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CEO dominance risk in the Healthcare SOE – the case of Portugal

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ABSTRACT

The aim of this research is to evaluate the **"CEO dominance risk"** in the **Healthcare** sector in Portugal among the institutions belonging to the state – **the state-owned enterprises (SOEs).**

There is no abundant research on Corporate Governance (CG) related to SOEs. One of the reasons is that usually there are very few SOEs by industry, sometimes even just one (v.g. Post-Office, Railroad). To study these entities between several countries, one has to isolate the regulatory, legal, cultural and general business environment factors that are peculiar to each situation. In the Healthcare sector, each country despite being more or less social concerned, will always have a considerable number of public Hospitals. Due to the impact of New Public Management theories that spread all over the world, some of the public Hospitals transformed into corporation form, constituting SOEs. Hospital management has been considered a very complex one due to the clashes between professional values and culture and the hard realities of economic performance and cash constraints. In this environment, clinical professionals may become managers thus constituting a hybrid executive balancing these conflicting demands and not having the formal authority of a typical command and control organization.

Previous researchers found that the average performance of firms is not affected by CEO dominance – the possibility to exercise their will despite or removing dissenting. However, they noted that the range of performance was wider when CEO dominance was present. Excellent and poor results would occur more often. In the public sector dominated by the balance of procedures and outcomes, there is a tendency to risk avoidance, thus considering CEO dominance a risk.

This research was based in previous models and questionnaires, but adapted to the particular conditions of SOEs and legal framework in Portugal during the analysis period (2011-2015). A practical power index model was developed, and the results demonstrated that some Hospital CEO´s may have a dominant position but also exposes some underpowered situations. Regarding the motivation for Physicians to become CEOs and how they are perceived by their peers, the research confirmed the five groups expected and highlighted that on one side the most senior professionals are supported by their peers, and the younger ones are regarded as not having the required expertise.

Keywords: corporate governance, CEO dominance, Hospital management, State-owned enterprises, Hybrid professionalism

JEL classification: G34, G39.

RESUMO

O objetivo deste estudo é avaliar a existência de "**risco de dominância do CEO"** (PCA) no **setor público empresarial da saúde** em Portugal.

A investigação científica sobre a Governança Corporativa relacionada com o setor público empresarial não é abundante. Uma das razões deve-se a que normalmente existem poucas empresas públicas por setor de atividade, frequentemente apenas uma (v.g. Correios, Caminhos-de-ferro). Para estudar estas entidades em vários países, há que isolar os aspetos regulatórios, legais, culturais e o ambiente de negócios em geral, que são peculiares a cada situação. No setor da Saúde pelo contrário, cada país, tenha maiores ou menores preocupações sociais, possui sempre um conjunto considerável de Hospitais públicos. Um dos impactes das teorias do New Public Management que se espalharam em todo o mundo, foi o da transformação de alguns destes Hospitais em estruturas empresariais, constituindo um setor público empresarial da saúde. A gestão de um hospital tem sido considerada uma das mais complexas devido ao confronto entre os valores e cultura dos profissionais clínicos e as duras realidades dos resultados económicos ou das restrições de tesouraria. Neste ambiente os profissionais clínicos poderão assumir papéis de gestores, tornando-se executivos híbridos que têm de balancear solicitações conflituantes e não têm a autoridade formal típica das organizações reguladas por comando e controlo.

Estudos anteriores demonstraram que a média dos resultados das empresas não era afetada pela dominância do CEO – a possibilidade de exercer a sua vontade apesar de ou removendo as opiniões contrárias. Contudo, esses estudos assinalaram que a dispersão dos valores era maior quando em presença de dominância do CEO. Resultados excelentes ou muito fracos ocorriam frequentemente. Como o setor público é dominado pelo equilíbrio entre o procedimento e o resultado, existe uma tendência para evitar riscos, donde podemos considerar que no setor público dominância do CEO é um risco.

Este estudo foi baseado em modelos e questionários anteriormente utilizados por investigadores internacionais, mas adaptados às condições do setor público e restrições legais em Portugal durante o período de análise (2011-2015). Um modelo prático de índice de poder foi desenvolvido e os resultados demonstram que em alguns hospitais existe o risco de dominância do CEO, mas também evidenciaram situações de falta de poder dos mesmos. Em relação às motivações dos Médicos para exercerem o cargo de CEO e como são avaliados pelos seus pares, este estudo confirmou os cinco grupos esperados, realçando que os mais seniores têm o apoio dos seus pares e que os mais jovens são percecionados como não tendo a necessária competência.

Palavras-chave: Governança corporativa, dominância do CEO, gestão hospitalar, setor empresarial público, profissionais híbridos.

Classificação JEL: G34, G39.

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CHAPTER 1 – INTRODUCTION

1.1 Research Rationale

The aim of this research is to evaluate the ***"CEO dominance risk***" in the **Healthcare** sector in **Portugal** among the institutions belonging to the state – **the state-owned enterprises (SOEs).**

Corporate Governance (CG) studies on SOEs are not abundant. The recommendations from the worldwide organizations such as OECD and the World Bank focus, on rules and procedures that make SOEs neutral to the markets where they operate thus avoiding market imbalances favoring SOEs against private companies. Another focus is on procedures and recommendations to avoid SOEs to become sole political instruments, with disrespect towards common management practices, or preventing the Boards and executives to act as pure government servants. Although in many legislations SOEs by-laws respect the private sector practices, usually there is a country specific framework of rules that make SOEs comparisons between countries more difficult to analyze. Usually, these SOEs become incorporated after being a pure public institution in order to provide citizens with goods and services when the general market is not able to produce. These SOEs usually operate in a monopolistic sector and often they are the only company providing those services in the country that makes the studies harder to produce considering the different countries business environment and rules.

That is why one would find one Post-Office, one Electricity, and one Railroad Company per country before liberalization was introduced. That is not the case of public Hospitals; there are dozens per country even in the public sector due to their size and coverage limitations. In this research 29 institutions are covered including all Teaching Hospitals, several Group Hospitals (Centro Hospitalar), independent Hospitals and combined Primary and Hospital Care Institutions (ULS- Unidades Locais de Saúde). In this research, the term Hospital(s) refers to any of these institutions when the distinction is not relevant.

Although formally there is no direct translation in the Portuguese Commercial Law to the CEO (Chief Executive Officer) concept, the common language is to associate to PCA/PCE (Presidente do Conselho de Administração/ Presidente da Comissão Executiva).. Most of the private companies have a monist structure with just one Board, and in many, the CEO duality (CEO also the Chairman) is in place. The public sector, most of the time tries to mimic the private practices, and that is the common recommendation from the cited institutions. In Portugal all SOE but CGD (Caixa Geral de Depositos), a bank institution, adopted the one tier Board structure with no or very few non-executive Board members. In the case of the SOEs of the Healthcare sector, the current legislation is to have a totally executive Board, with one President (PCA).

This format means that the strategic direction and monitoring of the Healthcare SOEs is done by the sole shareholder using a combination of mechanisms. Formally the Finance Ministry is the shareholder in the name of the State, and the Hospitals report their financial statements to both the Healthcare and the Finance Ministries. Regarding strategic guidelines and monitoring, most of this activity is concentrated in the Healthcare Ministry.

The SOEs´ sector is a particular case of companies whose shareholder is the state, represented in the case of Portugal solely by the Finance Minister (Decreto-Lei 133/2013 de 3 de outubro – artº 39º) although in cooperation with the sectorial Minister. The fact that the shareholder itself is represented by an agent, who in the case of the Portuguese government does not need to be elected, but rather chosen by the Prime Minister and ratified by the President, introduces legitimacy questions.(Lino & Lomba 2011) Board members of Regulatory Agencies are evaluated by a Parliament commission and once in function it is almost impossible to dismiss before term, but Hospital Board members in Portugal have a different procedure, only dependent on the Government decision (Resolução do Conselho de Ministros).

Hospital management, as in professional or academic institutions are hybrid organizations with a different management framework. The professionals are bound to their judgment and responsible for their actions, and a Board member cannot use a command and control approach, the same way he might do in industrial or commercial organizations. Guidelines can be set, and limits can also be put in place in order to restrain cost or expensive practices, but no direct order can be given to clinical professionals. Usually, there is a latent or explicit conflict between clinical best practices and innovation and business or budget restrictions. The Clinical Director (Diretor Clínico), a Board member, has the power to approve the guidelines for the prescriptions of medicines, exams and other means as well as clinical protocols, being responsible for their cost-benefit results, and he is not subordinated to the Board. (Decreto-Lei 18/2017 de 10 de fevereiro – artº 9º d))

This research takes into account the cultural context and particular characteristics of the business environment in Portugal. The structure of private companies is dominated by family-owned firms, even when their shares are quoted in the stock market.(La Porta et al. 1999) Financing is done mainly through banking institutions rather than by mass shareholders using market mechanisms. Most of the large companies have gone through a privatization process even before liberalization. There is no relevant hostile takeover that succeeded, and the mergers and acquisitions were often agreed long before they become public. On one side, this environment, where the major or sole shareholder directly controls the management team by having family members or affiliates as Board executives with often all top management team (TMT) as board members, reduces the agency issues; on the other side, it also reduces the management discretionary power and initiative. For an SOE it is a usual practice to have frequent face to face meetings with the Minister

and CEOs without the presence of other TMT members, which reinforces the direct links and chain-in-command from the CEO to the Board.

Hofstede studies of cultural characteristics highlight two areas where the Portuguese culture has the highest scores: Uncertainty avoidance and Power distance. Keeping these two major factors in mind, and given a long history of dictatorship and lack of citizen participation in common and daily problems, and you have a breeding ground for a power concentration on the leader.

CEO dominance is associated with the power (Mintzberg 1983) that an individual possesses in relation with his TMT and the possibility to exercise his will. Several studies have been done on power measurement and distribution and the correlation with firm performance. A careful review of those studies reveals that there is no significant performance difference between companies with CEOs dominating the Board and the others, but the deviations are significant. That means that firms with dominant CEOs might have extreme performances either by assuming bigger risks and correspondent's rewards (and punishments) or by deviating from the mainstream strategy of that particular industry. Some contingent approaches have found differences in management discretion depending on the sector structure.

Risk avoidance is imbedded in public governance mostly because the impact can be disastrous for the society and citizens. Within the framework where SOEs operate, values like transparency, fair treatment of all parties, predefined processes and public justification of the decisions are as important as the outcomes of business decisions. There is a strong preference for a no-surprises business even if it means avoiding excellent results. Hence, CEO dominance on SOEs might be seen as a risk to be avoided.

This research creates a tool to evaluate the CEO power in Healthcare SOEs in Portugal by investigating 29 Hospitals in the period of 2011-2015, using public data. This research also used a survey on Board Executives of those Hospitals, gathering anonymous answers, rating CEO characteristics including dominance, and motivation of clinical professionals to assume CEO positions. Four Health Ministers gave the researcher their perspectives in private interviews; several executives also shared their views of Board processes and an informal panel of health executives reviewed the results and findings.
The tool is based on objective measurement, and it is not deterministic, several other factors like personalities, personal relations and power links have to be taken into account. However, the findings are consistent with the panel´s expectations.

This research contributes to the understanding of CG in Healthcare sector, populated by SOEs with reinforced hybrid characteristics, an industry whose importance for the society is growing at a considerable pace. Also, it produces a tool for the CRESAP to evaluate the Board nominees, and even for the existing Boards to get self-awareness of their power distribution.

By gathering relevant support from different areas of knowledge this research also contributes to a holistic view of CG in SOE Healthcare in Portugal as shown in the figure below.

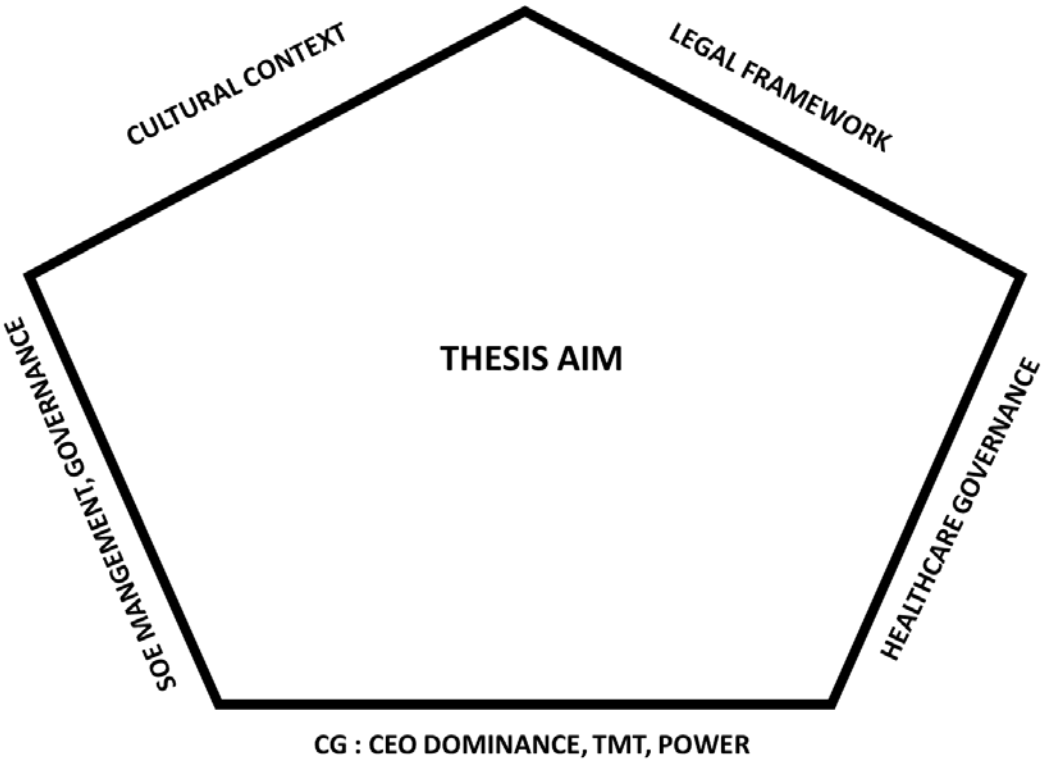


Figure 1 – Thesis Aim

1.2 Research Structure

This research is presented in five chapters. **Chapter One** presents the research rationale, describes the research question, the context where the question is relevant and the main contributions both to theory and practitioners. The overall structure of the research is presented concluding this chapter.

Chapter Two presents the literature review most relevant to the research question. It starts from general theories on CG asserting where they are pertinent to the issues presented, then how Boards composition and functions are assimilated in the context. Prior studies have shown that TMT size and contribution to the firm's performance are of interest to the relationship between the CEO and the Board. The main contributions to the theory regarding CEO dominance are reviewed and how to design a Power Index and its usefulness. When one looks at power concentration, one should also look on dissenting. How often, what consequences to the firm and to the person,

have been investigated and this research presents their contribution to help analyze the conditions where directors diverge formally from the CEO´s will. SOEs are also regarded as Hybrid organizations and part of the Public Administration and Governance. This contribution is essential to understand the context of a sole shareholder – the State. Hospitals are one of the most complex organizations where activity/production and outcomes do not have a direct relationship.
The Hybrid Professionalism of the Clinical activity and the motivation of those professionals to be part of the management team is essential to understand the context of the research. The cultural context and the Legal Framework, as well as the evolution of the National Health Service (SNS), is a key factor that shapes the environment boundaries of Hospital TMT decisions.

Chapter Three describes the conceptual model of the power index, the different approaches and the one chosen in the empirical study. A detailed explanation of the analysis tools and techniques is provided regarding public data and the Questionnaire submitted for the survey. Also the main conclusions from the Ministers interviews and the executive contributions are described. Due to the length of the tests an appendix is also included at the end of this research for thorough analysis. In this Chapter the Power Index Tool components and results are presented.

Chapter Four starts by exploring the results of the Power Index Tool. Demographic differences are explored and also the balance between Clinical Power and Management is detailed. A CEO grade of their power concentration is presented. From the survey results the research concentrates on CEO evaluation in general comparing with previous results from other research studies on the private sector in Portugal. The relative prestige and expertise perception of the CEO regarding other TMT members and the correlation with the power concentration perception is evaluated also in this Chapter. Finally the relevance of the medical profession and the motivation to assume CEO roles are described in these findings.

Chapter Five completes this research by revisiting the main question, presenting the implications and limitations of the research as well as the main contributions both on the theoretical and the managerial level. This research opens areas of further investigation and continuous update on the data analysis for future use.

CHAPTER 2 – LITERATURE REVIEW

2.1 Introduction

There are two major ways to construct a research question from existing literature: gap-spotting or problematization. (Sandberg & Alvesson 2011). Several reasons make gap-spotting more common than problematization, mainly because the latter has a superior level of difficulty and the reinforcements work in favor of the first option. An opportunity to contribute to science is also a recognition of all that was achieved before. This research makes its contribution by looking at a neglected area: the CG on Healthcare SOEs and in particular the CEO dominance issue, and makes an application in the Portuguese specific environment. This chapter explores the existing theories that are relevant in framing the research question and highlights how the formal theory applies to the case.

This Chapter starts from general theories on CG, then how Boards´ composition and functions are implemented in the context. TMT size and contribution to the firm's performance are of interest to the relationship between the CEO and the Board. The main contributions to the theory regarding CEO dominance are reviewed and how a Power Index can be created and how to be used. When one looks at power concentration, one should also look on dissenting. How often does it happen, what are the consequences to the firm and also on the individual level; these are questions that this research presents, and analyzes the conditions that make directors diverge formally from the CEO will. SOEs are also regarded as Hybrid organizations and part of the Public Administration and Governance. This contribution is essential to understand the context of a sole shareholder – the State. Hospitals are one of the most complex organizations where activity/production and outcomes have a complex relationship. The analysis of the Hybrid Professionalism of the Clinical activity and the explanation of the reasons why those professionals accept to be part of the management team is essential for this research. The cultural context and the Legal Framework, as well as the evolution of the National Health Service, (SNS) is a key factor that shapes the environment boundaries of Hospital TMT decisions.

2.2 Corporate Governance Main Theories

The notion of Corporate Governance is associated with the creation of the Dutch East India Company. In 1602, more than 1000 investors faced issues we would qualify today as a conflict of interests and self-dealing business. Adam Smith described these in particular detail:

> *The directors of such companies, however, being the managers rather of other people's money than of their own, it cannot well be expected that they should watch over it with the same anxious vigilance with which the partners in a private copartnery frequently watch over their own. Like the stewards of a rich man, they are apt to consider attention to small matters as not for their master's honour, and very easily give themselves a dispensation from having it. Negligence and profusion, therefore, must always prevail, more or less, in the management of the affairs of such a company* (Smith 1776).

The main problem reflected here is the separation of ownership and management. Do the managers act for their own benefit rather than the Firm's success? Are the Firm´s objectives confined to the shareholders´ pursuit only? What role does the TMT play in the corporation? Is it determinant or do the surrounding factors supersede their contribution?

2.2.1 Agency Theory

The separation of ownership and management is the root cause of the agency dilemma (Tricker 2009). Whenever the owner (the principal) contracts another person (the agent) to look after the former´s wealth, the owner has to assure that the actions of the latter have the principal´s best interests in mind. There is an asymmetric access to information, and even a detailed contract lacks completeness to provide answers and solutions to every situation. (Hermalin 2014) Trust is essential between the parties. "If both parties are utility maximizers there is a solid ground for conflict"(Jensen & Meckling 1976). Another area of concern is the risk taken by management decisions. The reward could be bigger for the management if the bonus were set in advance, while the losses may be limited to job security and reputation whereas the owner may incur in its total savings loss. (MacCrimmon & Wehrung 1986). In an opposite view, a manager can limit the Firm risk by not choosing to diversify and keep his job more secured thus reducing the possibility of bigger owner´s profits (Fama 1980).

Costs, such as contract definition and renegotiation, incentives and penalties to the agent to act on the principal interests, are agency costs (Esperança et al. 2011). These can comprise monitoring cost, bonding costs, and residual loss (Jensen & Meckling 1976). "Monitoring costs are expenditures paid by the principal to measure, observe and control an agent´s behavior, including auditing, hiring and firing executives" (Clacher et al. 2010). On the other side managers will set up structures, to provide evidence to the principal of their commitment in serving, these are bonding costs. Agency losses arise from conflicts of interests and of incentive contracts often being suboptimal (Clacher et al. 2010).

There are different forms of agency conflicts, other than risk taking, such as Moral Hazard, Earnings Retention, and Time horizon Conflicts. Examples of Moral Hazard Agency conflicts are as follow: a management decision to make a Firm investment where the manager's skills have the best fit thus precluding a replacement, or relaxing on the duty of care. In the context of this research, one can easily identify possible situations where a clinical professional in management position favors investment in his specialty or mastery knowledge. Earnings retention conflicts arise when management retains excess profits in forms of reserves, not distributing them to the shareholders. In a similar situation, a management agreement with the Health Minister may use all funds available in the budget against the will of the Finance Minister. Time horizon conflicts may exist when shareholders and management have different expectations on cash-flow timing, in order to keep their jobs or even to hide results that are better than expected, to the next cycle, protecting their future. When starting a mandate, initial write-offs may be exaggerated, providing room for unexpected losses or bad decisions.

"The focus of agency theory is to reduce the costs of monitoring by designing the most efficient contract" (Eisenhardt 1989). This reduction is achieved by focusing the contracts more on outcomes rather than on activities and also, by providing timing and accurate information to the owner that, at least, creates a scenario of active monitoring; these are contributions from positivist researchers in agency theory. Principal-agent researchers have a more mathematical approach and are more concerned about behavior versus outcome (Eisenhardt 1989). The more complex it is to define the desired behavior of the agent tasks as in the case of management, the harder it is to design the contract. Eisenhardt coined that characteristic *"Programmability*." Outcomes are also, sometimes, difficult to measure as in the case of Healthcare and dependent on the length of the contract.

Agency theory highlights the importance of incentives and self-interest. It also reveals the importance and cost of information and emphasizes the role of Boards in monitoring behavior of TMT (Eisenhardt 1989). The critics of agency theory, cite its relatively narrow theoretical scope (Tricker 2009). These critics, point out that more than just contracts, a complex group dynamic is established and cannot be reduced to statistical formulas. Furthermore, Board independence correlation to performance was challenged, and the effect of network connections prevails as shown in later studies. (Muth & Donaldson 1998). The moral assumption of the agency theory is that people are not inherently trustworthy.

In the modern world, most of the investment in large Firms are made through institutions much more than single shareholders. Mutual funds, ETF´s and the like determine who sits on Boards, and who will be the CEO. These institutions are also managed by agents of other principals, subject to the same issues and constrains that the final agents have. In addition, with the volatility of shareholders in capital markets, it is difficult to determine who are the first principals at all, and if results ought to be pursued in the short or long term. This is also applicable to SOEs, of whom the shareholder is represented by a Government acting on behalf of the final principal. Conflicts may also surge when multiple principal-agent relationships are present (Hoskisson et al. 2013). In the case of SOEs, the Finance Minister is concerned with the financial and fiscal achievements, thus may create a natural conflict with other stakeholders, who have a different goal - to serve the society – and they represented either by Sector Minister, the Parliament or a myriad of multiple local and state pressure groups.

2.2.2 Stewardship theory

Stewardship theory is based on a different moral assumption, similar to McGregor´s theory Y or McClelland studies (Donaldson 1990). These authors argued there is no implicit conflict between owners and managers and they cooperate to a common goal. *"In stewardship theory, the model of man is based on a steward whose behavior is ordered such that pro-organizational, collectivistic behaviors have higher utility than individualistic, self-serving behaviors*"(Davis et al. 1997). This view relaxes the restrictions on Board independence and CEO duality and introduces a contingent approach to the model. Stewardship theories also recognize that the corporation has

duties to a diversified group of stakeholders, although being accountable in the first place to shareholders (Tricker 2009). In the case of SOE Hospitals, stakeholders are also shareholders as citizens or related economic parties. Rewards for stewards are not only those of explicit market value, but stewards are primarily guided by opportunities to grow, achievement, affiliation, and self-actualization (Davis et al. 1997). This applies in particular to public administration and SOEs, where rewards are tightly controlled, and salaries for TMT are usually below average for similar positions in the private sector.

The control-oriented approach is based on separating thinking and controlling from actually doing, while for a long term relationship and unstructured tasks, the three activities should be combined, because of much of the next action, is dependent on the feedback from previous activities.

Culture aspects based on Hofstede studies (Hofstede 1993; Mooij & Hofstede 2007) also impact the choices of agency versus stewardship model. Collectivist cultures idealize managers as stewards as in the case of Portugal, but also, in contrast, high-power distance cultures tend to favor agency models (Preda 2012). Cooperation is at the essence of the stewardship model, and it is improved when the first move is based on trust, and it is reciprocated. Stewardship supporters argue that the reallocation of corporate control from owners to professional managers can be a positive development (Muth & Donaldson 1998).

The critics of stewardship theory argue that this approach is rather naive and simplistic and that in modern corporations the relationships are far more complex to be able to identify the principals (Tricker 2009). When there are major and minor shareholders, the stewards may want to represent a fair view, however, laws may not support it, especially in Continental Europe where civil law is more deterministic on ownership rights and procedural steps.

When the stewardship model is applied in combination with the stakeholder theory of the firm one can argue that the TMT can always act in their self-interest, claiming to serve a diffuse stakeholder and thus making the controlling function more difficult.(Donaldson & Preston 1995) This recognition is refuted by the supporters of the stakeholder model, who claim that actual models of controlling already allow such behaviors and moreover, practice and law can always improve to contain such self-serving managers.

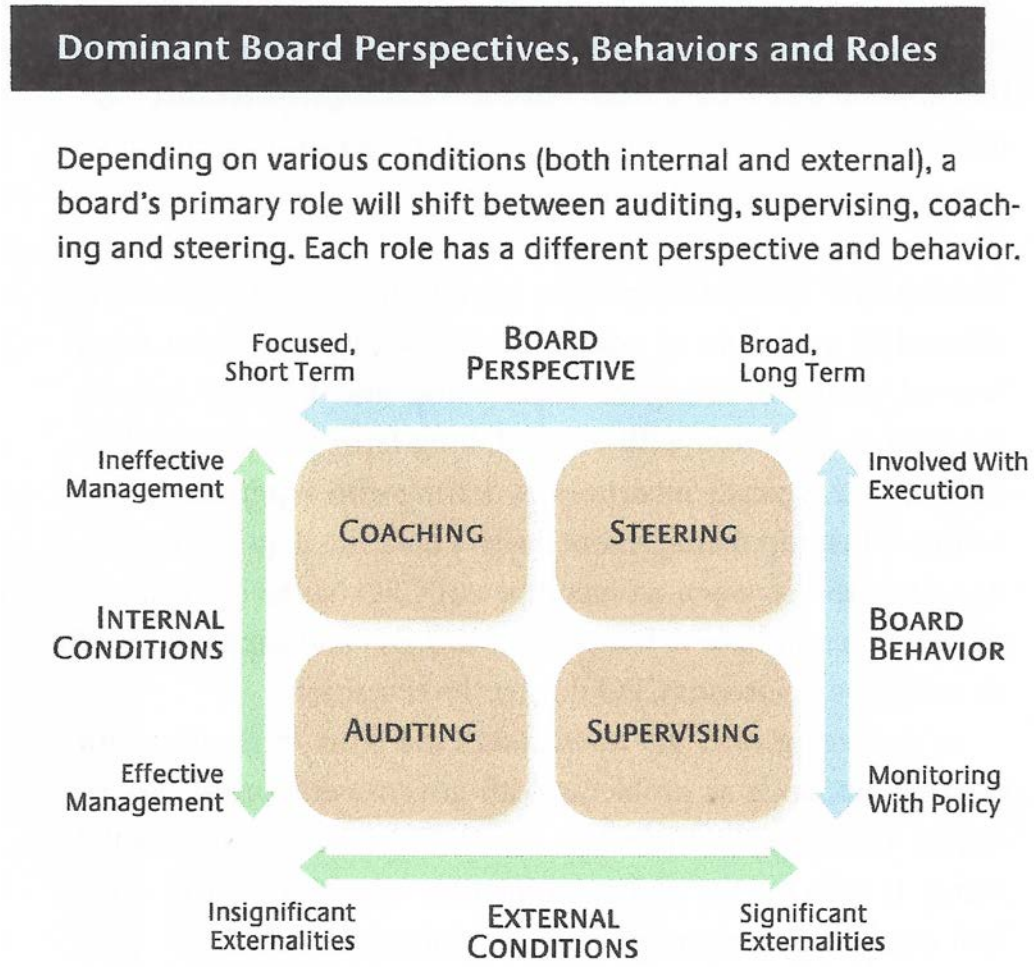
2.2.3 Resource Dependence Theory

The Resource Dependence theory is concentrated more in the external relationships of the company than with the internal ones concerning agency and stewardship theories. A firm exists with its relationships with the exterior, and these resources can be material, access or reputational (Pfeffer & Slancik 1978). Board members are key to bringing resources such as information, skills, access, and legitimacy to the Firm, thus reducing uncertainty and transaction costs (Hillman et al. 2009). Inside directors bring expertise and are internally focus while they provide useful information to the Board. Business experts can also provide expertise, and with their long tenure, experience on decision-making, Support specialists may also provide channels of communication and legitimacy to the Firm decisions. Lastly, Community influentials provide non-business

perspective on issues, and they bring all legitimacy (Hillman et al. 2000). The task complexity and specialist involvement may drive the network needs and coordination efforts. Hospitals are a good example of these coordination needs, a place where strict command and control does not solve all problems. Task complexity in conjunction with time pressures needs teams to coordinate by mutual adjustment (Hillman et al. 2000).

2.2.4 Contingency approach

There is a generalized effort to find best practices applicable to all institutions and countries to make systems converge and reduce uncertainty in a global environment (OECD Secretary-General 2015). The globalization of equity markets has now decades and doing business on a worldwide scale is now the norm for large enterprises. Some principles may be shared like equitable treatment, responsibility, transparency, and accountability, and often they are translated in generally accepted codes of conduct for corporate governance. Facing changing conditions companies and their Boards have to adapt to externalities (Strebel 2004). Sometimes Boards have to enlarge their scope beyond oversight monitoring and take a bigger role in the conduct of the firm, especially when dealing with externalities (Boyd et al. 2011). Four main roles are proposed by Strebel depending on the level of Effective Management and External Conditions determining Boards Perspective and Behavior.



Source: The Case for Contingent Governance (Strebel 2004)

Figure 2 – Dominant Board Perspectives, Behavior and Roles

Boards should perform three roles: (1) setting organizational direction and strategy, (2) monitoring or providing oversight of the CEO, assets, and programs of the organization and (3) ensuring necessary human and financial resources (BoardSource, 2010). The first is aligned with stewardship theory, the second to the agency and the third with the resource dependence perspective (Chelliah et al. 2016). Like a not-for-profit (NFP) organization, an SOE needs to attend to competing interests and not only to the financial results. *Contingency theory represents the movement away from a notion that characterized early classical management theory: that there is one ideal way to organize* (Bradshaw 2009). Recognizing the need to change to maintain fit and thus rejecting the one-size fits all approach is essential to understand the specific case.

One of the criticisms of contingency theory is that it allows everything and the opposite considering the right circumstances. It should be noted, however, that principles do not change, but procedures may have to be adjusted (Donaldson 2006).

2.3 Board Composition and Functions

2.3.1. The need of a Board

Corporate organization charts usually depict individuals as responsible for decision-making over large parts of the business, sometimes with cross-responsibilities but at the top, one may find a collective body –The Board. In fact, multiple decisions within the organization are prepared through committees and then proposed to decision, but the case of the Board is different it is the decision-maker by nature. The preference for a group rather than just one individual has several roots (Li 2009). Social experiences show that two heads are better than one (Blinder & Morgan 2000; Cooper & Kagel 2008). This superiority is not only regarding the average group member but in certain circumstances beats even the best individual of any group.(Bainbridge 2008) In some cases even with the burden of coordination and information sharing the total time to decide was not significantly higher for a group vs. individuals. One of the benefits of collective decisions resides not only in the volume of information and options but also to the collective memory and the precedence of past situations and who knows what as a collective trump (Bainbridge 2008).
"While a board helps to solve managerial agency problems, it also entails costs by introducing an additional agency layer to the organizational structure" (Burkart et al. 2017).
Bounded rationality makes individuals lack the total range of solutions or the consequences that a group may provide (Page 2006). A group decision is not exempt from several flaws, being Groupthink one of the more frequent (Janis 1988). It happens when concurrence-seeking becomes so dominant that overrides appraisal of alternatives. Even more cohesive groups create a model conformity and stereotypes that generate unanimity, thus providing each member with a sense of security and invulnerability, sometimes even pride, reinforced by the group support. Overconfidence often may occur when tasks require creativity that is better generated individually (Bainbridge 2008). All in all, on a predictive task a group usually is more accurate than individuals as explained in a popular book "*The Wisdom of Crowds* " (Surowiecki, 2005).

2.3.2 What do Board members do?

Boards are in the broader sense the link from owners to management (Monks & Minow 2010). Legally board members – the Directors have two duties the duty of care and the duty of loyalty, and their conduct should be evaluated according to the business judgment rule.
Tricker defined a matrix of Board functions considering the inward-outward looking and the past-future focus (Tricker 2009).

	Past and present focused	**Future focused**
Outward looking	*Accountability*	*Strategy formulation*
Inward looking	*Monitoring and supervision*	*Policy making*

Figure 3 – Board functions matrix

Tricker´s research found that the time spent in those activities differ a lot from the desired objectives of the Directors, spending a lot more time in the past and present focused then into the future and also much more Inward looking than Outward. External events are described as the cause of this concentration in supervision rather than in advisory role.

To do an effective monitoring job a Director needs to have four attributes: independence, expertise in that domain, bandwidth and motivation (Hambrick et al. 2015). **Independence** means the ability to be objective, **Expertise** as to understand the issues on hand, **Bandwidth** to devote the requisite time and attention to the job and **Motivation** to exert oneself on behalf of shareholders.

More than 45 years ago, Mace's seminal study: *Directors: Myth and Reality*, showed that Directors, only in time of crisis, devote a profound attention to strategy formulation and only after dealing with the on-going reputational effects.

> *The two questions most asked about boards concern what determines their makeup, and what determines their actions. These questions are, however, fundamentally intertwined— the makeup of boards is interesting because it affects what the board does; and, consequently, their makeup is influenced by a desire to affect what they do*. (Renee Adams,† Benjamin E. Hermalin 2008)

Much of the literature on Boards focus on the Board´s monitoring role, although boards that engage in strategic guidance perform better in financial terms (Adams 2017).

2.3.3 Who sits on the Board?

The typical Board has about half of their members as former executives (CEO´s, COO´s, VP´s), twenty per cent have operational or functional experience, and the rest comes from diverse backgrounds (D. Larcker & Tayan 2016). Some of the non-executive Directors are full time in those functions because they serve on several Boards. Interlocked boards occur when executives of one firm also sit on the other´s Board as non-executives, and that is reciprocated.

The Chairman presides over board meetings and is responsible for scheduling meetings, planning agendas and distributing materials in advance. The role of Chairman is considering as having a distinct effect on board dynamics, role and contribution and the monitoring and support of management (Kakabadse 2007). Employee representation, as in German firms has mixed valuation according to different studies. While some studies support this representation as a way of having direct links to the operations at floor shop levels; others advocate that the presence of workers hinders the possibility of total openness and sharing of crucial financial information. Board size tends to reflect the size and the mix of shareholders of one Firm. The issue of gender diversity has gained more and more attention on Board´s composition although there was no correlation found between diversity and performance (Ferreira 2010).

Agency theory posits that Board independence (Adams 2017) should correlate with better business results (Dalton & Dalton 2011)(Pearce & Zahra 1991), but it is not always supported by evidence. (Bhagat & Black 1999; Bhagat et al. 2010) In innovative firms, some researchers suggest that the larger the Board and including more insiders, the better (Coles et al. 2008).

Board composition is very different in the US, Germany, Italy or France (and Portugal). While in the US, Boards have a majority of outsiders in a single structure, in Germany the Executive level is insiders-only, and the Supervision Board is outsiders non-executives only, while in France and Italy (and Portugal) boards have a majority of insiders (Gillette et al. 2008).

Besides the formal position, Board members interact in a network of informal relationships (Stevenson & Radin 2014). This informal network could generate a more candid advice to the CEO (Westphal & Zajac 1996; Westphal 2010) and not be taken as a reprimand. "Board structure and network ties affect the cognitive structures of their members, thus affecting their rationale for decision using different casual systems" (Mintzberg et al. 1976). Some Directors have far more influence than others (Hambrick et al. 2008; Brooks 2012), which leads to a profound effect on information, cognition and decision making (Stevenson & Radin 2014). By having more human capital, prestige or expertise; some board members can have a greater influence (Pfeffer & Slancik 1978; Pfeffer 2015). These informal networks occur regardless of insider or independent status of the Director, forming an "inner-board".

2.3.4 Diversity

It is still unclear if a work group's perspective on the role of cultural diversity mediates the impact of that diversity on its functioning, meaning the already existing bias can affect the results (J. Ely & Thomas 2001; Erhardt et al. 2003; Rhode & Packel 2014; Giannetti & Zhao 2015). "*Perspectives matter because "what is next to what" determines how a person locates new solution*"(Page 2006; Page 2014). Diversity may improve ability, although simple tasks do not need diverse approaches and most of the Executive Board work is routine approvals. Board diversity has its roots in the mere need of a Board and not just one individual (Adams & Ferreira 2008). The mixed findings of the relationship between diversity and firm performance can be attributed to methodologies, time horizons, exogenous factors and other contextual issues. Some studies found that when boards represent different employees´ constituencies, namely by gender, race or functional background, the organization seems more attractive to work and retention is higher (Jones & Cannella 2011).

The success of those minority executives is also key in setting an example for others to follow (Nishii et al. 2007). Some researchers have a very cautious position on the theme of diversity.(Ferreira 2010) Stanford researchers (D. F. Larcker & Tayan 2016), just recently surveyed the different published views. *There are many instances in which members do not come to a Board as individuals, but rather come as representative factions being shareholders, bank creditors or internal constituencies* (Li & Hambrick 2005). Boards with factional groups can be viewed as having "*engineered*" faultlines. These can be magnified if those representatives also have a different gender, race, background, age or tenure (Li & Hambrick 2005; Lynall et al. 2003).

Regarding employee participation in the Board, the German model is the reference. First, one has to understand that under German Law the Board is a two-tier Board with a Supervisory and Executive level (Hopt 2016; Hopt 2015). Labor participation is typically limited to the Supervisory

Board, but in companies with more than 2.000 employees, a "*labor director*" (Arbeitsdirektor) must be appointed to the management Board (Hopt 2016). "*Although equal-representation companies are unionized by means of law, codetermination is different from unionization because employees, and not just those in unions, can potentially influence the firm's operations and the distribution of the surplus*."(Gorton & Schmid 2002) A research made in 2002 showed that German companies with labor parity, performed below those with just one-third labor participation, but one has to understand that this participation is determined by size, so different performances may be attributable to other factors (Gorton & Schmid 2002). Employee involvement can also be seen as an insurance mechanism as a 2014 study found.

> The results show white-collar and skilled blue-collar employees of firms with parity-codetermination are protected against layoffs during shock periods and pay an insurance premium of about 3% in the form of lower wages. Unskilled blue-collar workers lack real representation on the board, and they are not protected against shocks. "The effects of insuring employees manifest in higher operating leverage and lower average profitability" (Kim et al. 2014).

"*A majority of the 28 states of the EU plus Norway provide for employee representation at board level, although in some this is limited to companies owned in whole or part by the state or privatized companies*" (Cope 2015; Conchon 2011).

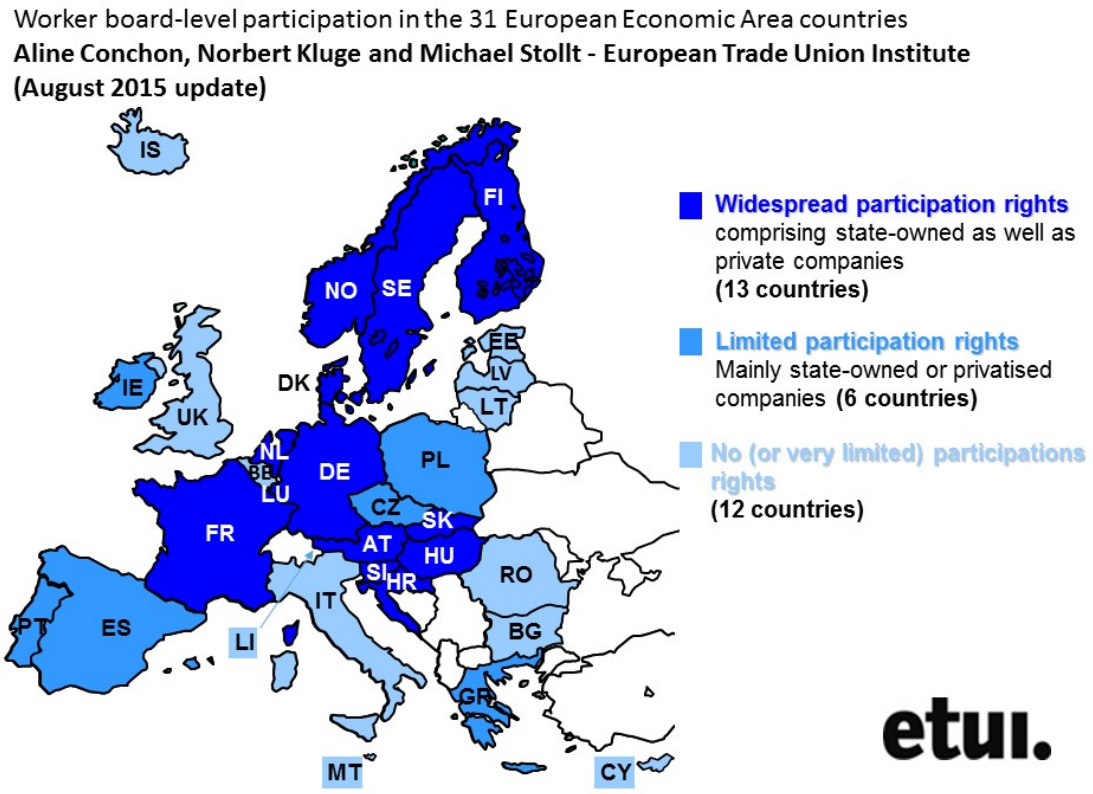


Figure 4 – Worker Board-level participation map

The discussion of the German model, and its influence in the European Union, is still a matter of future research (Steger & Hartz 2006).

The decline of inside Directors – a Board member, currently employed by the corporation – has been seen as a mark of more Board independence.(Fairfax 2010) Although insiders are seen as source of information, knowledge, experience, and resources their lack of independence and their CEO loyalty are impediments to their participation.(Joseph et al. 2014)

Nowadays, many Boards only have one insider: the CEO, but the need of CFO participation and sign-off is also common. Some studies associate Board diversity with more performance volatility, even though, there is no evidence that diverse Boards take more risk (Giannetti & Zhao 2015).
"*Whether boards of directors are dominated by managers or outsiders only matters when their strong external connections give them clout and the possibility of diverging interests from the focal company*" (Muth & Donaldson 1998).

2.4. The Board, the Top Management Team, and the CEO

2.4.1 TMT

Top Management Team (TMT) is not clearly defined in the literature. They either represent the upper echelon, an "internal dominant coalition," or the formal group of executives reporting to the Board or the CEO (Jones & Cannella 2011). The emphasis of TMT research shifted from questions such as "*if managers matter*" to questions "*under what conditions they matter*."
Tenure has a large influence on how TMT act: long-tenured executives will tend to have (1) persistent, unchanging strategies, (2) strategies that conform closely to industry averages, and (3) performance that conforms to industry averages (Finkelstein & Hambrick 1990).
Long tenured teams develop a risk avoidance culture because they may loose more than the perceived gains, so they conform to the status quo.
With organizational tenure, managers tend to develop a particular repertoire of responses to environmental and organizational stimuli that act against any change in policy (Miller, 1988).
Teams with short tenures have fresh, diverse information and are willing to take risks, often departing widely from industry conventions. In both cases, the management discretion has a moderating role (Finkelstein & Hambrick 1990). This means that different industries may provide different discretion latitudes to their management. A stable, quality driven, standard process industry may be less affected by keeping the status quo than an innovative industry that need more risk taking and experimentation.

2.4.2 CEO-Board Relationship

Director´s behavior is influenced by interpersonal relationships, by perceptions of position and prestige, and by the processes of power (Tricker 2009). The sources of power are several: Personality, Knowledge, Political, Interpersonal, Organizational, Networking, Societal, Ownership, Sanction, Representative, and Functional background. In general terms, Finance background gives an edge to a CEO even over the CFO, and also, deep industry knowledge and experience is a trump. How do CEOs influence their Boards to gain approval for his proposals? Even in nonprofit organizations, key behavior processes indicate how the influence occurs. These processes are: exploiting key relationships, managing impressions, managing information and protecting formal authority (Maitlis 2004).

The CEO- board power relation was defined by (Pearce & Zahra 1991) using a matrix of relative power of both parties.

High	*Statutory*	*Participative*
CEO POWER		
Low	*Caretaker*	*Proactive*
	Low	**High**

BOARD POWER

Figure 5 CEO-Board power relation

Caretaker Boards are viewed just as a legal necessity, *Statutory* Boards reflect the prototype image of ineffective Boards, *Proactive* Boards are the true instrument of corporate governance, and *Participative* Boards are seen as forums for discussion and disagreement (Pearce & Zahra 1991). This study found that Participative Boards had the highest level of financial performance. Another interesting result was, that CEOs (weak and strong) prefer Strong Boards for they make quicker decisions.

Another look at the power distribution between a powerful CEO and other Board members power is shown below after an unexpected CEO death:(Combs et al. 2007)

Table I. Expected relations among CEO power, board composition, and stock market returns

	Following an unexpected chief executive officer death	
	Outside director dominated board	Inside director dominated board
High CEO power	I Prediction: The firm's stock price should fall. *Why? The firm has lost a CEO whose power facilitated good strategic focus while the board reigned in any potential self-serving actions by the CEO. The death represents an overall loss to shareholders.*	II Prediction: The firm's stock price should rise. *Why? The deceased had a high probability of acting in self-serving ways and eroding shareholder value. The death represents an opportunity for a shift to a more board constrained CEO and thus a potential gain for shareholders.*
Low CEO power	III Prediction: The firm's stock price should rise. *Why? The board was an excessive and potentially counterproductive layer of control. The likely successor will be an outsider with an established rapport with the board. The death represents an opportunity to improve a poor situation.*	IV Prediction: The firm's stock price should fall. *Why? The deceased was focused on the long-term investments that inside director dominated boards facilitate. The likely successor will be a lesser-known, less powerful insider. The death represents increased uncertainty and an overall loss to shareholders.*

Figure 6 – The Effect of CEO Power

Outgoing CEOs and existing board members may have somewhat divergent preferences regarding CEO successors, with each preferring a successor who is demographically similar to themselves (Westphal & Zajac 1996).

Consistent with Drucker findings that effective executives "*get the right things done*," research on what characteristics are important to CEO success include: extraversion, emotional stability, agreeableness, consciousness and openness to experience (Kaplan et al. 2012).

A more detailed list known as **Five Factor Model** was developed.

The five factor model

Openness	Conscientiousness	Extroversion	Agreeableness	Neuroticism
Imagination	Competence	Friendliness	Trust	Anxiety
Artistic Interests	Orderliness	Gregariousness	Straightforwardness	Hostility
Emotionality	Dutifulness	Assertiveness	Altruism	Depression
Adventurousness	Achievement-striving	Activity level	Compliance	Self-consciousness
Intellect	Self-discipline	Excitement seeking	Modesty	Impulsiveness
Liberalism	Cautiousness	Cheerfulness	Tender-mindedness	Vulnerability

The first row identifies the five factors. The next five rows contain the five lower-order traits ("sub-factors") for each factor. Within each factor, traits are highly correlated; across factors, they are not. *Source*: MIT Laboratory for Financial Engineering (2004).

Figure 7- Five Factor Model

"*CEO acts on the basis of his or her paradigm, or simplifying model of reality*" (Hambrick & Fukutomi 1991). Decision making is a combination of assumptions on future events, alternatives and consequences as well as individual preferences (Marsh and Simon 1958). These preferences vary with age as older people become less willing to change. The same happens with tenure and insider versus outsider (Hambrick & Mason 1984). This seminal paper posits several propositions for future research. Two main ideas were brought up: TMT and not only CEOs matter regarding decision-making (Papadakis, V. M. and Barwise 2002) and that the demographic characteristics of executives can be used as valid proxies of executives' cognitive frames (Hambrick 2007).
Recently, it was noted that CEO´s became more consequential, with the best (and worst) leaders making increasingly distinctive marks on their firms (Quigley & Hambrick 2014).
Leader life cycle theory predicts an inverted curvilinear relationship between CEO´s tenure and company performance (Hambrick & Fukutomi 1991). The full life cycle is presented below:

Critical CEO Characteristics	**1 Response to Mandate**	**2 Experimentation**	**3 Selection of an Enduring Theme**	**4 Convergence**	**5 Dysfunction**
Commitment to a Paradigm	Moderately Strong	Could be strong or weak	Moderately strong	Strong increasing	Very strong
Task Knowledge	Low but quickly increasing	Moderate somewhat increasing	High, slightly increasing	High, slightly increasing	High, slightly increasing
Information diversity	Many sources, unfiltered	Many sources but increasingly filtered	Fewer sources moderately filtered	Fewer sources highly filtered	Very few sources highly filtered
Task interest	High	High	Moderately high	Moderately high but diminishing	Moderately low and diminishing
POWER	**Low, increasing**	**Moderate increasing**	**Moderate increasing**	**Strong increasing**	**Very strong increasing**

Figure 8 – The Five Seasons of a CEO´s Tenure

More recent studies which merge, the leader life cycle and Finkelstein´s notion of structural power confirm this inverted curvilinear relationship with performance (Wulf et al. 2011). Another study on Board tenure reveals that longer tenures are rewarded in stable environments but their monitoring function becomes less effective and they may miss technological advances (Livnat et al. 2016).

2.4.3 CEO Power, Dominance, and Overconfidence

A seminal study (Finkelstein 1992) started a new series of research over TMT interactions, defining the **concept of Power as the capacity of individual actors to exert their will**. Four core dimensions are defined: Structural Power, Ownership Power, Expert Power and Prestige Power. To measure these components using objective indicators, the following variables were created:

Structural Power: Percentage of higher titles, Compensation, Number of titles (thus implying that Duality retains more power).

Ownership Power: Executive shares, Family shares, Founder or Relative.

Expert Power: Critical expertise power, Functional areas, Positions in a firm.

Prestige Power: Corporate Boards, Nonprofit Boards, Average board rating, Elite education.

The scale was validated for statistical consistency, and a questionnaire was sent to the managers of the studies firms to confirm the results.

Other measurements of CEO power are based on CEO pay compared to other executives or other Firm assets (Brown & Sarma 2007; Bebchuk et al. 2007). *Firms with greater coordination needs will exhibit smaller CEO pay gaps, and the combination of higher coordination needs and smaller gaps will enhance firm performance* (Henderson & Frederickson 2001).

Another approach from Gavin (2014) was based on Finkelstein´s model but added: CEO tenure, CEO-Board member similarity (age, education, and functional background), CEO-Board member nominations and Classified (staggered) Boards (those that Directors have different time-end mandates)(Gavin & College 2014). This study also highlights, how much a CEO can influence decisions, by intervening in the choice of the other Board members.

CEO dominance is in this research defined as a disproportioned distribution of power favoring the CEO. It measures how much decision making is handled by the CEO regarding his peers. It is their capacity of making unilateral decisions despite disagreements or avoiding any criticism at all (Tang et al. 2011). That dominance may create a restrict flow of information from the CEO to the rest of TMT and the Board (Jiraporn et al. 2012). Analyzing the power distribution at the TMT was the method to calculate the possibility of CEO dominance (Haleblian & Finkelstein 1993). Another study found that large teams with less dominant CEOs were more profitable in a turbulent environment but had no effect on stable cases. CEOs with a large tenure or a collectivistic orientation that emphasize sharing, cooperation, group harmony, and welfare can affect TMT collaboration, positively (Simsek et al. 2005).

The possibility of extreme decisions (good or bad) increase in organizations that have a powerful CEO and this power is based on structural power.(Adams et al. 2005) The average performance did not show significant differences, between more and less powerful CEOs (Adams et al. 2005). CEO centrality – the relative importance of the CEO within TMT regarding ability, contribution or power – a similar measure of dominance, was found negatively associated with firm value. (Bebchuk et al. 2007) Dominant CEOs are positively associated with a deviant strategy from the industry they operate, hence the extreme results.(Tang et al. 2011) The effect of large shareholders with blocking votes and CEO dominance is also explained in a recent thesis (Washington 2016).

Firms in countries where the cultural variable **power distance** (Mooij & Hofstede 2007) has a high value, tend to accept and even legitimate, powerful CEOs (Krause et al. 2016).

CEOs are subject to overconfidence (Kieff & Paredes 2010). This means overestimating their abilities and have the illusion of control, blaming others or externalities when they fail (Brown & Sarma 2007). The causes are lack of feedback or restraining dissent. Sometimes an overconfident CEO is also an inspiring leader and has a very good track record. These are danger signs that preclude him from looking objectively at the risks and rewards the decisions carry. Overconfidence differs from Dominance, the former is an aspect of personality and therefore intrinsic to the individual, while the latter is in principle an objective fact of behavior (Brown & Sarma 2007). There is no coincidence though, that considerable overlapping may occur. "*This combination can be a real issue for corporate governance because, by the time the problem manifests, it is often after the fraud, illegal activity or mismanagement has caused harm to the corporation*" (Barclift 2009). Because Boards are highly cohesive and tend to be homogeneous, they often rely on social norms which limit their effectiveness in detecting the undesirable behavior of the group leader (Kurana & Pick 2005).

Based on (Finkelstein 1992) seminal work and the Five Factor model, a recent study from (Jones & Cannella 2011) concluded that: CEOs accept more involvement in the process and the decision when they have low structural power. Ownership and Expertise power command decision making. CEOs with high expertise power in areas of their mastery tend to reduce collaboration and involvement from TMT. CEOs who rate highly in extraversion, openness to experience and agreeableness accept more involvement from TMT.

2.4.4 CEO duality

The new movement to have Boards, with the CEO being the only insider, actually increased CEO power by controlling and having privileged access to information (Joseph et al. 2014).

Duality – the coincidence of Chairman and CEO – increases CEO power by also managing the agenda, the sequence and time allocated to each item and the information flow.

There is no evidence of substantive, systematic relationships between corporate financial performance and board leadership structure (Dalton & Dalton 2011)(Krause et al. 2014).

Agency theory strongly supports separation, while Stewardship theory accepts Duality (Boyd et al. 2011). The resource dependence perspective suggests that CEO duality might improve organization performance in certain contexts. (Boyd 1995) The decision of splitting versus combining the CEO and Chairman position is an endogenous decision (Kwok 1998).

When CEOs have strong informal power or when firm performance is good, the risk of CEO entrenchment increases, making duality less desirable (Finkelstein & D'Aveni 1994). CEO duality is also associated with entrenchment, thus protecting poorly performing CEOs (Firth et al. 2014).

The "fit" between cultural values and organizational arrangement is a known preference(Hofstede 1993). Hofstede´s model identifies four major dimensions: Uncertainty avoidance, Individualism vs. Collectivism, Masculinity vs. Femininity and Power distance. CEO duality is positively associated with Uncertainty avoidance, Masculinity, Individualism and Power distance (Li & Harrison 2008).

Recently some Firms have begun to challenge the basic concept of *unity of command* by appointing two CEOs to lead simultaneously (Krause et al. 2015). Opinions on Co-CEOs validity diverge, but the majority of researchers and practitioners reject the idea although many corporations already have matrix structures in place (Vantrappen & Wirtz 2016). Preliminary results show that power gap between CO-CEOs is beneficial to firm performance.

2.4.5 Dissenting

Dissenting is the act of a Board member, a Director to vote against the majority, and have that vote registered in the minutes of the Board meeting, that may lead (or not) to a further resignation. In most countries, dissenting is the only way, that a Director has, to be acquitted from the Board decision.

> *Resigning from the Board*. This is the most common and typical response of directors who suspect or conclude that the president is unsatisfactory. Resignation from the board for plausible reasons such as conflict of interest enables a director to avoid facing the ultimate and inevitable unpleasant task to acting to replace a president. In addition, with public disclosure of an apparently reasonable basis for a resignation, typically there is no embarrassment to the company or to the believed-to-be inadequate president (Mace 1971).

Sources of conflict between Board members and Executives are several:

- Lack of information or clarity - unclear differences between governance and management which lead to micromanagement by the Board or lack of trust from executives.
- Change – of member of the Board or executives, or organization strategy.
- Communication tools and candid environment for the exchange of ideas
- Personalities and styles.
- Also more substantive reasons like inadequate capabilities of individuals, team-wide shortcomings, harmful rivalries, Groupthink and fragmentation meaning competing teams within the Board or Executive teams (Hambrick 1995).

CEOs´ dominance and overconfidence also may silence for some time other TMT, but there may be an occasion when all the issues surface breaking the existing status quo. Dissent is not a value in itself and not so different from pure conformism (Marchetti et al. 2016).

The Dissenting is a less studied topic also because it is less frequent and lacks public information. Also, there is no incentive for Directors to dissent, because they are not rewarded and may lose bonuses, and, additionally, their chances to be nominated for other Board diminishes (Marshall 2010).

Dissenting occurs, regardless of Director´s independence, a severe dysfunctional board or just because of differences of opinion. The occurrence of dissenting is more frequent in smaller firms, with less independent members, CEO dominance and duality, and on younger and shorter tenured directors. The average dissenting director experiences a net loss of 85% over the next five years (Marshall 2010).

"The regulatory environment in China offers a rare window to observe the inner workings of independent directors dissent because the law requires that public firms disclose those facts "(Ma & Khanna 2013). Conclusions of this research are that there is still a punishment for dissenting and the fact that it is publicly disclosed may somehow hinder dissenting. In many European legal frameworks directors dissenting cannot be liable for the prejudice caused by the Board decision provided they noted their dissent in the minutes of the board meeting (Marchetti et al. 2016). It is always possible for dissenting directors that resign, to hide their real motives invoking “personal reasons” or similar formulas. Marchetti (2016) research in Italy showed that the highest reason for resignation was Internal Corporate Governance and the three most often reasons for dissent were: Related-party transaction, Information disclosure, and internal corporate governance. Directors appointed by minority shareholders are more likely to dissent but, surprisingly, they receive a higher compensation although sitting on fewer boards. In the US, a study (Agrawal & Chen 2008) found that such conflicts are more common among management, especially when CEO dominance is present. Furthermore, Directors with shorter tenure or very powerful are more often involved, and finally those disputes affect stock prices of the companies in the next future.

2.5 Governance in the Public Sector

2.5.1 Public Governance

In public administration the meaning of theory is normative – theories of what ought to be.(Frederickson et al. 2012) To Herbert Simon or Mintzberg it was difficult empirically to unbundle politics from administration, and vice-versa (Simon 1946; Simon 1985; Simon 2000; Mintzberg 1996). According to Kofi Annan, former UN Secretary-General, “*good governance is perhaps the single most important factor in eradicating poverty and promoting development*.”

Hyden (2002) used this definition: "*Governance refers to the formation and stewardship of the formal and informal rules that regulate the public realm, the arena in which state as well as economic and societal actors interact to make decisions*", to establish the following dimensions (Hyden et al. 2002):

Functional Dimension	Institutional Arena	Purpose of Rules
Socializing	Civil Society	To shape the way citizens become aware of, and, raise issues in public
Aggregating	Political Society	To shape the way issues are combined into policy by political institutions
Executive	Government	To shape the way policies are made by government institutions
Managerial	Bureaucracy	To shape the way policies are administered and implemented by public servants
Regulatory	Economic Society	To shape the way state and market interact to promote development
Adjudicatory	Judicial System	To shape the setting for resolution of disputes and conflicts

Figure 9 – Public governance functional dimensions

Public intervention in society is not only based in public needs but also on people´s rights.

Needs Approach	Rights Approach
Needs are met or satisfied	Rights are realized
Needs do not imply duties or obligations	Rights always imply correlative duties
Needs are not necessarily universal	Human rights are universal
Needs can be met by outcome strategy	Rights can be realized only by paying attention to both outcome and process
Needs can be ranked in a hierarchy of priorities	Rights are indivisible because they are interdependent
Needs can be met through charity and benevolence	Charity is superfluous in a rights perspective

Figure 10 – Public intervention approach

In this sense Public Governance is subject to the following principles: (Hyden et al. 2002)

- *Participation: the degree of involvement and ownership of affected stakeholders;*
- *Decency: the degree to which the formation and stewardship of rules are undertaken without humiliation or harm of the people;*
- *Fairness: the degree to which rules apply equally to every one in society regardless of status;*
- *Accountability: the degree to which public officials, elected as well as appointed, are responsible for their actions and responsive to public demands;*
- *Transparency: the degree to which decisions made by public officials are clear and open to scrutiny by citizens or their representatives;*
- *Efficiency: the degree to which rules facilitate speedy and timely decision-making*

The enforcement of these principles in five main domains resulted in 25 indicators, which may have different weight in different contexts:

Principle / Arena	**Participation**	**Fairness**	**Decency**	**Accountability**	**Transparency**	**Efficiency**
Civil society	Freedom of association	Society free from discrimination	Freedom of expression	Respect for governing rules	Freedom of the media	Input in policy making
Political society	Legislature representative of society	Policy reflective of public preferences	Peaceful competition for political power	Legislators accountable to public	Transparency of political parties	Legislative function affecting policy
Government	Intra-governmental consultation	Adequate standard of living for citizens	Personal security of citizens	Security forces subordinated to civilian government	Government provide accurate information	Best use of available resources
Bureaucracy	Higher civil servants part of policy-making	Equal access to public services	Civil servants respectful towards citizens	Civil servants accountable for their actions	Clear decision-making process	Merit-based system for recruitment
Economic society	Consultation with the private sector	Regulations equally applied to all firms	Government's respect for property rights	Regulating private sector in the public interest	Transparency in formulating economic policy	Obtaining licenses free from corruption
Judiciary	Non-formal processes of conflict resolution	Equal access to justice for all citizens	International human rights incorporated in national legal practice	Judicial officers held accountable	Clarity in administering justice	Efficiency of the judicial system

Figure 11 – Public governance indicators

The reduction of State intervention in society and, in particular, in economic sphere, has been constant in the last decades, and fundamentally this intervention would only occur when there are market failures or to guarantee equal access (World Bank 1997).

2.5.2 The impact on New Public Management (NPM)

The movement, known as NPM, posits that Government (acting as the agent of the State) should steer the intervention but could be freed from actually doing what is needed (Osborne & Gaebler 1992). The key elements that traditional public administration struggle with are: the dominance of the rule of law; a focus on administering set rules and guidelines; a central role for the bureaucracy, a commitment to incremental budgeting and hegemony of the professional in public service delivery. (Hood 1991) The NPM intent was to introduce more private sector instruments in the public sector, namely incentives, accountability, management contracts, competition, and meritocracy. Also, the implementation of quasi-market conditions namely price, choice, *value for money* budgets and funding, and progressive transformation of typical public civil servant organization into SOE (Denis et al. 2015). One of the consequences was to separate the regulatory activities from production (in *independent* agencies) even when the supply side was mainly or only public (Grossi et al. 2015; Bruton et al. 2015). NPM beliefs are that public and private management do not differ that much, a shift from process accountability to results, a preference for just one principal, rationalizing organizations for a single-purpose, funding by PPP rather than just the Fiscal Budget, contracting-out over in-house development, a preference for monetary incentives and a stress on cost-cutting (Boston 2013).

NPM was also referred as *new managerialism* and focus on six issues:

1. **Productivity** – to do more with less.
2. **Marketization** – leveraging market mechanisms.
3. **Service oriented** – to better connect government with citizens.
4. **Decentralization** – to make those who decide close to those who are affected.
5. **Policy** – to improve government´s capacities to create and implement public policy.
6. **Accountability** – to make government deliver on what it promises.

According to (OECD 1995) the impact of NPM was worldwide, in contrast (Pollitt 2001) considered that convergence a myth. In some countries, the ideas came from outside influence whereas in others the reforms were internally driven and then got the label of NPM (Christensen & Laegreid 2013).

A common theme for the NPM was the control of the bureaucracy, seen as the great devil (Osborne & Plastrik 1997).

NPM was contested on theoretical and specific applications. (Meier & O'Toole Jr. 2009) found what they called 10 Proverbs that show different results, especially concerning:

> *Organizations could be stable and perform well and they are not always vulnerable to political pressures.*
> *Good managers can make some difference and do not necessarily need to choose between competing goals*.

In response to NPM, the New Public Governance based its theoretical support on Stakeholder theory versus Agency theory, and on sustainable public services versus competitive market behavior (Osborne 2010). On the limits of managerialism and public and private boundaries, Mintzberg´s article (Mintzberg 1996) exposes a balanced view, on the use of managerial tools and public service principles.

2.5.3 Corporate Governance and State-Owned Enterprises (SOE)

According to agency theory the State, as the principal, provides weak monitoring and soft budget restrictions, create weak incentives for managers, as the agents. Also, by simultaneously performing, functions of regulator and owner of economic actors creates conflict of interest. The State creates more opportunities for corruption and may create obstacles for independent firms to compete (Musacchio et al. 2015). From the Resource dependence theory also a critic is made that the endowment with state resources makes SOE reluctant to develop skills to obtain these resources without state support. There are also some positive effects of state control such as a power disproportionate resulting from the shareholder status, public transparency procedures on purchasing and benefits from synergy by belonging to the largest group (Grosman et al. 2016).
Claims of unfair completion or lower performance by SOE have been found anecdotal or unsupported in recent OECD study (Kowalski et al. 2013). A fundamental characteristic of SOEs is that they fulfill a public mission,(Del Bo & Florio 2012) but that requires that SOEs have transparency and reporting covering more dimensions than a private company (Del Bo & Florio 2012). SOEs tend to mimic the existing private companies regarding CG, hence the more common Board composition and CEO role replicated (Yaacob & Basiuni 2013; Bruton et al. 2015).

2.5.4 OECD Guidelines on Corporate Governance of SOE

In 2005, OECD issued the first guidelines on corporate governance of SOE(OECD 2005) in order to provide governments and other stakeholders with a referential to establish CG practices on SOE. Aligning with NPM and agency theory these Guidelines recommend that *the state should exercise its ownership functions through a centralized ownership entity, or effectively coordinated entities, which would act independently and in accordance with a publicly disclosed ownership policy*.
Other aspects highlighted, like not distorting completion in favor of SOE, and that nomination of Board members should not impose undue political interference in the management of the company. The first section is dedicated to recommendations to ensure a level-playing field in markets where SOE compete with private sector, assuring that financing terms, law applicability, and creditors rights have equitable terms to other companies. Section two concerns about governments not interfering in the day-to-day management, and that the ownership entity should be accountable to representative bodies and the supreme audit institutions. A note is also included about remuneration to attract and motivate qualified professionals. Section three deals with equitable treatment of shareholders when SOEs do not have the state as a sole shareholder. Section four is dedicated to the relations of stakeholders and internal codes of ethics. On the fifth section, recommendations are made regarding internal and external audit to promote disclosure and transparency. Section six deals with the Boards, claiming as a best practice duality avoidance and creation of specialized committees for audit, risk management and remuneration.

An interesting note is made on detailed explanations:

> *Centralization of the ownership function in a single entity is probably most relevant to SOEs in competitive sectors, and it is not applicable to SOEs that are mainly pursuing public policy objectives. Such SOEs are not the primary target of these Guidelines and in their case, sector ministries may remain the most relevant and competent entities to exercise ownership rights which might be indistinguishable from policy objectives*.

In addition, observations are made, regarding the assignment to the Board of the appointment and dismissal of CEO´s. Otherwise it would be difficult to exercise their authority. OECD recommends that, Board members should not act as individual representatives of the constituencies that appointed them; and that they should be recruited from the private sector, even detailing that the audit committee should only be composed of independent and financially literate board members. Highlights are also made regarding duality avoidance and, preventing appointment of the retired CEO to the Chair position.

A decade later OECD produced an updated Guidelines document (OECD 2015).

The first section is new and provides a rationale for state ownership:

> *It should carefully evaluate and disclose the objectives that justify state ownership and subject these to a recurrent review.*
>
> And the annotation explains:
>
> *In OECD countries, the rationales for establishing or maintaining state enterprise ownership typically include one or more of the following: (1) the delivery of public goods or services where state ownership is deemed more efficient or reliable than contracting out to private operators; (2) the operation of natural monopolies where market regulation is deemed infeasible or inefficient; and (3) support for broader economic and strategic goals in the national interest, such as maintaining certain sectors under national ownership, or shoring up failing companies of systemic importance.*

An interesting recommendation added is: *SOEs' economic activities should be required to earn rates of return that are, taking into account their operational conditions, consistent with those obtained by competing private enterprises*.

Other updates adjust the language, and establish recommendations on diversity, transparency rules regarding public policies pursuing and political independence, but most of the recommendations are kept as before.

On 2013, OECD published a report on national practices regarding the Boards of SOE (Oecd 2013). Aligned with previous guidelines some good practices are predicated such as: making the appointments on a whole-of-government basis, having a specialized body in charge of advising or accrediting the nominations, limiting the number of individual board appointments. The analysis of country specific practices shows that there are large differences, and the way the guidelines implementation is evaluated, is not too strict.

Complementing the OECD guidelines, the World Bank issued a Toolkit Manual with detailed explanations and checklists for corporate governance of SOE (The World Bank 2014).

2.6 Hospitals and Governance

2.6.1. Managing Hospitals

Running even the most complicated corporation must sometimes seem like child's play compared to trying to manage almost any hospital (Glouberman & Mintzberg 2001).

Hospital Governance concerns a complex system of checks and balances of decision-making in order to conduct the effectiveness and good performance of a Hospital assuring efficacy and sustainability. (Eeckloo et al. 2004) *In essence, it is an integrated governance* (Delaney 2015; Kuhlmann et al. 2016). The term integrated governance has not been stabilized in the literature, (Institute of Public Administration Australia 2002) but as a working definition, this research adopts the NHS´ statement: (Blackburn et al. 2006)

> *'Systems, processes and behaviors by which trusts lead, direct and control their functions in order to achieve organizational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organizations'*

The Government as policy maker have its expectations aligned with the citizens: Equitable access, no delays, and quality services. As an owner Government wants no scandals and costs within the budget with a high level of activity. Professionals want to do a good job with manageable stress and rest, with good tools and systems. Boards have to balance these conflicting expectations (Barnett & R & Powell 2001).

Hospitals have to confront with clinical autonomy. This is a characteristic of professional bureaucracies (Mintzberg 1989).

> *In fact, not only do the professionals control their own work, but they also seek collective control of the administrative decisions that affect them, decisions, for example, to hire colleagues, to promote them, and to distribute resources. Controlling these decisions requires control of the middle line of the organization, which professionals do by ensuring that it is staffed with "their own."*

NPM reforms pushed in the opposite direction by adopting typical command and control approach to internally organize and manage clinical operations.

> *Adopting NPM across Europe, a movement to challenge the dominance of clinical professionals, started and spread in waves of transformation, from ownership, management model and financing. One of the features of these reforms has been the recruitment of new cadres of specialist managers who took responsibility for coordination and control tasks, resource allocation (including staff) to meet performance objectives* (Kirkpatrick et al. 2016).

A study (Johnson & Dobni 2015) on Canadian hospitals based on Mintzberg´s model confirmed that the tendency from management to execute multiple roles and functions, including numerous, variable and nonroutine tasks are magnified in the public sector. The tendency to act immediately, as reflection is sometimes seen as inaction, is also present in the healthcare sector.

The results of how and whom managers spend their time is shown in the table below comparing results with previous Mintzberg´s study almost forty years ago.

	Mintzberg (1973)	Johnson & Dobni (2012)
Meetings	64%	61.2%
Tours	2%	2.3%
Telephone calls	6%	5.2%
Desktop	20%	23,8%
Transportation	8%	12.7%
Average working time/week	***45h 24 m***	***56 h 34m***

Figure 12 –Time spent by Hospital managers

The place of internal meetings has moved from the CEO office, to a common Conference room or outside premises, and, those meetings changed from being mostly one-on-one to four or more people together; that may explain the move from the CEO office.

The data shows that healthcare CEOs, of this Canadian study, spend considerable time with superiors being, Board members, politicians or high-ranking bureaucrats. Outside contacts were not that relevant thus the CEOs social network does not seem to have a key role.

Contemporaneous to Mintzberg´s study, (Pfeffer 1973) researched 57 hospital in USA, including four types: state/local owned, for-profit hospitals, owned and operated by religious denominations and private nonprofit with no religious affiliation. Regarding the size of the Boards, Pfeffer concluded that they will be larger when the boards are used to link the organization to its environment (e.g. raising funds), and smaller when the organization is state/local owned or when the board is used for managing and administration.

After healthcare transformation in Czech Republic a study (Pirozek et al. 2015) found in a sample of 100 Hospitals that legal form had no influence on economic results. Also the size of the hospital, the size of the supervisory board and the medical qualifications of the senior management had no statistically variable influence on the efficiency.

A different result was achieved by (Prybil 2006) in a study on the USA developed in 2004, concluding that the presence of about 25% of physicians on the board achieved a better performance than others where their presence was none or minimal.

The higher ratio of insiders on the Board, particularly medical professionals, led to the highest financial performance, contradicting the agency theory in a sample of New Hampshire hospitals in 2010 (Brooks 2012).

Supporting agency theory, a study in 2011 revealed quite the opposite, showing that management presence in the Board hinder financial results (Collum et al. 2014).

These studies confirm that it is difficult to have a definitive opinion on Hospitals´ Board composition, and that including clinical professionals and insiders is still a matter of debate.

2.6.2 Hybridity in Hospital Management

As Mintzberg (1989) pointed out, Hospitals are professional bureaucracies. NPM impact (Denis et al. 2015) on Hospital management aimed to reinforce finance dimensions which, clinical professionals would not be so prepared and, include managers with a distinct background. It also acted on a deeper level on the mental processes changing somehow the framework. (Numerato et al. 2012) Even in typical hierarchical organizations like military institutions the person-in-command cannot make a physician intervene or not against their own will.

Hybrid professionalism arises when professionals and managers collide on how work is coordinated, on how authority is established and what values are at stake (Noordegraaf 2015).

	Professionalism	**Managerialism**
	Protected professionals treat cases	*Well-run organizations deliver goods and services for customers*
Coordination	*Skills, Norms*	*Hierarchy, Markets*
Authority	*Expertise, Service Ethic*	*Results, Accountability*
Values	*Quality, Humanity*	*Efficiency, Profitability*

Figure 13 – Professionalism vs Managerialism

When these conflicts are solved, Hybrid Professionalism result in Professionals treating cases with well-managed organizational contexts (Noordegraaf 2015).

Through soft mechanisms of market compensation and control, an organization can pursue what in the past was only conceived through bureaucratic mechanisms and hierarchical command, a process now coined “soft bureaucracies” (Courpasson 2000). This is an example of **co-optation** of management culture. Another form of hybridization is achieved using **negotiation** by which doctors as seeking to limit managerial involvement, assuming some managerial aspects in self-regulation. A third form is called **reverse managerialism**, when physicians assume managerial discourse and take charge in order to preserve their professional objectives. This includes paperwork compliance, and use of standardized formal vocabulary or language while hiding the content. One known example is the so-called EBM – Evidence-based Medicine.

> *Professionalism can create blind spots within organizations, blocking the flow of critical information about unsafe conditions. This is because professional groups develop unique subcultures, specialized language, and communication habits that tend to separate them from other professional groups, even when those groups work within the same organization* (Holtman 2011)

Finally, resistance to management is sometimes clear in **professional opposition** manifested in a reluctance to use clinical guidelines, utilization review and other tools, focusing on ethic norms of conduct that reinforce independence from management (Numerato et al. 2012).

Tactics like the creation of expert networks tend to undermine individual freedom and increase the demand for accountability some type coupled with some monetary incentives. Forms of professional resistance may include their participation in norms creating so many conditions and

exceptions that make the implementation almost impossible or ineffective at all or by occupying themselves control positions. It is important to understand these types of reaction from the medical professionals to put into perspective their willingness to assume management and board roles in Hospitals.

(Mcgivern et al. 2015) found five hybrid role claiming narratives:

The **first** suggested that professionals have been volunteered by professional colleagues for hybrid roles and felt obligated to do a "*turn*", justifying as a *passive professional obligation*.

The **second** narrative is out of a sense of obligation and in response to departmental or managerial problems. It is a *reactive professional obligation*.

The **third** option is to position hybrid roles as senior professional positions dismissing its managerial component and, assuming themselves as *professional representatives*.

A **fourth** situation occurs when the hybrid role is a consequence of a hybrid identity work earlier in professional's careers. These are more managers than physicians.

Finally, a combination of medical and progressive management positions that allow professionals to grow both professionally and experience coordination is an explanation for a **fifth** narrative.

As we can see from this description some professionals reluctantly and other willingly enacted hybrid roles. The former keep their professional status and this role is temporary, others assume their roles as formative for new generations of professionals, but are often caught between the two worlds of managerialism and professionalism.(Currie et al. 2016) Usually, incidental hybrids may be Clinical Directors but seldom CEOs, while willing hybrids seek CEO status or Public Health Officer roles.

2.6.3. International review

(Richard B. Saltman et al. 2016) in their comparative study of public hospitals in Europe defined three levels of governance: the **macro-level** is part of policy making (e.g., finance, coverage, structure and organization of hospitals); the **meso-level** mainly focused on decision-making at institutional levels of the hospital and the **micro-level** referring to everyday operational management.

The range of models in Europe (Richard B. Saltman et al. 2016) is considerable from:

- "self-governing trust" and "foundation trusts" (United Kingdom)
- "joint-stock companies" and "foundations" (Estonia)
- "limited liability companies" and "joint-stock companies" (Czech Republic)
- "public-stock (state or locally owned) corporations" (Sweden)
- "state enterprises" (Norway)
- "PEEH – public enterprise entity hospitals" (Portugal) –
- "public healthcare companies", "public healthcare foundation", "administrative concessions" and "consortia" (Spain)

These different structures can be seen as four general types:

1. regular public hospitals with direct political management, mostly existing in tax-funded systems (Finland, much of Sweden, Ireland, the former Yugoslav Republic of Macedonia) but also some – especially tertiary care university hospitals – in social health insurance (SHI)-funded systems (France, Germany, Switzerland);
2. semi-autonomous public hospitals with various degrees of independent decision-making, existing in tax-funded systems of various types (Norway, Estonia, England; some hospitals in Spain – Andalucía, Balearic Islands, Catalonia, Madrid, Murcia and Valencia – as well as in Portugal; several northern regions of Italy; Israel; and the Czech Republic);
3. non-profit-making private hospitals – typically with religious or community missions and boards, which mostly receive funding through public channels, particularly in SHI systems (Netherlands, Germany, Switzerland), but also in small numbers in some tax-funded systems (England, Sweden);
4. profit-making private hospitals – typically small clinics that are often started by physicians, particularly in countries with SHI systems (France, Germany, Switzerland), but also a small number in some tax-funded countries (Denmark, Norway).

How Hospitals are financed is a crucial dimension regarding their management, traditionally there was a global budget with some detailed items managed like any other public institution with centralized control. The move to pay for activity and based on case-mix-based values is now common.

To have a physician on the Board or at the Executive level is also relatively common in Europe. In Sweden, the public hotel governance is characterized by the strong inclusion of professional actors in regulatory bodies and policy-making. Marketization is linked to patient choice thus reflecting a culture of equity and quality. (Kuhlmann et al. 2016) Almost all hospitals are publicly owned, financed and controlled by a board appointed by the responsible County Council. On the top-level of the organization, the executive manager is often a doctor or another health professional. Nurses usually have a strong position in the middle to lower levels of management.

Survey of doctor managers in 15 OECD countries extracted from (Rotar et al. 2016)

Country	MDs in Top Management Team	Formalized interaction between MDs and TM	Formalization into force since	MDs involvement in TM tasks	Type of tasks	MDs role in TM decisions
Belgium	Medical doctors	YES	1987	YES	mostly advisory	Consultative
	Economists					
	Managers					
	Nurses					
	Jurist					
Czech Republic	Medical doctors	YES	2012	YES	all - most managers are MD	Decisional
	Managers					
Denmark	Medical doctors	YES	1990	YES	support the development of clinical indicators & practice guidelines; education; human resources;	Decisional
	Economists					
	Managers					
	Nurses					
England	Economists	NO	N/A	YES	depending on internal processes and regulation; nothing standardized	
	Finance					
France	Medical doctors	YES	-	YES	e.g. infection management	Decisional (in practice)
	Managers					Consultative (in theory)
Germany	Medical doctors	YES	-	NO	N/A	Consultative
	Economists					
	Managers					
	Academia - where the case					
Israel	Medical doctors	YES	2009	YES	National Programme of Quality Indicators	Consultative
	Economists					
Italy	Medical doctors	NO	N/A	YES	only at a medical unit level	Consultative
	Managers					
Luxemburg	Medical doctors	YES	1998	YES	coordination of medical interdepartmental activities	Consultative
	Economists					
	Nurses					
Poland	Medical doctors	YES	1998	YES	advisory and decisional	Decisional
	Managers					Consultative
Portugal	Medical doctors	YES	many years ago	YES	e.g. infection control	Decisional
	Economists					
	Managers					
	Nurses					Consultative
	Legal					
Slovenia	Medical doctors	NO	N/A	YES	e.g. delivery of services, volume of services, waiting times;	Consultative
	Economists					
Spain	Medical doctors	YES - depends on the region	2006	YES	local guidelines	Decisional
	Managers					
Sweden	Medical doctors	NO - in most regions	N/A	YES	e.g. setting Quality Indicators and guidelines	Consultative
	Managers					
Turkey	Medical doctors	NO	N/A	YES	all hospital management task	Decisional
	Economists					

Figure 14 - Doctor managers in 15 OECD countries

In models with Supervisory Board, it is the norm that the Executive Management or the CEO-only is appointed by the former. Several models (Czech Republic, Norway, and Spain) the regional or municipal government appoints board members. Rules regarding composition exist for example in Portugal, determining that one member should be the clinical director (a physician), and another a nurse director (a nurse). Direct citizenship participation is largely absent in the countries surveyed (Richard B. Saltman et al. 2016).

Performance related incentives may affect staff and management but to a lower percentage, usually not more than 20%. Benchmarking of performance indicators is common, but the availability to the general public varies from country to country.

> *Semi-autonomous hospital models are seen as being reasonably successful in most if not all of the eight countries studied in this volume. Despite the various difficulties detailed earlier, most of these hospitals have considerably more discretion in their operating decisions than their traditionally managed public peers, and at least some have a certain level of input in decisions regarding more strategic issues, such as budget, finance and capital development. The conclusion is that, for all practical purposes, no publicly owned hospital is, or can ever expect to be, fully autonomous* (Richard B. Saltman et al. 2016).

Continuum of hospital governance strategies from Saltman (2016).

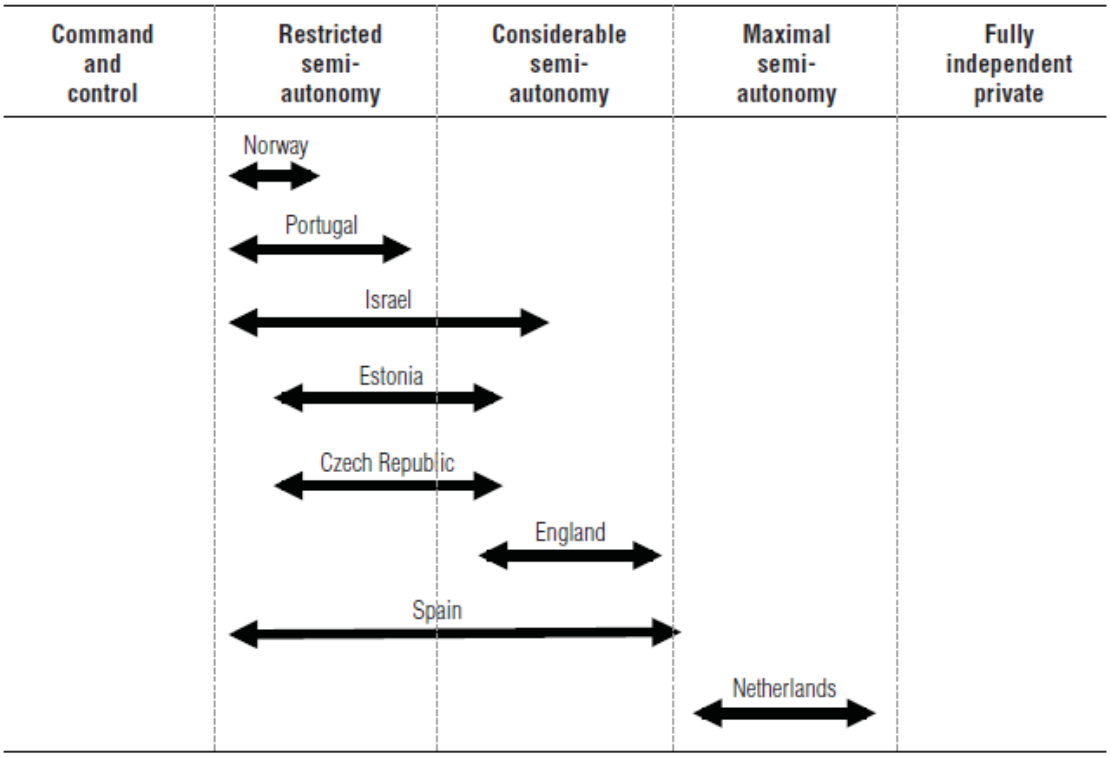


Figure 15 – Hospital governance

2.7 Cultural Context

2.7.1 Cultural differences and implications

A country's social and cultural characteristics have an important influence on governance structures (Hofstede 1993). To be effective, corporate governance principles must be part of the culture of an organization (Mintzberg 2005).

Hofstede´s model defined four basic dimensions, updated later to consider the short or long term orientation regarding decision-making, as a fifth dimension, thus explaining Asian differences.

> **Individualism versus Collectivism**. This dimension concerns the relationship between individual and group. It refers to a preference for loosely knit social relations in which individuals are expected to care only for themselves and their immediate families versus tightly knit relations in which people can expect their relatives, clan or other in-group to look after them in exchange for unquestioning loyalty.
> **Large versus Small Power Distance**. This dimension deals with the extent to which the members of a society accept that power in institutions is distributed unequally. People in large power distance societies accept a hierarchical order in which everybody has a place which needs no further justification. People in small power distance societies strive for power equalization and demand justification for power inequalities.
> **Strong versus weak Uncertainty Avoidance**. Uncertainty avoidance is the degree to which members of society feel uncomfortable with uncertainty and ambiguity. Strong uncertainty avoidance societies maintain rigid rules, codes of belief and behavior and are intolerant of nonconformists. Weak uncertainty avoidance societies maintain a more relaxed atmosphere in which practice counts more than principles and deviance is easily tolerated.
> **Masculinity versus Femininity.** This dimension deals with the social implications of gender. Masculinity stands for preference in society for achievement, heroism, assertiveness and material success, while femininity emphasizes relationships, modesty, caring for the weak and interpersonal harmony (Mooij & Hofstede 2007).

Although some critics have arisen, concerning the methods and conclusions of Hofstede´s model, it remains today a valid framework for analysis and understanding of cultural differences (Sondergaard 2001). More recently the Globe project expanded on Hofstede´s model to a more comprehensive set of dimensions, but the essence of the original model is present(Hoppe 2007). Following Hofstede´s model governments in countries with high values of power distance and uncertainty avoidance (Portugal) tend to prefer centralized bureaucracies in which there are strict regulations, and administrative behavior is directed by hierarchical leadership.(Verhoest 2013) Management by Objectives and performance-related pay would apply to countries with lower values of power distance and uncertainty avoidance and high values of individualism and masculinity (opposite case of Portugal).

(Bloom et al. 2012) research on management "best" practices across firms and practices, defined "best" as those that continuously collect and analyze performance information, that set challenging and interlinked short and long-run targets, and that reward high performers and retrain/fire low performers. Under those parameters government-owned organizations scored low across all sectors, they were particularly weak at incentives or punishment, valuing tenure over performance. It seems that country specificity is not that important because multinational could score high in almost country in which they operate.

Management practice scores by country as in (Bloom et al. 2012)

Country	Overall Management	Monitoring Management	Targets Management	Incentives Management	Firm Interviews
Argentina	2.76	3.08	2.67	2.56	246
Australia	3.02	3.27	3.02	2.75	392
Brazil	2.71	3.06	2.69	**2.55**	568
Canada	3.17	3.54	3.07	2.94	378
Chile	2.83	3.14	2.72	2.67	316
China	2.71	**2.90**	**2.62**	2.69	742
France	3.02	3.41	2.95	2.73	586
Germany	3.23	3.57	3.21	2.98	639
Greece	2.73	2.97	2.65	2.58	248
India	**2.67**	2.91	2.66	2.63	715
Italy	3.02	3.25	3.09	2.76	284
Japan	3.23	3.50	**3.34**	2.92	176
Mexico	2.92	3.29	2.89	2.71	188
New Zealand	2.93	3.18	2.96	2.63	106
Poland	2.90	3.12	2.94	2.83	350
Portugal	2.87	3.27	2.83	2.59	247
Republic of Ireland	2.89	3.14	2.81	2.79	106
Sweden	3.20	**3.63**	3.18	2.83	382
U.K.	3.02	3.32	2.97	2.85	1214
U.S.	**3.35**	3.57	3.25	**3.25**	1196
Average	2.99	3.28	2.94	2.82	9079

Figure 16 –Management practice by country

2.7.2 Portugal cultural context

The graphic shows Portugal´s scores comparing with Germany and the USA (Hofstede et al. 2010). These countries possess quite different corporate governance models for Board structures and power distribution.

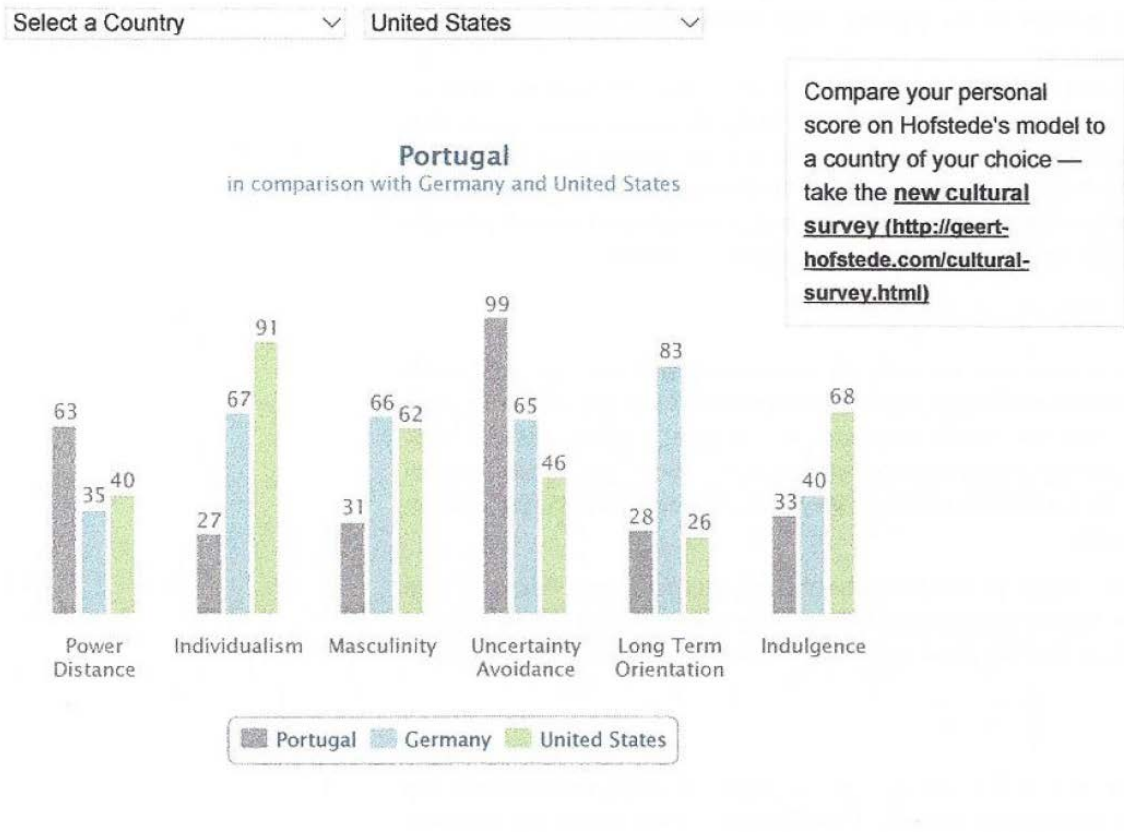
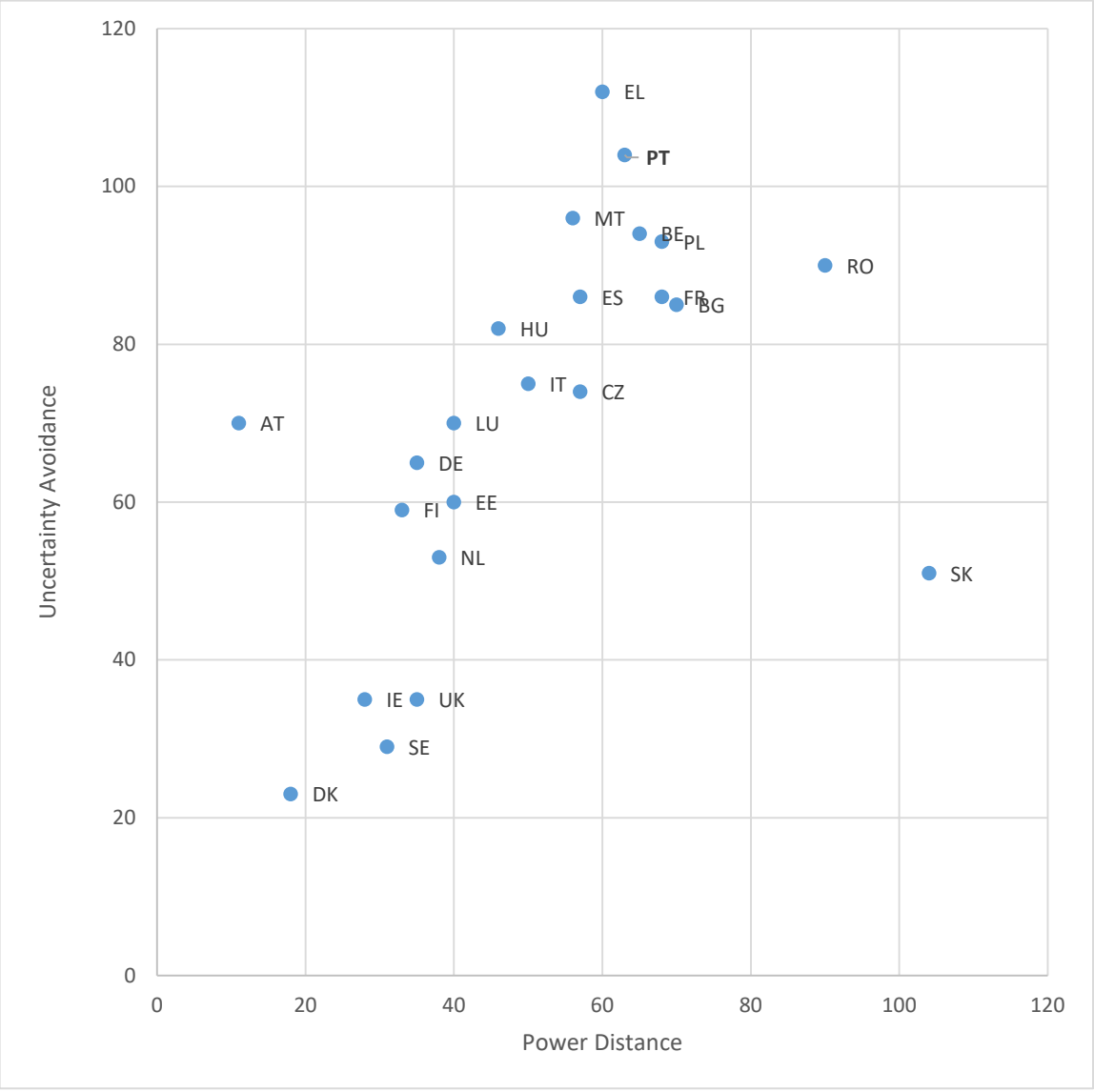


Figure 17 – Hofstede´s scores

*Portugal's score on **Power distance** (63) reflects that hierarchical distance is accepted and those holding the most powerful positions are admitted to have privileges for their position. Management controls, i.e. the boss requires information from his subordinates and these expect their boss to control them. Negative feedback is very distressed so for the employee it is more than difficult to provide his boss with negative information. The boss needs to be conscious of this difficulty and search for little signals in order to discover the real problems and avoid becoming relevant.*
*Regarding **Individualism** (27) Portugal, in comparison with the rest of the European countries (except for Spain) is Collectivist. Loyalty in a collectivist culture is paramount, and over-rides most other societal rules and regulations. In collectivist societies offence leads to shame and loss of face, employer/employee relationships are perceived in moral terms (like a family link), hiring and promotion decisions take account of the employee's in-group, management is the management of groups.*
*Portugal scores 31 on **Masculinity** meaning that it is a country where the key word is consensus. So polarization is not well considered or excessive competitiveness appreciated. In Feminine countries the focus is on "working in order to live", managers strive for consensus, people value equality, solidarity and quality in their working lives. Conflicts are resolved by compromise and negotiation. Incentives such as free time and flexibility are favored. Focus is on*

well-being, status is not shown. An effective manager is a supportive one, and decision making is achieved through involvement.
If there is a dimension that defines Portugal very clearly, it is ***Uncertainty Avoidance*** *(99). Such countries maintain rigid codes of belief and behavior and are intolerant of unorthodox behavior and ideas. In these cultures there is an emotional need for rules (even if the rules never seem to work), innovation may be resisted, and security is an important element in individual motivation.*

Using the results presented for some EU countries (Preda 2012) it is possible to notice the relationship between power distance and uncertainty avoidance.



AT – Austria **BE** – Belgium **BG** – Bulgaria **CZ** – Czech Republic **DE** – Germany
DK – Denmark **EE** – Estonia **EL** – Greece **ES** - Spain **FI** – Finland
FR – France **HU** – Hungary **IE** – Ireland **IT** – Italy **LU** – Luxemburg
MT – Malta **NL** – Netherlands **PL** – Poland **PT** – Portugal
RO- Romania **SE** - Sweden **SK** – Slovakia **UK** – United Kingdom

Figure 18 – Power distance and Uncertainty avoidance scores

2.8 Legal Framework

2.8.1 Corporate Governance in Portugal

The ownership of the corporations in Portugal is still mainly family owned (66,7%) (Esperança et al. 2011) Portuguese legislation allows for, both one and two tier Board structures, and some of the one tier companies may be composed by all executive members (OECD 2017).

Portugal[*2]	[2C] The "**Classic**" model*	-	Board of directors	A board of directors and a supervisory board (*conselho fiscal*) appointed by the shareholders; the board of directors may delegate managerial powers to one or more executive directors or to an executive committee; members of the supervisory board cannot be directors and, in case of listed companies, the majority must be independent.
		-	Supervisory board (*conselho fiscal*)	
	[2A] The "**Anglo-Saxon**" model	-	Board of directors	A board of directors and a supervisory board (*comissão de auditoria*) appointed by the shareholders; the board of directors may delegate managerial powers to one or more executive directors or to an executive committee; members of the supervisory board must be non-executive directors and, in case of listed companies, the majority must be independent.
		-	Supervisory board (*comissão de auditoria*)	
	[2G] The "**German**" model	-	Executive board of directors	A board of directors and a supervisory board (*conselho geral e de supervisão*); members of the board of directors are appointed by the supervisory board (unless the articles of association provide for appointment by shareholders); members of the supervisory board cannot be directors and are appointed by shareholders; in case of listed companies, the majority must be independent; there are more restrictions to delegation of managerial powers by the board of directors.
		-	Supervisory board (*conselho geral e de supervisão*)	

The German two-tier model does not mean a total separation from supervision and management as the legislation of 2002 (*Transparenz und Publizitatsgesetz*) expresses that the Supervisory Board as a duty and the power to limit management decisions through some authorizations required.

One could find here some parallel with the Portuguese SOE legislation with only one executive tier, maintaining Government officers the supervision power and reserving some matters to their approval.

The three main structures in Portuguese firms related to corporate governance matters are: the general meeting of shareholders, the board and the audit committee (Conselho Fiscal). The company by-laws may limit to one-third the maximum number of board members proposed by a group of shareholders and also may allow at least one board member of minority shareholders representing at least 10% of the share capital (OECD 2017). The notes on CEO and executive turnover from OECD (2017) :

> *The market for CEOs is mainly internal. Although there are a few exceptions as to foreign board members (most of them representing a qualified foreign shareholder), there is only one foreign CEO at this point. Traditionally, CEOs stay in the company through several mandates; on average the CEOs in office today have been in the job for 8 years and 13% of the existing executive members at the end of 2015 had been appointed in 2015. Despite some degree of mobility within companies of the same group, there is no significant mobility from one group to another. Furthermore, there are also companies that due to their small structure do not have an executive commission and therefore have no CEO. An increase of foreign executives has been verified in the context of share capital increases underwritten by foreign investors and M&A transactions.*

Transparency on remunerations and disclosure of information situates Portugal legislation as one of the most advanced within OECD members.

2.8.2 . CG in Portuguese SOE

The SOEs have been present for many years in Portugal although, after 1974 and the nationalization of banks, utilities and several other sectors, their relevance became higher. The regime of the law (Decreto-Lei nº 260/76 de 8 de abril) forty years ago had strong limitations to management decisions without prior authorization from the Government. A formal Public Management Statute was enforced by Decreto-Lei nº 831/76 de 26 de novembro. After EU integration several legislation was promoted and by 2007 two major laws were approved: Decreto—Lei nº 558/99 de 17 de dezembro, with a new configuration for the SOE; a new Public Management Statute by Decreto-Lei nº 71/2007 de 27 de março and a Council of Ministers Resolution defining the Principles of good Management Practices for SOE.

SOE in Portugal may assume two different forms: a share-based corporation in which the State has the total or a significant part of the capital; and the PEE – Public Enterprise Entity in which the State has always the total capital. The first example is similar to a private company with some special duties and limitations because of government ownership.(e.g. RTP, SA, CGD,SA)

SOE Hospitals concerning this research started belonging to the first model (S.A.) and then were transformed into PEE (EPE – Entidade Publica Empresarial) (Ferreira 2009).

As part of the Finance Ministry duties annually is published a report evaluating how the recommended good management practices for SOE are achieved (DGTF 2013).

In 2013 a new legislation was approved (Decreto-Lei 133/2013 de 3 de outubro) revising the SOE statute and creating a new agency (Unidade Tecnica de Acompanhamento e Monitorização do Sector Público Empresarial) to monitor SOE and support the Government as shareholder.

This legislation reinforces the power of the Minister of Finance as the sole member of the government responsible for the shareholder function (Paz Ferreira 2013).

Remuneration of Board members has also been subjected to normalization and reduction through a classification of entities in terms of size and responsibility, greatly diminishing the CEO remuneration. Other members ´ compensation, (executives or non-executives), was established as a percentage of the CEO´s. For Executive Board members, of the same entity, this percentage varies from 80 to 100% and considering the total range of classification of entities the range varies from 64 to 100% of the highest compensation (Ministros 2012a; Ministros 2012b; Ministros 2012c; Ministros 2013).

By the end of 2011 a new mechanism was created to screen and evaluate Public Executive Managers. CRESAP (Comissão para o Recrutamento e Selecção para a Administração Publica) in its scope will evaluate not only Direct Public Administrators but also board members of SOE as well as Executives to be nominated to Regulatory Agencies.(Assembleia da República 2011)

A generic “best fit” profile for SOE Board members was developed including 12 characteristics: Leadership, Cooperation, Motivation, Strategic orientation, Results Orientation, Public service Orientation, Change Management and Innovation, Social sensibility, Professional Experience, Academic background, Professional education, Knowledge of the Institution.(CRESAP 2013c; CRESAP 2013b; CRESAP 2013a) Also, IPCG developed a set of recommendations for the nomination of SOE Executives (IPCG 2011).

2.8.3 National Heath Service (SNS) evolution

In the sixties, there was virtual no public network of hospitals in Portugal, mainly dominated by nonprofit organizations (*Misericordias*), with the exception of some specialized Hospitals, those connected with the Universities and the *Hospitais Civis de Lisboa*. Only in 1979, and taking the UK NHS example, seen as a model, the SNS was created by law. From the late eighties to the end of the XX century some innovative reforms for Health were approved:

- 1980 Health Foundations – Lei das Bases da Saúde
- 1993 SNS Statutes - Estatutos do SNS
- 90-91 Medical and Nurse career legislation
- 1995 First National Hospital on Private Management Contract (Amadora-Sintra)
- 1999 First ULS (Matosinhos) – Integrating Primary care with Hospital Care.

In 2002 following the NPM movement (Nunes & Harfouche 2015) a new reform was approved changing Hospital Management and transforming 31 Hospitals in corporations, but the only shareholder was the State. (Hospitais, SA). These were then in 2005 transformed in PEE (Entidade Publica Empresarial).

This new model reduced the self-regulation by the professionals and put the emphasis on a benchmarking culture by using clinical protocols (Carvalho 2009).

The Clinical Directorates that already exists, were reinforced by assuming the head a formal sit at the board as an executive. A formal power was given to the Clinical Director, having to report to the Board but not subject to its approval. A recent evaluation shows that, in practice, clinicians are allowed to profit from their activity and to perform autonomously from the board (Correia & Denis 2016).

The Regulatory Health Agency was also created in 2002, and its scope is to look to normal economic regulation, to correct market failures but also to provide the citizens of correct health choices and ethical procedures (Anjos 2015).

Due to permanent imbalances of the Hospital financials, from 2005 started a process of rationalization of the supply side, namely maternities, emergency and urgency services, and medicines prescriptions. On top of the SNS there are still private or public subsystems of compulsory contribution that serve almost 22% of the population that may choose in each instance, the SNS or the network of the subsystem they belong (Alves 2011).

Regarding centralization and power, a former Heath Minister Campos(2004) wrote :

> *Central command does not forcefully imply effective authority. Frequently the central capacity is more apparent than real. It became frequently weakened by the share of power at central level. Stakeholders and pressure groups are centrally organized: unions, doctors', nurses' and paramedical associations, private pharmacists, the pharmaceutical industry, the private health insurance companies, the civil servants' subsystem, the recently created health business groups, all of them are firmly established at central level, in order to exert pressure over the central government* (Campos 2004).

SNS is now under pressure of higher citizen demand, focus on prevention more than in the cure, to cope with ageing phenomena and therapeutically innovation (Fernandes 2015).

2.8.4 SOE Hospitals in Portugal

This research is concentrated in a specific period of 2011-2015, and the scope is the existing SOE Hospitals and their Boards. Defined by law as public institutions endowed by corporate identity, administrative, financial and patrimonial autonomy and an enterprise nature. (Raposo & Harfouche 2011). Boards are appointed for three years and at the timeframe on analysis could have renewals with no limitation. (Ministros 2005) Boards would be composed of a President (CEO/PCA), a Clinical Director, a Nurse Director and one or two other Directors, all executives. Decisions are taking y simple majority, and the CEO holds a quality vote when a tie occurs, of the meetings, minutes are produced and approved and signed at the beginning of the next meeting. Although internal organizational rules and regulations can be decided by Hospital Boards, many procedures are subject to authorization and approval by the Government, such as:

- Work plans and budgets
- Statement of accounts and annual report
- Any investment or expense exceeding 2% of the registered capital.
- Human resources beyond approved plan

> Hospitals sign annually a state budget-funded contract (on average, about 80% of annual hospital revenues) framed by the National Framework Contract Programme (programme contract). The programme contract covers a period of three years, subject to annual reviews, and is followed on a regular basis by the relevant Region. Hospital budgets were traditionally based on the previous year's funding, updated to allow for inflation; since 1997, a growing fraction has been based on DRGs and on non-adjusted hospital outpatient volumes. The methodology for such programme contracts is published each year as guidelines allocating global budgets through ACSS in most cases as a top-down process with only a limited amount of residual bottom-up capacity for the AB to influence the final result (Raposo & Harfouche 2011).

The contract stipulates the level of activity of the Hospital but production over budget is paid as a small percentage of regular production and the reductions in the budget due to lower production also uses a different percentage (higher than over budget but smaller than regular production) (Escoval 2003).

2.8.5 Hospital Boards and evaluation

Raposo (2007) studied 8 Hospitals in Portugal covering the Board composition and activities. At that time found many changes in the Boards due to political changes and influences In the 2000-2007 period on those 8 Hospitals, 22 different board compositions and 21 different CEO´s were observed. (Raposo 2007) At that time the majority of the executives were former public officers, only 2 out of 58 had experiences outside the public Health sector. One-third of the executives were physicians, and that percentage grew to 72% as CEOs.

Regarding the consequences for not meeting the performance criteria, set by the Hospital contracts, the opinions of the executives interviewed were, that there is a substantial difference on what the law determines and the practical consequences. "*Nobody got fired*", but "*public*

reprimands" have some effect. Several reasons were pointed as root causes: late discussion after the year already started, levels imposed top-down, the contracts´ flexibility of interpretation and the political influence. The political nomination by the Health Minister of trustworthy executives was accepted, provided that, they had the necessary competence and experience. The local political influence was less tolerated.

All CEOs interviewed assumed they had chosen their Boards but other comments from executives refer some imposition by the government (Raposo 2007).

Alves (2011) found that SOE Hospitals have inherited the culture and values of traditional public administration, more bureaucrats than managers, supported by excessive regulation, lack of evaluation or merit retribution.(Alves 2011) The total dominance by the financial (budget) and economic control have precluded a broader perspective of the introduction of a Balanced Scorecard approach. Evaluating the need for a supervisory board in the actual SOE hospitals Alves (2011) considers that the representation of other stakeholders could be a plus but the minus of another layer in a territory full of competing competencies would be a burden more than an advantage.

The Audit Office (Tribunal de Contas) developed an evaluation of the enterprise model over the 2001-2004 period. (Contas 2006) concluding that the enterprise model was not less efficient and for some groups of hospitals was even more efficient. Comparing with the UK, Portuguese Hospitals showed more efficiency on emergency procedures but not on inpatient treatment. There was not a consolidated balance of the SNS, showing the deficit and debt incurred by the Hospitals. On another report (Contas 2011b), The Audit Office posits that the inclusion of Clinical director and Nurse Director as members of the Board can represent corporative lobbying and based vaguely in La Porta studies sustain that insiders should not be members of the Board. It needs to be said that, only insiders are members of the Board, and it is a one-tier executive board. Comparing with pure direct administration, another report goes on, recommending that these two technical professionals should be non-executive members. (Contas 2011a) The researcher here is puzzled, how these members, tied on operational decisions on a daily basis could exercise the non-executive roles namely evaluating the CEO; that remains to be explained. The management contracts defined in the legislation without which the mandate should be revoked, were not defined at all, and there is no formal model of evaluation. Even the annual reports and financial account statements were not timely produced and published.

Regarding executives´ remuneration, within the limits established by law, and the restriction during the Troika period, 90% of the Clinical Directors and 38% of the CEOs made the option available to be paid according to their last salary before nomination (Contas 2011a).

2.9 Literature review summary and the research question

In this Chapter, the researcher introduced the main theories that help the understanding of the context of the research question: "**CEO dominance risk in Portuguese SOE Hospitals**".

From the main CG theories, one could see where agency and in this case multiple agency theories can explain some behaviors of Board members, that are also somewhat stewards due to the lack of discretion and of financial incentives. The legal framework confirms these limitations, one of the reasons why physicians only sit on Boards as Clinical Directors or CEOs and sometimes opting for their previous compensation.

The Portuguese cultural context of high power distance and high uncertainty avoidance, the existence of just one shareholder, explains the structure of just one executive Board. Thus duality is the norm, although no formal special power is given to the CEO. The hybridity of the Hospitals is confirmed by the special power that the Clinical Director has not submitted to the Board, what is usual in professional bureaucracies.

NPM had influenced Hospitals by confronting managerialism into a very resistant professional body that reacted in several ways to adjust to the new pressures and limitations.

Some political dependency is noted that, combined with no formal Board evaluation, led to a culture of extended tenure and bureaucratic procedures being more important that outcomes.

Power in the context of Boards, and within the TMT has been the object of serious approaches by scholars with different methodologies. The applicability in the context of SOEs, the specific case of Portugal Hospitals inspires the basis for the methodological approach described in the next Chapter.

CHAPTER 3 – RESEARCH METHODOLOGY

3.1 Introduction

The well know approach to research from Saunders (2009) depicts an onion as a metaphor of the research philosophy.

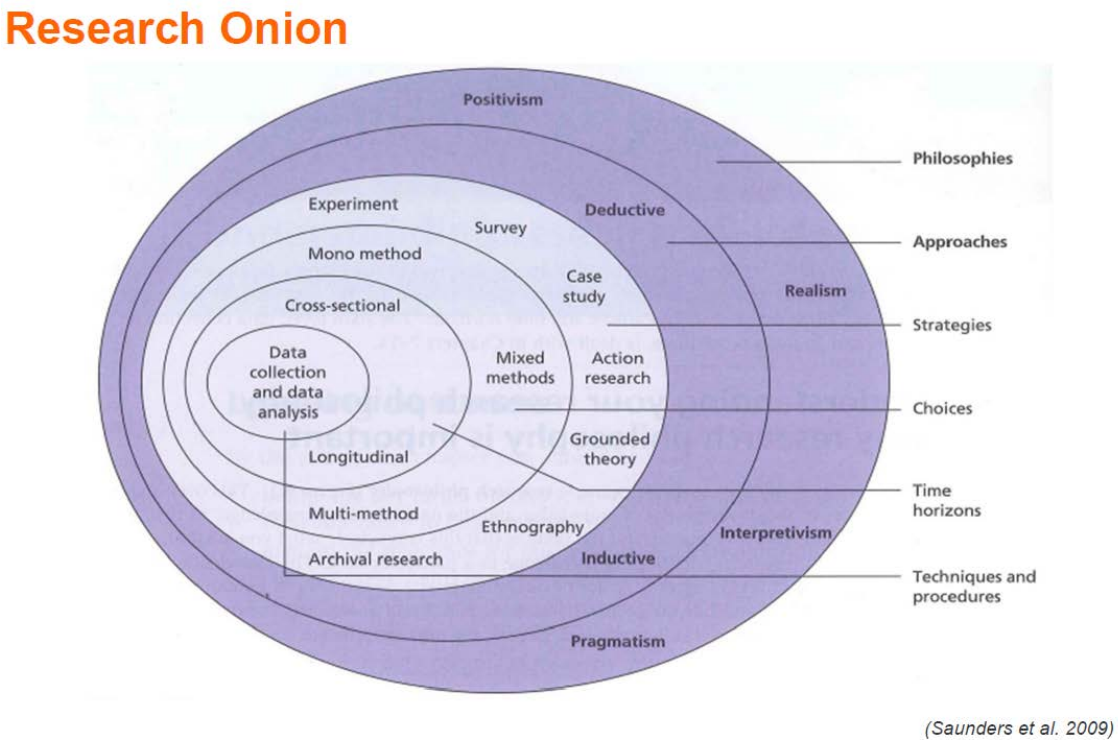


Figure 19 –Research Onion

Power in corporations is ontologically subjective in nature. It only exists in the context of the institutions and the actors to whom that power is relevant including third parties dealing with the institution. But the phenomena described in the research question is observable although one needs to interpret through social norms and give a proper explanation. One method could be to sit on several Boards or read the Minutes of Board meetings and observe if CEO´s dominance is quantifiable by the number of decisions in which he made the Board agree against their initial will. The presence of the observer could jeopardize the normal function of the meeting in the first case and as we observed in the literature review about dissent, minutes tend to be "*politically correct*". Searle (2003) in *"Social Ontology and Political Power"* presented a distinction between Power and Leadership:

> Roughly speaking, power is the ability to make people do something whether they want to do it or not. Leadership is the ability to make them want to do something they would not otherwise have wanted to do (Searle 2003).

This distinction would not be easy to establish by observing Board meetings and minutes.

Based on the chart provided above the researcher opted to an approach as much as possible based on Realism but also considering a Pragmatism view.

Looking at the methods that are available: biographic data on Board members published at the Ministry of Finance website www.dgtf.pt, the set of laws that determine the remuneration of the SOEs´ board members, and the literature review explained before, there are a set of objective dimensions that can be analyzed. However, one's need to validate this method with the Board members´ perception of the power distribution lead to administrate a survey using basically proven tools (Simoes 2011; Kakabadse & Kakabadse 2008; Kakabadse 2007).

Finally and of qualitative value to help shape the questions and also evaluate the assumptions, a set of structured interviews with former Health Ministers and actual Board Members were held as a formal method of collecting data.

This research is far from theoretical or mathematical modeling, (Baldenius et al. 2014), thus the empirical research may contain endogeneity issues (Renee Adams,† Benjamin E. Hermalin 2008). On the other hand it is not dominantly qualitative, although mostly exploratory and also aimed at testing theory (McNulty et al. 2013).

Although this research started as a case study, (the Portuguese State-Owned Hospitals), with the support of informal focus groups of Hospital executives, it uses Questionnaires and interviews as well as quantitative data observation. It mainly falls in the overlap area (quantitative and qualitative) of the continuum designed by (De Villiers 2005)

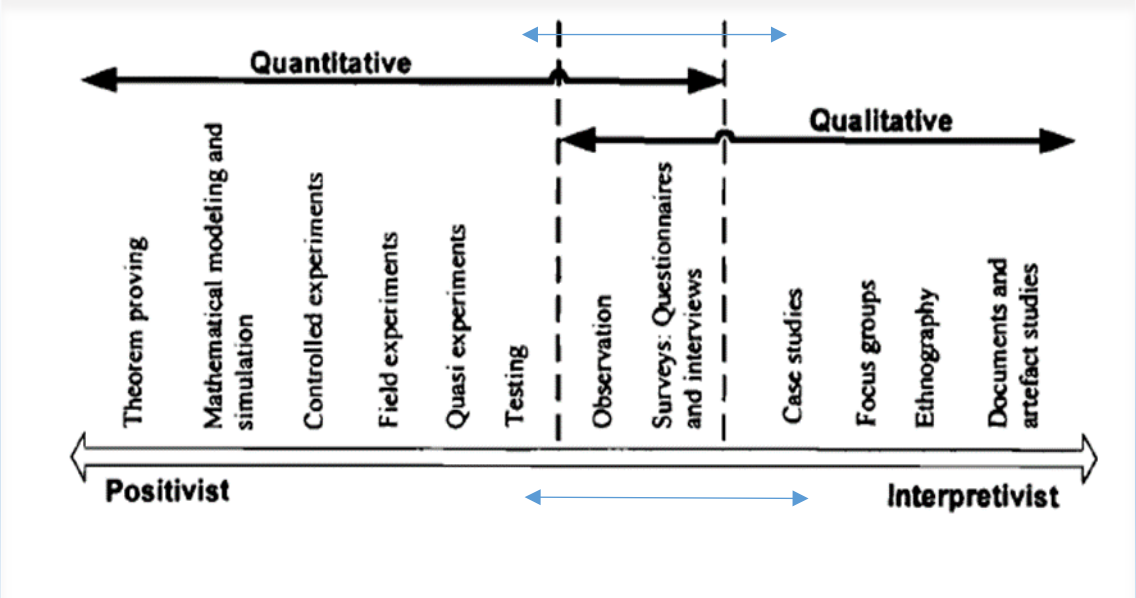


Figure 20 - Continuum of Research

3.2 Methodology and research design

3.2.1 Interviews

Portugal´s government has been led by two parties in alternating periods: The Socialist Party and The Social-Democrat Party. Both parties agree on the maintenance of a public SNS, and the Health Ministers had a moderate view on the issues facing sustainability. The researcher decided to interview four Ministers, two from each party, who agreed to be cited on the record for the exclusive purpose of this research. The Corporate model of SOE was introduced in 2002 and later evolved to PEE (public enterprises) in 2005. The two Ministers who promoted these legislations were interviewed. The timeframe of analysis of the Boards covers 2011-2015, a period when Portugal was under Troika´s surveillance and agreements and had the same minister during all legislation so obviously, the researcher choose to interview this Minister. And lastly, an interview was registered with the succeeding Minister.

A disclaimer should here be noted, that the researcher, started the investigation prior to the period of analysis on the theoretical foundations, he was in charge of the Health Central Procurement and CIO functions, during two years (2011-2013), (when he suspended the doctoral program, and could have personal knowledge of Hospital management and Board functioning), and he was already acquainted with all the interviewed Ministers.

Additionally, a set of interviews were done with different Board members from distinct Hospitals, so no two interviews cover the same Board. The researcher interviewed two CEOs (one physician), two Clinical directors (one working with a physician CEO), and two Board members with management background (one with a physician CEO). All the interviews were very friendly and cooperative and from people with whom the researcher was previously acquainted, during his assignment at the Health Ministry. The principal objective of these interviews was to shape the questions for the survey that would constitute one of the bases of this research, to ascertain the relevance and the proper understanding of the issues. The choice of combining physicians and non-physicians was also valuable to format the right language, to some specific questions added to the basic survey.

These interviews were preceded by the script to focus the interviews (annexes A and B), and each was voice recorded in agreement with the interviewees, with no limitations in language or references that would be afterward edited. On the first transcript of these interviews, the researcher edited to take out personal or institutional references, cut all the small talk and then sent for final editing by the interviewee.

3.2.2 Sample and data collection process on Boards demographics

The choice of the period of 2011-2015 was made for a number of reasons. First, it was one of the longest periods in Portugal with the same Health Minister. Thus any Board changes were less politically driven; plus, the personal knowledge of the researcher of the members that would help future surveys and the data availability.

In Portugal all nominations of SOEs Board members are public and a short CV (most of the times prepared by the nominee) is also published justifying the decision. The ministry of Finance as the shareholder also keeps the record of all SOEs, their Boards, and remunerations. http://www.dgtf.pt/sector-empresarial-do-estado-see/informacao-sobre-as-empresas

Hospitals belonging to Portuguese SOEs, may have three different structures: an individual Hospital, a Group of Hospitals under the same management (Centro Hospitalar) or the combination of primary care and Hospital(s) (ULS Unidade Local de Saúde), As explained before the term Hospital(s) is used indistinctively in the research meaning the PEE - an SOE institution. An a priori decision was made, not to mention specific data of an institution, which lead this research to exclude the Algarve region, where there is only one Centro Hospitalar, which resulted from a merger of existing two individual hospitals during the period of analysis. Also, those institutions that were merged within or after that period were excluded for data consistency. Thus, of the 39 existing Hospitals, the researcher studied 29, including all University-hospitals, and representing all major cities and regions, excluding Algarve. The full list of Hospitals covered is included in annex C. The distribution of the Hospitals covered by type and zone is shown in figures 21 and 22.

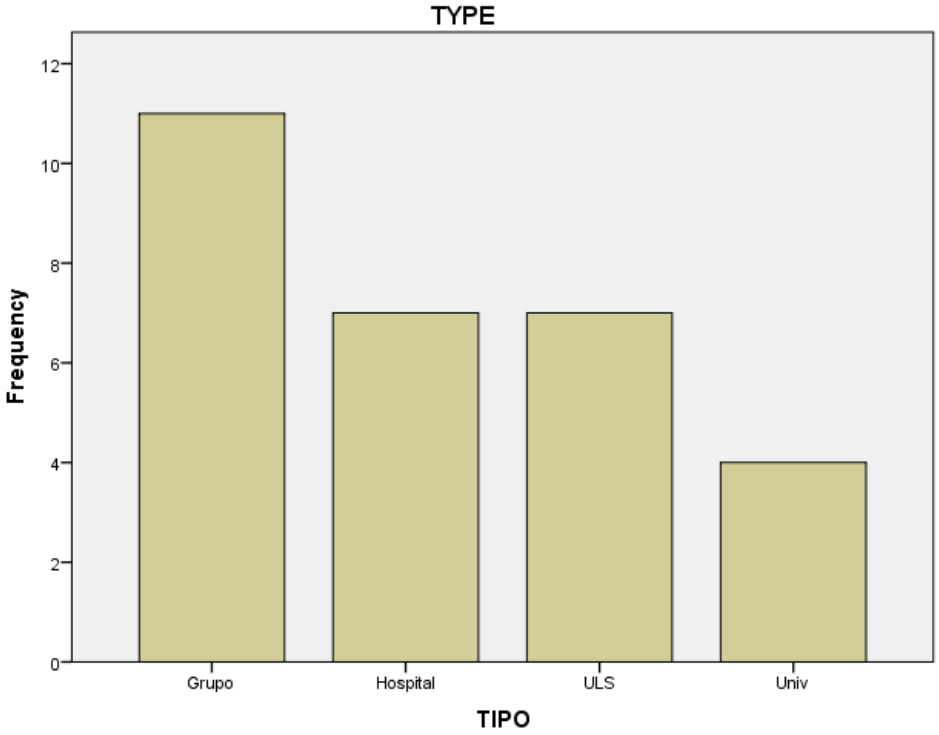


Figure 21 - Hospitals by Type

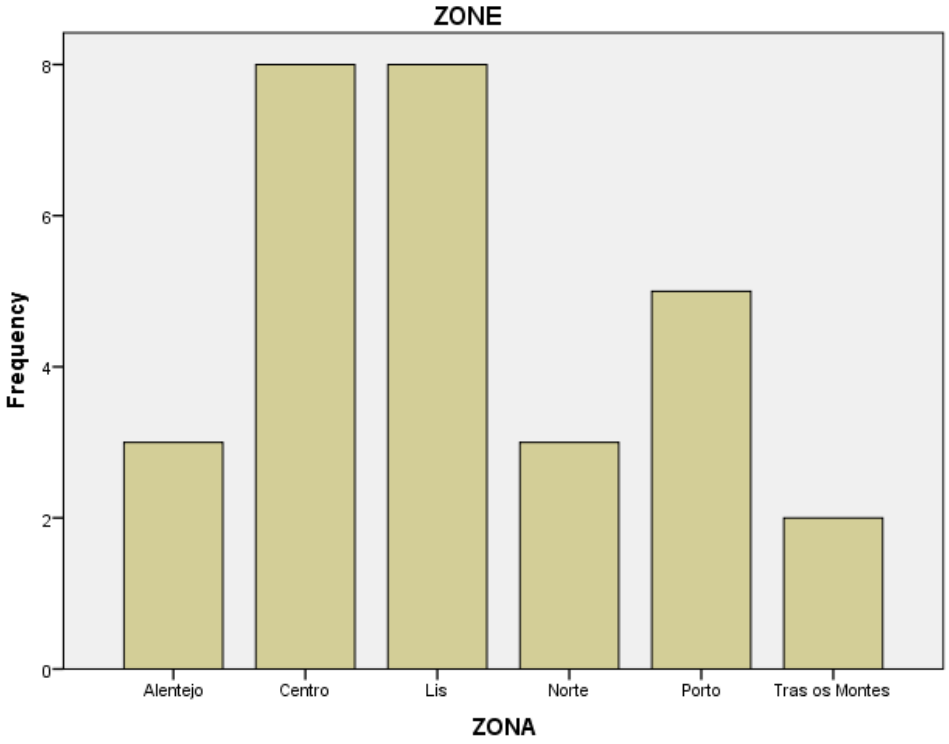


Figure 22 - Hospitals by Region

The total number of Executives is 138 and all references by age or tenure (number of years as member of the board of any hospital mentioned in the cv) are referenced to 2015. These Executives represent 29 CEOs, 29 Clinical Directors, 29 Nurse Directors and 51 Other Directors (vogal). There is an unusual case of one Hospital that the CEO was also the Clinical Director, which is no longer allowed, and there is a case of ULS that have two Clinical Directors, one for Primary Care and the other for the Hospital, thus adding the same number 29.

The demographics of the total population and just the CEOs is presented below:

	TOTAL POPULATION	CEOs
Number of Executives	138	29
% of Females	38,4%	13,8%
Age average as of 2015	54.46	60.1
Age standard deviation	7.8	7.0
Tenure average	7.41	10.66
Tenure std. Dev.	6.0	6.49
% of Masters & PhDs	21.0%	17.2%

Figure 23 - Population demographics

The age distribution of the two populations, shows that most of the CEO´s are very seasoned professionals at the last track of their careers due to mandatory retirement when they reach the age of 70.

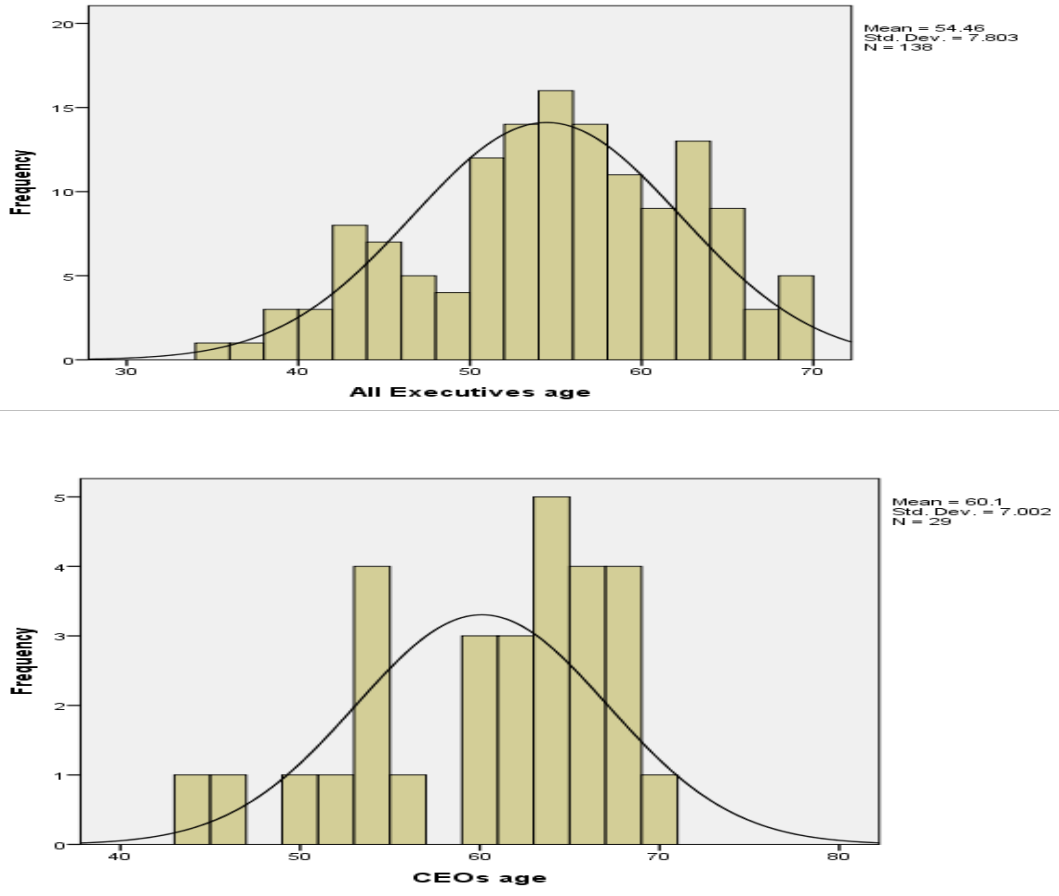


Figure 24 - Age distribution

The tenure distribution shows that CEOs have three groups: seasoned health professionals having more than 15 years of management experience, very recent ones nominated this period (2011-2015), and a majority of CEO´s that maintained their role even during a political change.

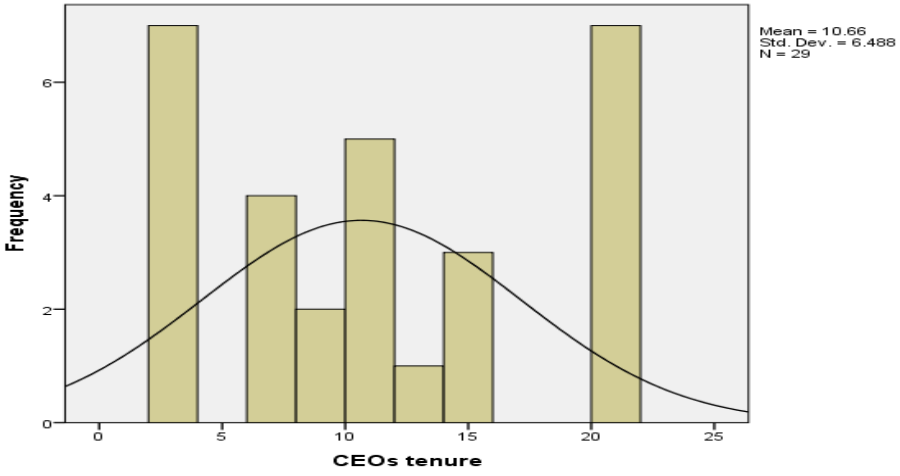


Figure 25 - CEO´s tenure distribution

In terms of background of the Executives the population shows, that following Medicine and Nursing, Law is the third most common degree.

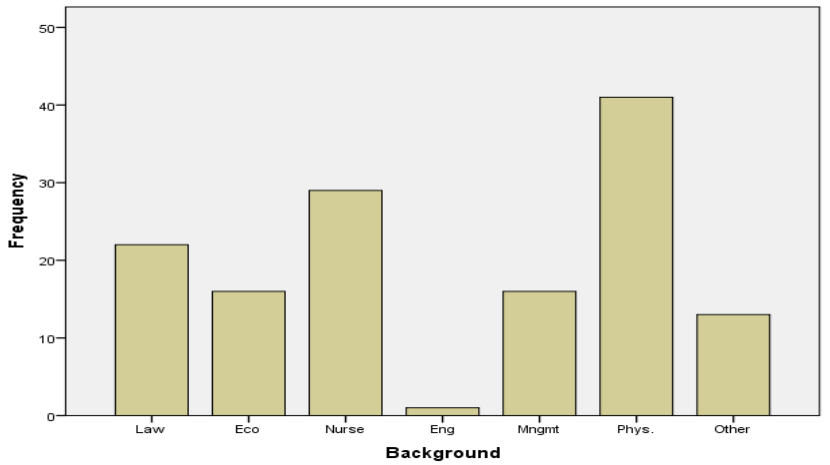


Figure 26 - Executives´ background

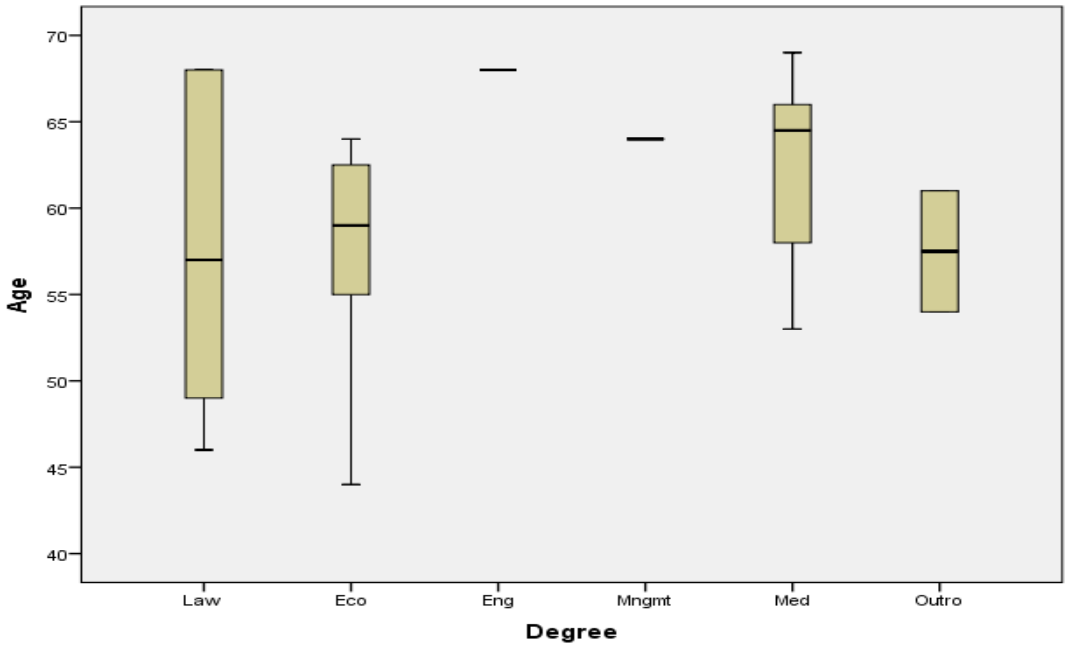
There is no CEO whose background degree is on Nursing and they are mostly Physicians:

Degree

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Law	6	20.7	20.7	20.7
	Eco	7	24.1	24.1	44.8
	Eng	1	3.4	3.4	48.3
	Mngmt	1	3.4	3.4	51.7
	Medic.	12	41.4	41.4	93.1
	Other	2	6.9	6.9	100.0
	Total	29	100.0	100.0	

Figure 27 - CEO´s background

Analyzing CEOs´ age by background, data will show that Physician CEOs are older, but their tenure is lower than those who possess degrees are in Law or Economics.



	Degree				
Tenure	Law	Mean	13.00	Std. Deviation	6.633
	Eco	Mean	12.57	Std. Deviation	7.300
	Med	Mean	10.67	Std. Deviation	5.898

Figure 28 - CEO´s age and tenure by background

Of note, that, there is no Physician on the Boards that is just a pure Director (they either are the CEO or Clinical Director) and that they might reach the CEO level, later in their professional life.

3.2.3 Power index methodology

Using indices in corporate governance is a promise and a peril.(Bhagat et al. 2008) In this case, the researcher did not attempt to have a global measure of corporate governance or relate it to overall performance. Furthermore, previous attempts to evaluate CEO power, relating to private corporations with issues on independence and ownership, are not applicable to the case. One of the main issues with the dimensions is to set the right scales in order not to have one factor biasing the whole analysis (Black et al. 2016).

Finkelstein´s (1992) work was based on four pillars: Structural, Ownership, Expert and Prestige Power. Of these pillars Ownership is not applicable to Hospital SOEs in Portugal.

Another approach, based on compensation (Brown & Sarma 2007; Bebchuk et al. 2007), would define a fixed relation in all cases of 100 to 80 from CEO to Directors, but that would not take into account that some executives, especially physicians may opt for their professional salary that is

higher than what is defined for a Board member. The close range of salaries, the total absence of variable compensation, indicated that this is not the right parameter to include in the index.

Looking in more detail into each of the dimensions and sub-indices used by other researchers, we find that:

Structural Power is based on formal position and authority. By law, public executives do the job on an exclusive basis, except for higher education teaching, and there is CEO duality; actually, the Boards are all-executive Boards, and the CEO assumes the Chairman role during meetings. Hambrick (1981) and Finkelstein (1992) also refer this as a legitimate power, and its strength is captured by the position in the organization.(Daily & Johnson 1997). The composition of the Board, and how much CEOs can influence the choice of his colleagues is also considered as a source of power.(Gavin & College 2014) In the Portuguese cultural framework with a high power distance and uncertainty avoidance, the formal position of PCA (CEO) that many times is referred in the press and the common language just as "the President of the Hospital", is also significant to the structural power that the position carries. Regarding other Board member appointments, from the interviews with the Ministers, the CEO involvement ranges from "CEOs make their own teams subject to Minister´s approval", to I "nobody is appointed with a clear sign of rejection from the CEO". The Clinical Director has also established powers by law. As physicians, normally they have formal and informal networks to establish protocols and guidelines. They are clearly distinct from the Nurse Directors and the other executives on the Board.

Expert Power is the ability to deal with environmental dependencies.(Finkelstein 1992) The initial study by Finkelstein assessed critical expertise by the types of functional experience and background that a manager possesses, inputs such as purchasing, personnel; outputs such as sales, marketing; throughputs found in operations, accounting and regulatory concerns or in law. The total different positions a manager had in the company was also computed in this dimension. In Daily & Johnson (1997)'s words: "The absence of critical firm-specific information may place directors at a substantial disadvantage in boardroom discussions."

The importance of specific knowledge is also reinforced in cultural terms by a high uncertainty avoidance. Degrees in Medicine are considered more important for Hospitals, followed by Law as it configures specific knowledge and the public administration is full of regulations, and then Nursing, Economics, Management, and Engineering are considered as providing more specific expertise than Sociology, Marketing or International Relations. Being a higher education professor or researcher with published articles is also recognized as possessing more expertise.

Prestige Power is related to a manager´s ability to absorb uncertainty from the institutional environment (Finkelstein 1992). This variable was originally measured by participation in other boards either for-profit or non-profit and also the type of elite education by using a high education ranking and measuring the degree attained. In Portugal, all public executives have at least a formal degree, and it is considered that a Ph.D. degree is much more relevant than a Master degree, especially after the Bologna´s reform. Prestige can also measure how a manager is "bonding" to a higher political and executive network thus having access to information and lobbying.

Other dimensions that are associated to power within the organizations are age and tenure namely in studies of (Krause et al. 2016),(Jones & Cannella 2011)(Finkelstein et al. 2009) and (Gavin & College 2014). These dimensions have been used in the referred studies usually by transforming the number of years in intervals with a specific value related to the overall range used.

3.3 Power index

The researcher intended to create an index that was rigorous and also easy to understand and implement. The choice of predefined intervals where one could check the variables seems to be the right one versus a total recalculation each time new data is added. Intervals have the negative utilization near the borders of each interval where the distance may not be so relevant, but in the context and with all the variables taken into account it does not show inconsistencies of notice.

Age, in the case of this research, seems an obvious indicator of different power within the organization. In the Portuguese cultural context age is associated with respect and thus it is more difficult to contradict an older person than one of the same age. Based on the overall mean and standard deviation, three groups were set: number 1 for those who were younger than (mean – std. dev); number 2 for those between mean (- std. dev, + std. dev), and number 3 for those older than (mean + std. dev).

The researcher did not calculate for each board the mean and standard deviation for age because some results could be inconsistent. Imagine a Board of 4 members that just the CEO is 42, and all other executives are 40. The mean would be 40,5 and the standard deviation=0,87. If we apply the logic of one standard deviation distance, we would conclude that in this case age difference would be significant when that is not the case, but mostly it would be difficult to reuse the index.

For **Tenure** the same procedure was adopted for this variable, considering that experience at board level is also a contributor to prestige, expertise and thus power.

To evaluate functional background (**degree),** the index was based on the values: 2 for Medicine; 1,5 for Law; 1 for Nursing, Economy, Management and Engineering and 0 for Others as explained before in the power index methodology. The values for the **level** attained were: 3 for Ph.D.; 1,5 for Master and 1 for Graduation. Three other binary variables were considered to reflect Science/research recognition, Specific degree or post-graduate in Hospital Management and explicitly being a Politician (Minister, Secretary of Health or Other areas, Mayor, President of the Medical Order/College of Physicians).

Dimension of analysis	Variable name	Values possible
Age	Auxidade	1, 2, 3
Tenure	Aux	1, 2, 3
Functional background	Curso	0,1, 1.5, 2
Level of degree	Grau	1, 1.5, 3
Research/teaching status	Cientista	0, 1
Politician or similar	Politico	0, 1
Hospital management educ.	AH	0, 1

Figure 29 Variable dimensions

The researcher expected some correlation between Age (auxidade) and Tenure (aux), as one cannot have a long tenure being too young, and between the level of Degree (Grau) and Researcher status (Cientista); probably PhDs and high education professors are more often published researchers, but the results shown by Spearman´s test showed correlations but at values lower than 0.5 (Finkelstein 1992).

Correlations

			auxidade	Valcurso	Grau	Politico	Cientista	AH	aux
Spearman's rho	auxidade	Correlation Coefficient	1.000						
		Sig. (2-tailed)	.						
	Valcurso	Correlation Coefficient	.334**	1.000					
		Sig. (2-tailed)	.000	.					
	Grau	Correlation Coefficient	-.042	.028	1.000				
		Sig. (2-tailed)	.624	.747	.				
	Politico	Correlation Coefficient	.205*	-.141	-.050	1.000			
		Sig. (2-tailed)	.016	.099	.557	.			
	Cientista	Correlation Coefficient	.109	.338**	.435**	-.133	1.000		
		Sig. (2-tailed)	.205	.000	.000	.121	.		
	AH	Correlation Coefficient	-.188*	-.155	-.133	-.151	-.053	1.000	
		Sig. (2-tailed)	.027	.069	.120	.078	.540	.	
	aux	Correlation Coefficient	.294**	.126	-.025	-.039	.087	.221**	1.000
		Sig. (2-tailed)	.000	.140	.767	.652	.310	.009	.

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Figure 30 - Variables correlations

Analyzing the components, the reduction to 3 main factors based on eigenvalue > 1, does not give confidence that one can get variables in just one factor. A factor analysis was also done (annex D) but the results are just above poor, with no particular distribution of the dimensions or final index level, which is consistent with the notion that no particular variable would determine alone, the final result. One can see that Valcurso, Grau and Cientista can measure part of expertise but also part of prestige.

Most variables do not correlate with AH. Age is negatively associated, meaning that younger executives take this post-graduation, and typically only after a certain stage of professional hybridity, physicians look after hospital management education.

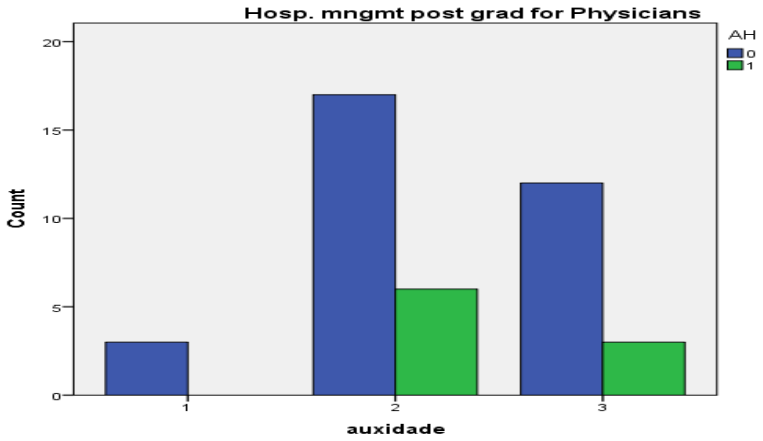
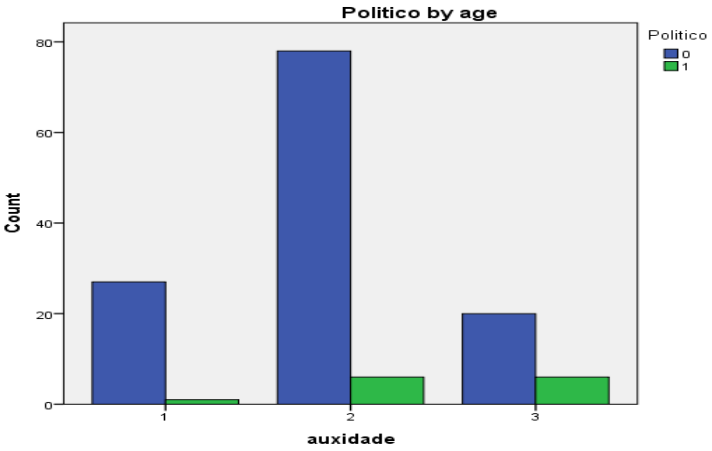


Figure 31 - Executive Physicians and Hospital management

The Politico variable is highly associated with age and also with CEO´s role and negatively associated with all others.



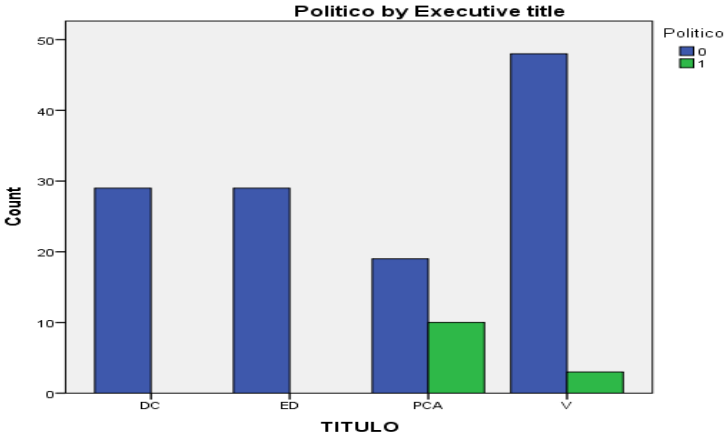


Figure 32 - Politic variable by age and title

The first part of the index is calculated by adding the individual values of each variable into a variable called **powindiv** that represents the total power index an individual has independently of the role he is performing on the Board.

Then the role has to be factored in the index: 3 for CEO, 2 for Clinical Director and 1 for all other executives. Two options could be taken at this point: to add the value to powindiv or to multiply the title-value by the powindiv. Both options were studied, see annex E, however after consulting with the experts´ panel, the second approach was preferred. Intuitively it was hard to think that being a Ph.D. executive could offset a Graduated CEO. Actually, all depends, on how the power index is then analyzed and the levels are established. With this approach of multiplying the title-value as a weighted factor, one will find that normal boards of 4 or 5 members, will have a total title value of 7 or 8 (CEO=3, DC=2, Others=2 or 3).

The final step was to evaluate the total power of each Board (the sum of individual values) followed by the calculation of the percentage of total power of each executive. Note that in the case of the Other Directors (V) the average is represented when there are two Executives.

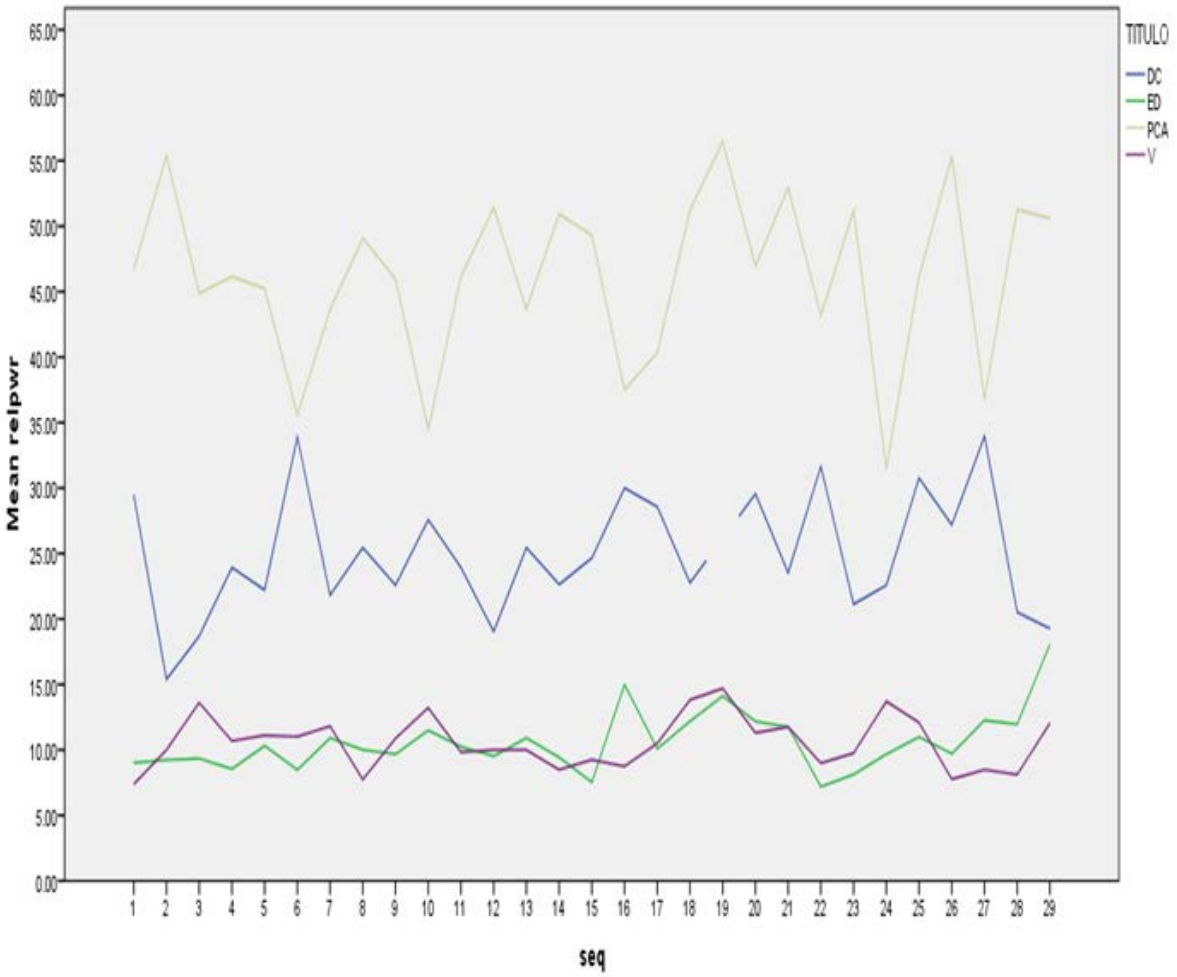


Figure 33 - Relative power by institution

Showing the same data on a cumulative bar, one can see the differences in the power share of CEOs and other members. Two horizontal lines were added at 37,5% and 52,5%, that will be explained as risk levels.

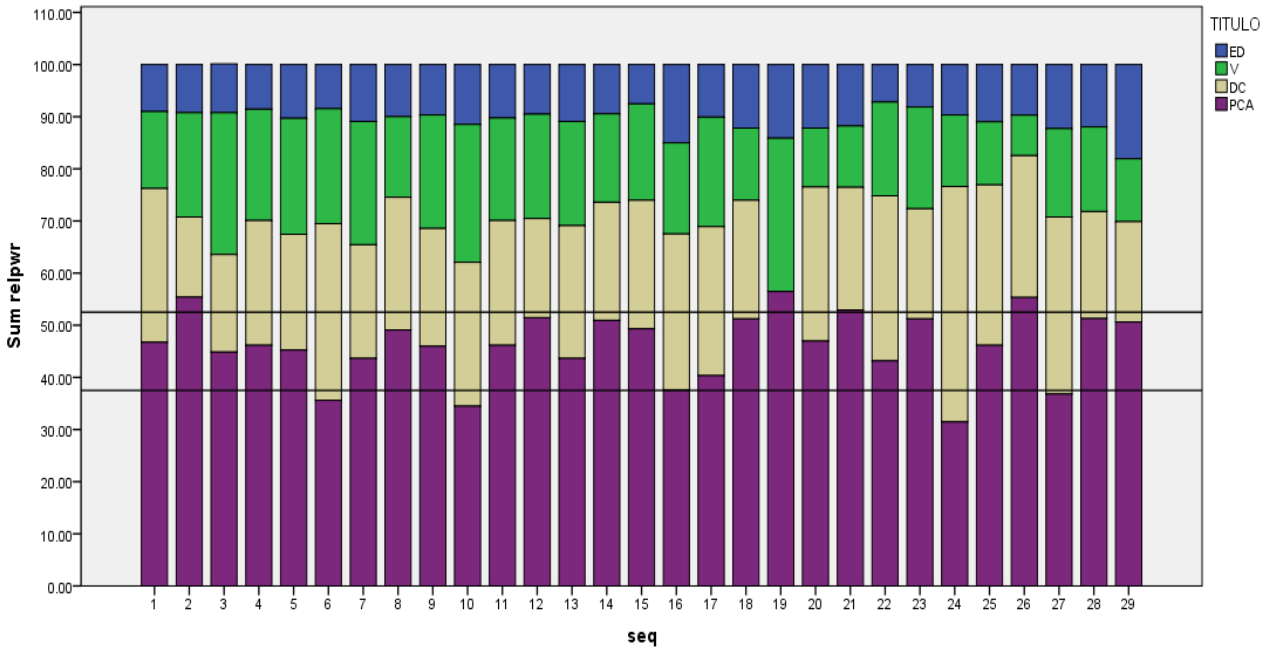


Figure 34 - Power distribution by institution

A level of risk was then set based on the following rule-of thumb. A CEO member of a 5-person Board should represent 3/8 of the total power on an equality basis, thus a threshold of 37,5% was established as a lower bound. This value was considered very low by the panel without knowing the results. On a Board of 4, that should represent 3/7, =42,8% but for the purpose of having equal intervals the limit was set on 42,5%. Then just applying the 5% range, the other intervals were set on 47,5% and 52,5%. To note that the 50% threshold is the middle point of the fourth interval, already revealing some dominance.

Level	Limits	Meaning
1	< 37,5%	Significantly underpowered CEO
2	>= 37,5% & < 42,5%	Somehow underpowered CEO
3	>= 42,5% & < 47,5%	Fair distribution of Power
4	>= 47,5% & < 52,5%	Significantly dominant CEO
5	>= 52,5%	Extremely dominant CEO

Figure 35 – Risk levels

Note that the levels are established admitting that some concentration of power would be in the CEO by the model whilst considering age and tenure. Using average relative power would present no particular advantage when analyzing a new member, for the need of total recalculation. In any case for the sample analyzed the mean was 46.20, within group 3, and the standard deviation was 6.48 hence all of the elements of groups 1 and most of group 5 are more than one standard deviation distance from the mean.

The distribution of CEOs in this research by levels is:

pcagroup

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	5	17.2	17.2	17.2
	2.00	1	3.4	3.4	20.7
	3.00	11	37.9	37.9	58.6
	4.00	8	27.6	27.6	86.2
	5.00	4	13.8	13.8	100.0
	Total	29	100.0	100.0	

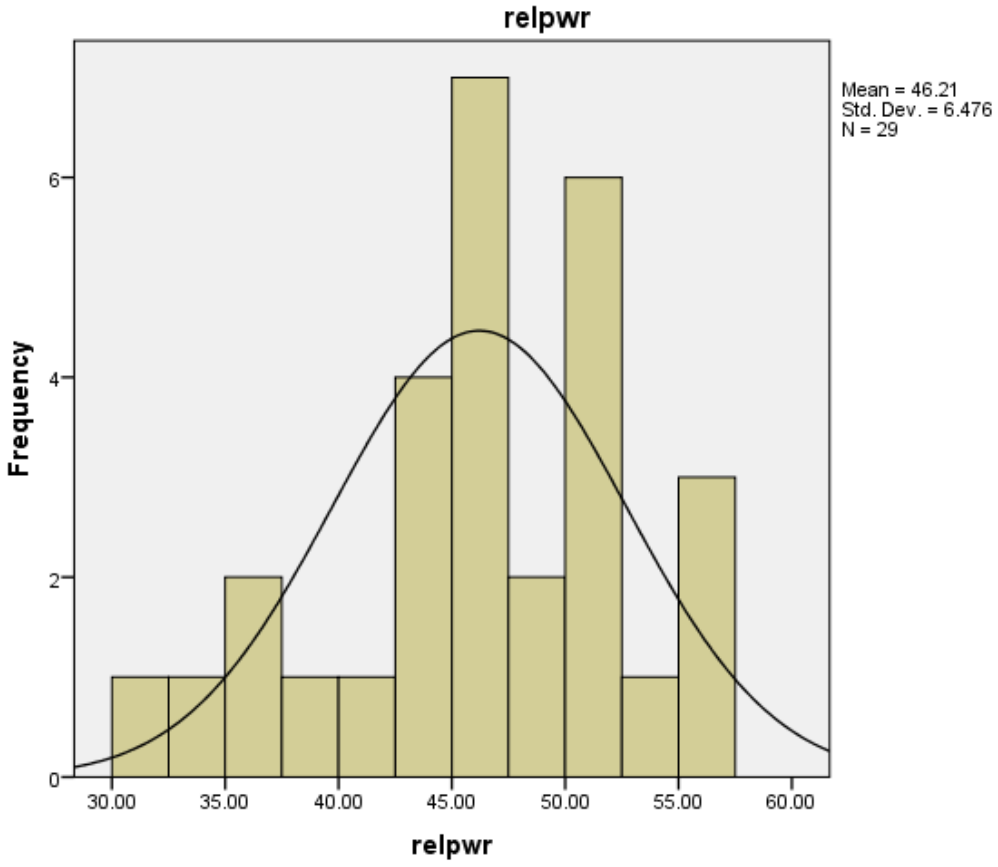


Figure 36 - CEO power group distribution

3.4 Questionnaire

The third instrument of this research was a survey based on a paper questionnaire sent to Board members, to collect their views on CEO qualities, style and behavior. Special attention was given to the relative positioning of CEO´s prestige and expertise and the determination of the reasons to become CEO, for those who were also Physicians.

(Simoes 2011) had replicated a Kakabadse (2007) survey, and administered the questionnaire to Portuguese Board members of listed corporations.

The value of the replication process has been recognized by many scholars, and it also gave the researcher a basis of comparison of the perception of the SOEs Hospital Boards compared to the private sector in other industries.

Two options were taken by the researcher: the first and most important one, to guarantee total anonymity to the respondents, and the second one to remain short and simple to warrant accuracy. The anonymity is crucial to ensure sincerity and to foster cooperation. Therefore the researcher only administered paper questionnaires where checkboxes were provided, making calligraphy recognition impossible. The responses were sent by self-addressed stamp envelope given to the Board members, some in person and the majority were included in a larger envelope sent to the Board CEO with an explanation letter of the purpose of these questionnaires.

The Questionnaire was fairly short, one first page for demographic identification of the respondent and the CEO, a one page Likert scale questions (17) and 15 ratings.

The questionnaires were administrated from March to end of May 2017; 90 were sent because some of the Boards at the moment of the survey were very different and had gone to institutional restructurings, and 44 were received although a few did not answer all the questions.

The Questionnaire did not ask what Board the respondent or the surveyed CEO belonged, not allowing to relate the responses to a particular CEO and compare with the specific power index.

Also, the questionnaire did not ask specifically to survey a CEO from the period 2011-2015, only to relate to just one CEO all answers. Self-responses from the CEO were encouraged without disclosing the situation as far as possible. Same age, gender, degree, and background could lead to guessing, but that was not the purpose of the exercise. Also, the number of responses (44) indicates that in several cases more than one view could be on the same CEO.

The first page of the Questionnaire addressed the demographic data of the respondent and CEO, covering age, gender, degree, and background. One more controversial question was added to indicate who was the principal responsible for the respondent´s nomination (political power, the CEO, professional structures or regional health authorities) and the CEO´s. Two other questions were also on the front page: about the frequency and duration of Board meetings. Usually, Hospital Board meetings should occur every week, and all responses were coincident with that, but the reason to include these items was to note if there was an anomaly in the response or a deeper analysis on the specific answers of that questionnaire was needed. (Annex F and G include the Questionnaires in Portuguese and English translation.)-

Duration is of notice to look to any unusual length. Less than two hours seems fairly unreasonable regarding the number of items in the agenda of a Hospital Board and that very few discussions are taken place.

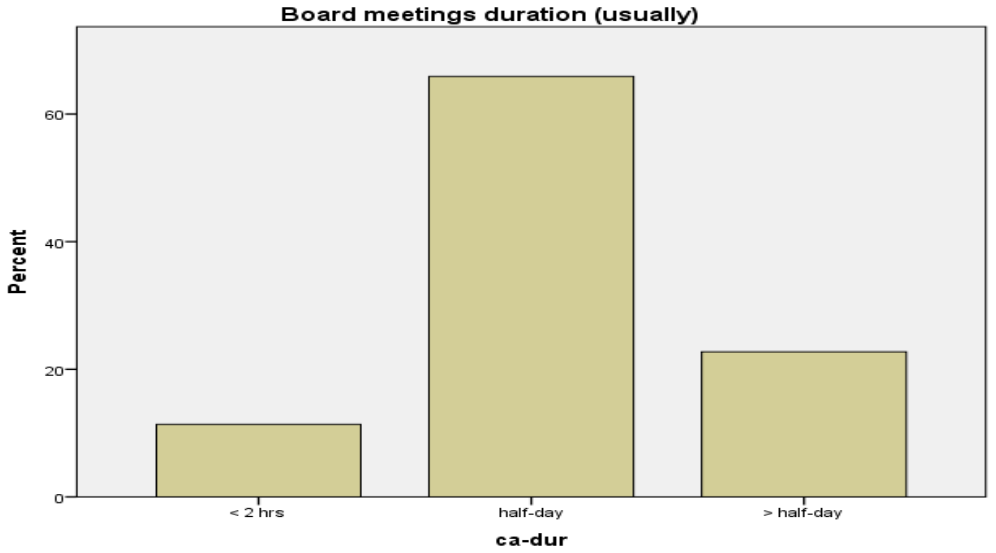


Figure 37 – Board meetings duration

For the age groups, the researcher used the mid-point (35, 45, 55) for the closed intervals and the extreme values of 28 and 64. The same procedure was also recorded in the sample population of the power index for comparison purposes, later developed in Chapter 4.

Using the same 9-point Likert scale, where 1 means “not at all” and 9 “total agreement”, the first three questions on the CEO evaluate their contribution to the vision and strategic decisions. The researcher used the same wording used by Cristina (2011).

The next 14 items covered the CEO´s style. 10 Questions are the same used by Cristina (the researcher removed one that clearly refers to Chairman-CEO cooperation, and one about discipline). One of the questions was highly relevant to this study although the wording (sustained) was a bit indicative: Q230 -“Operationally, becomes too involved”.

Four other questions were added. Q231: “Takes the initiative on decisions” and Q232: “Is the last to give an opinion on issues” could be seen as opposite in meaning, but in the panel prior discussions of the Questionnaire, the researcher was advised to keep both. The same happens to Q233: “Encourages antagonist opinions” and Q234: “Criticizes objections”.

To note that the Cronbach´s alpha coefficient is higher when one does not invert the scale for those Questions that one should expect lower ratings (Q230, Q231, and Q234).

Overall Cronbach´s alpha – no scale inverted 0.960

- With inversion 0.906

In the case of using an inverted scale the coefficient would rise significantly if one would delete those questions.

Looking at the alpha coefficient by group of questions (without inversion)

Vision - 0.929

Style - 0.949

Two more group of questions were added to this Questionnaire regarding how the respondent rate the CEO expertise and prestige comparing to the other Board members as a group.

A five-point scale was provided varying from: Much less (competent), Somehow less, the same, somehow more, and much more. The relative expertise was evaluated in five items:

- Strategy and Organization: this item refers characteristics often seen as CEO´s attributes and were also evaluated on absolute scale
- Finance and Economic management: these items were of crucial importance during the analysis period (2011-2015) with strong constrains on budget spending.
- Hospital clinical activity: this is the major activity
- Regulations and compliance: due to the multiple laws and regulations that SOEs are subject and that may lead to personal penalties to the Board members.
- Negotiation related skills: this item was suggested by the panel due to the multiple negotiations that Hospitals are involved with corporate powers, unions and the Ministry.

The relative prestige of CEOs compared to overall Board members was also evaluated in five items:

The academic society

The Public Health senior management group

The local community

The region

The press and social media

Finally, and following (Mcgivern et al. 2015) the questionnaire asked the respondent to indicate on a 9-point Likert scale what was the reason the CEO accepted the role.

"His turn"; Peer pressing

To do a better job following his criticism

Normal path towards seniority

Had some experience in intermediate management

From early stages opted for management

Although these reasons could be seen as mutually exclusive, this is not the case, and the combination of factors may occur. The use of a 9-point scale was only to be consistent with previous items. These questions were mainly dedicated to Physicians, but that was not told to respondents to allow all sort of answers which would be filtered at the data treatment stage.

CHAPTER 4. ANALYSIS AND DISCUSSION OF RESULTS

4.1 Power Index analysis

In the previous chapter the results of the application of the power index were presented in aggregate terms of levels and CEO distribution. First this research presents the differences within the sample studied and the possible sources of variability. In terms of Board average power i.e. the sum of individual power as given by the variables and weighted by their role and then divided by the number of members to compare 4 and 5-member Boards, showed no significant difference in terms of regions or type of institutions, running ANOVA tests.

ZONA	Mean	N	Std. Deviation
Alentejo	11.5750	3	.89408
Centro	12.1531	8	1.60843
Lis	11.5938	8	1.59204
Norte	11.0667	3	2.05020
Porto	12.5550	5	2.11131
Tras os Montes	10.6875	2	.44194
Total	11.7948	29	1.60702

ANOVA Table[a]

			Sum of Squares	df	Mean Square	F	Sig.
pwravg * ZONA	Between Groups	(Combined)	8.428	5	1.686	.607	.695

TIPO	Mean	N	Std. Deviation
Grupo	11.2727	11	1.14463
Hospital	12.4179	7	2.51271
ULS	11.6607	7	.93907
Univ	12.3750	4	1.71731
Total	11.7948	29	1.60702

ANOVA Table[a]

			Sum of Squares	df	Mean Square	F	Sig.
pwravg * TIPO	Between Groups	(Combined)	7.188	3	2.396	.920	.446

Figure 38 – CEO Power by Region and Type

Individual power shows that CEO and Clinical Directors already possess more power before weighting according to their titles.

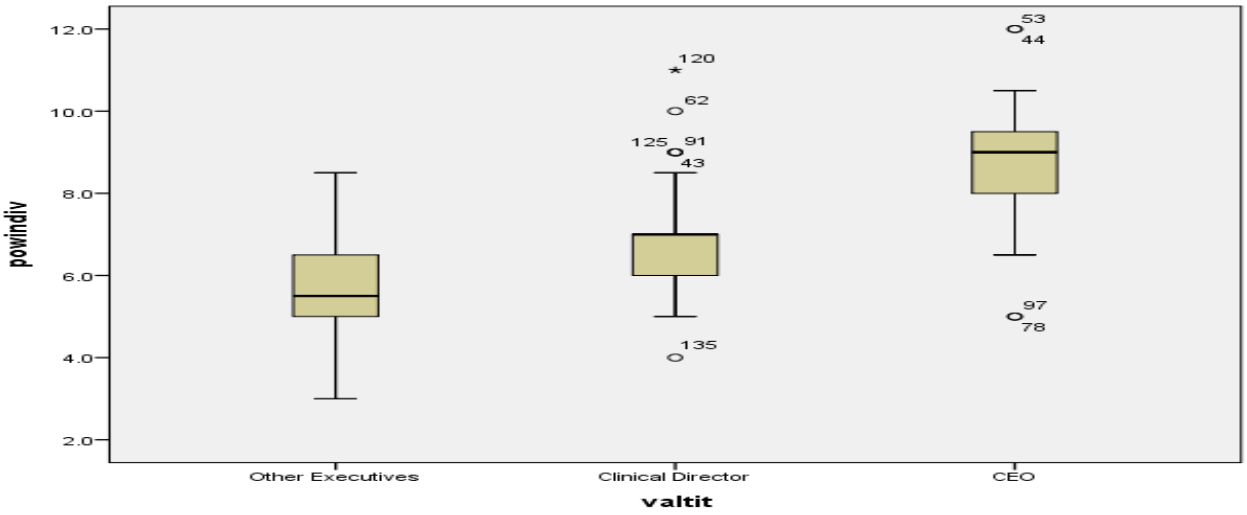


Figure 39 – Power by title

The value of that individual power was also analyzed and it showed **significant variances** (ANOVA test) by: Title, Age, Tenure, Degree, Background, Politician and Researcher.
The only factor that did not show significant differences in the means was the variable Post-graduation on Hospital Management.

AH	Mean	N	Std. Deviation
0	6.466	74	1.7910
1	6.883	64	1.8033
Total	6.659	138	1.8023

ANOVA Table[a]

			Sum of Squares	df	Mean Square	F	Sig.
powindiv * AH	Between Groups	(Combined)	5.956	1	5.956	1.845	.177

Figure 40 – Hospital management and Individual Power

The gender in the total population did not show significant variances in power. When we analyze the individual power weighted by their title, because there are few Female CEOs than the percentage in the total population the results already show significant differences.

powindiv

Sexo	Mean	N	Std. Deviation
f	6.292	53	1.6333
m	6.888	85	1.8730
Total	6.659	138	1.8023

powtit

Sexo	Mean	N	Std. Deviation
f	9.330	53	6.4046
m	13.271	85	9.2860
Total	11.757	138	8.4935

ANOVA Table[a]

			Sum of Squares	df	Mean Square	F	Sig.
powtit * Sexo	Between Groups	(Combined)	506.870	1	506.870	7.352	.008

Figure 41 – Power by gender

The distribution of weighted power by background shows the balance in favor or Medicine and Law.

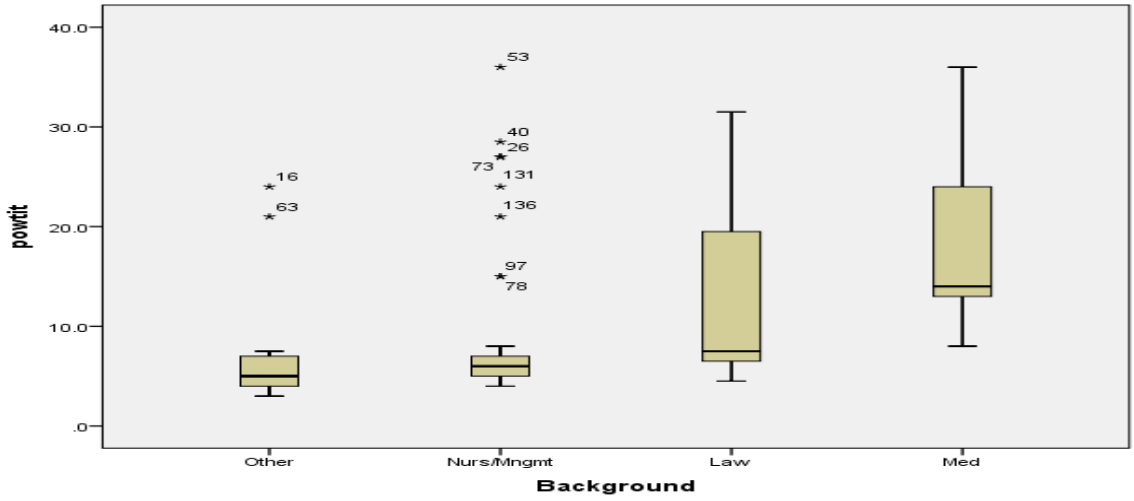


Figure 42 – Power by background

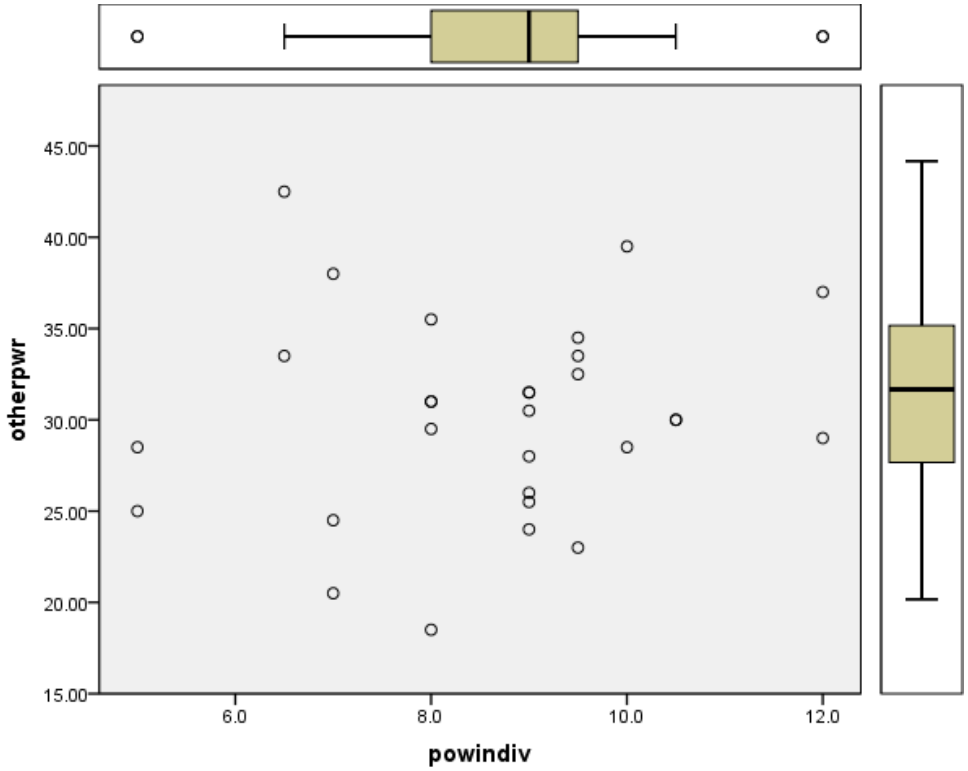
4.2 CEO Power index analysis

Within the CEO Group there was no significant difference (anova test) on the mean values for absolute and relative power, regarding Hospital type, region, CEO gender or background. The following tables illustrate the values obtained:

Means by		Absolut	Relpwr	N
TOTAL	Mean	25.862	46.2082	29
Type	Group	26.182	46.0937	11
	Hospital	25.500	46.9413	7
	ULS	24.429	46.1202	7
	Univ	28.125	45.3937	4
Gender	Female	25.500	42.9020	4
	Male	25.920	46.7372	25
Region	Alentejo	24.500	46.4014	3
	Centro	27.188	48.6017	8
	Lisboa	25.313	44.5979	8
	Norte	25.000	44.1412	3
	Porto	27.300	45.7147	5
	Tras-os-Montes	22.500	47.1194	2
Course	Other	22.500	40.2265	2
	Nurs/Mngmt	24.500	47.2369	9
	Law	25.250	41.9599	6
	Medicine	27.750	48.5777	12

Figure 43 – CEO absolute and relative power

There is of course a strong correlation of the CEO´s absolute power, even without weighting for the title, and the relative power regarding his Board. Also, a negative correlation between the CEO relative power and the sum of other´s absolute power; but there was no correlation between the CEO´s absolute power and the others´ power. This means that neither weak nor strong CEO´s choose weak colleagues.



Correlations

		powindiv	relpwr	otherpwr
powindiv	Pearson Correlation	1	.689**	.125
	Sig. (2-tailed)		.000	.519
	N	29	29	29
relpwr	Pearson Correlation	.689**	1	-.616**
	Sig. (2-tailed)	.000		.000
	N	29	29	29
otherpwr	Pearson Correlation	.125	-.616**	1
	Sig. (2-tailed)	.519	.000	
	N	29	29	29

**. Correlation is significant at the 0.01 level (2-tailed).

Figure 44 – Correlation of CEO power and other Board members

The distribution of CEOs by the 5 groups of risk as mentioned in the previous chapter, showed that older, seasoned executives and physicians are all contained in the **3 most powerful groups**, and no significant differences were found for type, region or gender.

		pcagroup					
		1.00	2.00	3.00	4.00	5.00	Total
TOTAL		5	1	11	8	4	29
ZONA	Alentejo	1	0	0	1	1	3
	Centro	0	0	4	3	1	8
	Lis	2	1	3	0	2	8
	Norte	1	0	1	1	0	3
	Porto	1	0	2	2	0	5
	Tras os Montes	0	0	1	1	0	2
Type	Group	1	0	7	2	1	11
	Hospital	1	1	2	1	2	7
	ULS	2	0	1	3	1	7
	Univ.	1	0	1	2	0	4
Gender	Female	1	0	2	1	0	4
	Male	4	1	9	7	4	25
Background	Other	1	0	1	0	0	2
	Nurs/Mngmt	2	0	2	2	3	9
	Law	2	1	2	1	0	6
	Medicine	0	0	6	5	1	12
Age group	1	2	0	0	0	0	2
	2	3	1	4	3	2	13
	3	0	0	7	5	2	14
Tenure group	1	4	0	4	3	2	13
	2	1	1	2	4	1	9
	3	0	0	5	1	1	7

Figure 45 – CEO levels and variables

The only Physician that was codified into group 5 (the most powerful) was from the median group (2) of age and tenure, and as we noted before there is no Physician on the younger group being an Executive.

In this research, we also used the power index to study the Clinical Power (sum of powers of Clinical director, Nurse Director and CEO if physician). Note that in the sample 12/29 (41,4%) of the cases we have this occurrence. In these cases, the average clinical power is 81,41% with a minimum of 70,59% and a maximum of 88,70%.

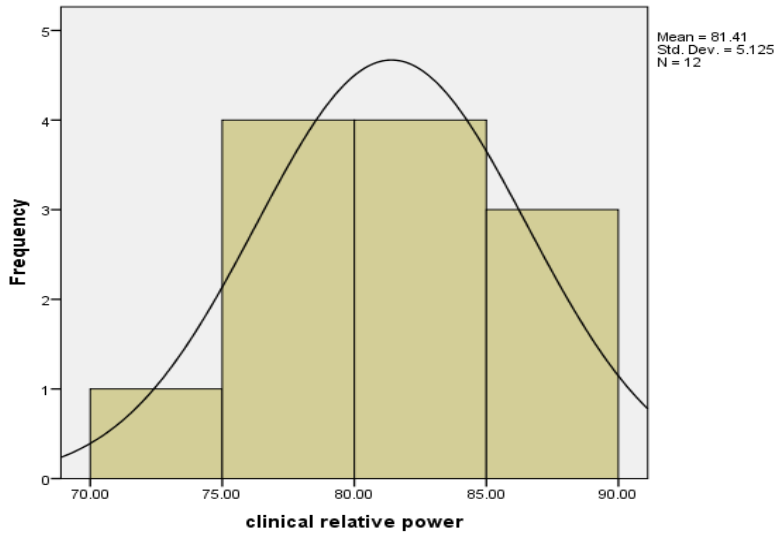


Figure 46 – Clinical relative power

If one considers just the sum of the Clinical Director and Nurse Director and compare with the relative power of the CEO, one would verify that all Physician CEOs have individually, more relative power than the sum of the Clinical Director and Nurse Director, which is not always the case for other CEOs; Five of them having less relative power.

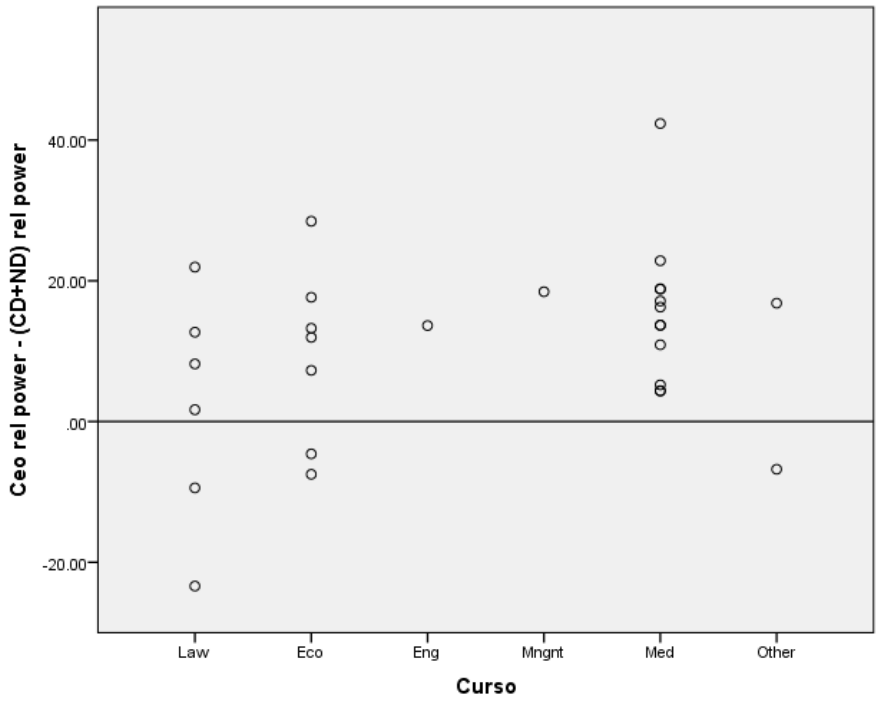


Figure 47 – CEO Power vs CD+ND by background

4.3 CEO Evaluation

4.3.1 Respondents demographic description

The results of the Questionnaire obtained in 44 different responses, showed a sample similar to the one used for the power index creation, although somewhat younger (within t-test significance values) and more educated. Also, there was an underrepresentation of female executives, and less Physicians than in the sample with an over-representation of economics/management background.

Parameter		Power Index Sample	Questionnaire Sample
Age mean		54.86	52.30
Age group	30-40	3.6%	6.8%
	40-50	19.6%	31.8%
	50-60	48.6%	40.9%
	Over 60	28.3%	20.5%
Female representation		38,4%	29,5%
Degree	Grad.	79%	47.7%
	Master	15.9%	45.5%
	Phd.	5.1%	6.8%
Background	Medicine	29.7%	18.2%
	Nursery	21%	20.5%
	Law	15.9%	13.6%
	Eco/Mngmt	23.9%	43.2%
	Other	9.4%	4.5%

Figure 48 – Demographic background of sample and survey

The distribution of the executives surveyed, in terms of who was the first responsible for their nomination, including the CEO´s self-answers was:

Appointments by:

the political power (could be some CEOs in self-answers)	13 = 33,33%
the region health administration	5 = 12,82%
the CEO	21 = 53.85%

Figure 49 – Appointments sponsors

4.3.2 Surveyed CEOs demographic description

The number of responses from the questionnaire were 44, and the Power Index sample included 29. Some answers may refer to the same CEO, but direct feedback and comparison was not possible, nor was the intention of the Questionnaire. The age mean was lower and using the T-test showed a significant difference that did not allow to reject that the samples are different. Could be that some Executives under estimate the CEO's age or some self-answers were biased. A higher representation of female CEOs surveys was obtained and a good distribution of background and degree level was also achieved.

Parameter		Power Index Sample	Questionnaire Sample
Age mean		59.55	54.86
Age group	30-40	0%	2.3%
	40-50	10.3%	18.2%
	50-60	27.6%	47.7%
	Over 60	62.1%	31.8%
Female representation		13.8%	20.5%
Degree	Grad.	82.8%	65.9%
	Master	13.8%	20.5%
	Phd.	3.4%	13.6%
Background	Medicine	41.4%	40.9%
	Law	20.7%	13.6%
	Eco/Mngmt	30.9%	22.7%
	Other	6.9%	22.7%

Figure 50 – CEO demographics comparison between index and questionnaire

The distribution of the CEOs surveyed, regarding who was the first responsible for their nomination, including the CEO´s self-answers, showed recognition that the political power is the first responsible for the CEO´s nominations.

Appointments by:

the political power	30 = 68.2%
the region health administration	4 = 9,11%
the social-professional structures	1 = 2,3%
No answer	9 = 20,5%

Figure 51 – CEO´s nomination sponsor

4.3.3 Views from Executives on CEOs

In terms of Vision and Strategic decisions, a mean score of 7.0 was obtained and the three questions asked were:

QUESTION	Mean	Minimum	Maximum
R211 – Drives the vision	7.07	2	9
R212 – Determines organization strategy	7.18	2	9
R213 – Enables understanding of organization strategy	6.75	2	9

Figure 52 – CEO´s evaluation on Vision and Strategy

For the Style component, the mean score was 6.77 and was obtained from fourteen questions. Note that some questions, (only for data treatment), begin with X. Those were the questions, the researcher initially thought that the scale should be inverted for consistency of Cronbach´s alpha test:

QUESTION	Mean	Minimum	Maximum
R221 – Encourages open debate	6.66	1	9
R222 – Summarizes well	6.64	1	9
R223 – Captures the essence of the argument	7.07	1	9
R224 – Is easy to talk to	7.48	2	9
R225 – Raises sensitive issues	7.11	2	9
R226 – Handles tensions/sensitivities well	6.66	2	9
R227 – Encourages consensus	7.25	2	9
R228 – Promotes teamwork	6.86	2	9
R229 – Uses teamwork to stifle debate	6.43	1	9
X230 – Operationally, becomes too involved	6.82	1	9
X231 – Takes the decision initiative	7.80	4	9
R232 – Is the last to give an opinion	6.41	1	9
R233 – Encourages antagonist opinions	5.82	1	9
X234 – Criticizes objections	5.91	2	9

Figure 53- CEO´s evaluation on Style

The scores obtained by the CEO´s of Portuguese listed companies (Simoes 2011), although her study integrated more questions and some added in this research may reflect lower evaluations on style, are higher than those obtained in this answers, indicating a more candid view than in the Health sector:

Combined Strategy and Style evaluation:

7,24 (other Director´s evaluation)

7,67 (Chairman´s view on the CEO)

7,75 (CEO self evaluation)

Results obtained in this survey: CEO Strategy = 7.00 CEO Style = 6.77

Ranking the CEO against the group of Board colleagues, in terms of technical expertise was done on a scale 1-5, where 1 indicated much less competent, 5 much more competent; and 3 about the same level, for these five items:

QUESTION	Mean	Minimum	Maximum
R15 – Strategy & Organization	3.93	2	5
R16 – Finance and Economic Management	3.21	2	5
R17 – Clinical activity	3.58	2	5
R18 – Legislation and regulations	3.44	2	5
R19 – Negotiation and diplomacy skills	3.88	1	5

Figure 54 – CEO´s relative expertise

One can note that CEOs were rated higher than their peers in Strategy and Organization, and that Finance is not one of their strengths, especially if the CEO´s were Physicians.

CEOs were also ranked against the group of Board colleagues in terms of prestige. This was done on a scale 1-5, where 1 indicated much less prestige, and 5 much more prestige; for these five items:

QUESTION	Mean	Minimum	Maximum
R20 – Among the academic society	3.71	2	5
R21 – Health Senior management group	3.90	2	5
R22 – Local Community	3.86	2	5
R23 – The Region	3.88	1	5
R23 – Press and social media	3.95	2	5

Figure 55 – CEO´s relative prestige

These results confirm that CEO´s are well accepted within the Health Senior Management group and they have positive Media coverage.

Regarding the Hybrid Professionalism, five questions were made, evaluating the motivation and reasons why CEOs accepted said role. The treatment of these variables was only done for Physicians, a group of 17 answers from a total of 44 and the scale used was the same 9-point Likert scale already used for the evaluation questions.

QUESTION	Mean	Minimum	Maximum
R31 – “His turn”; Peer pressing	4.29	1	9
R32 – To do a better job following criticism	4.71	1	9
R33 – Normal path towards seniority	5.29	1	9
R34 – Had some experience in intermediate management	6.18	1	9
R35 – From early stages opted for management	4.41	1	9

Figure 56 – Why Physicians become CEOs

What is particular of notice is that the range of answers in almost every question varies from both extremes, meaning that either some people took very extreme positions, or that the CEO group was fairly heterogeneous.

Several tests to detect differences on opinion based on age, sex, background, degree, and responsible for nomination were taken for the respondent and for the CEOs surveyed. Most of the difference were not statistically significant, but some showed results that required further attention. Younger respondents have a clear different opinion on **CEO´s availability (r224)** and their ability to **raise sensitive issues (r225).**

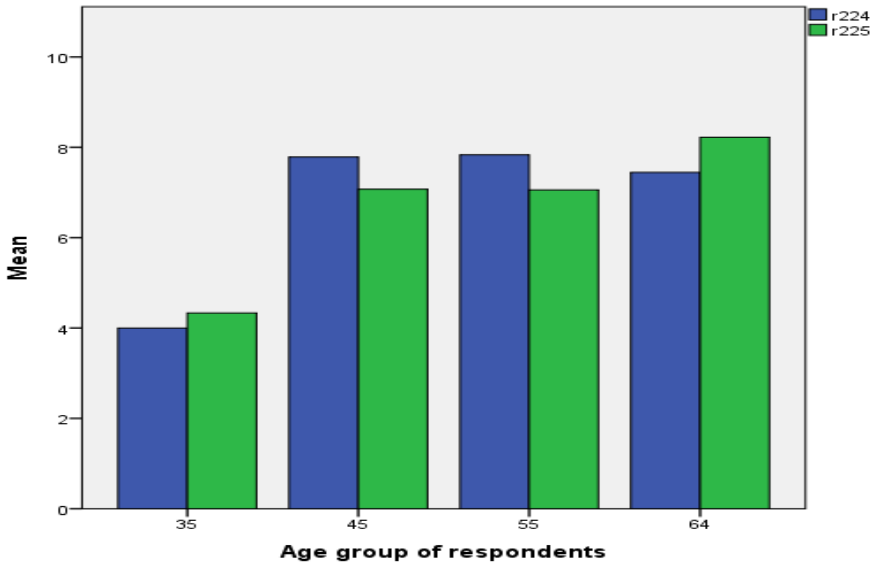


Figure 57 – Age differences in CEO´s evaluations

Generally, respondents did not show significant differences by gender, but the overall CEO prestige (an average of the 5 items individually measured on the CEO prestige vis-a-vis their peers), indicated that for female respondents, CEOs did not perform so much better than their peers in this item.

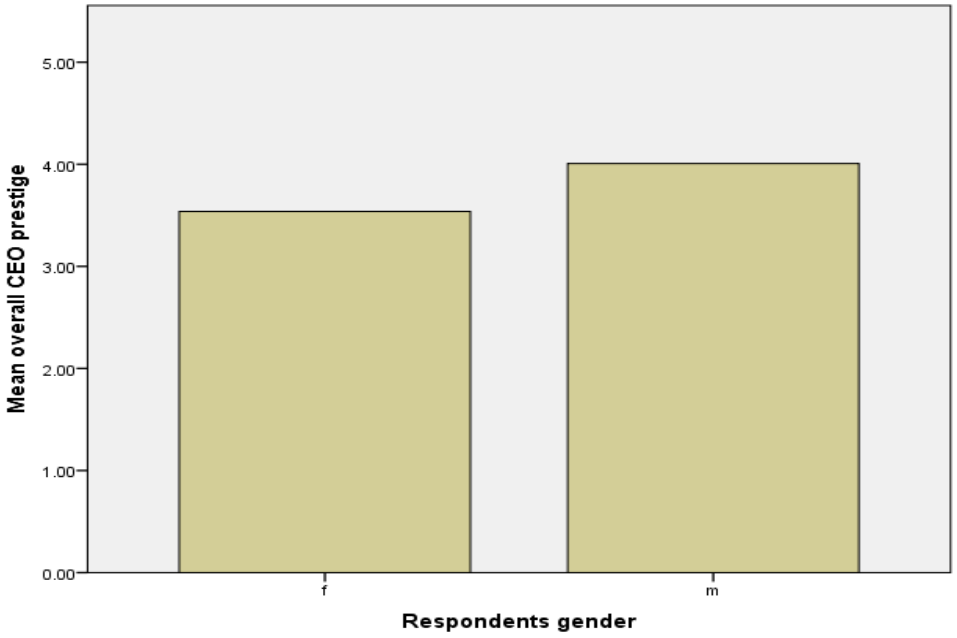


Figure 58 – Respondents' Gender relevance on CEO´s prestige evaluation

Respondents having a PhD degree, found CEO´s more competent than their peers, when evaluating overall expertise.

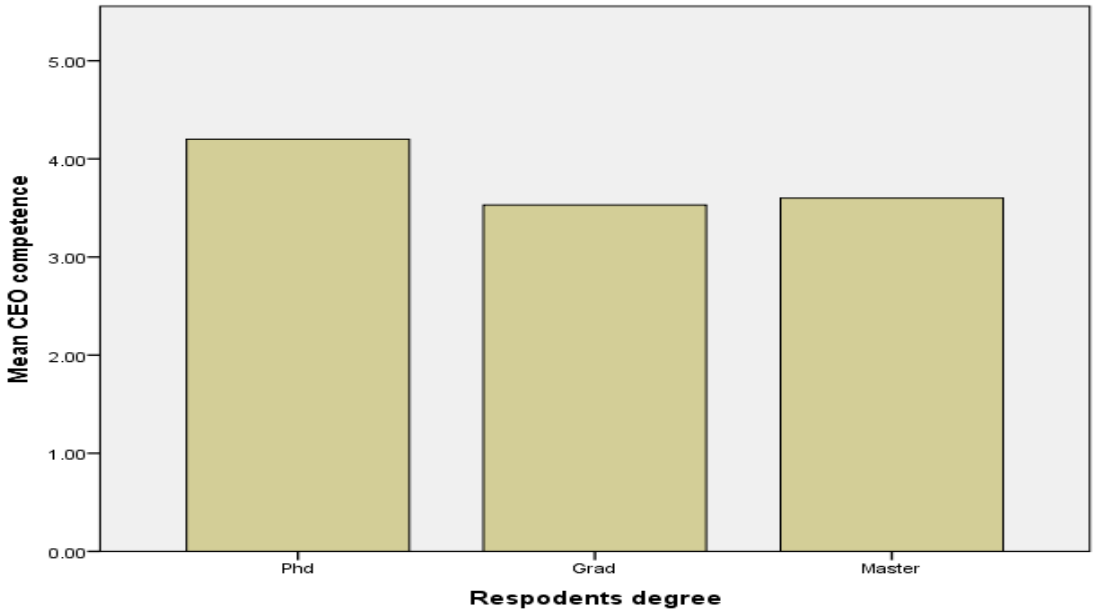


Figure 59 - CEO´s prestige by respondents´ degree

Respondents with background on Law reported less appreciation for CEO´s vision and decisiveness.

X231= Takes the decision initiative **R211**= Drives the vision

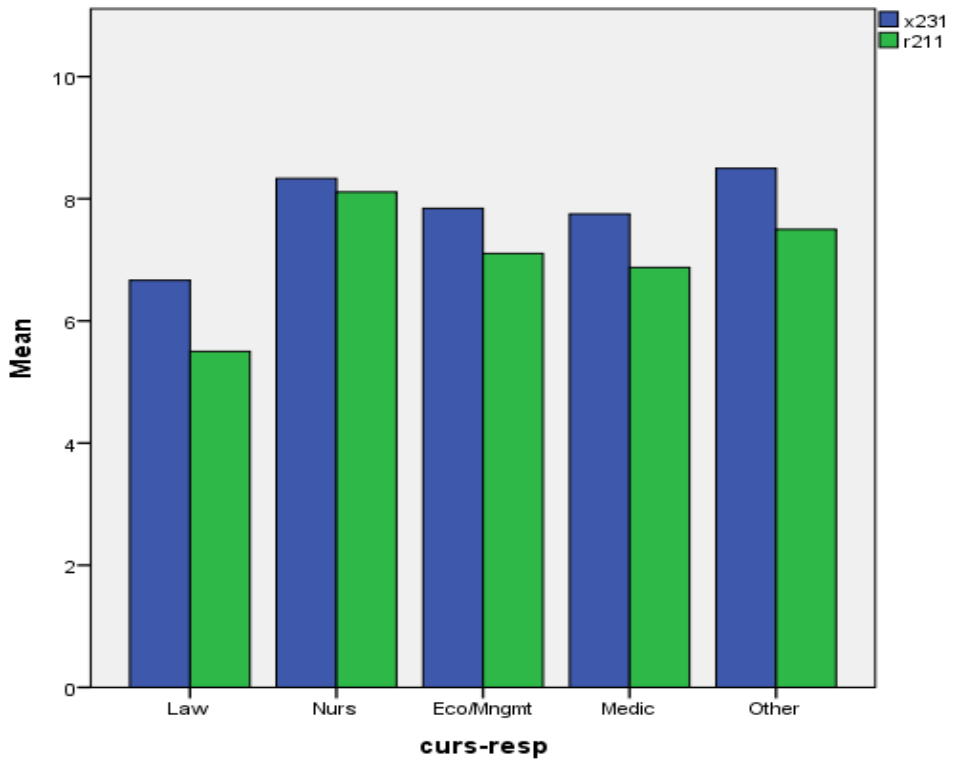


Figure 60 – CEO´s evaluation by respondents´ background

CEOs´ Physicians are the less ranked in their Finance expertise and it is the Physicians themselves who are the harshest group, positioning CEOs below their peers.

Mean16 = CEO´s relative expertise to their peers in Finance and Economics

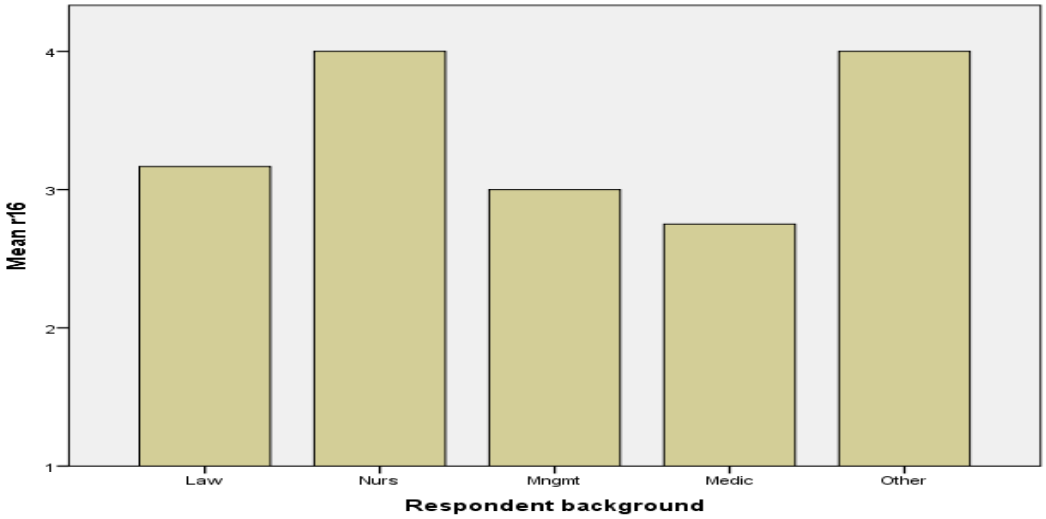
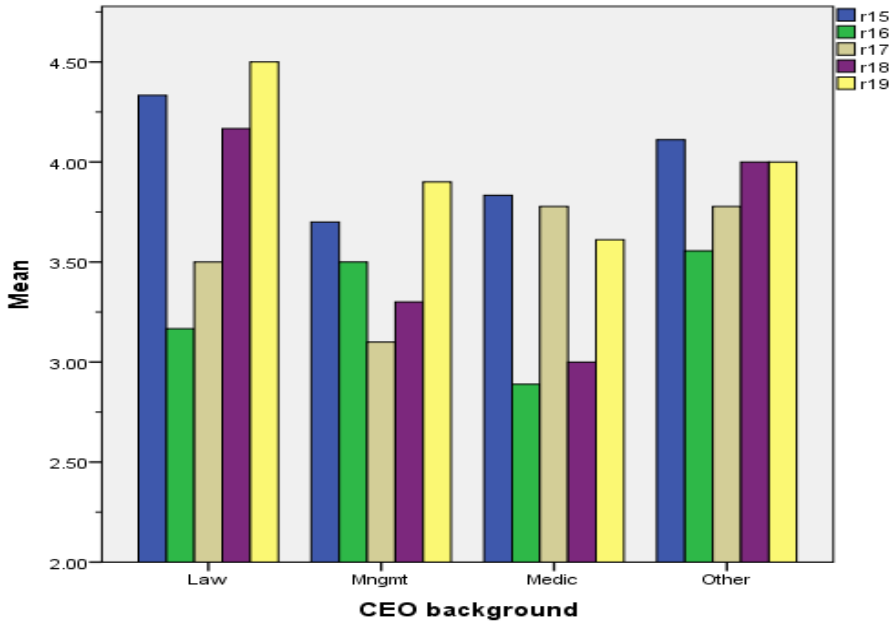


Figure 61 – CEO´s evaluation on finance expertise by respondents´ background

For the respondents who indicated that their nomination was primarily driven by the CEO, the only notable difference in their answers, although not statistically significant, was mentioning. on R16, that CEO´s have a lower level of expertise than their peers in Finance matters with an average of **2.4**, where 3 is equal expertise.

Differences in opinion based on CEO´s characteristics are relevant in some cases. For instance, CEO´s background shows that Physicians only excel on Clinical Activity and are ranked below their peers in Finance matters. If we take into account that Physician respondents also evaluate CEO´s lower in Finance, maybe their self-evaluation is accurate.



R15 = Strategy and Organization R16 = Finance R17= Clinical activity R18= Regulations R19 = Negotiation skills

Figure 62 – CEO´s relative expertise by respondent´s background

There are statistically significant differences when considering CEO´s gender from the responses obtained by the Questionnaire. In terms of competencies compared with peers, **R15 (Strategy and Organization) and R19 (Negotiation skills)**, although both above average of their peers, show that Male executives are better evaluated than Female.

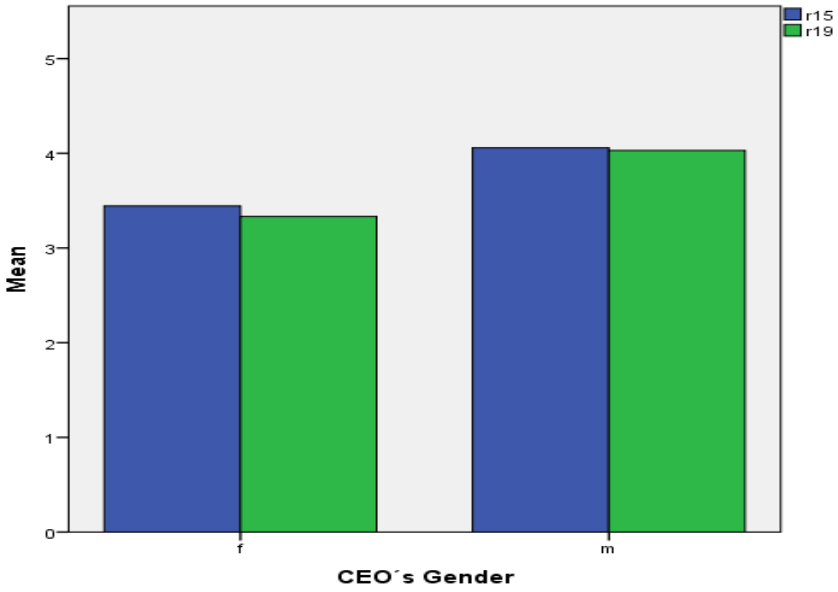


Figure 63 – CEO´s expertise evaluation by Gender

Same type of differences were shown in compared prestige: **R21 (Among Health Senior Management group) and R24 (Media)**:

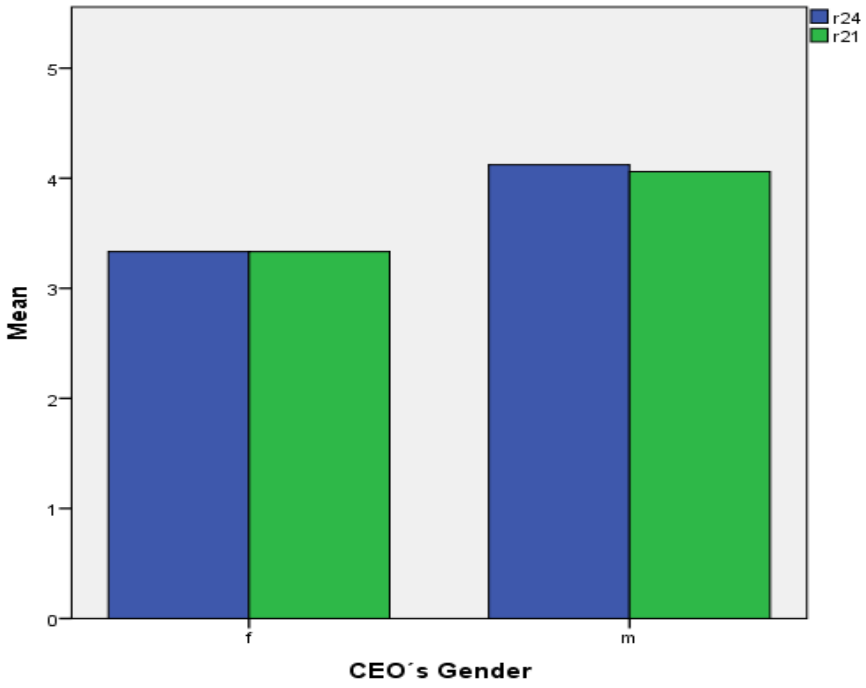


Figure 64 – CEO´s prestige evaluation by Gender

Clearly CEOs who possess a PhD degree are seen as more competent and have more prestige than the others, but there is no significant gap for Masters degree.

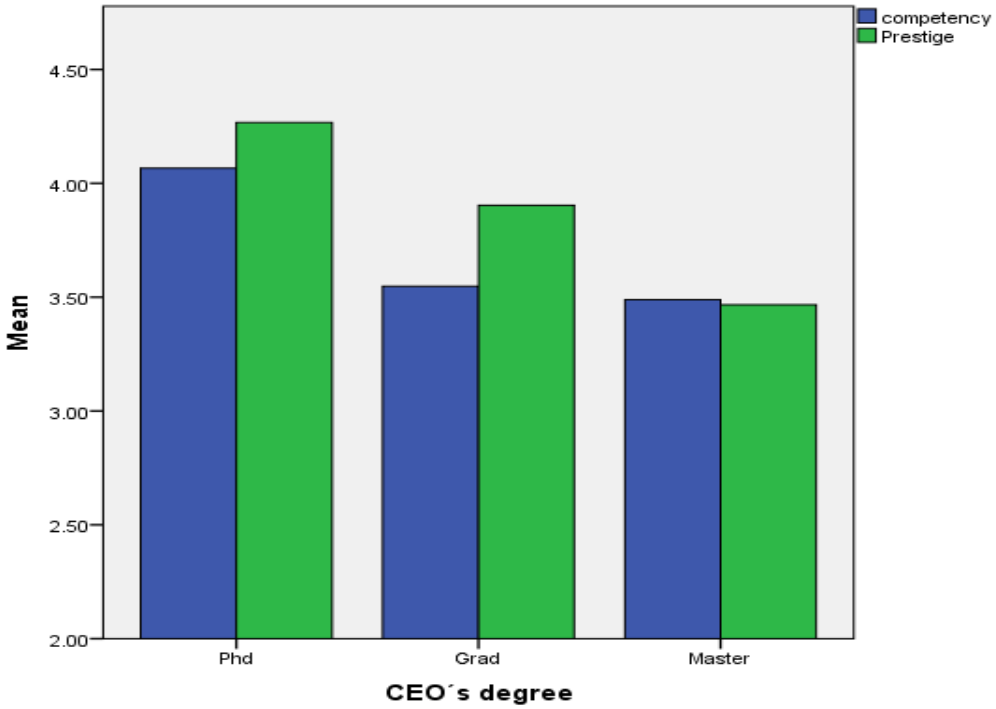


Figure 65 – CEO´s evaluation by degree

Another area that this research looked into, was differences in appreciation motivated by age or by background. That questions whether there are generation gaps or executives that tend to praise CEOs with the same background. A variable was created representing the difference from CEO´s age and the respondent´s age. Negative values mean CEOs younger than respondent and positive the opposite. The next table shows the possible age groups and differences and the frequency that occurred in this survey:

Age Difference value	Frequency	Respondent´s age group	CEO´s age group
-19	**2**	Over 60	40-49
-10	**2**	40-49 or 50-59	30-39 or 40-49
-9	**1**	Over 60	50-59
0	**25**	Same group	as the CEO
9	**3**	50-59	Over 60
10	**4**	30-39 or 40-49	40-49 or 50-59
19	**4**	40-49	Over 60
20	**2**	30-39	50-59
29	**1**	30-39	Over 60

Figure 66 - Age difference variable

Ages differences shows that extreme groups, regard the CEO as being less a teamwork supporter and consensus building. Younger respondents than the CEO evaluations are less favorable showing that some generation conflicts exists:

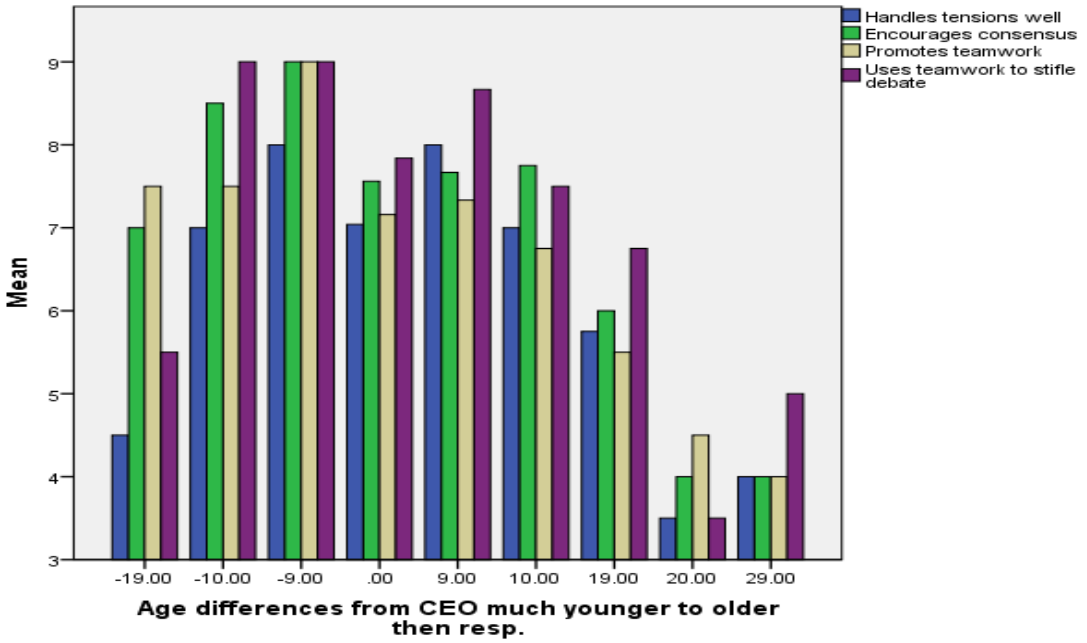


Figure 67 – Differences in evaluations from age differences

Overall age differences do not result in different evaluations of relative expertise or prestige.

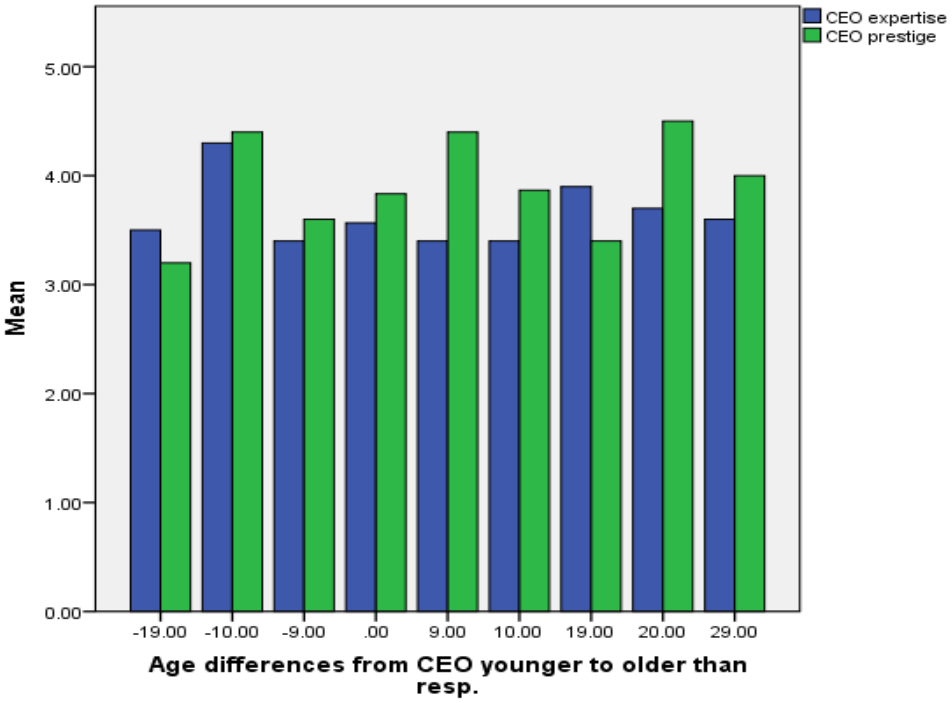


Figure 68 – CEO´s relative evaluation by age differences

This research also analyzed the differences in background and of particular interest the Physicians opinions and evaluations as CEOs. A variable was created that assume the values and meaning of the following table:

Value	Meaning	Frequency
-3.0	CEO = Physician & Respondent = Econ/Mngmt	13,6%
-2.5	CEO = Physician & Respondent = Law	4,5%
-2.0	CEO & Respondent = Physician	13,6%
-1.0	CEO = Physician & Respondent = Nursery	9,1%
-0.5	CEO = Law & Respondent = Econ/Mngmt	6,8%
0	CEO & Resp = same & none = Physician	34,1%
1.0	CEO = Other & Resp = Econ/Mngmt	11,4%
1.5	CEO = Other & Respondent = Law	2,3%
2.0	CEO = Other & Respondent = Physician	4,5%

Figure 69 – Variable representing different background from CEOs

There was no significant difference in the answers obtained, but one should note that Executives with a Law background do not consider that Physician CEOs are too involved. Also, Respondents with a background in Law or Medicine reported that their CEOs cannot handle well the tensions. People with a background in Nursery indicated that Physician CEOs are too involved but they can handle well the tensions.

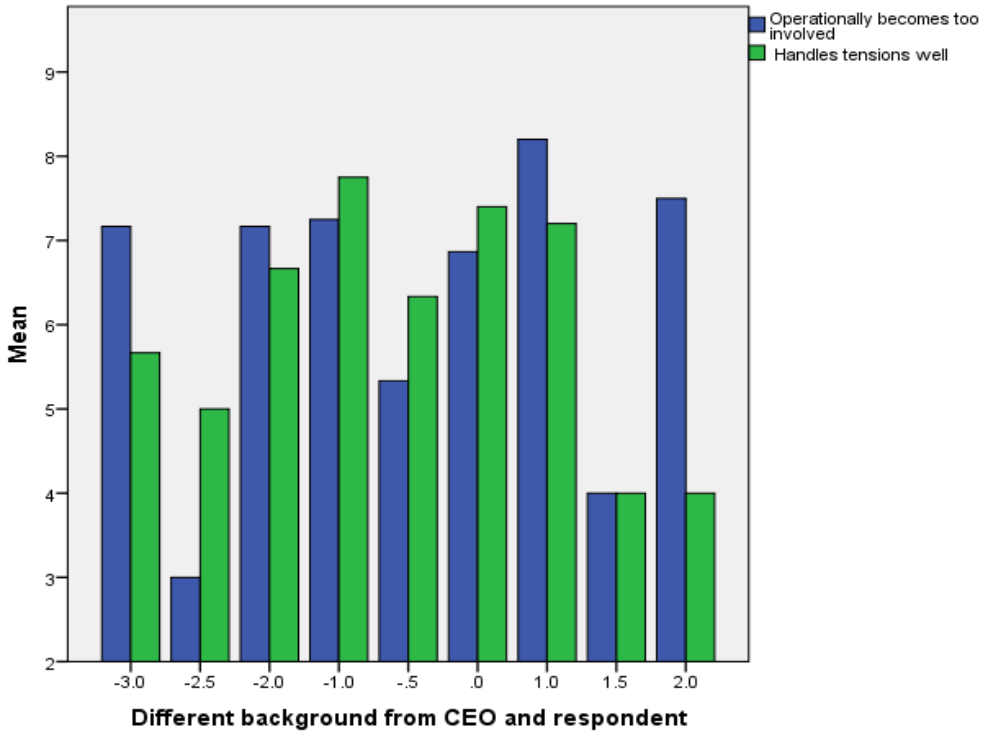


Figure 70 – CEO´s evaluation by different background

The surveyed also showed several high correlations of the answers. Taking the average of Strategy (R211-213) and Style (R221-234) that are absolute values and the relative scale of Expertise and Prestige of the CEOs with their peers, it shows:

Correlations

	Expertise	Prestige	Strategy	Style
Expertise	1	.606**		
Prestige	.606**	1		
Strategy	.559**	.632**	1	
Style	.514**	.451**	.818**	1

**. Correlation is significant at the 0.01 level (2-tailed).

Figure 71 – CEO´s evaluation and variables correlations

Regarding the "hard" question **X230 = Operationally, becomes too involved**, the answers show that older than CEO reported more of that involvement than younger people. It seems a typical reaction: "*I know my job, this young fellow does not need to be around all the time*". Note that when there is no age difference the range is very high. A possible explanation is that in self-evaluations CEOs do not deem themselves to be too involved.

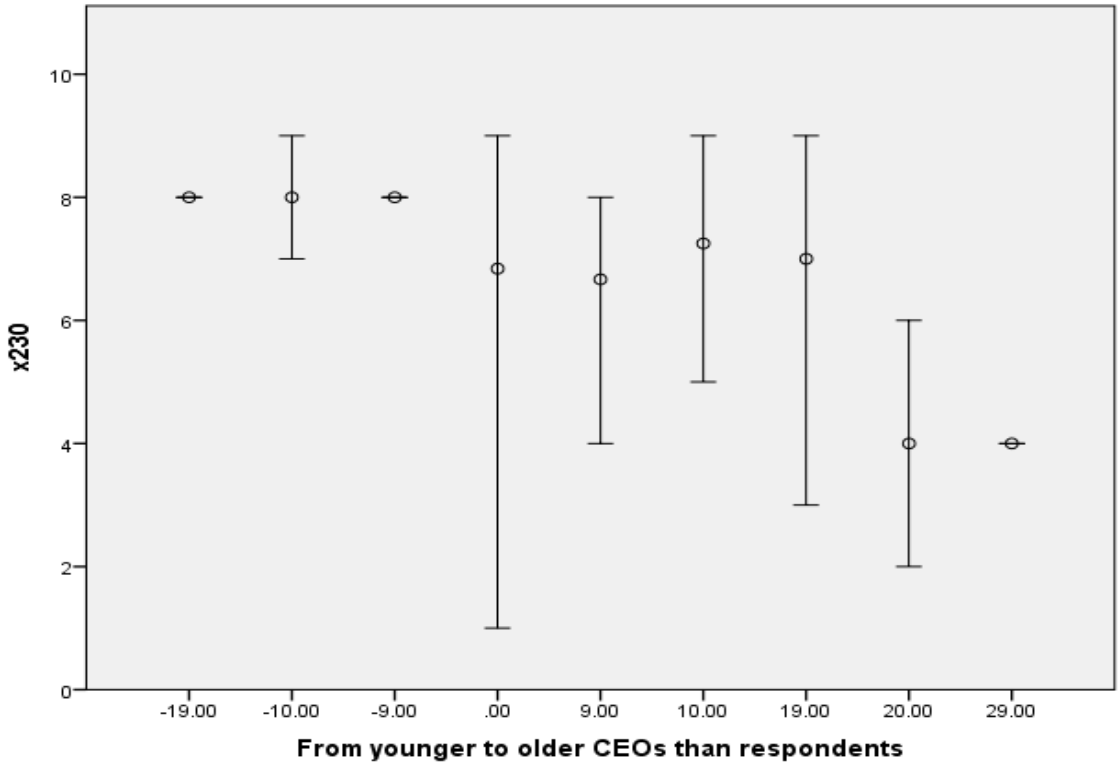


Figure 72 – CEOs´ involvement by age difference

This research analyzed how the **X231 – Takes the decision initiative** is related **to R232 – Is the last to give opinion.** These answers showed significant positive correlation and the explanation might be, that, the CEO listens to other opinions and then makes a decision, as if the other board members were only advisors to his final saying on the matter. Anyhow, it is better than giving his opinion in advance and therefore precluding further discussions.

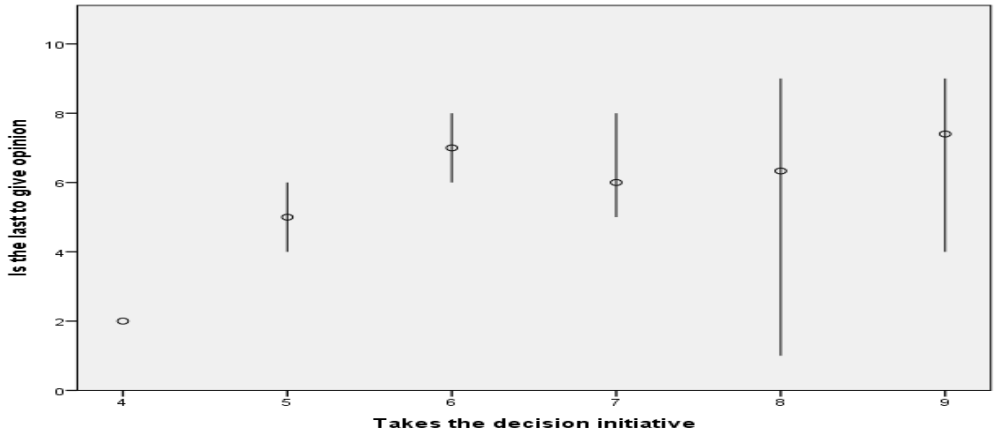
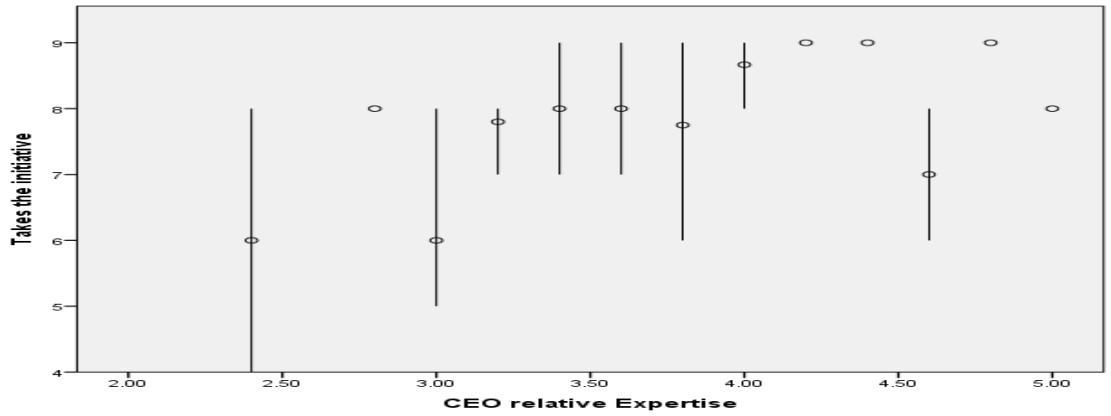


Figure 73 – CEOs´ style characteristics and relations

This parameter "**Takes the decision initiative"** is also correlated with the higher relative expertise and prestige.



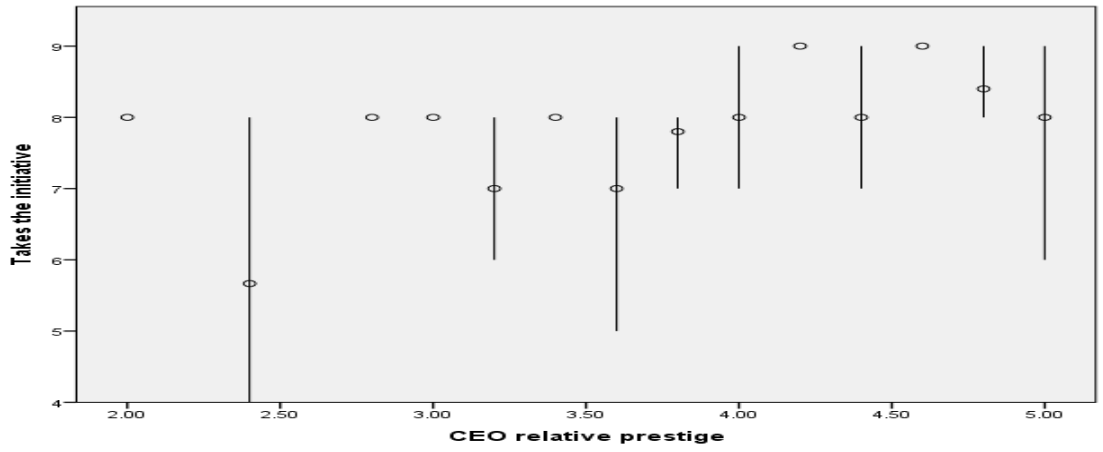


Figure 74 – CEO´s taking the initiative and expertise/prestige

The last "hard" question **X234 – Criticizes objections**; is relevant to evaluate if the CEO is a supporter of discussions or just one that wants to pursues his will. The answers showed significant correlation with **Q222 – Summarizes well**, that may indicate that, as the meeting Chairman, he does not allow discussions to last forever and that is appreciated by the other executives.

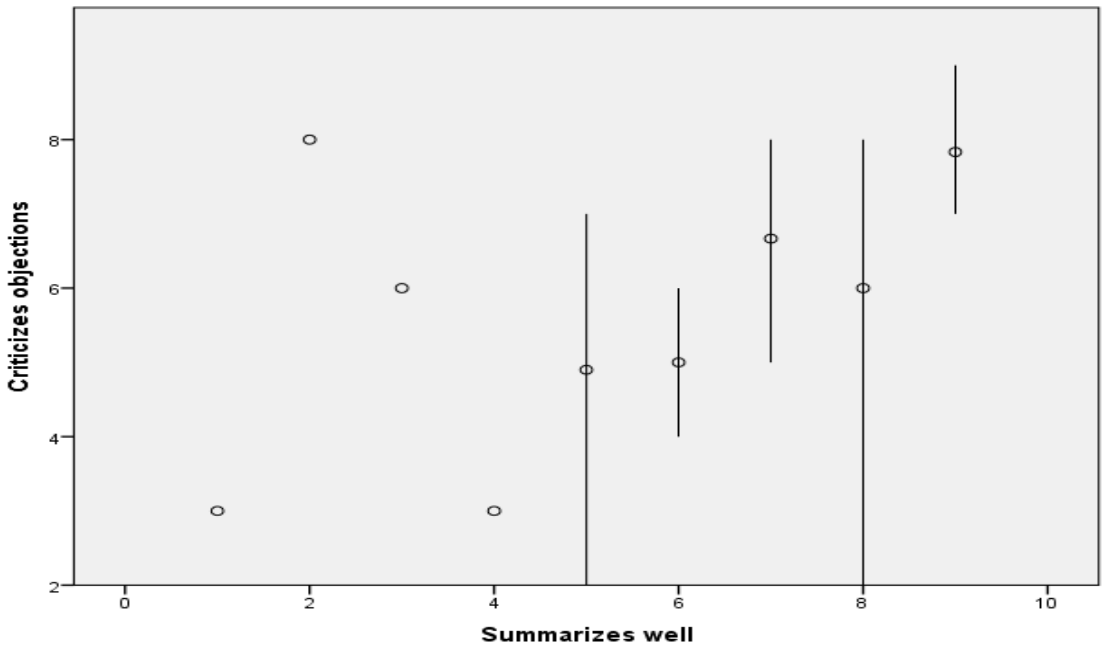


Figure 75 – Correlation of CEO´s characteristics

Of particular notice is the correlation of a **higher relative expertise and the style of criticizing** objections. It relates to the cultural value of uncertainty avoidance, thus allowing the experts to decide. There is no correlation with prestige and objections handling.

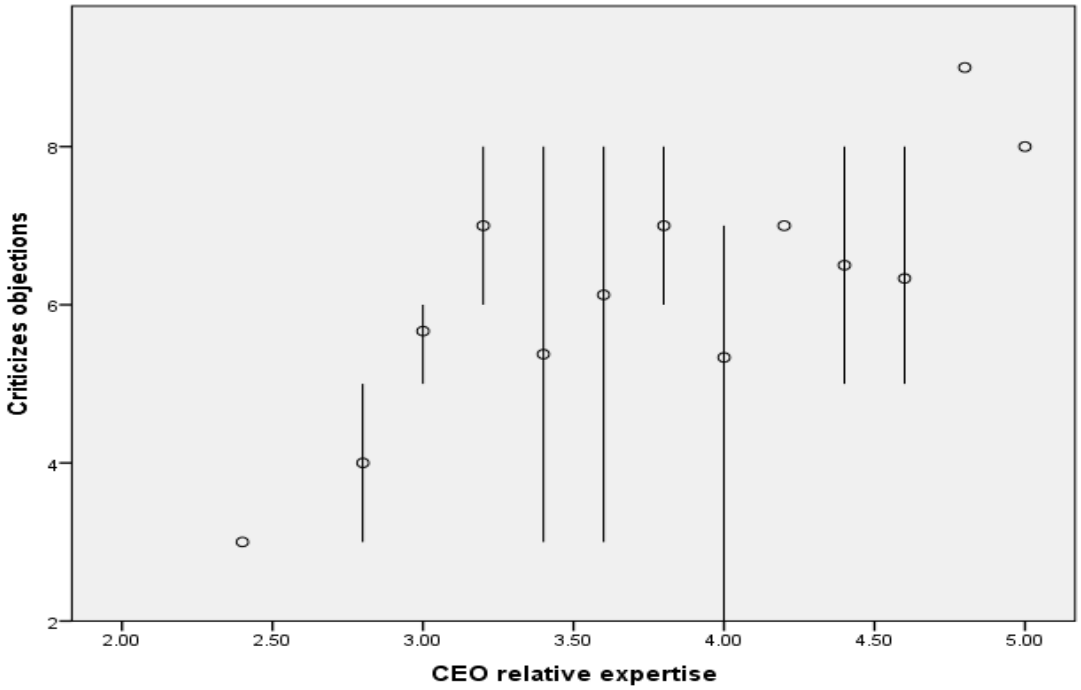


Figure 76 – Correlation of CEOs´ expertise and style

Criticizing objections is highly correlated with expertise on Finance and Legal dimensions. In fact, taking only opinions of Physicians on CEO´s, one could note that, not only the score is higher when evaluating CEOs with other background, but also the range of evaluation of CEOs with the same background is wider, but that could also contain self-evaluations usually more candid.

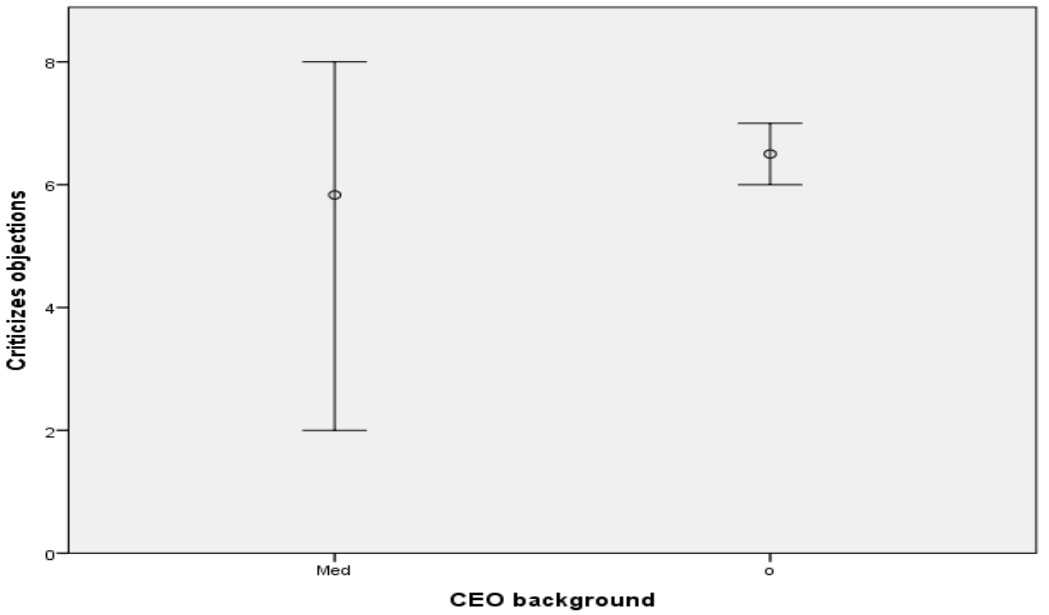


Figure 77 – CEO´s Style by background (Physician respondents only)

Upon evaluating CEOs with Medical background, Executives with Nursery background indicated that they are shut down, and Lawyers accepted better CEO´s criticizing objections.

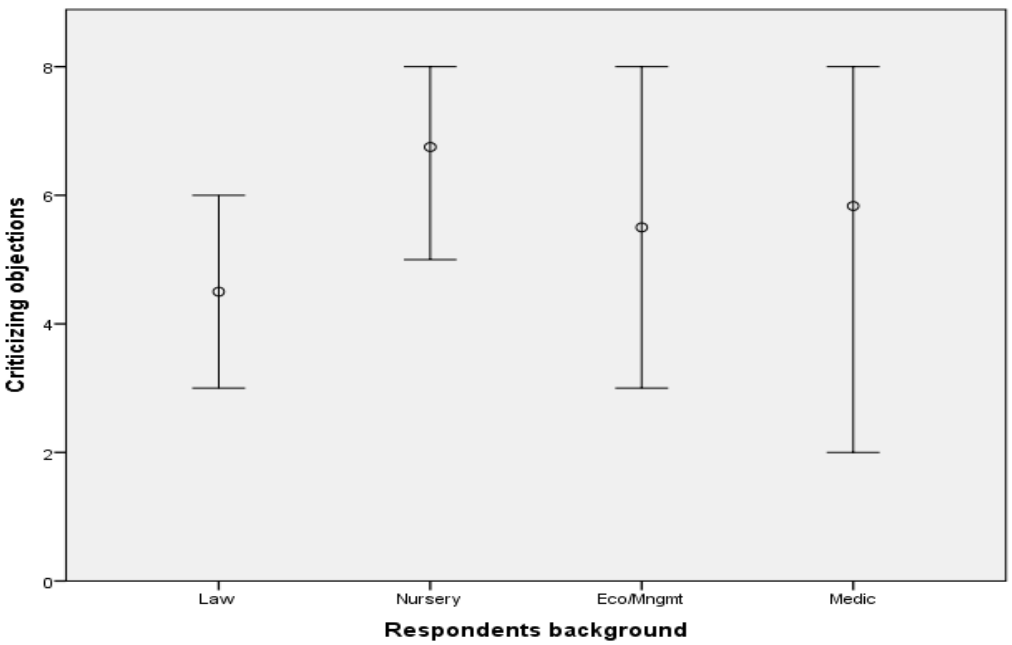


Figure 78 – CEO´s Physician evaluation

The cluster analysis did not show significant distinct groups. When forced, the 2-step model, showed that the group that was seen as shutting more objections, were 100% male, age-group 40-50 and a lower level of expertise on Clinical Activity, with background on Other/Management. Maybe this is the common Clinical and Nurse Director´s view on younger CEOs.

Clusters

Input (Predictor) Importance
1.0 0.8 0.6 0.4 0.2 0.0

Cluster	3	1	2
Label			
Description			
Size	39.5% (17)	34.9% (15)	25.6% (11)
Inputs	curso m (100.0%)	curso o (46.7%)	curso g (81.8%)
	r18 2.88	r18 4.20	r18 3.27
	idade 55 (64.7%)	idade 45 (46.7%)	idade 64 (63.6%)
	r16 2.76	r16 3.40	r16 3.64
	r19 3.53	r19 4.33	r19 3.82
	sexo m (70.6%)	sexo m (100.0%)	sexo m (63.6%)
	r17 3.88	r17 3.53	r17 3.18
	r15 3.76	r15 4.27	r15 3.73
	x234 5.65	x234 6.60	x234 5.73
	x230 6.65	x230 7.47	x230 6.18
	x231 7.82	x231 7.87	x231 7.64

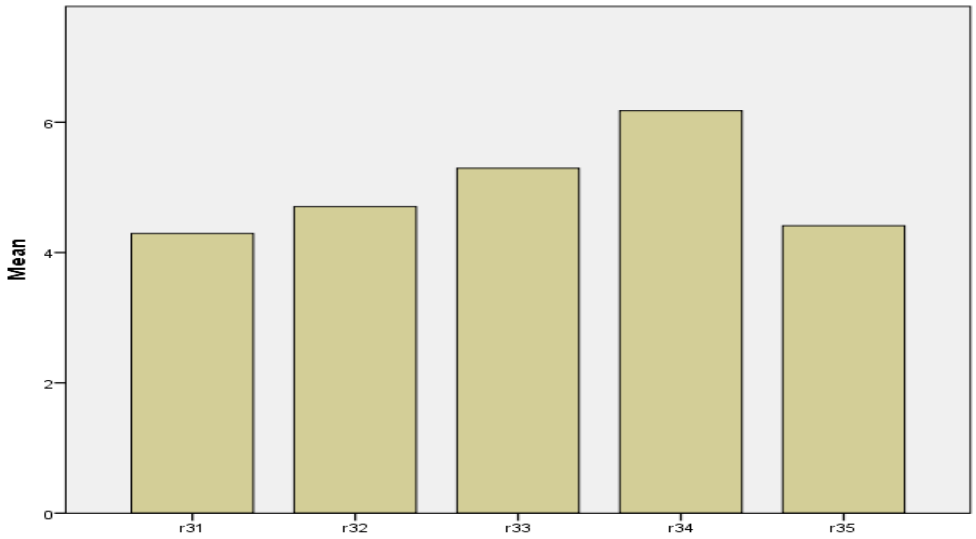
Figure 79 – Forced clusters on CEOs

The forced three clusters, also aggregated a group of all Physicians, who excel in Clinical Activity but lack expertise when compared to their peers on Regulations (R18) and Finance (R16), they score high on “Taking the decision initiative” (X231), fairly involved in operations (X230), but they are the lowest score group in shutting objections (X234).

The survey also showed that 5 out 44 answers mentioned that **Board meetings last less than two hours**. In those cases they also reflect Physician CEOs that also scored low in (R221) “Encourages open debate” and scored high on (X231) “Takes the initiative of the decision”.

4.3.4 Motivation of hybrid professionals

The Questionnaire also revealed the motivations of Physicians to become CEOs in the views of the Executives (including self-assessment). As expected, the Cronbach´s alpha was low (.389) on the five questions related to motivation. They may be not mutually exclusive, but the questions intend to define different paths to become a CEO for Physicians.



R31 = "His turn" **R32**= "To do a better job" **R33** = Normal path
R34= Some hybrid roles before **R35** = "A manager more than a doctor"

Figure 80 – Physicians´ motivation to become CEOs

The main reason is that the CEO role follows some hybrid ones, perhaps Clinical Director, and it fits the path of a professional that is now in management. The next most frequent motivation has also a similar explanation. The explanation for a low frequency of the CEO role to be a "push" from colleagues or a distinct path created at the beginning of the career is that it applies to distinct age groups. The reasons to become CEO seem not highly correlated to any factor of gender, age, degree, relative prestige or expertise or any other dimensions evaluated, with one exception: Being operationally too involved has some correlation with being pressured by his peers to take the turn (**R31**). Possible reasons are unclear to the researcher. The other notable fact is that these motivations seem to be better defined at the age group of 50-59 than at the older group, that seem more motivated by their peer pressure.

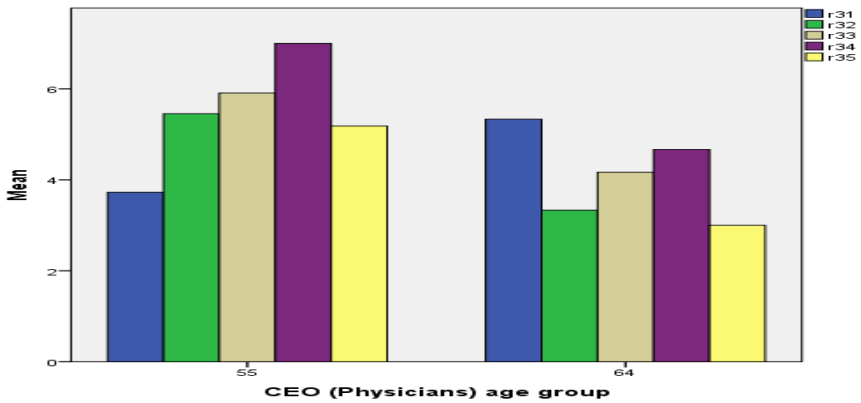


Figure 81 – Physician´s motivation by age group

This path to CEO, moving along a professional career and taking hybrid roles is consistent with what was observed in the sample for the CEO index. Of the Executives with a background in Medicine, only 14% of the Clinical Director had taken a post-graduation in Hospital management, while that percentage for the Physician CEOs was 42%.

Most of those who felt the need are part of a generation in the age-group of 50-59. In this group of Physician CEOs, 2 out of 3 took the post-graduation while in the older group (over 60) the ratio is 3 out of 9. One explanation might be, that in the past the Finance and Legal expertise requirements were not so demanding to manage a Hospital and they are becoming increasingly essential today.

Using a 2-step cluster analysis with 5 clusters requested to force the separation by Motivation, Strategy, Style, Relative Expertise and Prestige, a fair distribution was produced:

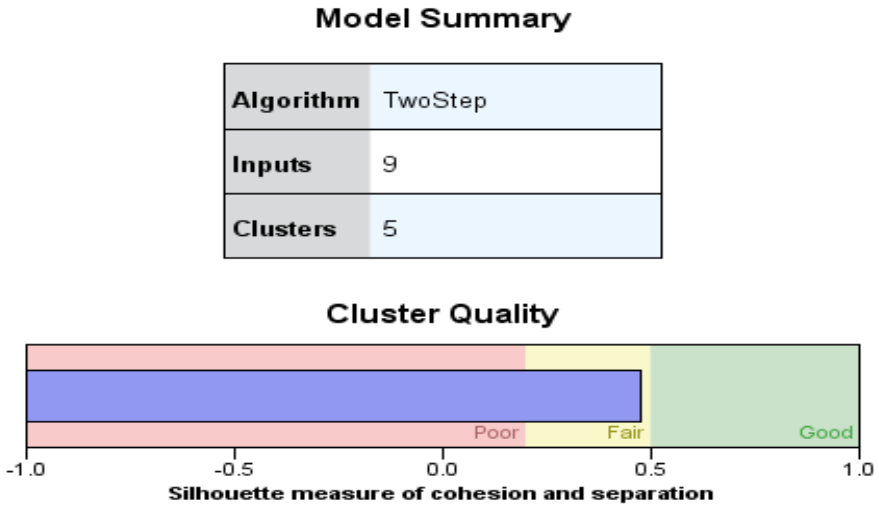


Figure 82 – Cluster analysis on Physician CEOs

The characteristics of these five groups drove to a classification of the clusters that met some of the expectations revealed in the interviews with the panel of executives consulted.

The five groups were labeled:

1. **Seasoned professionals** – the older group highly regarded and supported by their peers.
2. **Change Agents** – those that are critics of the status quo but also highly regarded.
3. **Top Professionals** – those with the highest scores, not active critics, and seen more as good professionals
4. **Average Professional** – perhaps the bigger group, that became managers on a normal career path with some lower evaluations in terms of style.
5. **Power focus** – the younger group that moved earlier to management and are not perceived as having the best qualities.

Clusters

Input (Predictor) Importance
1.0 0.8 0.6 0.4 0.2 0.0

Cluster	1	2	3	4	5
Label	Seasonned professionals	Change agents	Top Professionals	The Average Professional	Power focus
Description	Older group. Highly regarded by their peers who support them	Group noted by being critics of the way things are done. High on Vision, Prestige and style. Supported by peers	Professionals higjly regarded but not critics of the status quo. The normal professional carreer path.	Professionals but with some lack of quality in Vison and Style reflected in Expertise and Prestige.	Ceos that moved to mgmt earlier. Low scores on style, strategy end relative expertise. Also younger group.
Size	11.8% (2)	23.5% (4)	17.6% (3)	29.4% (5)	17.6% (3)
Inputs	competpca 3.50	competpca 3.50	competpca 3.67	competpca 3.36	competpca 2.80
	prestpca 4.40	prestpca 4.15	prestpca 4.27	prestpca 3.44	prestpca 3.07
	r31 8.00	r31 6.75	r31 2.00	r31 4.00	r31 1.33
	r32 1.00	r32 8.25	r32 2.00	r32 5.60	r32 3.67
	r33 2.50	r33 8.00	r33 5.67	r33 4.00	r33 5.33
	r34 1.50	r34 6.75	r34 8.33	r34 7.00	r34 5.00
	r35 1.50	r35 4.25	r35 6.67	r35 3.00	r35 6.67
	tot21 7.50	tot21 8.17	tot21 8.11	tot21 7.00	tot21 3.11
	tot22 7.05	tot22 7.61	tot22 7.91	tot22 5.96	tot22 2.36

Figure 83 – Five Clusters of Physician CEOs

The relationship of these clusters with the "hard" questions, match the labels and reveal what the executives expect from their CEOs, confirming the cultural context.

Group 5, also seen as people that want to keep their power and position, have the lowest scores on operational involvement, decisiveness and criticizing objections.

Group 1 of seasoned professionals, who are also seen as not being too involved operationally, or leading objections but they take the decision initiative.

Groups 2 and 3 are seen as operationally involved and taking the initiative.

Group 4 is noted for below average decisiveness and above average criticizing objections.

CHAPTER 5 – CONCLUSION

5.1 The Research Question and the Empirical Conclusions

This research proposed to evaluate the "**risk of CEO dominance in the Healthcare SOEs in Portugal**". In order to study the issue, several steps were needed, and the first one was to define power dominance and how to measure it. Having a Board and not just one person to decide is a natural choice and internationally accepted, both by agency and stewardship supporters. These two views clash on the role of the CEO also as Chairman – Duality. Stewardship theory supports Duality while Agency theory evaluates it negatively. Insiders on the Board is also seen as a weakness because of their lack of independence from the CEO.

Models of power distribution at the board level, that are based on relative compensation, ownership or number of positions in different companies, had to be discarded because of the restrictions that apply to SOEs´ Executives in Portugal.

Nevertheless, the participation of the CEOs in their colleagues´ nominations, the relative prestige and expertise were variables wholly applicable, in the sense that they imply some sort of power.

Also, age and tenure are elements that enable some power, especially in the Portuguese culture.

Portugal has a cultural context that is characterized as having: a high Power Distance and Uncertainty Avoidance and also a preference for Collectivism and Femininity dimensions.

The first two factors favor a powerful leader, and the last two require that this leader takes care of the group and keeps the tensions low. A model comparable to a benevolent father, who works hard, looks after his family, decides what is best for all, sometimes with consultation, but his words are the end of the discussion. Perhaps, these characteristics, were taken in mind when the legislator in Portugal, assigned no special rights to the CEOs in corporate law and also determined that he should be the last one to vote at the Board of SOEs; although, very seldom this procedure is followed.

In complex organizations like Hospitals, professional bureaucracies resisted the managerialism in several ways, thus the role of the clinical professionals is crucial to define how the power is exercised and accepted. The option to have these professionals represented at the Board level is also common in many geographies and especially in the SOE sector. These are not elected member of the labor force, and their role should not be confused with diversity requirements. It is by virtue of their professional independence that their participation is crucial to becoming part of the overall economic, fiscal and access equity consequences. In this research, a particular highlight was done it terms of explaining the motivations of the Physicians to accept the CEO role, their career path, and how they are perceived by the Executives.

Combining all these ingredients, it may seem that, Hospital CEOs with a long and prestigious career, Physicians by profession, with good political connections, already experienced in Board roles as Clinical Director, would be the obvious case, of CEO dominance. What this research shows is, that this description is true in some cases, but not the whole truth, and there are several other cases of CEO dominance. The research illustrates the components that may create the

conditions to have a powerful CEO, but also highlights that dominance is a relative power, it also depends on how powerful the other Board members are.

One thing is to have the conditions to exercise power at the Board without taking into consideration the other executives' opinions and objections, and, the other is to possess the personality characteristics that lead to their behavior. One could ask the Executives to do a self-assessment test to determine their authority style or ask the executives to evaluate how the CEOs use their style in the boardroom context. The latter was the natural option, for practical reasons, and because proven surveys were already done on this subject by previous researchers.

The number of responses, although not many in total (44), were very good regarding demographic dispersion, and completeness.

Many of the views on this survey confirmed what some Executives have already told the researcher, but the interviewees tend to reinforce the same points and do not reveal all angles.

This survey revealed that the Hospital executives are in some cases very harsh in evaluating CEOs, although they recognize the CEO´s relative higher expertise and prestige compared with their peers. The answers also showed that the majority of the Executives allow a CEO that shuts down objections or that sometimes is overly involved in operations, as long as he is competent, a fact that confirms the cultural context.

The distribution of CEOs by the five levels of the power index showed that there are more than 40% of CEOs who may have the conditions to exercise dominance, but also indicated that 20% have harder conditions to exercise his role as being underpowered.

In one of the interviews with executives, the case of the underpowered individuals was illustrated as being more in the role of Chairman than of the CEO, and, these people would act more on the external relations of the Hospital, which is also of value, according to the Resource dependence theory.

The generation gap is perceived along the survey, significant differences appear, and especially older professionals do not appreciate younger CEOs too operationally involved.

Although there were some differences in the evaluations, depending on the respondent demographic diversity, or the CEO´s age and background, or the combination of the two, but overall the answers were pretty consistent, showing that no real clusters are present in the Portuguese hospital´s CEOs.

In the case of Physician CEOs, two major groups appear: the younger CEOs who have embraced management earlier in their career (a small group), and who are not so supported by their peers and the older group who took the professional path, some from time to time take management positions, that may lead to the CEO role. This bigger group have nuances regarding critics to the status quo, their peers´ recognition and sometimes just take the role at a later stage.

Having a balanced Board, with the right expertise, external prestige, a diversity that reflects the operational conditions, and sound clinical professions as part of the executive team, even in regions where the talent availability is not abundant, seems a rather tough task.

5.2 Implications of the research

The topic of Board dynamics is not often present in the Healthcare SOE sector in Portugal with some notable exceptions (Raposo 2007; Alves 2011). Many of the contributions take a professional point-of-view either arguing about the role of the Clinical Executives or the need for a specific graduation to become a Board member.

The role of the Board of monitoring and advising is assumed by the Health Ministry and Health agencies, and the Finance Ministry takes care of fiscal policy and some major expenses authorizations that are endorsed by the Health sector.

Even the role on non-Executives is seen more as a consultative position with no clear responsibility, other than providing the Board a local connection and a certain level of legitimacy. Most of the people do not even believe that non-executives should evaluate the CEO. That is also true in the private sector in Portugal; many executives consider that the role of non-executives is purely advisory and to please some shareholders.

On the other hand, the citizens and the media ask for Government responses and responsibilities when a major event happens in a public Hospital. It would be hard for the Health Minister to tell the press that hospitals are independent and they are the institution to answer those questions. As all the Ministers expressed, in the interviews, any serious situation drives responses, always coordinated with the Minister himself, and that the big Hospitals have conversations as frequently as on a weekly basis.

To change this relationship and assume that Hospital Executive Boards do not operate as such and nominate just one CEO (Administrador-Delegado), would remove, at least formally one barrier to total dominance (at least the CEO has to face his Board weekly),and also remove from the collective responsibility for performance, the clinical executives.

The enforcement of the procedures that make the Board operate as a collective body, also needs that clear guidelines were prescribed on matters that can be delegated, to whom, and reviewed by the Board at what periodicity, because of the uncertainty avoidance factor. These procedures would remove, from weekly meetings, much of the burden and would let the Board concentrate on more important decisions, with evaluated alternatives, rather, than just ratify what was already approved.

The new recently approved legislation (Decreto-Lei n.º 18/2017 de 10 de fevereiro 2017) may moderate some effects of dominance by limiting the tenure and by especially assigning powers to the Finance Minister nominee.

5.3 Contributions of this research

Hospital management is considered to be a complex system, even within the professional bureaucracies. The context of the SOEs is one that clearly depicts the conflict of fiscal policy and the public service, in a highly regulated market. It also confronts the objectives of private health agencies, sometimes working on behalf of SNS, contractors and almost "pure market driven" activities.

This study develops an integrative approach to several theoretical contributions, the executives surveyed evaluations and sound opinions from former Ministers and current prestigious Executives. Its main contribution in to integrate several sources of knowledge with an empirical work sustained in sound statistical tests.

It contributes to evaluating management dynamics at companies with a sole shareholder (not only state-owned but also some family-owned), with just an Executive Board, in a professional environment (Universities, Research labs).

To the Public Administration this research provides a tool for evaluating Board compositions, to assess the existing procedures and regulations and to improve the executive management roles definition. Especially for CRESAP, this tool will provide another view on the power balance within the nominees and together with their personality study will help to determine the risk of dominance.

For the practitioners, the simple fact that they can make their Board self-assessment may also help in understanding their dynamics. For powerful CEOs, recognizing that they possess the enablers of dominance may make them reflect on what type of advisory and conduct will better serve their Boards.

After acknowledging the legal procedure, mandating him to vote as last, one interviewee revealed that he would use it more often, because sometimes he felt that all the others were waiting to see his inclination to vote.

5.4 Limitations of the research

This study was based fundamentally on public data that is commonly available and could be compared with several distinct institutions, which is not so often in the SOE domain. However, the options of the scales of the variables as well as their weighting were choices made by the researcher, using the available literature and the pooling of executives. Still, they are choices, and they only support the enablers of power. The way power is exercised is different from Board to Board, and there was no direct relationship from the survey answers and the sample used for the index. That was not the intention because that might preclude the answers, and also because some of the executives had in the meantime passed away, making any evaluation of their style very sensitive.

The researcher had been in several ways involved in the Health sector, and as a professional consultant since 1988. The researcher had the privilege to serve the Health public sector for about two years in a period covered by the study. Some of the interactions, the personal relationships, surely had an impact on the way the research was conducted. But, that is also the case of the several studies, thesis and papers read along this literature review. All of them are full of passion, at least a common passion for better health for all. The devil is always in the details, when one has to define what a better health is.

Another limitation to this study is the lack of a good understanding of the Nurses view on management roles. From the interactions, to the researcher it seems that they protect their own territory and avoid conflicts that are out of the boundaries with physicians, meaning the overall holistic view from the Board. The study of (Carvalho 2009) gives some light on the issue.

5.5 Areas of further investigation

In the researcher past career as a consultant, it was a common theme, to say that when a project was finished, the team was really ready to do it. It is always a process of learning along the study and refining the knowledge by incorporating antagonistic views and shaking the preconceived notions one has, even if the subject is neutral, and clearly this one is not.

This type of survey should be done periodically and possibly extended to other areas, removing some of the questions because they only provide confirmation of others, and, the openness of the respondents would allow more specific questions that the researcher avoided, with the fear to alienate the surveyed executives.

With the new legislation now in place, it would also be recommended that a new study of the population of the Board members take place after the changes are in effect.

Of extraordinary practical importance would be the publication of a small document sponsored by the Health and the Financial Ministers for the Boards addressing the topic “I became a Hospital Board member – now what?”, covering not only practical guidelines, but also illustrated with short stories from former Executives on what went wrong and what gave them most pleasure in their roles.

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ANNEXES

ANNEX A – INTERVIEW SCRIPT

O objeto deste estudo é a composição, funcionamento e relação com a tutela dos conselhos de administração dos Hospitais no setor público (aqui Hospitais no sentido lato englobando Centros Hospitalares e Unidades Locais de Saúde).

O que especificamente gostaria de ver focado nesta entrevista é :

1. Formação do conselho de administração:
    a. Razões para manutenção ou substituição quer no novo ciclo legislativo quer no fim do mandato.
    b. Escolha do Presidente do conselho de Administração : fatores que influenciam, coordenação com ministério das finanças, outras fontes de aconselhamento (ARS, ACSS, outros)
    c. Escolha dos membros do CA : papel do PCA nesse processo (escolhe, aceita, veta ?)
    d. Membros que têm funções específicas : Diretor Clínico e Enfermeiro-diretor : seu papel e relevância.
    e. Criação da equipa, delegação de competências, atribuição de pelouros
    f. Orientações de gestão : como são formuladas, pela positiva, pela negativa, atos de gestão que necessitam aprovação.
2. Relação entre tutela setorial e CA :
    a. Frequência de contato, principais temas envolvidos.
    b. Com quem a tutela dialoga : PCA, PCA + Vogal; todo o CA
    c. Fiscalização, ações inspetivas, coordenação com Min. Finanças.
    d. Casos mediáticos, coordenação da comunicação pública.
3. Avaliação do CA :
    a. Importância da avaliação individual e coletiva.
    b. Benchmarking e audição de outros parceiros
4. Recomendações :
    a. Papel de membros não-executivos
    b. Papel do ministério das finanças
    c. Inerência de cargos
    d. Transparência e Eficiência das tomadas de decisão
    e. Administrador-delegado

ANNEX B – Interview Script – English translation

This study focuses on the constitution, functioning, and relation with the Health Ministry, of Hospitals´ Boards in the public sector (Hospitals in a broader sense, thus also referring to "Centros Hospitalares" and "Unidades Locais de Saúde").

What I would like to be focused in this interview, specifically, is:

1. Boards:
   a) Reasons for the maintenance or substitution whether at a new legislative cycle whether at the end of term.
   b) Choice of the CEO: factors that influenced, coordination with the Ministry of Finance, other sources of counselling (ARS, ACSS, others).
   c) Choice of members of the Board: CEO's role in the process (choose, accepts, veto?).
   d) Members with specific functions: Clinic Director and Nurse-Director: role and relevance.
   e) Team creation, competence and function distribution.
   f) Management's objectives: how they are formulated (positively or negatively), management's decisions that require approval.
2. Relation between sectorial guardianship and the Board:
   a) Contact frequency, main topics involved.
   b) With who the guardianship deals: CEO; CEO + Executive, the whole Board.
   c) Controlling, inspective actions, coordination with the Ministry of Finance.
   d) Top media situations: coordination of public information
3. Evaluation of the Board:
   a) Importance of individual and collective evaluation.
   b) Benchmarking and consulting other stakeholders.
4. Recommendations:
   a) Role of non-executive members.
   b) Role of the Ministry of finance.
   c) Reserved seats on the Board
   d) Transparency and Efficiency of decisions.
   e) "CEO –only member "

ANNEX C – Hospital List

Centro Hospitalar Barreiro Montijo, E. P. E	CHBM
Centro Hospitalar de Lisboa Norte, E. P. E	CHLN
Centro Hospitalar de Lisboa Ocidental, E. P. E	CHLO
Centro Hospitalar de S. João, E. P. E	CHSJ
Centro Hospitalar de Setúbal, E. P. E	CHS
Centro Hospitalar de Trás-os-MonteseAltoDouro, E. P. E	CHTMD
Centro Hospitalar do Baixo Vouga, E. P. E	CHBV
Centro Hospitalar do Porto, E. P. E	CHP
Centro Hospitalar e Universitário de Coimbra, E. P. E	CHUC
Centro Hospitalar Leiria, E. P. E	CHL
Centro Hospitalar Lisboa Central, E. P. E	CHLC
Centro Hospitalar Médio Tejo, E. P. E	CHMT
Centro Hospitalar Póvoa deVarzim/ViladoConde, E. P. E	CHPVVC
Centro Hospitalar Tondela Viseu, E. P. E	CHTV
Hospital da Senhora da Oliveira Guimarães, E. P. E	CHAA
Hospital de Magalhães Lemos, E. P. E	HML
Hospital Espírito Santo de Évora, E. P. E	HSE
Hospital Garcia de Orta, E. P. E	HGO
Hospital Professor Doutor Fernando Fonseca, E. P. E	HFF
Instituto Português de Oncologia de Coimbra Francisco Gentil (IPO), E. P. E.	IPOC
Instituto Português de Oncologia de Lisboa Francisco Gentil (IPO), E.P.E	IPOL
Instituto Português de Oncologia do Porto Francisco Gentil (IPO), E. P. E.	IPOP
Unidade Local de Saúde de Matosinhos, E. P. E	ULSM
Unidade Local de Saúde do Norte Alentejo, E. P. E.	ULSNA
Unidade Local de Saúde do Alto Minho, E. P. E	ULSAM
Unidade Local de Saúde do Baixo Alentejo, E. P. E.	ULSBA
Unidade Local de Saúde da Guarda, E. P. E	ULSG
Unidade Local de Saúde de Castelo Branco, E. P. E.	ULSCB
Unidade Local de Saúde do Nordeste, E. P. E	ULSNE

ANNEX D – Cluster analysis of Executive data

A tentative to reduce the factors did not result as shown below.

Correlation Matrix[a]

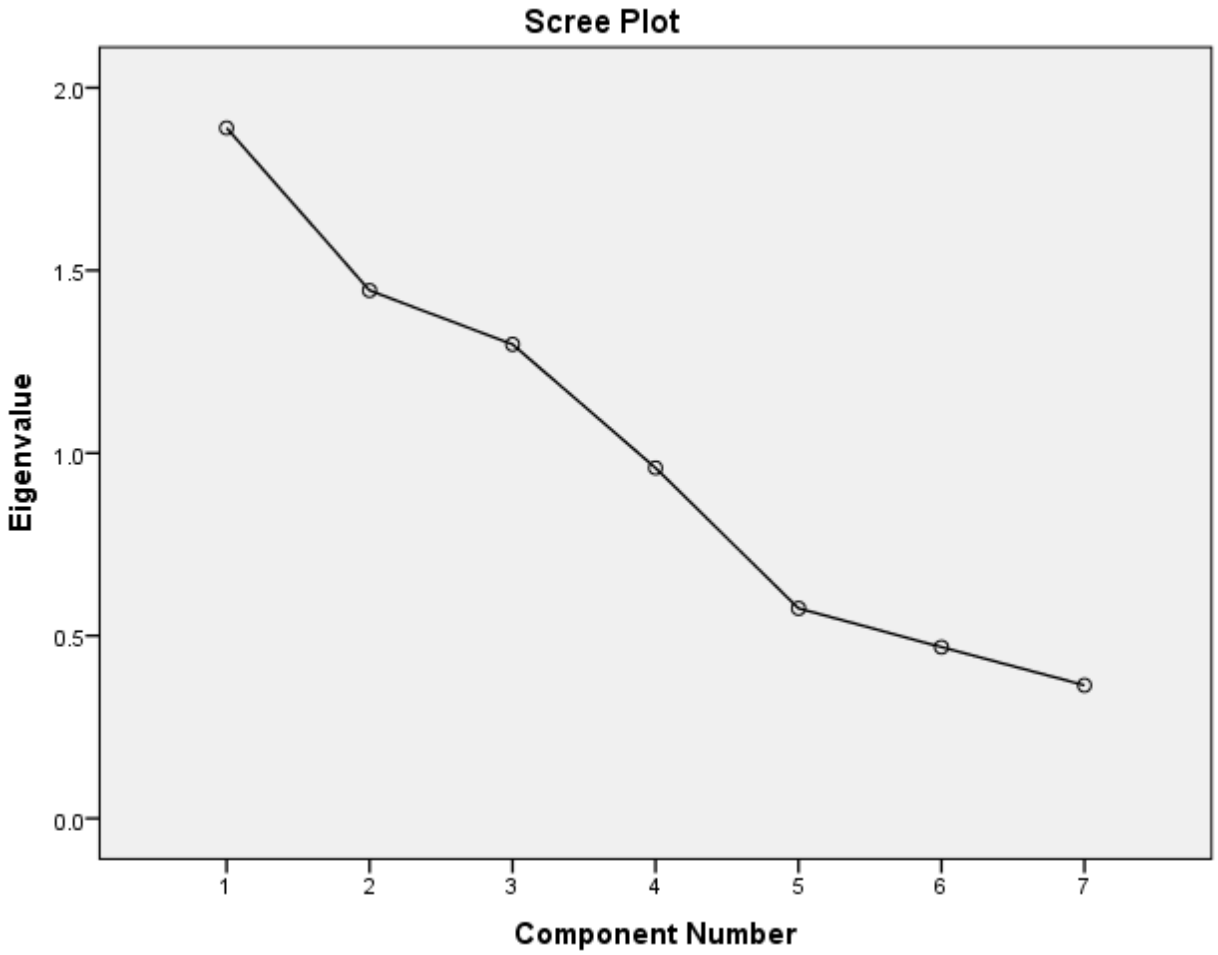
		auxidade	Valcurso	Grau	Politico	AH	Cientista	aux
Correlation	**auxidade**	1.000	.334	-.016	.206	-.188	.108	.317
	Valcurso	.334	1.000	.132	-.175	-.174	.325	.136
	Grau	-.016	.132	1.000	-.073	-.162	.579	-.057
	Politico	.206	-.175	-.073	1.000	-.151	-.133	-.005
	AH	-.188	-.174	-.162	-.151	1.000	-.053	.226
	Cientista	.108	.325	.579	-.133	-.053	1.000	.079
	aux	.317	.136	-.057	-.005	.226	.079	1.000
Sig. (1-tailed)	**auxidade**		.000	.426	.008	.014	.103	.000
	Valcurso	.000		.062	.020	.021	.000	.056
	Grau	.426	.062		.196	.029	.000	.252
	Politico	.008	.020	.196		.039	.060	.475
	AH	.014	.021	.029	.039		.270	.004
	Cientista	.103	.000	.000	.060	.270		.178
	aux	.000	.056	.252	.475	.004	.178	

a. Determinant = .334

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	1.890	26.997	26.997	1.890	26.997	26.997
2	1.445	20.643	47.639	1.445	20.643	47.639
3	1.298	18.537	66.177	1.298	18.537	66.177
4	.959	13.706	79.883			
5	.575	8.213	88.095			
6	.469	6.698	94.793			
7	.364	5.207	100.000			

Extraction Method: Principal Component Analysis.



Component Matrix[a]

	Component		
	1	2	3
auxidade	.445	.744	-.117
Valcurso	.677	.224	.095
Grau	.663	-.478	-.106
Politico	-.151	.432	-.568
AH	-.314	-.044	.776
Cientista	.792	-.298	.122
aux	.211	.580	.570

Extraction Method: Principal Component Analysis.

a. 3 components extracted.

One could define three components, being the first the academic background, the second the combination of age/tenure and the third one would be rather difficult to explain as Politico appears as negative correlated. It only correlates positively with age. And still these three components would only explain 2/3 of the variance.

A cluster analysis as shown below would also connect the Executives by Power, thus joining powerful CEOs and Clinical Directors and underpowered Other Executives.(Vogal)

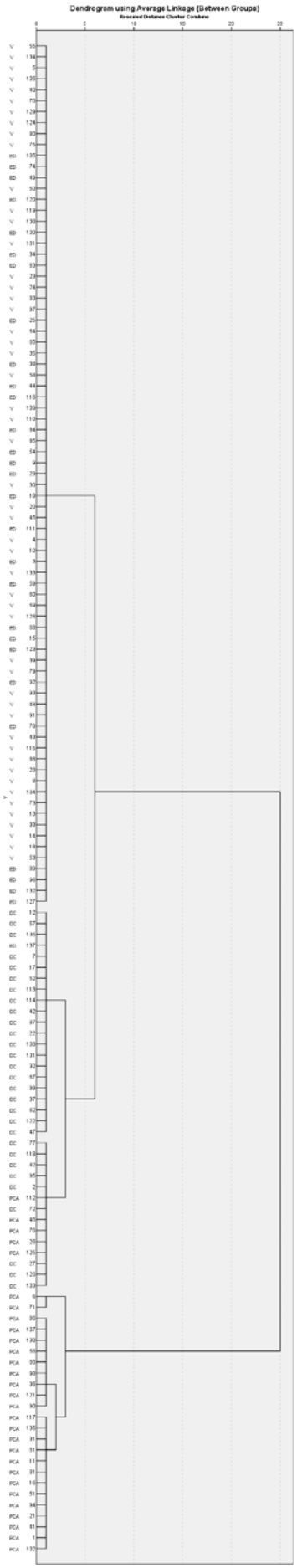
It was shown in the reliability analysis of the seven items, that their correlations were weak and that the Cronbach´s Alpha would increase if one deletes any variable.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.357	.308	7

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
valtit	6.471	2.718	.549	.488	.357
auxidade	6.116	3.505	.402	.303	.450
Valcurso	6.819	3.642	.373	.429	.465
Grau	6.920	4.486	.075	.369	.560
Politico	8.007	4.664	.074	.352	.551
AH	7.638	4.831	-.108	.195	.612
Cientista	7.957	4.232	.335	.422	.499
aux	6.783	3.529	.330	.218	.480


Dendrogram using Average Linkage (Between Groups)
Rescaled Distance Cluster Combine

ANNEX E – The title position – Add or Multiply

During the definition of the Power Index a question took some discussion on how to use the title position on the Board, meaning how to score for the CEO, Clinical Director and Other Executives. Two options were presented: one to calculate the individual power and then to multiply by (3,2,1) depending on their role (CEO, CD, Other Executive), or to add (3,2,1) to the individual power.
The researcher opted for the first option in agreement with the panel, and that was the method used for the power index in this research.
If one have added the title position instead of multiplying, the results would not be very different, as presented in this annex.
First one should look at the possible extreme values that each position can take.

VARIABLE/VALUES					
Age group		1		2	3
Tenure group		1		2	3
Academic degree		1	1.5 (Ms)		3 (PhD)
Background	0 (other)	1 (nurs,mngmt)	1.5 (Law)	2 (Med)	
Politician	0	1			
Academic	0	1			
Postgrad Hosp. Mngmt.	0	1			

The possible individual values by title adding the score for their position are:

Title Position	Min	Max
CEO	6	17
Clinical Director	7	16
Nurse Director	5	14
Other Executive	4	14.5

A CEO with the lowest score (6) and on a 5 member Board all low scores (26) would have 6/26 of the total power, = 23%. A CEO with the highest score (17) on a 5 member Board all high scores (76) would also have 17/76 of the total power, = 22,4%.
Using the same method for a 4 member Board the low score CEO would have 27.27% and the high score CEO would have 27,64%.
Let us define these levels the Group 1 – Significantly underpowered CEO less than 23% of total power and the Group 2 - Somehow underpowered CEO – between 23 and 27%. The next levels were defined by somehow smaller intervals because by adding instead of multiplying the scale does not grow so fast. So Group 3 - Fair distribution of Power was set from 27 to 30%; and group 4 - Significantly dominant CEO was defined from 30 to 32.5% and Group 5 - Extremely dominant CEO was above that level.

Applying these values and comparing to the multiply formula, we got:

Frequency	Multiply formula	Add formula
Group 1	4	3
Group 2	2	6
Group 3	11	8
Group 4	8	8
Group 5	4	4

There were some movements and not all CEOs kept the same group but the results are consistent and the risk levels of CEO dominance are the same.
Both groups are highly correlated as expected.

Correlations

			pcagroup	pcagrouptit
Spearman's rho	pcagroup	Correlation Coefficient	1.000	.808**
		Sig. (2-tailed)	.	.000
		N	29	29
	pcagrouptit	Correlation Coefficient	.808**	1.000
		Sig. (2-tailed)	.000	.
		N	29	29

**. Correlation is significant at the 0.01 level (2-tailed).

ANNEX F – Questionnaire submitted to Health Executives

Questionário sobre os Presidentes dos Conselhos de Administração

Estudo em Portugal

Instruções:São convidados a participar neste inquérito confidencial sobre o papel desempenhado pelos Presidentes dos Conselhos de Administração (PCA) no setor público da Saúde em Portugal. Por favor seleccione apenas um PCA para guiar as suas respostas neste questionário. Este está dividido em duas partes e não deverá demorar mais do que dez minutos a completar. As suas respostas serão tratadas com a **máxima confidencialidade** e serão somente apresentadas de uma forma agregada. Mesmo que seja o PCA responda por favor.

Por favor envie as respostas ao questionário até 30/03/2017

Muito obrigado pela sua colaboração

A. Caracterização

	Sua	Do PCA
1. Idade		
a. Menos de 30	___	___
b. 30 a 39	___	___
c. 40 a 49	___	___
d. 50 a 59	___	___
e. 60 ou mais	___	___
2. Sexo		
a. Masculino	___	___
b. Feminino	___	___
3. Habilitações literárias		
a. Ensino Secund.	___	___
b. Licenciatura	___	___
c. Mestrado	___	___
d. Doutoramento	___	___
4. Área da habilitação:		
a. Medicina	___	___
b. Enfermagem	___	___
c. Direito	___	___
d. Economia/Gestão	___	___
e. Outra	___	___
5. A sua principal indicação para o CA partiu de :		
a. Poder politico	___	___
b. ARS	___	___
c. Estruturas socio-profissionais	___	___
d. Pelo PCA	___	N/A
e. Não é membro do CA	___	N/A
f.		

6. As reuniões do CA são normalmente : (normalmente) :
   a. Semanais ___
   b. Quinzenais ___
   c. Mensais ___

7. A duração das reuniões
   a. Menos de 2 horas ___
   b. Meio dia ___
   c. Um dia ou mais ___

B. AVALIAÇÃO

O Presidente do Conselho de Administração

Por favor classifique o Presidente, mesmo que ocupe esse cargo, quanto aos seguintes aspectos (*desde 1=não corresponde até 9=corresponde totalmente)*

2.1. Decisões estratégicas	**Não corresponde**								**Corresponde totalmente**
1. Impulsiona a visão	1	2	3	4	5	6	7	8	9
2. Determina a estratégia organizacional	1	2	3	4	5	6	7	8	9
3. Promove a compreensão da estratégia organizacional	1	2	3	4	5	6	7	8	9
2.2 Estilo	**Não corresponde**								**Corresponde totalmente**
1. Encoraja um debate aberto	1	2	3	4	5	6	7	8	9
2. Sumariza adequadamente	1	2	3	4	5	6	7	8	9
3. Interpreta a essência do argumento	1	2	3	4	5	6	7	8	9
4. Disponibiliza-se com facilidade	1	2	3	4	5	6	7	8	9
5. Traz à discussão assuntos sensíveis	1	2	3	4	5	6	7	8	9
6. Gere tensões/sensibilidades adequadamente	1	2	3	4	5	6	7	8	9
7. Encoraja a existência de consensos	1	2	3	4	5	6	7	8	9
8. Promove o trabalho de grupo	1	2	3	4	5	6	7	8	9
9. Utiliza o trabalho de grupo para estabelecer o debate	1	2	3	4	5	6	7	8	9
10. Operacionalmente, envolve-se demasiado	1	2	3	4	5	6	7	8	9
11. Toma a iniciativa da decisão	1	2	3	4	5	6	7	8	9
12. Reserva a sua opinião para o final	1	2	3	4	5	6	7	8	9
13. Encoraja as opiniões antagónicas	1	2	3	4	5	6	7	8	9
14. Critica as objeções apresentadas	1	2	3	4	5	6	7	8	9

Como compara o PCA face aos restantes membros do CA (globalmente) :

Na competência técnica no domínio :	Mto.Inf	Inf.	Identica	Sup.	Mto.Sup.
15 .Estratégia e Organização					
16. Finanças e Gestão económica					
17. Atividade assistencial					
18. Legislação e normativo					
19. Diplomacia e negociação					

No prestígio :	Mto.Inf	Inf.	Identica	Sup.	Mto.Sup.
20. No meio académico					
21. Entre os dirigentes da Saúde					
22. Na comunidade local					
23. Na região					
24. Na Comunicação Social					

Por favor avalie o Presidente, mesmo que ocupe esse cargo, em relação às seguintes frases
(*desde 1= total desacordo até 9=concordo totalmente)*

3. O PCA assumiu o cargo porque :	**Total desacordo**							**Concordo totalmente**	
1. Foi escolhido/ "voluntariado" pelos colegas de profissão. " A sua vez de assumir o posto"	1	2	3	4	5	6	7	8	9
2. Por ser crítico em relação a vários aspectos da gestão. "Tentar fazer melhor"	1	2	3	4	5	6	7	8	9
3. Como o passo seguinte natural na senioridade. "Um profissional que agora está na gestão"	1	2	3	4	5	6	7	8	9
4. Tendo já várias experiencias de gestão intermédia, ganhou competências para PCA	1	2	3	4	5	6	7	8	9
5. Muito cedo desviou-se da profissão e tem sido consistentemente visto mais como gestor.	1	2	3	4	5	6	7	8	9

Muito obrigado pela sua colaboração.

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ANNEX G – Questionnaire (translated) submitted to Health Executives

Survey on CEOs of Health Public Entities

Portuguese study

Instructions: You are invited to participate in this confidential survey on the role of the CEO of a Public Health Entity in Portugal. Please select just one CEO to guide your responses to the following questions. The questionnaire is divided in two parts and should take about 10 minutes to complete. Your responses will be treated in the **strictest confidence** and only reported in aggregated terms. Even if you are the CEO please answer the survey.

Please return your completed questionnaire by 31/03/2017

Thank you for your cooperation

A. Demographics

	Yours	CEO´s
1. Age		
a. Less than 30	___	___
b. 30 a 39	___	___
c. 40 a 49	___	___
d. 50 a 59	___	___
e. 60 ou mais	___	___
2. Gender		
a. Male	___	___
b. Female	___	___
3. Highest level of education		
a. College	___	___
b. Undergraduate	___	___
c. Masters	___	___
d. PhD	___	___
4. Background:		
a. Medicine	___	___
b. Nursery	___	___
c. Law	___	___
d. Economy/Mngmt	___	___
e. Other	___	___
5. The main sponsor of your Board appointment :		
a. Political power	___	___
b. ARS	___	___
c. Socioprofissional body	___	___
d. CEO	___	N/A
e. Not a Board member	___	N/A

6. Frequency og Board meetings :
   a. Weekly___
   b. Bi-monthly ___
   c. Monthly___

7. Typical length of Board meetings :
   a. Less than 2 hours ___
   b. Half day ___
   c. One day or more ___

B. Evaluation

The CEO

Please rate the CEO, even if this is you, on the following aspects (*ranging from 1=Not at all true to 9=Very true).*

2.1. Strategic Decisions	**Not at all true**								**Very True**
1. Drives the Vision	1	2	3	4	5	6	7	8	9
2. Determines organization strategy	1	2	3	4	5	6	7	8	9
3. Enables understanding of organization strategy	1	2	3	4	5	6	7	8	9
2.2 Style	**Not at all true**								**Very True**
1. Encourages open debate	1	2	3	4	5	6	7	8	9
2. Summarizes well	1	2	3	4	5	6	7	8	9
3. Captures the essence of the argument	1	2	3	4	5	6	7	8	9
4. Is easy to talk to	1	2	3	4	5	6	7	8	9
5. Raises sensitive issues	1	2	3	4	5	6	7	8	9
6. Handles tensions/ sensitivities well	1	2	3	4	5	6	7	8	9
7. Encourages consensus	1	2	3	4	5	6	7	8	9
8. Promotes teamwork	1	2	3	4	5	6	7	8	9
9. Uses teamwork to sitffle debate	1	2	3	4	5	6	7	8	9
10. Operationally becomes too involved	1	2	3	4	5	6	7	8	9
11. Takes the decision initiative	1	2	3	4	5	6	7	8	9
12. Is the last one to voice his opinion	1	2	3	4	5	6	7	8	9
13. Encourages antagonic opinions	1	2	3	4	5	6	7	8	9
14. Criticizes objections raised	1	2	3	4	5	6	7	8	9

How do you rank the CEO against their peers (globally) :

On his competency in the following domains:	Much Less	Less	Equal	More	Much more
15. Strategy and Organization					
16. Finance and economic matters					
17. Clinical activity					
18. Legislation and Regulation compliance					
19. Negotiation and diplomatic skills					

On his prestige	Much Less	Less	Equal	More	Much more
20. Academic pespective					
21. Among Health Senior Management					
22. Local community perspective					
23. The Region perspective					
24. The Media perspective					

Please evaluate the CEO according to your agreement with the following sentences. Even if you are the CEO (ranging from 1=Not at all true to 9=Very true).

3. The CEO accepted the role because :	**Not at all true**								**Very True**
1. He was "volunteered" by his peers. His turn.	1	2	3	4	5	6	7	8	9
2. He was critic of the status quo. He could do better.	1	2	3	4	5	6	7	8	9
3. A natural step towards seniority. "A professional now in management"	1	2	3	4	5	6	7	8	9
4. He had previous management experiences and gain competencies to become a CEO	1	2	3	4	5	6	7	8	9
5. Very early in his career moved to management path.	1	2	3	4	5	6	7	8	9

Thank you for your cooperation.

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