taking in HR, and 30% said that they widely had freedom. 75% of respondents said that they widely carried out activities to increase their employees' competencies and 25% said that this was barely done. 60% of respondents said that activities to boost links between employees and family was barely done, 37.5% said it was widely applicable, and 2.5% said it was not done at all. 67.5% of respondents said that activities to increase emotions of employees towards their job were widely applicable and 32.5% said it was barely done (Figure 4). 100% of respondents said a board of directors existed in the hospital. Then, we went further to ask about characteristics and roles of this GB in their hospitals. 7.5% of the hospitals skipped the question regarding their GB. 40% of respondents said that their GB consisted of family members only, 32% said this was barely applicable and 20% said that their GB was fully made of non-family members. 72.5% of respondents said that their GB approves of budgets, 75% said it defines the long-term strategy of the hospital, 67.5% said it evaluates the hospital results, 50% said it evaluates the performance of key management posts, 37.5% said it defines values to guide the hospital, 60% said that it establishes external relationships and contacts to obtain critical resources, 35% said that it decides on entry of new family members to the business 30% said this was barely applicable and 27.5% said the GB had no say in this, 35% of respondents said that the GB defined succession planning and 52.5% said this was barely applicable, 35% of respondents equally said the GB controlled family interest in the hospital or barely did that (Figure 5).

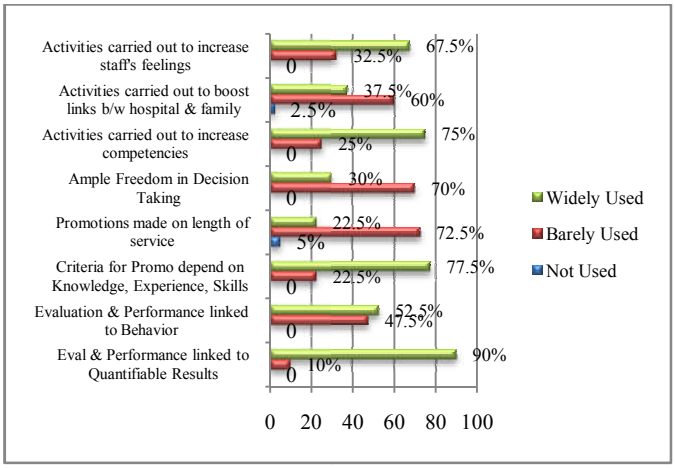

Figure 4 HR Activities

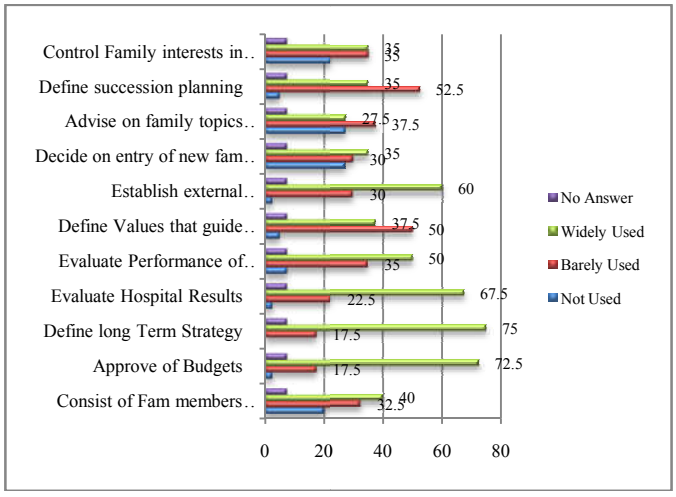

Figure 5 GB Characteristics and Roles

Shows the answers of numbered hospitals to our third open-ended question which asked about the opportunities for improvement that were given to the hospital in their last audit.

Table 1 Opportunities for Improvement (Third Question: Qn. 16)

Hospital	Opportunities for Improvement as per Respondents
7	Enforcement of training and staff development, strategies regarding standard operating procedures.
11	Grade A, Renovation and enhancement of Laundry Department.
14	Improvement of documentation in medical records.
16	Securing the processes of care; Structure renovation; Buying medical material to accommodate technologies in market; training employees on ISO 9001:2008
17	Contracting with safe waste management to handle contaminated waste
18	Bedside shift report to ensure consistency among all departments
20	Improvements already done among different committees, and decentralizing of quality management system so that all

	teams can get more involved in quality process
21	Renovation of ER
22	Regular training and audit; Follow up on patient and employee satisfaction; Establishment of Institutional Review Board authorized by MOPH
25	IT support, Improvements to ER; Contracting with Doctors
28	Improvements to Waste management; Isolation; Documentation

Case Study

Table 2 In-Depth Analysis of Audit Report for question 20-HR: Competency training of employees is widely applicable in the hospital

Hospital 1	–Pediatrics: Competency skills should be performed to staff as conformity provided in the policies and procedures. –SCU: Competency test on drug calculations, hemodynamic, defibrillation / cardio version and cardiac dysrhythmias are very important and contribute highly to patient's safety so staff should be tested and any deficiencies should be acted accordingly. –CHEMO: Competency testing should target practical tasks and not only theoretical knowledge. –STERIL: Competency testing should be conducted by the head of the department and should cover the roles and responsibilities of the staff. –IMAGING: Corrective actions (specific training) resulting from competency tests and performance appraisal should be done regularly. –DIET: Competency testing should cover the roles and responsibilities of the kitchen staff. –HYGIENE: Competency testing is very well implemented and corrective actions are completed; however, it should cover more the roles and responsibilities of the staff. –HR: Consider ensure proper control on the trainings planned and executed according to the performance appraisal. –Employment contract needs to be created including all the requirements. –IT: Regular competency tests for personnel on routine duties should be performed. –FS: Ensure evidence for continuous training of all hospital staff and physicians. A plan of action has been observed regarding a better training on code red. GB: Consider creating an orientation program for the new GB members.
Hospital 2	–AN: Competency tests must be done and signed by the staff. –PED: Competency tests on drug calculations and dangerous drugs should be done for pediatric nurses. –ER: Staff educations on CPR/ACLS should be given the highest priority. –Antidotes for poison must be available in the department always and staff be educated in it. –SCU: Competency test for Hemodynamic monitoring should be done for SCU at least twice a year. –LAB: Competency on patient safety like identifying patients by double identifier is highly recommended. –IMAGING: There is need for more licensed technical personnel to run the department. –OR: X-ray technologist can only operate the equipment. –DIET: The dietician demonstrates ongoing education to kitchen staff, though there is a need to demonstrate ongoing education to general staff such as nurses and others. –HYG: Increasing the number of competency tests during the year would be more efficient to improve the employee's performance. –BM: Increasing the number of employees in the electromechanical department and the training on patient safety and risk management –FS: Ensure evidence for continuous training of all hospital staff and physicians. –PS: Continue with the plans to improve patient- safety culture among hospital staff. –RECRUITMENT OF MED STAFF: There is no evidence that an independent organization is represented in the medical appointment committee. –Frequency of Meetings of the governing body must be increasing
Hospital 3	–AN: Competency tests must be signed by the staff. –MED RECORDS: Recommend staff in medical records to benefit from studies in Medical Records management. –SCU: The night shift must be well oriented and more involved in quality (Plan, do, check, and act). -STERIL: More in-service training and pertinent competency testing relating to CSD employee roles and responsibilities and sterilization activities should be carried out. –IMAGING: Corrective actions (specific training) resulting from competency tests and performance appraisal should be done regularly. –BMS: Training of the personnel by the biomedical department can be enhanced. Training aspects: Safety, how to handle and utilize correctly the equipment. –MAINT: Orientation of new employees is verbal. It should be done through a written document. –DIET: More in-service training sessions and competency testing on material related to roles and responsibilities of the kitchen staff should be carried out. –HR: Competency testing should be well realized by the HR manager. –CPR training must be provided by qualified instructor. –BM: Responsible for the building is knowledgeable about building details (HVAC, Generators, etc), but the employment of an electro-mechanical engineer would be recommended. –FS: Ensure evidence for continuous training of all hospital staff and physicians. A plan of action is being devised. –OCC MED: The OH&S committee members should be educated and trained on how the OH&S program functions in the hospital. –PS: Committee members should be well trained with respect to the principles of patient safety and risk management. Committee members should know the operation of the action plan of patient safety and risk management.
Hospital 4	–PED: Increase the duration of orientation program for new staff. –MED REC: Suggest scheduling training of MC Manager or MC assistant in a university medical center to get a certificate in medical record management, taking into consideration language barrier if applicable & Recommend scheduling a yearly competency testing program for MC staff on applied P&Ps. –Suggest training MC staff on concept of QIP and selecting smart indicators. –SC: Competency testing plan should not only cover what the accreditation standard mandates but also observed performance deficiencies. –RD: We also call on the involvement of the nurse manager in the self-assessment report (promoted very recently). –Testing staff in relation to their skills in CPR following training should be evidenced. –Staff should be regularly audited on compliance with universal precautions. –STERIL: Intensive training and pertinent competency testing relating to CSD employee roles and responsibilities and sterilization activities should be carried out. –PH: Recommend scheduling a yearly competency testing program for PH and hospital staff on applied P&Ps. –Suggest including physicians and para-medical staff among the invitees for future educational sessions. -Suggest adding to the orientation checklist training on patient safety issues, reporting of incidents/accidents/hazards and filling the forms. –BS: Training of the personnel by the biomedical department can be enhanced. Training aspects: Safety, how to handle and utilize correctly the equipment. –MAINT: Orientation of new employees is verbal. It should be done through a written document. –HYG: Corrective actions to ameliorate gaps identified of the competency testing should be activated. –HR: A linkage between performance appraisal and planned education should be established. –The specific orientation checklists should be modified to include more departmental activities and aspects.

	–OCC MED: The OH&S committee members should be educated and trained on how the OH&S program functions in the hospital. –PS: Train all hospital staff on disaster management & communication of disaster plan.
Hospital 5	–ER: Need to make effort with regards to reviewing and analyzing of performance appraisal especially when deficiencies are detected (PA done on January 2011 with result 66%, no action taken in this regard). –STERIL: Competency testing should be reflecting the specific roles and responsibilities in the department and in language understood by the CSD staff. –REC OF MED STAFF: Encourage the medical director to pursue tertiary studies. –Recommend general orientation and specific orientation to be more organized and to have a checklist to verify all sections of the orientation program. –HR: The orientation manual has to be written in one language, preferably in Arabic. –FS: Training for new staff needs to be complete during orientation. –PS: Training on the principles of patient safety and risk management should be given to members of the patient safety and risk management committee. –GB: Terms of reference for the Governing Body have to be established and to be detailed in the by-laws.

DISCUSSION

Questionnaire

No correlation was worthy of mentioning; we were unable to correlate any variables with responses given to variables related to outcomes/performance. We performed Non-Parametric Mann Whitney U-test for binary variables and Non-Parametric Kruskal Wallis Tests and results by SPSS were all >0.05, hence insignificant. An explanation for this may have been as a result of a very small sample size of respondents who fully disclosed information about their performance (outcomes indicators or market share) (17.5% only). Also, responses given to outcome indicators were very similar. It was obvious that hospitals assumed perfection in their answers, bias of self-report.

The results confirm that when making decisions, owners pay the most attention to maintaining good family reputation among internal and external stakeholders (82.5%) and family member emotional attachment to the business (80%). These were followed by 75% of them considering family control of the business as extremely important. A considerable 70% regarded family social bonds with the community as extremely important. This may be due to the 'family' factor being preserved in the business. Profit maximization was ranked 4th with 70% of respondents considering it a primary goal when making their decisions. 50% of respondents regarded family wealth creation an extremely important goal, and 40% of them said income to support the family was a primary goal. Most respondents noted that creating profit is an undeniable fact of their business. We can notice from the results that the owners least considered maximizing firm value for future sale when making decisions, this may be due to their emotional attachment to their businesses whereby they do not consider its sale; instead they consider succession of the coming generation. Most of them do not have political ambitions with only 17.5% considering this important to them.

Results implied that most family-owned hospitals follow the stewardship theory, whereby 75% of owners said that they make their decisions with respect to the organization's interest. Only 5% follow the agency theory whereby decisions are taken with respect to the owner's interest only and 17.5% of hospital owners take into consideration both interests when making decisions. 2.5% of hospitals also mentioned having political influence considered. It was concluded that this could be due to the fact that most hospital owners believed that the greater the family hospital's similarity to business-first ideal type, the more successful it is. This was further proven when owners were asked about their strategic process, whereby a higher percentage of respondents said their strategic process was aligned with business aims than family aims.

Our results confirmed that a professional HR management is positively correlated with family-owned hospitals' management. Motivational techniques are widely applied for example promotions: (90% said they were made based on quantifiable results and 77.5% based on experience and skills) and being emotionally intelligent by increasing employees' feelings such as organizational citizenship behavior and job satisfaction is well applied in family-owned hospitals.

Results also confirmed that training and increasing competencies of employees was widely applicable (75%), however this was contradicted when we carried out our case study whereby most hospitals severely lacked competency training in various aspects and were recommended to perform competency tests, regular performance appraisals, and corrective actions. Results confirmed that all family-owned hospitals had a GB that more or less performed the roles of a professional board of directors with highest percentages for approving budgets and defining long-term strategy.

Highest percentage (40%) said it consisted of family members only. It is worthy of mentioning that many interviewees mentioned that the GB barely met and was there for accreditation purposes only. 7.5% of hospitals did not answer questions about their GB, implying either its non-existence or its existence with very low impact also re-affirming "family control" in family-owned hospitals.

The very low response rate (17.5%) to our open-ended questions which spoke about outcome indicators, market share and opportunities for improvement indicates the hospitals' reluctance to disclose information regarding the performance of the hospitals.

Hospitals that did answer our third open-ended question (Qn.16 opportunities for improvement) gave brief answers, also implying reluctance for disclosure.

As these questionnaires were self-reported so the hospital owners may have given what they perceived as the "most correct answer", the results are useful for future studies. A greater attention to the education of the need of more transparent disclosure of data in healthcare environments is needed. This could be used to focus on study of performance of family-owned hospitals which could also be further compared to management styles and performance of non-family owned hospitals.

Case Study

After carrying out the case study for 5 family-owned hospitals, contradictions were noticed between responses given to questions in the questionnaire and what the in-depth analysis of the audit reports revealed. This might be due to the respondents giving what they perceive as the "most correct answer" and the immaturity in transparent culture in Lebanon whereby hospitals assumed perfection.

Study Limitations

Several limitations were faced while making this study happen. First, contacting hospital owners and reaching them all around Lebanon was a hard feat, so the process of data collection was not only hectic but also time consuming (2 months). Second, hospitals were not very responsive; whereby 50 responsive hospitals were our aim, however after trying to reach all of the family-owned hospitals across Lebanon (64 hospitals), only 40 hospitals responded positively. Third, this study's target is to explore management principles of hospitals and this area is to be considered taboo for most of the owners. Furthermore, this area also touches relationships, communication, and behavior and therefore has a high susceptibility to bias of responses. This bias was partially addressed by the anonymous completion of the questionnaires, as well as the addition of the case study. Furthermore, only 17.5% (7 hospitals) of all hospitals "fully" answered the open-ended questions. 45% of respondents attempted to answer the open-ended questions and 55% did not answer at all. Of those who attempted to respond, 39% (7 hospitals) "fully" answered all 3 questions and 61% "partially" did. Therefore, due to this limited size of sample, it was very hard to find any significance while analyzing the responses or mentioning any correlation at all.

Last but not least, a very important limitation of the study is that retrospective self-report is not the same as actual observation of behavior and art of management used. Although we were very careful to reach the biggest number of hospitals in order to achieve represent ability of sample, we could not get our hands to more than 5 audit reports in order to lessen bias and reveal unanswered questions.

CONCLUSION

We can conclude from this study that family-owned hospitals are not as bad as the impression the public has about them. They highly preserve the 'family factor' in their businesses (82.5%); emotional attachment to their business is also displayed in the hospital (80%). 'Family control' factor is obvious through red zones in the hospitals, HR, management styles, and GBs with low impact. Stewardship theory is mainly applied in the hospitals (75%) and an obvious belief is noted, especially in the newer generation, that the closer the family business is to 'business-first ideal types' the better its performance. A general reluctance is noted when it comes to disclosing indicators that display hospital performance (17.5% response rate) indicating a need for awareness of the usefulness of transparency.

Recommendations

Based on our conclusion, we can recommend the need for family-owned hospitals to create a professional board of directors distinguished by a limited size, a high degree of independence, and a higher impact on decisions. We can also recommend the application of a more professional HR management which could improve the productivity of employees through more competency training and testing, and motivational techniques such as promotions, job enrichment, and rotations. Another recommendation would be keeping emotional intelligence high (which was already noticed), by increasing employees' feelings especially organizational ownership behavior and job satisfaction. A final recommendation would be increasing their awareness on transparency of outcomes and interoperability of data which could be done through the use of EHRs; this will definitely improve the quality of care and performance, hence patient experience.

Future Work

One way to put family business performance in perspective is to compare what we know about family owned hospitals versus other kinds of hospitals. Using this study as a base of family-owned hospital's management grounds, outcomes, and performance, a future study could compare these parameters to those of other non-family owned hospitals in Lebanon.
Our study targeted to give a general idea of the art of management of as much areas as possible. Future studies could take one or two areas only and examine all details of these areas.

A future study could categorize outcomes of family-owned hospitals according to certain measures and motives of the hospital in order to differentiate why some family-owned hospitals perform well and others not so well.

A future study could develop performance of family-owned hospitals based on economic/financial indicators and compare this with performance of other types of hospitals.

Knowing that the future of the healthcare industry is associated with high level of investments in technology and Health Information Management System, a future research could explore the sustainability of family-owned hospitals in such a setting.

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