KINGS FUND COLLEGE

Better MANAGEMENT Better HEALTH

FINAL REPORT ON THE PHARE HEALTH SECTOR MANAGEMENT PROJECT 1992/1993

LESSONS FROM THE PHARE HEALTH SECTOR MANAGEMENT PROJECT

KINGS FUND COLLEGE

1 June 1993

Dear Colleagues

The new governments in the Czech and Slovak Republics made fundamental reform of the health sector an important element in the much wider programme of social and economic reconstruction launched at the end of 1989. These reforms set out with idealistic goals and have involved intensive efforts to find the most appropriate means for achieving these goals in the turbulent conditions which have since prevailed.

Both the scope and the speed of this transformation are unique in the history of advanced countries. No one could reasonably claim to be sure they know how to manage the necessary changes successfully. Rather like the bold explorers who set out in earlier times to discover the New World, health sector leaders have begun a long journey with an unclear destination, poor maps, inexperienced navigators, different views among the crew and expecting to encounter some very bad weather.

It has been our privilege to join in part of this journey. At the invitation of the two health ministries in the Spring of 1992, and with support from the European Communities PHARE programme, we undertook to provide assistance in strengthening the management infrastructure required to implement health sector reforms. This project has been led by the King's Fund College with the collaboration of the Instituto de Estudios Superiores de la Empresa, Barcelona and the South East England Institute of Public Health.

Its aims have been to:

* work with health sector managers in seeking to understand the challenges of achieving radical transformation;
* assist these managers through on-site consultancy and a range of training opportunities; and
* use this experience to identify ways of strengthening the in-country capacity for management and information systems development in 1993 and beyond.

The project was funded from April 1992 until April 1993. During this period the six members of the project team spent between them more than twelve months visiting the three pilot districts (Litomerice, Pisek and Trencin) and the two capitals, meeting a wide cross-section of local and national health sector leaders; more than three hundred

King Edward's Hospital Fund for London
2 Palace Court, London W2 4HS.
Telephone: 071-727 0581 Facsimile: 071-229 3273
Director: Jo Ivey Boufford, MD

managers contributed their experience to educational events and forty-five managers participated in study visits to Spain and the United Kingdom organised by the project.

Important outcomes from this work have been the actions taken by these managers to improve health services in their own localities and, we believe, to increase their capacity for informed leadership in future.

This report draws together lessons from their experiences and the full range of project activities for wider discussion. It is addressed to managers in other districts seeking to develop their own responses to similar challenges, to experts in management development and management information systems, and to leaders at the Republic level who have the responsibility for national strategies for management and information systems development.

Consistent with the approach taken throughout this project, we do not try here to provide Western 'answers' to Czech and Slovak problems. Rather, we invite colleagues to consider our analysis and recommendations in the light of your own experiences with a view to defining the best ways forward in your situation. This report is intended therefore to be one contribution to a growing Czech and Slovak health management literature which will increasingly chart the progress of reforms and share what is being learnt in different places about the strategies for success.

Like other travellers on this journey, we have often been stimulated by the courage and creativity of the managers we have assisted and sometimes felt 'sea sick' as we have sheltered from the 'bad weather'. Throughout the project, however, we have greatly appreciated the opportunity to work and learn with colleagues during this critical period of change in the two Republics. We particularly wish to acknowledge the pleasure we have gained from working with leaders in the three pilot districts and the assistance to the project provided by the project co-ordinators appointed by each ministry.

This report brings the formal work of the project to a conclusion. We retain, however, a strong interest in subsequent progress within the two Republics and with other Western colleagues we look forward to sustaining and extending the links between health sector leaders in our countries over many years to come.

Yours sincerely

JO IVEY BOUFFORD MD
Director

DAVID TOWELL MA PhD
Project Team Leader

BETTER MANAGEMENT, BETTER HEALTH

CONTENTS

1. INTRODUCTION

Background and aims

An expert mission from the European Community visited the CSFR in September 1991 to assess challenges facing the health sector and discuss with health ministry representatives their priorities for investment from the PHARE programme (the CEC's main form of assistance to economic and social reconstruction in Central and Eastern Europe). By that time, both Republics were already committed to major strategies for health sector reform which aimed to improve health and health services through a fundamental transformation in the previous centralised state system. Plans were already well advanced for dissolving former state structures to establish a pluralist health system, establishing new arrangements for financing health services (particularly the creation of health insurance agencies) and decentralising decision-making so that better services would be achieved through transactions between more autonomous local payers, providers and users of health care.

The health ministers recognised that investment in management infrastructure - to get the right things done well - was critical to the success of these reforms. As the PHARE project was to show in more detail, pluralism and decentralisation required a radical change in management practice away from the administrative centralism characteristic of the previous system. Managers would be required who could provide leadership for change and mobilise the support of other staff. They would need new skills to define the goals of more autonomous organisations, improve efficiency and operate in a more competitive environment. They would also need new tools, especially effective information systems which replaced the previous attention to collecting large amounts of data for vertical transmission with a new focus on information relevant to management tasks, particularly the requirements of new funding arrangements.

Ministers appreciated that this radical change in management and the way managers are prepared, would take several years to accomplish. It was agreed with CEC representatives that the PHARE programme could make a useful contribution to meeting this challenge through an initially modest one-year project to develop health sector management and information systems. The contract to undertake this

project was awarded by competitive tender to the King's Fund College and work began at the end of March 1992.

The specification for this project was distinctive in seeking to use the learning from direct assistance to managers in the short term (particularly collaboration with leaders in three pilot districts identified by the ministries) to shape the Republic level strategies required to strengthen health sector management and information systems in the medium term (i.e. over the next two to five years).

More specifically, the project involved:

* working with managers in the three pilot districts to understand the challenges they face in achieving health sector reform;
* assisting these managers to improve management and information systems through on-site consultancy and providing a range of training opportunities;
* working with officials at the Republic level and in relevant training institutions to assess the existing in-country capacity for management and information systems development; and
* using all this experience to suggest ways of strengthening this in-country capacity in 1993 and beyond.

In each pilot district, the project team (two members working with each district) sought to identify a small group of senior managers as project partners, with whom the plan for local work was agreed. At Republic level, each ministry appointed a project co-ordinator who met regularly with the project leader to set priorities and review progress. These arrangements provided vehicles for the team to adapt project activities to meet the changing situation in each Republic as the work proceeded. (Further details of project activities are reported in the Appendix).

The project team's approach

In accepting the invitation of the two health ministries to undertake this project, the King's Fund College made clear its distinctive approach to such work.

Most Western technical assistance to date has concentrated on knowledge transfer, using the 'expert adviser' methodology. Put simply, in this methodology the outside consultant contracts to provide solutions to locally defined problems using established expertise. There are problems to which this approach is appropriate but

they need to be ones where the in-country 'client' is able to make a precise diagnosis, Western expertise is clearly relevant and the client is already equipped to implement the proposed solution. However, in the radical transformation of Czech and Slovak society, these conditions are uncommon. Accordingly, Western assistance is often criticised for its limited relevance and sensitivity to the actual situation in the two Republics.

The project team took note of these criticisms. We set out to use the opportunities for working closely with managers to gain a real understanding of their situation and capacity. We expected they would make their own judgements about how best to use our contribution.

This approach was based on the 'process consultation' methodology*. In this methodology the consultant seeks to establish a partnership with the client (whether individual manager, group, organisation or larger system) in 'making a diagnosis' and to help managers themselves design and implement solutions. This methodology is appropriate for complex problems, where the client's own experience is an essential guide to what is most likely to work. It has important advantages over the 'expert adviser' methodology not only in being more likely to produce workable solutions to current problems, it is also likely to develop the managers' capacity to solve other problems without assistance.

Although unfamiliar, this approach was quite quickly seen as valuable by leaders in the pilot districts and by managers who participated in educational opportunities provided by the project. While our expertise in Western health sector management often provided a starting point for discussions between the project team and Czech and Slovak colleagues, we were typically able to overcome the barriers of language to establish gradually a 'partnership for development' focused on their managerial priorities. Our three most useful contributions here were our frameworks for analysing complex organisational questions, our ability to help managers learn from their own experiences and our skills in working with groups of people in ways which encourage active participation in solving problems together.

---

* The clearest description of this methodology for technical assistance is provided by Schein, E. Process Consultancy Reading, Massachusetts, Addison Wesley, 1987.

The evidence suggests that this approach was very valuable in strengthening the management capacities of the people and organisations we worked with most; it provided a demonstration of methods of management and organisation development previously unavailable in the two Republics and it gave us the opportunity to base our recommendations for the future on detailed understanding of the realities of achieving change with a sample of individuals, organisations and larger systems.

The form of this report

This report provides the means for sharing lessons from this project with a much wider group of interested health sector leaders. It is addressed to managers in other districts; to experts in the institutions concerned with management development and management information systems; and to Republic-level leaders responsible for future national strategies for management and information systems development.

Consistent with our approach, readers are invited to review our analysis and recommendations in the light of their own experiences and use this report as the basis for discussions with relevant colleagues about the best ways forward in the two Republics.

The logic of this report is as follows:

* Chapter 2, Managing Health Sector Reform provides an overview of the national strategies for health sector change in each Republic. It also identifies the nature of the new approaches to management required by the reforms and summarises the key challenges managers report they are facing at different levels (local and national) and in different agencies (e.g. ministries, insurance companies, hospitals, general practices, district authorities, health institutes, etc.);

* Chapter 3, Managing Change in Health Services at the Local Level seeks to illustrate the way these challenges are being addressed and therefore what management involves through more detailed analysis of experiences during project work in the pilot districts.

We describe how managers used our assistance to

- become more confident and proactive as individual managers and local leaders;
- introduce organisational changes to make hospitals more effective and efficient providers of services in the new, competitive environment; and
- work across more autonomous agency boundaries in order to reshape local health systems.

* Chapters 4 and 5 utilise this analysis to inform our recommendations for strengthening national strategies for developing health sector management and information systems. Chapter 4, Implication for Health Sector Management Development, examines the training needs of existing and future managers and how these can best be met. By comparing these needs with the results of a survey of current in-country capacities for management development (including recent initiatives to establish new kinds of training opportunities), it is possible to identify priorities for further initiatives and suggest how these might be implemented.

* Chapter 5, Implications For Developing Management Information Systems provides a diagnosis of current information system capacities and defines elements of the new management information systems required by health services funders and providers. Again, it is possible to identify priorities for further initiatives and suggest how these might be co-ordinated within national frameworks for information system development.

* Chapter 6. Managing For Better Population Health identifies lessons from across the project work in the two Republics about how health services managers contribute to improving population health. Attention is given to the managerial role in ensuring the relevance and effectiveness of health services and in contributing to multi-sectoral strategies for health promotion. Implications are drawn for national and local initiatives to strengthen action on pressing health problems and for the further development of relevant management training.

Complementing this report, we have produced for each health ministry separate recommendations for each Republic. To date, the project team's work at the Republic level has been less successful, partly because of the understandable difficulty during a period of national upheaval in identifying consistent and senior

representatives at ministry level for whom the project's focus on strengthening health sector management infrastructure is a priority. We hope that this final report will provide useful proposals for further discussion among the different parties at national level who share responsibility for the medium-term strategies for management and information systems development required to build upon this project.

2. MANAGING HEALTH SECTOR REFORM: AN OVERVIEW

2.1 NATIONAL STRATEGIES FOR REFORM

2.2 THE IMPORTANCE OF MANAGEMENT AND INFORMATION SYSTEMS

2.3 REPUBLIC LEVEL CHALLENGES AND RESPONSES

2.4 LOCAL CHALLENGES AND RESPONSES

2.1 NATIONAL STRATEGIES FOR REFORM

Introduction

The CSFR inherited from the pre-1989 era major problems in population health and serious deficiencies in the provision of health care. In contrast to the trends in most developed countries, the previous twenty-five years had seen a fall in life expectancy from the age of forty-five for both men and women, with several causes, notably a steep rise in cardio-vascular diseases. The state health system had become centralised, inflexible and institutionally dominated, its staff poorly rewarded and its patients often dissatisfied.

In both Republics, the new governments made radical reform in the health sector an important focus of the wider programme of social and economic reconstruction. Early efforts were made to formulate principled strategies for reform whose aims included:

* improving population health through stronger programmes of health promotion and disease prevention;
* ensuring universal access to standard health services;
* improving the quality and efficiency of services;
* shifting the balance of provision towards primary health care; and
* improving patient choice among doctors and health facilities.

It was also intended to raise the status and income of the doctors and other professional staff upon whom good quality services depend.

These aims were to be achieved through comprehensive system changes which combined:

* demonopolisation of the state system through creating plural forms of ownership, autonomy for provider institutions and encouraging private practice;
* new approaches to raising and distributing finance through the introduction of mandatory health insurance, thereby also separating the financing of services from their delivery;
* decentralisation in decision-making, particularly driven by the incentives provided by 'money following patients'.
* creation of new arrangements to regulate these changes and set standards for professional practice.

The choice of these means was determined by technical considerations and the wider political agenda which gave urgent priority to dissolving the previous state structures, redefining the relationship between individuals and society and greatly extending market mechanisms throughout the economy.

This political agenda was also an important determinant of the pace of reform and the different trajectories followed in each Republic.

In the Czech Republic, the post-1989 sense of idealism was combined with an equal sense of urgency, reflected particularly in the creation of the general health insurance company at the beginning of 1992 and its full operation from January 1993. This haste in introducing large-scale change was accompanied by the willingness to respond to mistakes, for example, by modifying the complex item-of-service points system used for paying providers. After the June 1992 elections, new Ministers reinforced this sense of urgency and added to the impetus for market mechanisms in health care by promoting privatisation of services and competition among insurance companies.

In Slovakia, reform was initially more gradual and therefore gave more time for technical analysis of the options. For example, the general health insurance company was preceded by creation of an institute to plan its introduction and a pilot study of the necessary financial information systems. After the June 1992 elections, however, this gradualism was replaced by a more urgent political agenda, partly shaped by strong pressures for cost reduction and the recently established insurance agency was incorporated into the larger system of social insurance.

With the division of the CSFR at the beginning of 1993, it remains to be seen whether these trajectories of health reform become more divergent. Over the period of the PHARE project, however, the broad strategies for change in each Republic remained quite similar.

There is no doubt that both in scope and speed these strategies would constitute a very bold programme of reform in any national health system. In the particular situation of the two Republics, where there are concurrent strategies for the wholesale transformation to market economies, major constitutional change and severe economic problems, they pose a formidable set of challenges.

In meeting these challenges, both Republics have been able to draw on significant assets. These include:

* strong political commitment to health sector reform;
* extensive personal efforts among people with leadership responsibilities to design the reforms and resolve urgent problems;
* professional expectations of significant change;
* emergence of new networks and associations (e.g. among hospital directors) which provide opportunities for mutual assistance and support more decentralised leadership;
* spontaneous growth in small-scale local innovations which offer wider lessons; and
* openness to exploring the relevance of international experience.

Accordingly, the last two years have seen substantial progress in dissolving previous structures, passing legislation, establishing new financing agencies and more autonomous providers, creating incentives for greater efficiency and mobilising widespread attention to the agenda for reform. At the same time, there remains considerable disappointment among many people about what all this effort has achieved. Some are anxious that change is happening too fast, leaving insufficient time for adequate preparation and evaluation. Others are impatient with the slowness and believe the reforms are failing to meet both professional and public expectations.

These competing views can partly be understood as arising from a natural deflation in the high hopes generated in the initial era of unity and enthusiasm which followed the events of 1989, as people have faced up to the complex tasks of reconstruction. However, they also reflect a number of problems in the way reform is being addressed, some inherent in a period of such upheaval, others perhaps avoidable.

Success in achieving large-scale change depends on

- the clarity with which ends and means are related in the design of reforms themselves;
- the design of effective arrangements for implementation; and
- the capacity of leadership (both nationally and locally) to manage transition.

In the two Republics:

(i) The initial proposals for reform did not specify precisely the relationship between idealistic principles and the structural and other changes which became the main foci of implementation. For example, the strong concern with population health status in these proposals is not yet clearly reflected in national health policies; the more specific aim to improve the pattern of primary health care is only loosely linked to the rapid privatisation of general medical practice. Moreover, the speed of change has left limited scope for evaluating particular innovations on a small scale before their general introduction.

(ii) As in all national health systems, reform involves balancing different goals (universal coverage, patient choice, cost containment, etc.) through negotiation between interests with different priorities (the health ministry, insurance companies, health care providers, the finance ministry, etc.). At a time of rapid change, however, this negotiating process can easily produce an impression of inconsistent leadership. Unless there are explicit mechanisms for consulting with patients and the wider public, their interests may also appear to be marginalised.

(iii) In the Czech Republic and Slovakia, the efforts to devise a consistent strategy were, of course, greatly affected by the elections in 1992 and the new political leadership they produced, subsequent personnel changes (particularly in Slovakia) among top managers, and the major diversion of attention from specific reforms to the broader issues raised by division of the CSFR.

(iv) As a consequence, health reform in both Republics has followed an uneven and uncertain trajectory, increasing the anxieties of those affected by change. A common response to these anxieties has been a retreat either into defense of existing institutional interests or into traditional modes of behaviour in which local initiative becomes dependent on central instruction.

(v) National strategies in both Republics have also reflected a narrow conception of what is required to achieve real changes in the delivery of health services. The implementation of reform has relied heavily on the

combination of legislative change (defining new structures, their functions and relationships) and market incentives (designed to promote policy goals through the transactions between more autonomous purchasers and providers). There has been relative neglect of the equally important need to establish the management infrastructure required to promote decentralisation and ensure the effectiveness of different elements in the new pluralist system.

2.2 THE IMPORTANCE OF MANAGEMENT AND INFORMATION SYSTEMS

Put most simply, management is required to get the right things done well. The health sector is one of the largest employers in national economies, it consumes a significant proportion of the gross national product and its services intimately affect the lives of the whole population. Just as in the wider restructuring of the economy, investment in management infrastructure is critical to the success of health sector reform. To quote the World Bank report* on the CSFR,

> "Delegation of responsibility and local autonomy will be no guarantee of success. They need to be matched with the tools of modern management and skilled managers to use them."

Effective management is required at all levels in the new health system to:

* provide leadership for change and motivate other staff whose support will be required for different ways of working;
* maintain attention to the goal of improving the quality of health services while implementing organisational changes;
* ensure the best possible use of resources, particularly so that the public see benefits from the reforms despite significant financial constraints;
* cope with uncertainties arising during the lengthy and turbulent period of transition;
* learn from experience as implementation proceeds; and
* ensure that relevant information is available to assist managers in performing their new responsibilities.

Management in this sense represents a fundamental change from the administrative centralism of the pre-1987 era. The most important aspects of this change are represented in Figure 1.

---

* The Health Sector: Issues and Priorities World Bank, 1991. This report on a World Bank study of the CSFR remains the most comprehensive external review of the challenges confronting health sector reform in the two Republics.

Figure 1. CHANGING THE MANAGEMENT CULTURE

FROM ADMINISTRATION	TO MANAGEMENT
* Depending on central direction	* Exercising leadership to meet local needs
* Following monopolistic administrative controls	* Addressing market pressures within a wider regulatory framework
* Conforming with procedures	* Pursuing better results for patients and increased local accountability
* Maintaining existing practices and stability	* Promoting innovation and encouraging change
* Accepting traditional norms of performance	* Improving effectiveness and efficiency continuously
* Collecting routine data for reporting purposes	* Generating information as an aid to decision-making
* Keeping up appearances	* Seeking to learn from experience

The reforms involve the redistribution of previously monopolistic and centralised functions to appropriate levels in a well-balanced pluralist system, with addition of new functions to make pluralism work. The matrix represented in Figure 2 provides a framework for identifying the mission and key tasks of different agencies (e.g. health ministry, insurance company and provider units) and at different levels in the national systems (e.g. Republic, intermediate and local). The precise requirements for effective management vary according to the distinctive functions of each agency (and also according to the level of management within each agency). The remainder of this chapter summarises the managerial challenges facing different agencies during 1992/3 and the responses required to meet these challenges.

Figure 2

SYSTEM DESIGN: MISSION AND KEY FUNCTIONS

	Government	Insurance Companies	Providers
Republic	* Health policy development * Overall system design * Legislation * Regulation * Tax Financing	* Operationalising revenue collection * Equitable financing of health services * Procedures for contracting, payment and quality control	* Joint Provider representation * Joint development (standards, management training) * Some tertiary provision
Intermediate (eg District)	* Local health policy * Population needs assessment and local targets * Promoting balanced pattern of health and social care	* Identifying population * Revenue collection * Contracting and payment * Quality control * Ensuring access	* Local environmental housing and sanitation provision * Local social care provision
Local (Institutes, Services)	* Environmental monitoring * Epidemiology * Prevention and health promotion programmes		* Local primary and secondary care provision * Quality and integration of services * Financial viability * Staff development

2.3 REPUBLIC LEVEL CHALLENGES AND RESPONSES

At the Republic level, the health ministries (together with other parts of government) have faced unparalleled demands in converting the principles of health reform into practice, while at the same time having to redefine the ministries' own functions to establish a new role in the demonopolised and decentralised health systems which are being created.

In developing strategies for national reform, the health ministries have had to meet the challenges of:

* establishing coherent health policies and designing the new health systems;
* co-ordinating change with other responsible ministries (e.g. finance, labour and social affairs, education, interior);
* preparing necessary legislation;
* gaining parliamentary approval for legislation and advocating for the health sector during a period when political attention has been focused on constitutional and economic priorities;
* gaining support for the reforms from professional groups and the public with possibly unrealistic or conflicting expectations;
* ensuring effective implementation of the reforms through both directly controlled and newly autonomous agencies;
* establishing the health insurance companies;
* establishing the conditions for successful provider privatisation;
* maintaining the quality and availability of services during the uncertain period of transition;
* ensuring staff training needs generated by the reforms are met;
* co-ordinating international assistance; and
* monitoring progress.

The ministries have been poorly equipped for these tasks. Of necessity, few if any people had previous experience either of the design of major system change or of the strategies required for successful implementation. Compartmentalisation within the ministries, competition between departments for influence and rapid staff turnover have reduced the coherence of ministry leadership and placed a heavy burden on ministers. There has also been inadequate support from institutions with independent research, development or training functions.

Through meeting Ministry officials and representatives of other national agencies, and through their involvement in in-country workshops and out-country study visits, the PHARE project has sought to assist health ministries in responding to these challenges by:

strengthening their own management capacity so as to provide clear and consistent leadership to other agencies involved in implementing the reforms;

making implementation a major focus of ministry attention; and

recognising the changes in the style of central leadership required to promote effective decentralisation.

This in turn requires that ministries:

improve central/local dialogue to ensure that policy makers and local implementers develop a shared understanding of the intentions behind policies and their actual impact on the provision of services;

recognise the importance of management and take the lead in ensuring appropriate investment in developing the management infrastructure required by pluralist and decentralised systems;

play a leadership or facilitative role in establishing national strategies for management and information systems development; and

promote, evaluate and disseminate the lessons from local initiatives.

At the same time, ministries are having to redefine their own functions in the new health system, giving particular attention to:

- leadership on health policy, including advocacy with other ministries so as to develop multi-sectoral strategies for health promotion;
- ensuring through tax financing that all citizens have access to basic health services;
- preparing future legislation and ensuring appropriate regulation of the new system;

- planning to meet personnel needs and influencing professional education; and
- promoting relevant international co-operation.

These revised functions require ministries to:

develop new approaches to policy-making which rely on negotiation with other agencies at the national level; and

redefine the needs of their health and management information systems to ensure their relevance to these functions.

At the Republic level, the health insurance companies, national associations (e.g. professional chambers, hospital associations), existing health institutes and the higher education sector are also having to create or redefine their functions and establish new ways of working. In responding to these challenges, they too are having to develop their own capacities for leadership, establish information systems relevant to these functions and ensure their staff gain access to relevant training.

2.4 LOCAL CHALLENGES AND RESPONSES

The dissolution of centralised and monopolistic state structures has major implications for local management in each part of the new health system.

In the **general health insurance companies**, directors are setting up completely new district organisations. They have to:

* create organisations, including recruiting staff and training them for new functions;
* manage their own transition into the role of directing a contracting agency;
* establish basic management systems (e.g. for pricing services, collecting premiums from the insured population, arranging payment to providers and developing management information to monitor performance) over a short timescale;
* implement these arrangements and cope with problems during a period when Republic-wide policies are still emerging;
* find appropriate ways to influence patterns of service provision to meet local needs in advance of the legal capacity to purchase services selectively.

The PHARE project has assisted local managers (e.g. in the pilot districts) to respond to these challenges by:

effectively managing the development of these agencies and explaining their roles in the health sector reforms;

addressing local anxieties about Republic-wide policies and feeding back local experiences into central policy-making;

fostering innovation in local services (e.g. home care) which permit shifts in the pattern of provision (e.g. earlier hospital discharge); developing performance standards and applying pressures on providers for greater efficiency; and working with leading clinicians to promote better quality services (e.g. by establishing joint guidelines for the primary and specialist contributions to treating particular common conditions);

considering the appropriateness of their information systems structures and how they link with the requirements of other stakeholders;

forecasting future requirements for information processing, based on the experience in other countries;

and in the medium term:

working with providers and population-oriented health agencies to identify local health needs and become more active in shaping the nature and quality of services available to meet these needs.

In the **hospitals** managers have to:

* prepare for new forms of ownership and new relationships with insurers and other providers in the local health system;
* secure significant improvements in quality (e.g. humanising care, achieving accreditation) and efficiency (e.g. bed occupancy, length of stay and energy utilisation);
* make plans for improving the capital stock and equipment;
* build staff commitment to necessary changes in the face of financial pressures and the risk of significant dissatisfaction due to uncertainty and potential job losses;
* recognise how the legislative and ownership structure of the health system poses new requirements in terms of the information required for internal management and external control (e.g.. management and financial accountancy procedures) and subsequently manage the changes to adapt to these new realities.

In the pilot districts, the PHARE project has helped managers (including hospital directors, chief economists and heads of departments) to respond to these challenges by:

developing their own capacity for a different kind of leadership; one which looks outwards to meet the new expectations of funders, customers and competitors while looking inwards to motivate the contribution of colleagues;

working with executive teams and senior clinicians to widen 'ownership' of the changes, increase management skills, encourage greater delegation of authority and promote initiative;

introducing organisational changes, budgeting arrangements and information systems which contribute to effectiveness and efficiency;

all with the aims during 1993 of:

developing a strategy for the hospital's future services which reflect clinical strengths, patient needs and likely resources;

establishing 'business plans' which define the implications of this strategy for finance, staffing and other issues.

improving quality, for example, in nursing by promoting new attitudes, increasing the status of nurse managers and distinguishing different skill requirements; and

sharing with other hospital managers in developing particular management information systems which would otherwise involve costly duplication.

In the **polyclinics and general practitioner** services, there are similar challenges in:

* creating new forms of ownership for premises, privatising general practice and establishing relationships with patients;
* developing new patterns of practice, referral arrangements (e.g. to and from hospitals) and relationships with patients;
* coping with the uncertainties arising from current methods of payment and competition from other general practitioners and medical specialists.

The PHARE project has helped polyclinic directors, leading general practitioners and paediatricians (e.g. through local workshops and - for a few - the opportunity to study British primary health care) to address these challenges by:

accepting the responsibilities of becoming the managers of 'small businesses', in marketing their services, business planning and establishing administrative support systems;

exploring partnership arrangements with other general practitioners and promoting appropriate collaboration with specialists (e.g. through protocols for shared care);

and in the medium term:

developing new approaches to primary health care, involving greater integration of services to children and adults, expansion in complementary services like home care, team working and improved standards of practice.

A variety of other agencies share an interest in the health of the local population, including the health department of the district authorities, the institutes of hygiene and epidemiology, branches of the institute of health information and the municipal authorities. Through consultancy and their involvement in multi-agency meetings and workshops, the PHARE project has helped managers in all these agencies review their priorities and develop new ways of working in the very different environment being established through the health sector and other reforms.

In responding to these challenges, **district authority health department directors** are having to:

come to terms with a quite different role and find new approaches to exercising influence (rather than control) over local health policies, drawing on the information and expertise of the hygiene stations and health information institutes:

establish new collaborative arrangements for multi-sectoral action on important health promotion issues like reducing smoking and accidents;

exercise leadership in improving the co-ordination of health and social care, particularly for elderly people.

Similarly, **hygiene station directors** are having to:

manage the shift from mainly inspection activities towards a stronger role in monitoring the state of population health; and

increase their credibility in work with other agencies to develop local health education and health promotion initiatives.

Looking across these different elements in the health system, it is clear that managers need to address not only the tasks for their own agency but also the challenge of contributing to development strategies which maximise the benefits of reform to local people.

In the pilot districts and through wider conferences, the PHARE project has helped managers respond to this challenge by encouraging:

active leadership for change in which managers recognise the necessary inter-dependence of these different agency contributions if the reforms are to succeed;

mutual support in assuming new roles, coping with uncertainty and implementing workable solutions during this period of transition;

identification of the mission of each of the stakeholders, the relation with the others' missions and the possible benefits of a common definition of their information requirements;

joint efforts during 1993 to establish a shared vision of the future pattern of local services defining the respective roles of primary and secondary care and agreeing criteria for assessing quality; and

new alliances between agencies to develop effective and realistic health policies.

The PHARE project has also assisted leaders of these local development strategies to pool lessons from their experience so that these can be fed back to those responsible for health policy and implementation at the Republic level. (See, for example, the recommendations of the Brno health management conference, summarised in Education Programme Report 3).

3. MANAGING CHANGE IN HEALTH SERVICES AT THE LOCAL LEVEL: EXPERIENCES IN THREE PILOT DISTRICTS

3.1 DEVELOPING LEADERS FOR CHANGE

3.2 CHANGING HOW ORGANISATIONS WORK

3.3 RESHAPING LOCAL HEALTH SYSTEMS THROUGH INTERSECTORAL COLLABORATION

3.1 DEVELOPING LEADERS FOR CHANGE

Introduction

In each of the three pilot districts chosen by health ministries to participate in the PHARE health sector management project, the project team's work sought to engage with a variety of individual, organisational and cross-organisational problems which local people identified as important in successfully managing change in their districts.

This, and the following two sections, draw on this experience to examine different aspects of managing change, in each case drawing particularly on the team's work in one of the three districts. In this first section the focus is on how individuals are learning new way of managing and on the development of leadership at the local level. The two following sections build on this analysis by examining how organisational change is being achieved and how new relationships are being established between different agencies to improve health and health services.

In this first section, we also give a relatively full account of what was involved in the programme of management and organisation development undertaken by the team over the period of the project.

The methodology used

All this work used the "process consultancy" methodology described in Chapter One and was informed by a view of managers as (seeking to become) reflective practitioners*. These approaches to management and organisational development are highly relevant to both diagnosis and intervention in systems undergoing major changes such as those required by the health sector reforms. Within the framework of these approaches, it is possible to make good use of the knowledge, skills and expertise already available. Testing people's ability to engage as clients within this framework was a vital first step. It could be seen as the first project intervention,

---

* This concept is drawn particularly from the work of Donald Schon. See Schon, D.A. The Reflective Practitioner London, Temple Smith, 1983.

especially given the need for the fundamental changes in managerial and professional behaviour demanded if the reforms are to succeed.

The essence of the process consultancy methodology is to work with client organisations and their managers in order to help them develop an open and shared understanding of what is happening and to create their own ways of moving forwards. This understanding includes recognising the range of subjective perceptions of the organisation as well as traditional objective data. It will include looking at both internal functioning and relationships with the outside world. The method does not assume that there is 'a problem' to be cured by the application of standard solutions from an external expert. It aims to enhance the capacity of the organisation and its leaders and staff to recognise and work with real situations, in all their complexity, themselves.

The reflective practitioner approach to individual management development notices the difference between "academic" and "practical" excellence and the problems which arise when they are confused. The Western tradition has been to value academic excellence highly. This includes working within rational and logical analytical models closely related to theories, hypothesis testing and control. The belief in generalisable truths is fundamental.

Donald Schon noticed that the way in which people become good practitioners in a range of professions including management is different. Although knowledge and general theories can help, he observes that starting with individuals working on their real problems and challenges in real situations is what makes the difference. Their experience may not match conventional theories. Their real worlds are much messier and more uncertain than those of the academic, and, critically, they must work with situations which by definition are unique, not generalisable.

Individual managers therefore need to learn to observe the realities of their own thinking and behaviour, and of their organisations and environments much more openly. They need to be encouraged to take risks by acting in uncertain conditions, and then notice what happens. They must draw on theory and knowledge freely when it is of real use, rather than because it is considered correct or conventional to do so. This in turn requires considerable self confidence as well as the ability to be open to learning from experience as much as from books.

In the Czech and Slovak situation, this implies the need for a greater recognition of individual differences between managers and their organisations and organisational environments. It implies making it possible for individuals to reflect without fear on successes and difficulties. It implies being able to talk honestly about how things are rather than how they are officially supposed to be -'the party line'. It implies bringing the whole person to the managerial role, not just a conventional stereotype. Again, these shifts are essential if there is to be a move away from administered central bureaucracy to locally responsive services. This means a shift from managers as functionaries to managers as responsible leaders. Even in theory, this is an enormous shift. In practice it is undoubtedly experienced as one.

Initiating local work

In the district described in this section, the local work required a total of 35 person-days on site over seven separate visits between the last week of May 1992 and early March 1993. Additionally, five key managers from the district attended the three week programme in London in November 1992 and the follow-up meeting in Brno in March 1993 (described fully in Educational Programme Report 3). There were also three two day workshops for local managers and professionals, with some involvement from Praha and from elsewhere in the region.

The purpose of the first site visit in May 1992 was to meet key local stakeholders and reach mutual agreement about involvement in the PHARE project. We also intended to make preliminary choices about the probable focus of the work in order to begin planning and shaping the next stages.

On arrival, it was clear that people in this district had very little idea about the project and about what involvement in it might require of them. The possible benefits were even less clear. Some were suspicious that we might be seeking to report on them to the ministry. Even people who felt quite enthusiastic were sometimes being warned by their friends and colleagues that participation would make them like "ants being observed by scientists for their own purposes".

Giving clear explanations was therefore essential to enable people to make free and informed choices about involvement. This needed to be done with care in order that we could also gauge commitment and interest without forcing it.

Confidentiality was clearly a crucial issue. We explained our responsibility to be able to draw general hypotheses and conclusions from our local work. We agreed that we would not disclose specific local data which might be seen as risky for individuals. We made it clear that we would need to write reports and to meet with officials at the Republic level from the ministry of health and the national insurance company. At each visit, we sought informally to let people know the kinds of things we were saying more publicly, and to check out informed consent.

A key person throughout the project was the director of hospital "A". He was familiar with the "process consultancy" methods used by the King's Fund College because of his involvement in earlier workshops in 1991. He speaks English and was a committed manager actively seeking to develop himself and his organisation. He also recognised the importance of linking with other parts of the local healthcare system. He agreed to act as the local co-ordinator, but was reluctant to assume any overt leadership role with colleagues from other parts of the district.

Diagnostic and individual consultancy phase

Visits in June, July and early September involved conducting a large number of individual interviews with key people in order to gain greater understanding of:

* the perceived impact of the health and wider political and economic reforms on the local health system and the working relationships between its different parts;
* the goals of individuals and their organisations and their relevance to improving the health of local people;
* the successes and difficulties experienced by individual managers at senior and middle levels in managing change;
* the likely development needs of individual managers and their organisations and the training methods and topics which might help in addressing their needs.

Our aim was to work with individuals, particularly at senior levels so that our diagnostic interviews and visits could assist them to reflect on and review their own understanding and practice as managers.

We sought to move from a position of being seen as either ill-informed foreigners who needed putting right, or experts with answers from our own countries. We wanted to have a more equal consultant-client relationship in which they valued their own experience, opinions and perceptions and "owned" the process of

problem-solving. The ease of doing this varied considerably, and this remained part of our agenda with increasing explicitness throughout the work in this district.

By our second and third visits, the senior managers whom we saw regularly became increasingly open with us in discussing their problems and difficulties, rather than simply telling us about their understanding of the official version of the reforms and legislation. We aimed to identify which people and organisations could reasonably become key clients for the intervention phase. Our criteria included willingness to work with us, stability of position and potential for influencing local healthcare and learning for wider application in the Republic.

Key participants

* In June 1992, our main focus was hospital "A". All meetings were planned with the hospital director and the whole visit began and ended with extended individual discussions with him. We knew that we had options of more in-depth work in the hospital, either as a whole organisation or via individual consultancy with the director and a few senior managers and clinicians. We also knew that the management of acute hospital services was a major issue in the reforms nationally and locally. On this visit we were shown the main departments of the hospital and met most of the chiefs of medical and support services, including informatics, finance and administration. One notable omission was the chief nurse. The relative marginalisation of nursing was evident.

  On this visit, we also had a long meeting with the director of the insurance company branch office and planned to spend more time with key managers there on the next visit.

* In July 1992, we worked in a more focused follow-up fashion with the hospital, including some individual consultancy on management style. We spent time with the economics director on cost centre development, with the informatics specialist on hospital information systems, and had a meeting with the chief nurse, at our request. We visited one well-respected adult services general practitioner and a paediatric general practitioner with her nurse in their own clinics. Within the hospital, we observed the regular department heads meeting

in order to help the director with his management of meetings and strategy development.

We again consulted the director of the insurance company branch office and spent individual time with each of the key managers (law, pharmacy, medical quality, administration and economics). We met a key member of the local medical chamber.

A review and progress meeting was held with the district health and social care department director. As the district differentiated into a set of relatively autonomous providers and the insurance company became the main buyer/payer, this individual's position was shifting rapidly as a result of the reforms from one of considerable power and authority, with strong financial control, to one of relying more on personal influence.

We also met the hygiene station director and some of her staff to discuss public health issues and the local UZIS representative to discuss the collection, analysis and use of local health statistics.

* At the beginning of September, a further visit marked the shift from diagnostic to intervention phases. We followed up work begun with the hospital director and his staff on a range of issues including general change strategies, clinical audit, pharmacy organisation and population health issues. We met the insurance company director. With both we sought to reach agreement for a next stage of active intervention.

Summary of observations from the diagnostic phase

During these few months, the impact of the reforms had resulted in a distinct shift from a coherent district health service to a differentiated and even fragmented one. Within and between sectors there was often a lack of good communication and even rivalry and conflict beginning to emerge. No-one felt able to take any clear lead, nor was there any sense of a real shared agenda for health despite often strong concern on the part of individuals.

The insurance company branch office tended to view providers with some suspicion, and to be concerned about legal constraints and punitive sanctions. The providers saw the insurance company as a kind of police force who did not understand the realities of health provision. Within the hospitals and in primary care, both entrepreneurialism and potential privatisation were also producing internal competition which was not always healthy. The relative isolation of health care from other local services, including poorly developed social care, made major change difficult.

Cost constraints were being sharply experienced at hospital level and within specialities. Some people still thought privatisation would be some kind of panacea. Others had doubts. Everyone was aware that it might lead to further fragmentation and competition. Focussing on patients, citizens and health was getting harder.

Many people felt caught between a wish to begin leading locally and a concern about waiting for legislation and instructions from Praha. The overall level of uncertainty and confusion was high, even amongst people who were willing to act. As one senior manager said "In the past, everything was the same all the time. Now there is constant change. Everyone wants more and more. But no-one takes responsibility for making it happen. Everyone blames and criticises others."

Tensions between managers and clinical professionals were becoming more prominent. "We all want to change doctors' behaviour" as someone put it. Doctors, in turn, were concerned about interference with their professional activities. Nurses were beginning to resent their traditional almost invisible role. Managers who came from clinical backgrounds were still trying to preserve clinical contact. Partly this was to inform their managerial roles, but partly to ensure an escape route if management did not work out for them.

Individual managers varied in their attitudes. However, most people were very tired and stressed. People who had been optimistic after the introduction of the reforms said that they now felt at least somewhat dispirited at the enormity of the tasks facing them day to day, and that it was hard to think ahead, long term. If they did, there were far too many things which clearly needed to be worked on. It was hard to select priorities. Everyone was worried about resources.

In dealing with particular issues, managers were also recognising their own development needs. Initially it seemed easy to draw up lists of skills. Over time it became more obvious that for senior managers, life was necessarily complex. They were recognising their own need to develop influencing and leadership skills, rather than managing merely by formal authority.

We agreed at this stage that hospital "A" and its director would be our main client and that a series of interventions in this district would focus on developing his team and other key leaders in the various local health sector agencies.

The intervention phase

Four formal development workshops were held between September 1992 and March 1993 with a key focus on district leadership development. Each is described briefly below.

A two-day residential workshop for senior people in September- The heads of each main agency in the local health system were invited and asked to bring a few of their most senior or influential staff. Over 20 people attended. The aims were:

* to think together about the most important local goals for the health sector;
* to agree individually and together how to make progress towards them;
* to learn useful techniques;
* to find effective ways of working together in the post-reform system, especially in the context of health insurance and privatisation.

It was explicit that the workshop would require active participation and include looking at issues and themes from people's actual work experience. People knew that this would involve individual work and discussion in a range of small and large groups. There would be a balance of pre-planned activity and flexibility.

On the first day, after introductions, participants were facilitated through a process of individual and group diagnostic review and strategy development. They were encouraged to discuss openly both facts and feelings about the recent past, the present and their aspirations and fears for the future. By the end of the first day, most people were participating actively and had worked in small groups with most other people in the room. There was considerable and, to the participants,

surprising agreement on their most fundamental wishes and concerns for healthcare and their own work.

The following morning, in a brief review session, people particularly noted that:

* learning to tackle apparently big and complex problems creatively was possible using structured methods;
* team-working could be easier than solitary working;
* they were re-discovering how to be positive in the face of negative situations;
* they were learning a range of new approaches to working together, reviewing and problem-solving.

During the second day we worked on establishing mission statements as a basis for planning actions and identifying specific measures to assess success. We also examined how information systems could provide tools for these managerial activities.

Representatives of the different agencies within the health system were encouraged to explore their relationships with each other. This was difficult, but illustrated vividly some of the shifts which had occurred. Particularly striking was confusion and marginalisation of the hygiene stations and the district authority health and social care department. The role of the insurance company was viewed with ambivalence.

Structured action planning for individuals and groups concluded the workshop.

Two main issues emerged in the written evaluations. One was described by a participant thus: "It reminded me that better ways of thinking and managing exist than those in which we were officially brought up (and which still survive and are being used). I will lead my subordinates to try to adopt better ways of thinking and apply them in practice."

Most people had found new ways of tackling problems, including prioritising, working in small steps and linking to longer term goals. They were also encouraged and optimistic. They had seen new ways of applying useful measurement to management goals within and between organisations. People noticed that it had been possible to disclose with reasonable honesty what was actually going on as a basis for planning.

The second main issue was joint working. Repeatedly we were told that this group of key people had never previously met or worked together. We were told that informal time getting to know each other as people, together with working together on shared tasks was very valuable. One person wrote that the most important thing was "that we actually got together".

The November 1992 Leadership Development programme in London - The district participants were directors from hospital "A" and the hospital in a neighbouring town, the chief nurse of hospital "A", the director of the insurance company branch office, a general practitioner for adult services and a clinician from hospital "A".

Each of them derived individual benefit from the various aspects of the programme. They were noticeably more confident and knowledgeable by the end. Importantly, they were working effectively as an identifiable group, with all individual members contributing more strongly. They agreed to share major responsibility for developing a population health approach in their district and for creating stronger local partnerships across sectors.

By this time, the director of hospital "A" had clearly moved from a co-ordinating role to one of accepted leadership within the group. The chief nurse was a much more active and recognised participant. The insurance company branch director was a partner, not an enemy. In general, common ground and shared goals were much more significant than differences. We worked on how this collaboration could be sustained after returning home.

Useful links were made with participants from other pilot districts, and there were discussions about ways of building on the PHARE project to expand management and organisation development within the two Republics during 1993.

A two-day residential workshop in December 1992 for key people from health and related sectors to develop a local approach to improving population health.- This workshop for 24 people included leaders of most major healthcare agencies and other relevant sectors in the district: the hospital directors and chief nurses, the insurance company, hygiene station, district health and social care department, municipal authority officials and members, managers from the two major employers outside health (both factories), and primary and secondary care doctors,

local and regional UZIS information officers, together with three officers from the ministry of health.

The explicit aims were:

* to clarify definitions of health and well-being for citizens of all ages;
* to identify local determinants of health and well-being and factors which adversely affect them;
* to explore local resources for improving health and well-being without significant extra cost;
* to work towards achievable projects involving two or more agencies;
  to begin to develop a framework for a comprehensive local health policy.

The level of active participation and engagement was generally high, with only a few exceptions. The people from the ministry found it hard at first to engage in action planning, but they found, with help, ways of trying to use their central role to complement local initiatives.

The range of potential local resources available was impressive. A large number of potential joint projects was identified, and participants chose a small number to follow through. Immediate evaluation was positive. People thought that their understanding of a broader definition of health had improved; that they had recognised positive action which could be easily taken even amidst uncertainty and lack of new resources; they had enjoyed their work together, and felt they had built the foundations for joint working which would have continued benefits.

Follow-up over subsequent months showed that the identified projects were being implemented. Especially encouraging was work with health officials of municipal authorities including moves to appoint a public health doctor to take a leading role in health needs and health promotion work. Overall, the strengthening of commitment to the common goal of the health of local citizens was sustained reasonably well. Given the stresses and changes of the early months of 1993, this was a major local achievement.

Another noticeable shift was the higher profile and greater recognition of the contribution of nurses and nursing in health care.

The director of the hygiene station had a stronger role to play in this workshop than in the previous one, contributed actively and seemed less marginalised. The potential relevance of hygiene stations was more readily recognised.

The two factory managers were clearly surprised to have been invited. However, they gradually joined in and were a valuable addition to the group because of the importance in the locality of their organisations both as employers and in their impact on the environment.

The strong roles of the core group of managers/practitioners from hospital "A", who had had most ongoing involvement with us as clients, was evident.

A two-day workshop for hospital managers from the Region in March 1993 - This workshop involved a small group of nine participants, all of whom were keen to examine how management could improve the quality of services. There were five hospital directors, three chief nurses, and one finance director. Our key client, the director of hospital "A", was now acting as a principal leader.

This final workshop had two main goals:

* review of the managers' recent experiences and identification of current problems with the aim of building mutual support and solving problems together.
* specific examination of how to improve quality within resource constraints (including using clinical audit as a means of improving professional practice, reviewing hotel services and strengthening administrative efficiency).

In the review session, it was noticeable that people were finding the pace of change difficult and felt that their major successes had been to stay sane and ensure that things did not deteriorate in their organisations.

They summarised their current feelings as managers by drawing a picture of a very small Sisyphus pushing a very large stone up a very steep hill, and said they wished only for the arms and legs to be a little stronger and the hill to be a little less steep.

We asked people to work in groups with similar people to identify the successes they would like to achieve in the next year and what would help them. Interesting differences emerged.

The people from financial and industrial backgrounds felt that they had brought some rational, grounded thinking to healthcare - "getting the doctors down from the clouds" - but admitted that building bridges with doctors was hard, and really wanted more effort to come from them. They saw their role as ensuring hospital survival and safeguarding quality standards - in essence, creating the context for doctors and nurses to work in.

The chief nurses all wanted to see a stronger professional role for nurses in hospitals, with much greater responsibilities. They also felt movement was needed from doctors, but recognised that many nurses were frightened of change. They believed changes in nursing roles would benefit patients.

The hospital directors who were doctors expressed a wish to maintain quality and to keep down the administrative and other costs of reform which they saw as removing resources from healthcare provision. They wanted greater freedom to act but accepted the need for some boundaries. The current situation felt too ambiguous. They were clearly keen to manage their hospitals and to manage actively with colleagues in other sectors of their local systems of healthcare, but felt that mixed messages came from the centre.

Despite considerable environmental difficulties, they now seemed a group of people determined to manage, but experiencing high demand and stress in doing so.

Our director-leader was keen to use the workshop to set up a regular mutual support and learning group. We discussed with him how to do this, and encouraged him to lead the session with minimal direct help from us. It was lively and engaged everyone. Particularly striking, again, was the joint working between doctor-managers and non doctors as equals, and the very active participation of nurses. We were told afterwards that there were now firm plans to continue as a self-help group, using some of the methods they had learnt over the past year, and seeking to use any external resources they could.

Conclusions

We felt that there was strong evidence that local people would be able to continue to develop as managers and to develop their organisations and the links between them to create a more effective local health system. This was despite continuing uncertainty and financial and political pressure. Perhaps most encouraging was the organisation of the local support group.

There remain many problems to be tackled. We remain concerned about relationships between providers and the insurance company, and whether some of the underlying good will and shared concern about health of local citizens was robust enough to withstand the problems which undoubtedly lie ahead. It is worrying that support and continuing development for managers is not a strongly recognised need at the centre. However, the perceived value of management development activity is stronger among the most senior people and they are clear about their need to be able to talk openly about the problems they are facing and the help they need.

We believe that our reliance on both process consultancy and the reflective practitioner model as foundations for our working methods were validated in practice. Reflection on our experience of working locally showed a major shift in working relationships with the senior managers to one which felt more equal over time. They are now able to work openly and constructively on real issues with much greater ease than previously. They seem to have become more courageous and able to bring more of themselves as whole people into the workplace. This is remarkable, given their history and the turbulence of the environment during the project period and is a tribute to the individuals concerned.

Importantly, many of the people with whom we have worked more clearly recognise the inherent difficulties and complexities of management, as contrasted with the role of administrative functionary. They undoubtedly find it tough, but mostly seem to know that this is part of the role, rather than evidence of personal failing or someone else's fault.

Almost any of the myriad practical issues involved in health system change can be useful starting points for management and organisational development, providing

this involves working on parallel agendas of developing individuals and fostering group working. The most important elements seemed to be releasing creativity and problem-solving capacity, giving safety for open discussion of real issues, and valuing emotion as well as intellect. The opportunity for people to expresss and affirm values was also important.

3.2 CHANGING HOW ORGANISATIONS WORK

Introduction

Our second focus is on processes of organisational change to increase effectiveness. Again, we draw particularly on experience in one pilot district. Most attention is devoted to the management of change in the large acute hospitals which consume the larger part of current annual expenditure on health services in both Republics.

At the time the PHARE project began, it was already more than two years since the political changes of 1989 and there had been a great deal of national attention to health sector reform. Even so, it was not immediately apparent that very much was actually changing on the ground: people's behaviour appeared to be rooted in the pre-1989 era and both those at the ministry and those at districts continued to rely on what remained of the bureaucratic model that they inherited. There were a number of dimensions to this:

* Central governments perceived that change could be effected by a combination of legislative change and executive instruction and were surprised that the periphery reacted with scepticism and resistance to this top-down imposition.
* Peripheral units continued to behave in one sense as if there had been no change. They assumed that constraints existed which prevented any serious exploration or testing of what could be achieved. One had the suspicion that districts and hospitals had a lot of latitude if only they had had the confidence to control their own destiny. Instead, they waited for instruction from the centre before they moved. The problem was, of course, that the instructions they did receive were often not perceived as being relevant to their priorities and were received negatively.
* Many of the pre-1989 administrative systems persisted. For example information systems were geared to provide the centre with information that would satisfy them rather than provide timely and useful data to help the unit run itself. There was much irrelevant and misinformation in the system.
* Individually, at both the centre and periphery, it felt very difficult to take personal risks. There was a also a persistent concern about individual job security.
* Styles of learning. The managers and professionals we worked with were mostly unfamiliar with our consultancy methods. Their learning models were

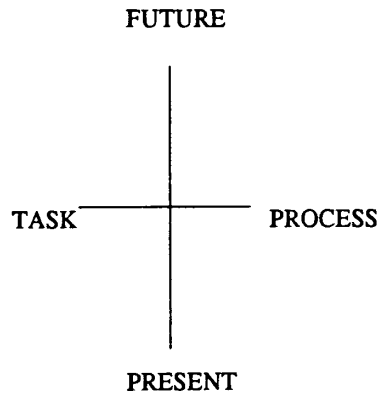
based on the transfer of knowledge principle: typically an expert would lecture didactically for a time and then there would be a very formal question and answer session.

These features are common in cultures with little previous experience of change and indicate the reality of the environment into which the ambitious reforms are being introduced.

Organisational Change

Management, as opposed to administration, is about making change happen.* The dilemmas of managers in dealing with their complex agenda can be depicted in the following way (Figure 3).

Figure 3.



Managers have to both manage the present and create futures. This is depicted on the vertical. Sometimes the key activity is distinguishing between what is important as opposed to what is urgent. Most managers have found themselves dealing with urgent things at the expense of addressing the important agenda. In

* Among many useful accounts Beckhard and Harris have described the technology of the change process and some helpful methodologies and tools to assist in that process. See Beckhard, R. and Harris, R. Organisational Transitions, Reading, Massachusetts, Addison-Wesley, 1987.

both the Czech Republic and Slovakia, it was evident that managers with whom we worked faced such dilemmas. Sometimes this was induced by the political agenda from the centre. The investment of time and energy in the introduction of the insurance systems (points system, fee for service, etc.) and privatisation diverted local managers from addressing the needs of their own institutions to become organisations that can start to deal creatively with local health needs. On other occasions, managers were clearly forced to deal with the present day events. It is, after all, difficult to plan for the future of a hospital, when confronted with a major reduction in income. Yet unless one deals with the immediate financial crisis in the context of the future the results will lead to short term pragmatism rather than sustainable solutions.

Over the last six months, however, we have seen emerging a much more sophisticated approach. The realities of the centrally driven agenda are being accepted, not as an intrusion but as something to be handled positively and assertively; at the same time the views of local people, the media and politicians are being considered while a sense of what the future holds is being developed.

In Figure 3, the horizontal axis depicts another dilemma: the relationship between task and process. One of the common observations when we started the project was the heavy focus on the task. For example, the assumption that passing legislation would make the change happen or that selecting correct features of certain Western health care systems would resolve problems, or a misconception that an information system could be acquired off the shelf to meet the needs of the health service.

Health care is task oriented. It is about providing real and tangible services to people on a day to day basis. However, change will not happen unless the process issues are also addressed. The process concerns the people in the organisation; understanding the attitudes, behaviours and fears that contribute to the culture of the organisations in which they work and how these affect efforts to achieve change. During our work in both Republics, it proved necessary to overcome a number of cultural issues to allow organisational change to happen. Critical examples of areas of traditional health care culture that need examining are:

* **The medical and nursing hierarchy**
  Doctors have been organised in hierarchies in Czech and Slovak hospitals since

well before the communists, so it is well ingrained. There is a chief, supported by specialists and a range of other doctors who have not gained their specialist training. The nurses worked in a hierarchy of their own but saw themselves accountable to doctors. We worked in hospitals where the hospital director wanted to introduce decentralised systems of management with budgets devolved to the departmental chiefs. However, this did not alter the relatively autocratic closed style of leadership that some of the chiefs were displaying. We therefore ran a series of interventions designed to explore and introduce more democratic and open styles of management that addressed attitudes of doctors to status, women and nurses and the use of authority.

* Respect for patients

Closely related to the style of management were attitudes towards patients. During the study trip to the UK, one of the major insights was that patients are, in comparison to the Czech and Slovak experience, respected and given a degree of privacy. The participants developed a determination to try and address this problem. We worked on the principles of what a demand led or user led service implied, exploring with varying degrees of success the difficulties which professionals have in <u>really</u> putting patients first. For example, in a hospital children's department the chief gained agreement to close under-utilised beds to create facilities where parents could stay to be with their children. However, this initiative was resisted by two associated departments, obstetrics and surgery; the potential involvement of parents in the management of children was seen as too threatening for demoralised medical professionals. Moving to a position where doctors will have the confidence and authority to allow patients, their relatives and carers to retain control will take time and persistence.

* The medical and non-medical chambers

The establishment of chambers was a very early part of the reforms. Their role is influential in both representing the interests of professional groups on issues such as pay and conditions as well as safeguarding the professional ethics of the respective groups. As one would expect the most powerful chamber is the medical one and will continue to be a significant influence when change is considered. The experience of doctors during the previous forty years had been an unhappy one - being poorly paid, undervalued and given little discretion. The professions, quite reasonably, want to re-establish themselves as a

respected, well paid, high status, ethically driven group and in considering any change in hospitals, polyclinics or primary care, the aspirations of the professions need to be addressed.

Achieving Change in a Large District Hospital

These issues were all important to our work in the second pilot district. Our main client there was the hospital director and the focus of the work was on developing the hospital's capacity to provide effective services in the context of the health sector reforms.

The diagnostic phase in this district occupied most of our first three visits in March, May and June 1992. We interviewed forty staff in some depth and visited a number of departments in the hospital, the polyclinic, health centres, the hygiene station and the district authority. Following the diagnostic phase we initiated a number of organisational development interventions. These ranged from seminars with medical staff (twice) and nursing staff to two workshops for an identified group of key staff (the first in July 1992 and the follow up in March 1993). In addition we organised a "Healthy District" workshop in October 1993 (See Chapter 6).

It was evident from this diagnostic place that we were dealing with a range of different issues but key types of thinking and behaving based on past experience needed to change if the hospital was to become an organisation that could take full advantage of its new independence, take risks, be more open, democratic and learn from experience. We know very few health related organisations that fulfil these characteristics but, nevertheless, it seemed clear that this was the single most important managerial task facing the health services in the district.

Intervention Phase

Following our initial series of interviews we discussed our findings with the hospital director and agreed that our first intervention should be a workshop to explore the nature of managerial responsibility and leadership within the organisation. It also provided an opportunity for a group of people to experience an alternative approach to managerial and organisational development.

Nineteen people, selected by the hospital director, were able to attend the first workshop. The workshop was centred on the experience of the participants, involving them throughout the two days. Those who attended were encouraged to review the strengths and weaknesses of present services in the district hospital and then attempt to develop a vision of the future. It was possible to agree three priority areas of work:

* To improve the way the organisation worked.
* To move from a provider dominated service to one that was patient-centred ie. in which the patient was *first.*
* To begin to take responsibility for the health status of individual members of the community.

These three priorities were worthwhile and realistic goals. It is important to note that there were no demands for more resources, medical equipment, or computers. Rather, these priorities concentrated on developing health services that were attainable and within the control and responsibility of the hospital and district staff.

The main focus of subsequent project work was the hospital. The hospital director and his deputy directors were undertaking a major initiative: the review of all the clinical departments in the hospital. This had entailed an appraisal of the work of the department; the staffing and skill mix; the equipment; and the expenditure. It was a large undertaking but essential to address the real managerial challenges. Importantly it necessitated very frank discussions between the senior managment and each directorate. An enormous amount of valuable information and understanding emerged from the process.

However, this process had revealed the need to develop more open and democratic management within the departments. The hospital director was concerned that there was no experience or capacity to manage departments in a way that would encourage participation, utilise nursing staff and allow patients and their relatives to be valued. We, therefore, agreed to use the project time available to concentrate on these issues by arranging to:

* Talk informally with a range of nursing staff.
* Organise a short workshop with twenty-five nursing staff.
* Organise a short workshop with twenty-five medical staff.

* Organise a one day workshop with six people from each of three clinical departments.

Talking to nurses was a first step in opening up some of the internal dynamics of the hospital. It was clear that the experiences of nurses varied and that in the mental health department the nursing staff were included and playing a central role in delivering the service. However, in other departments the opposite was the case and they were quite marginalised.

The nursing and medical workshops were designed to explore the difficult role of professionals within hospitals as very complex organisations. The nursing workshop highlighted the responsibilities nurses face in dealing with the very stressful aspects of hospital care; the loneliness and isolation patients experience, and so on. It became clear that achieving a more open and democratic environment depended amongst other things, on being able to deal with all aspects of hospital life and, particularly, these more distressing aspects. Indeed it occurred to us that these aspects might be particularly poignant in a society which had endured such difficult times during the forty years of communism and was facing the stress of such a massive change agenda.

The doctors workshop addressed the nature of organisations. We drew parallels with the United Kingdom experience of the change in the national health service from a large, autocratic public bureaucracy to one in which individual units were managed in a more autonomous decentralised fashion. In particular we focused on the experiences of a London teaching hospital and explored how it had undergone this transition. We noticed how the change process had started by addressing the tension between managers and the medical and professional staff, and the need to move from a provider driven organisation to one that was more patient focused.

We concluded that the role of doctors in making this latter change happen is fundamental for they must shift from their historical professional role to one that responds to the expressed needs of patients; allowing patients to participate in and control the decision making process, whenever possible.

Since both groups agreed that more open and democratic management were a prerequisite to attaining a patient oriented service, it was decided to hold a workshop which explored the working relationships between doctors and nurses.

The design of this workshop involved inviting teams from three different departments. Each department included the chief, two other medical staff and three senior members of the nursing staff. During the course of the day the teams worked together; groups from the same professional backgrounds worked together; doctors and nurses talked to each other, exploring their expectations of each other; and finally the teams reformed to think through how they might improve their working arrangements and communication within their departments and across the hospital.

This was the first time that individuals had the opportunity to work in this way so it represented a start towards a longer term cultural change. Also it was evident that the three departments were at different stages of development. One department was able to use the day very actively and produced a number of proposals about how, together, they would improve the working of the department to produce clear benefits for the patients. Other departments found producing tangible outcomes more difficult but they were able to articulate the need for training and education for all the staff and the importance of consultation with them before changes are made.

During the project, senior staff from the district hospital were also involved in a number of other activities. Five senior staff attended the three week London management development programme in November 1992. A further five senior staff attended the management information system workshop in Stupava in December 1992, and one person participated in the Barcelona study visit to expand the management information system work. These activities are reported elsewhere but clearly were also important development opportunities for individuals which complemented the work in the hospital.

Outcomes and evaluation

Assessing the benefits of management and organisational development interventions is notoriously difficult. The number of confounding variables make direct analysis of cause and effect impossible. However, during the course of the year's work within the district we kept on checking with our clients on the effectiveness of our interventions and the following summarises the results:

* Reaction to methods used.

We introduced participative and 'manager centred' learning methods which most people hadn't experienced previously. We never presumed to know the 'answer' and only used didactic teaching methods occasionally.

The people we have worked with found this style of working 'liberating', 'important', 'fun', 'enjoyable', and 'worthwhile'. The ability of the managers and professionals to work effectively in these ways raises important implications for applying such techniques to the working environment. There is no doubt that there is enormous talent waiting to be released and local and national leaders need to support this process and not waste the opportunity.

* Project progress overall.

In March 1993 a general review of the project was arranged with all the people who had attended the July 1992 workshop. Enormous progress had been made in a number of areas and a greater understanding of the managerial process had been attained. The following examples were given:

* Nurses have responsibility for designated patients in the departments of geriatric medicine and gynaecology.
* A foundation has been set up to assist people with personal financial deprivation.
* The first home care services have been initiated. In the mental health services psychiatric nurses, social workers and general practitioners were collaborating and supporting patients at home.
* A special 'night hospital' had been established in the department of dermatology for the treatment of people with psoriasis.
* A house of humanity had been set up (with charitable support) to provide residential care for older people.
* A health education programme had been arranged to help people who suffered from alcoholism.
* There had been a change in management behaviour so that it felt like democratic and just principles were being followed. Most staff felt they were being involved in decision making and the process was seen as being fair.

A number of continuing problems where identified:

- To safeguard this hospital's future, only excellent medical staff could be allowed to practice that this was not necessarily the case at present.
- Some people, physicians in particular, were disregarding the need to manage their services in cost-effective ways and it was very difficult to control their behaviour.
- Attempts to build relationships with local government had not been successful: however the need to achieve this was now strongly accepted.

There were also some powerful conclusions:

* "We are motivated by our 'attitude' not by money."
* "We mustn't wait for decisions to be taken at national level but be responsible for our own destiny."
* "Despite the grim economic situation, we are making progress by managing our affairs better."

Clearly, not all these outcomes were directly related to our interventions. There seems good reason to argue however that the PHARE project has contributed to making the hospital a managed health service organisation.

The position of senior management

In March 1993, there was also a final meeting with the hospital director and deputy directors. There was no doubt that the senior management team was facing serious dilemmas. Since January 1993 it was stated that the financial allocation to the hospital had been reduced to between 60 and 65% of the 1992 allocation. This had placed the organisation in severe difficulty. It was estimated that 500 jobs would have to be lost. Meantime there was national concern about the status of the health service and serious political protests were under way.

The ethical position which these senior professionals and managers faced was new and problematic. The dilemma was whether their loyalty lay to themselves as citizens, to the patients or to their boss, the ministry of health. The result of our discussion was a realisation that they had a primary responsibility to ensuring that

the patients were given the best possible care within the resources available; to jeopardise their ability to do this meant failing to lead the hospital.

Subsequently the hospital director decided to set up six working groups to improve the performance of the hospital:

* ethics
* services for patients with cancer
* services for mothers and children
* nursing
* quality
* international co-operation

Agreement has been reached with the local medical chambers and the unions to participate with these working groups and assurances given that the conclusions of the working groups will be accepted by management. The importance of this initiative, however, is that it demonstrates a change of approach. Here we see an example of a local hospital setting its own agenda and taking responsibility for determining its own future.

3.3 RESHAPING LOCAL HEALTH SYSTEMS THROUGH INTERSECTORAL WORKING

Introduction

In the preceding two sections, we have examined how the health sector reforms required substantial changes in the way individual managers tackled their jobs and new approaches to the management of whole organisations (for example, the hospitals). A third area of substantial changes must be in the relationships between different health agencies required by pluralism and decentralisation. This local development of inter-agency management and its importance in reshaping health services provision is the main theme of this section.

In brief, our experience suggests that the national health sector reforms are only likely to be successfully implemented where local leaders in different agencies appreciate both:

* the change in their own agencies' missions and the need to exercise greater autonomy in a pluralist system; and
* the inter-dependence between different agency roles and the need therefore to collaborate in achieving shared (or complementary) local objectives.

Securing the appropriate balance between autonomy and inter-dependence, presents a very substantial challenge in health systems which are strongly influenced by both the new philosophies of market competition and attitudes inherited from the previous state bureaucracies.

This transformation in relationships, particularly at a time of upheaval and uncertainty, is necessarily an evolutionary process. Focusing on our work with one of the pilot districts, we describe how over a period of nine months (from Summer 1992 until Spring 1993) local leaders explored together the benefits of collaboration and began establishing joint strategies designed to maximise the benefits of reform to the local population. We also examine the implications of this experience for how managers might learn the approaches and skills required for inter-agency management.

As in all project work with the three pilot districts, our work with this district involved a series of visits in which we met local leaders from different agencies, singly and together, both to understand the challenges they were facing and to explore with them appropriate responses. We concluded the work in this district with a small local conference - involving leaders from the district authority, the local branch of the health insurance company, the main hospital and the recently-privatised general medical practitioners - to review the progress made over the previous nine months and identify shared priorities for future local action.

In an environment of delays in expected legislation, major uncertainties about new responsibilities, considerable anxiety about the implications of new financing and ownership arrangements and a heavy workload for all concerned, much had been achieved during this period. In structural terms, managers had succeeded in dissolving the previous monopolistic state organisation and establishing the necessary new agencies, notably the health insurance company, but also a more effectively managed hospital and significant privatisation in general medical practice. While initially, each of these agencies were concerned with developing their own organisation and internal systems (e.g. relating to finance and information), each agency (also including the medical chamber and the municipal councils) was beginning to explore what could be done through their 'lateral' relationships with other agencies. Figure 4 represents the nature of this change.

This was reflected (Figure 5) in a range of substantive achievements: some basic to establishing the new arrangements, some significant developments in health services which built on these relationships, and some the priorities for future joint work.

In this difficult period, how was this local progress achieved?

Towards partnership

Following a preliminary visit to the district to introduce the PHARE project and explore local interest in participating as a pilot district, the diagnostic phase of our work started in August 1992. The project leader and a colleague spent three days in the district visiting services and meeting a cross-section of local leaders including the head of the district authority, mayor of the main town, directors of the insurance company, hospital and two polyclinics and chairman of the medical

Figure 4 **STRUCTURAL CHANGE AT THE DISTRICT LEVEL**

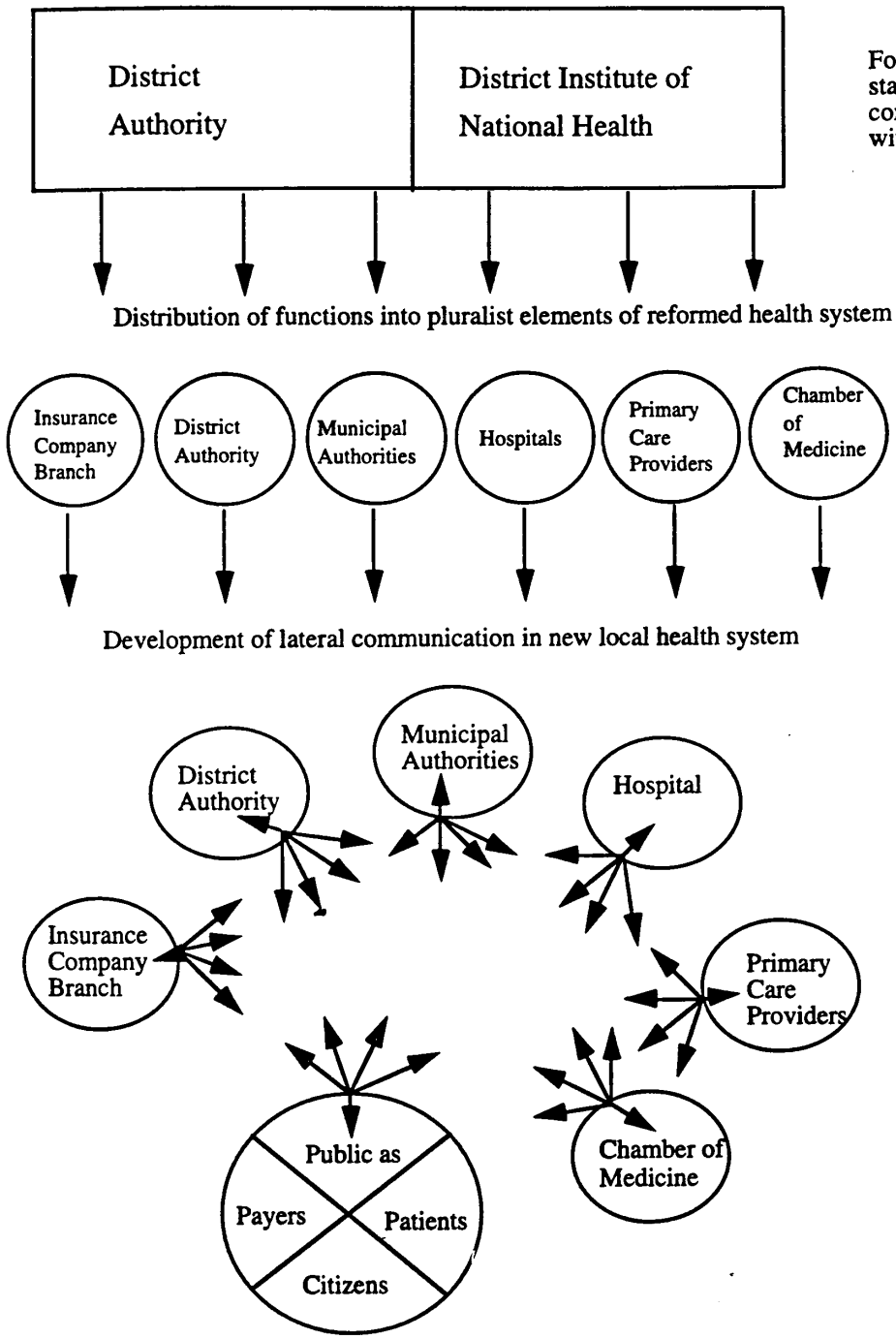


Figure 5 SUBSTANTIVE ACHIEVEMENTS, JULY 1992 - MARCH 1993

Establishing the new arrangements:

* Maintaining local services during the dissolution of previous state structures.
* Establishing new organisations, their functions and working methods, including:
  - setting up the insurance company and implementing new funding arrangements for providers
  - introducing management arrangements at the hospital, including new departmental budgeting and information systems
  - planning new forms of ownership for the polyclinics and privatising more than 50% of general medical practitioners
  - developing the medical chamber's role in licensing and professional communication
  - redefining the role of district authority health department director in coordinating change.
* Developing local understanding of the need to inprove efficiency and efectiveness.

Promoting developments in local health services:

* Leadership from the insurance company in encouraging providers to address local health needs.
* Complementary leadership from the district health department director to encourage payers and providers (of both health and social care) to improve the pattern of services
* Assistance from the municipal authorities (e.g. in finding suitable buildings) to establish new services (e.g. day care for elderly people).
* Significant efforts within the hospital to reduce costs while reviewing hospital provision.
* Discussion among doctors (e.g. through the medical chamber) to reduce the risks that competition between doctors will damage arrangements for referral to patients and mutual advice.
* Joint action to establish and evaluate new kinds of local home care services.
* Shared efforts to develop public understanding of the changes and improve the relationship between providers and patients.

Agreeing priorities for further joint action in 1993

* Developing local approaches to population need assessment in order to inform:
  - multi-sectoral programmes for health promotion
  - priorities for health services development
  - improved collaboration between health and social care
* Improving value for money through:
  - attention to ways of defining and monitoring the quality of services, and
  -further dialogue between clinicians and economists.
* Involving more staff in planning and implementing change.
* Establishing a local training centre so that more staff could learn the basic management skills essential to meet requirements of the new system.

chamber. The visit ended with a meeting with the directors of the district health department, insurance company, hospital and town polyclinic where we reported our initial impressions and discussed the next steps.

As visitors, by then with some knowledge of other districts, we were able to identify a number of strengths in the local situation:

* The district had a sense of identity and good personal relationships among many of the key people.
* Current leaders had typically grown up, or at least had a long association with the district and appeared to have a strong commitment to ensuring good health services for the population.
* They were therefore concerned to use the health reforms positively to achieve improvements which they knew were necessary.

At the same time, our discussions suggested that managers were also facing significant difficulties:

* The detailed attention needed to set up new agencies and plan for privatisation often meant that these structural changes had become ends in themselves rather than the means to improve health services.
* Little time had been given to clarifying and sharing views on the pattern of health (and other services) required by the district population.
* There were concerns that the changes being introduced would lead to fragmentation and conflict between different elements in the new system, including among doctors who increasingly saw each other as competitors.
* Leaders recognised that they lacked both the management experience and training required for their new tasks in the reformed health system.
* They were particularly conscious of the difficulty in spreading understanding of the reforms among their colleagues and gaining wider commitment to change.
* There was also considerable uncertainty about the way in which national policies were developing and a strong feeling that the authorities in Praha had little understanding of the challenges facing managers locally.

Perhaps most important, this meeting led the four leaders to recognise that in each of their organisations they were working separately to address these difficulties when there was much to be gained from working together to achieve health sector reform. They decided, therefore to meet regularly as a group, involving other

leaders where appropriate, to share views on the reforms and how best to improve services locally.

We called this regular meeting the multi-agency 'change management seminar' and it became the focus of collaboration between the PHARE project and this district. The project team leader joined in this seminar on all subsequent visits to the district and its four regular members were invited to participate (together with leaders from the other pilot districts) in the King's Fund College leadership development programme in London during November 1992.

At its next meeting in early September, the project leader helped the 'change management seminar' (including the four leaders joined by the chairman of the medical chamber and the director of the institute of hygiene and epidemiology) to develop an initial 'vision' of the future pattern of health services in the district and identify priorities for making changes towards this vision in the coming months. There was quite broad agreement on the importance of:

* clarifying public expectations on what patients should expect from the reformed health services;
* improving the quality of these services;
* shifting the balance of services towards primary health care and other kinds of support in the community;
* rationalising hospital services to reflect clinical strengths and population needs;
* giving greater emphasis to local strategies for health promotion and disease prevention.

Their short term priorities reflected each of these aspirations and it was agreed that the PHARE project would assist the leaders and other local people in considering how best to make progress on these issues.

Subsequent visits therefore combined meetings of the 'change management seminar', visits to particular services and further activities focused on one of these topics. In each visit, the project leader was accompanied by another member of the international team with most interest in the topic in question.

Three examples of local initiatives follow. In each, the active interest of the insurance company director in good value for money and the influence of the district authority health department director in shaping better services to the local

population were a significant encouragement to the action taken by particular groups of providers.

(i) **Rationalising the main hospital**

With energetic leadership from its director, the hospital became a key focus of change in this period. More than half (85 million crowns) of the district budget was spent there and the reforms (particularly new financing arrangements) required major changes in practice. The director sought to involve his senior staff in planning change and with the chief economist introduced management information systems at the departmental level, which provided the basis for new incentives for efficiency.

Steps were taken to reduce average lengths of patient stays (e.g. by shortening the time between admission and carrying out procedures), improve utilisation (e.g. of operating theatres), monitor drug usage and save energy. In a short period, bed numbers were reduced by ten percent and personnel by eight percent. At the same time, both doctors and nurses were devoting more attention to the quality of services and their relationships with patients.

The project contribution focused on consultation with the hospital director on ways of building commitment to these changes and included an all-day conference with heads of departments in December on their roles in leading change.

Looking outwards, hospital managers were also considering with colleagues how to ensure good communication with general practitioners, developing plans to use some facilities for nursing home care (with financial support from the ministry of labour and social affairs), and exploring with other hospitals the future pattern of specialisation in the wider region.

(ii) **Privatising general medical practice**

Major change was also taking place in primary health care, particularly associated with privatisation of general medical practice. Indeed, the implementation of privatisation formed an important part of the workload for the district authority health department, the medical chamber and, of course, for general practitioners themselves.

This change also proved quite problematic. There was oscillating enthusiasm among general practitioners, particularly because of uncertainty about the financial arrangements and the impact of competition. There was also confusion about what effect the generally preferred model of privatisation- general practitioners working on their own - would have on the pattern and quality of local services.

Project contributions, including a conference on privatisation in November, were used to help local general practitioners examine the future shape of primary health care, drawing on international experience and to bring local agencies together -general practitioners, the insurance company, the district health department, medical specialists - to consider their different roles in promoting positive changes.

Looking to the future, local people were able to envisage a stronger role for primary health care in which general practitioners were typically the point of entry into the health system and where current individualism was replaced by more teamwork among networks of doctors and other community staff (e.g. nurses), committed to good family medicine.

There were however many barriers identified in achieving this aspiration. In the short term progress was sought through:

* a focus on general practitioners themselves developing skills as managers of small businesses who need to establish appropriate relationships with the insurance company, medical specialists, other general practitioners, community services and patients; and
* each agency making efforts to improve quality, for example, through professional education and local self help, specialists sharing their expertise with general practitioners, the insurance company reviewing some aspects of its relationship with general practitioners and the district authority health department drawing attention to local health needs which could be addressed more effectively through primary health care.

(iii) Developing home care

On a smaller scale, the development of domiciliary nursing care services provide an illustration of the importance of the 'change management seminar' in identifying gaps in local provision and working together to find innovative solutions. In this example, common knowledge about the local population, particularly the needs of elderly people and recognition that shorter lengths of stay in hospital, possible loss

of geriatric nursing services during privatisation and reluctance to use poor quality social care, all suggested the need to develop new forms of domiciliary health care. One response to this need was to encourage an enterprising nurse to set up an independent home care service for a small population. Her charismatic leadership was vital in establishing and marketing the new service. It was made possible, however, by the efforts of the district authority health department director in gaining professional acceptance of the scheme and obtaining equipment; the insurance company director, in identifying funding possibilities; and some business sponsorship.

Managing inter-dependence

These and other substantive developments (e.g. the greater emphasis on multi-agency strategies for health promotion, discussed in Chapter 6) benefited considerably from the growing partnership between local health agencies through the 'change management seminar'. However, during 1992 its most important contribution was in helping local leaders steer a sensible local approach to implementing the reforms. Progress here was by no means smooth. There were times during our visits when the leaders were preoccupied with frustration at what were seen as mistakes in central policy-making. There were continuing fears that change would provoke damaging conflicts. In some meetings of the 'change management seminar', the main agenda was that of how to avoid 'going backwards'.

In this situation, the mutual respect among local leaders and their willingness to work together, for example, by sharing their understanding of central policies and discussing implications for their own agency, made an essential contribution to reducing the turbulence associated with the reforms and containing people's anxieties. This mutual understanding also increased the confidence of each leader in their efforts to ensure that local experience informed central policy-making.

In 1993, the continuing dialogue between inter-dependent partners was helping to promote further decentralisation and providing the foundations for a concerted local development strategy (as suggested in Figure 5). Local leaders increasingly recognised that in order to maximise the benefits of the reforms (and minimise their disadvantages) they needed to:

* work together to give local impetus to change;

* seek to develop a shared vision of the future pattern of services needed to meet the population's health needs;
* make changes in the direction of this vision central to the reform agenda;
* focus energy on local priorities;
* carefully design initiatives to address these priorities; and
* regularly review progress to ensure they were learning from experience.

They also recognised that this exercise of professional leadership would increasingly need to engage with local democratic structures (e.g. leaders of the municipal authorities) and test changes against the experience of the local population.

In assessing the PHARE project's contribution to the progress they had made, these leaders valued the opportunity to learn from experience in other national health systems. Much more important, however, was the way in which the project team's regular visits to the district over several months had assisted them to:

* explore difficult issues with each other within the supportive climate of the 'change management seminar';
* learn from their own growing experience about how to achieve positive changes;
* become more confident in their leadership roles; and
* learn to think managerially.

An essential component of this managerial thinking was recognition that a decentralised and pluralist health system requires not just effective management of each of its parts but also effective management of the interfaces between agencies in order to ensure services meet the needs of individual patients and local communities.

This in turn required leaders to adopt new roles (for example, in facilitating links between different agencies), new approaches (in which 'lateral' influence might be as important as 'vertical' control) and new skills (notably in relating the content of particular problems to the contribution different agencies could make to their resolution).

Three important conclusions can be drawn from this analysis for future investment in management development:

(i) Successful implementation of the health reforms requires concerted action by different local agencies. As this example suggests, external facilitators with the skills to help local managers build new relationships and establish their own local development strategies can make a significant contribution to progress.

(ii) At least some management development opportunities should be provided which bring managers from different agencies (and also different levels) in the health system together to improve understanding of each other's missions and develop the roles and skills required for managing inter-dependence. The 'healthy district' workshops, the London leadership development programme and the national management information system workshops arranged by the PHARE project each provide examples of how this can be achieved.

(iii) In a rapidly changing situation, a key aspect of management development must be well-structured opportunities for managers to share experiences and reflect on their own practice as managers in order to draw out lessons for becoming more effective.

4. IMPLICATIONS FOR HEALTH SECTOR MANAGEMENT DEVELOPMENT AND RECOMMENDATIONS FOR NATIONAL ACTION

4.1 THE NEED FOR NEW APPROACHES TO MANAGEMENT AND MANAGEMENT DEVELOPMENT

4.2 ESTABLISHING A MARKET FOR MANAGEMENT DEVELOPMENT

4.3 FRAMEWORK FOR A COMPREHENSIVE PATTERN OF HEALTH SECTOR MANAGEMENT DEVELOPMENT PROGRAMMES

4.4 RECOMMENDATIONS FOR NATIONAL ACTION

4.1 THE NEED FOR NEW APPROACHES TO MANAGEMENT AND MANAGEMENT DEVELOPMENT

As the preceding sections have shown in detail, the bold programme of health sector reforms in the Czech Republic and Slovakia pose major challenges for government and for the health sector institutions responsible for implementation. Good management and management information systems are vital elements in the success of these reforms.

Historically, because the health sector has been regarded as unproductive and was run as a command and control system from the centre to the periphery, there has been little priority for or, for that matter, need to invest in its management and information infrastructures.

Prior to November 1989, health sector management training was centrally controlled and directed. Administrator/managers were all physicians appointed by centrally controlled institutes (ministry of health, regional institute of health, or district/national institute of health). Appointments generally reflected political acceptability as well as clinical and research reputation. All administrative managers received training in the postgraduate institutes in Praha, Brno, and Bratislava.

Training focused on a detailed review of centrally generated regulations and prescriptions. Curricula focused on the training of administrators not managers. Administrators were not required to develop strategic plans, measure outputs, analyse costs, or exhibit any market oriented financial behaviours.

The success of the new health reforms depend on effective decentralisation, privatisation, and maintenance of quality health services at the local level within seriously constrained resources. These changes are about breaking up the old structures and changing all the old incentives. They are about fundamental change.

The critical need for new health sector management approaches was identified by health system reformers in the earliest stages of the reforms.

"The basic shortcomings of our health services are well known. The rigid, hierarchical system of health services, the lack of modern management, economic

stimuli and quality control has lost its ability to make rational decisions in the allocation of resources and to react flexibly to public needs...." (Czech reform document).

"Reaching of the major goal of reform; namely, improvement of the health status of the population is determined by materialisation of the following objectives....development of a mechanism of the management of health services and that of the economy; which would limit undesired superfluous administration and set management as close as possible to the level of the actual provision of the services." (Slovak reform document).

Despite a number of initiatives in each Republic over the last two years, this remains a critical need and requires a national strategy to gain maximum benefit from the limited skills and resources available for strengthening in-country management development opportunities.

As the analysis presented in Chapter 2 suggests, the precise development programmes needed to support the health sector reforms will vary according to both the type of organisation in the new system - insurance company, hospital, general practitioner, district authority health department - and the level of the individual managers or health professionals within these organisations.

As the detailed work in the three pilot districts shows however (Chapter 3), there is a common need throughout the health sector to bring about the shift from administrative centralism to decentralised management summarised earlier (see Figure 1). This radical change in the culture of health services organisations is fundamental to acquisition of the more specific knowledge and skills required to perform effectively in the new health sector environment.

For individual managers a new orientation is required which combines;

- a positive attitude to identifying what can be done to resolve current problems;
- the willingness to take risks by initiating action;
- a focus on outputs (the health care results achieved for patients, the overall productivity of the hospital or practice);

- a concern with implementing change through addressing both tasks (what is to be done) and processes (how this is to be achieved through the contribution of others); and
- the ability to balance increasing autonomy with recognition of the inter-dependence between different agencies in the new health system.

The case reports in Chapter 3 demonstrate what each of the elements in this new orientation are beginning to mean in practice. We have been impressed during this work by the high calibre of people accepting leadership responsibilities at different levels in health sector organisations. We have also recognised that many are coping under considerable stress and that most senior managers need better support, developmental opportunities and a wider range of experiences if they are to contribute fully. Similarly most less senior managers have not yet had the time or opportunities to develop the skills, both technical and human, that they need to provide good day-to-day operational support and prepare for stronger leadership roles themselves.

All this potential talent must be "unlocked" if the reforms are to succeed. A wide range of managers need the opportunities and support to become 'reflective practitioners'. In turn, these changes require fresh thinking about the approaches to management and organisational development which are most likely to promote the new managerial attitudes and behaviours required. In the following sections we identify the initiatives which are emerging in each Republic to address these needs and provide a framework for planning a comprehensive pattern of health sector management development programmes.

4.2 ESTABLISHING A MARKET FOR MANAGEMENT DEVELOPMENT

In both Republics, there have already been significant developments in both the demand for health sector management development and the way it is being provided which have shaped the nature of our recommendations.

The purchasers

As we have said before, the change agenda is enormous and involves many new activities and abilities never before demanded of Czech or Slovak managers. Many managers are only too keenly aware of the gaps in their knowledge and experience as they face the day to day operational demands of their respective organisations in the process of reform. These individuals will be the purchasers of management development services, and there are several trends that will influence the future opportunities for the uptake of these services.

First, for a variety of reasons, most people in senior positions in the pilot sites (and, it would seem in many localities) have long standing and close ties with their respective localities. This leads to several advantages: intimate knowledge of the district, long standing networks, and a strong commitment to making things better locally. Where such a pattern is identified, it can serve as a good foundation on which to build training programmes which are responsive to locally identified management development needs that go beyond those of a single organisation.

Second, a variety of networks are being established across district boundaries -through professional chambers, hospital associations, and among health service managers and health professionals themselves - to learn from each other and collectively seek the resources they need to do their jobs better. Increasing, but still small, numbers have been involved in management development programmes sponsored by foreign agencies and are able to sustain contacts with these organisations and become increasingly sophisticated purchasers.

Third, because of the exposure to those management development and exchange visitor programmes that have been made available, largely through foreign

assistance at this stage, individual senior managers are seeking wider opportunities for management development appropriate to different levels in their organisations. They are also increasingly aware of the new roles they must play in leading their agencies and are seeking help with this very different agenda.

All of these trends will lead to more informed "purchasing" of management development services and potentially offer mechanisms for more cost effective delivery of these services to larger numbers of health sector managers. However, there is still a stark lack of financial resources to directly buy the training needed. Most purchasers are still left trying to indirectly influence content and organisation of training programmes through informally advising potential providers, the ministries of health, or third party donors or investors.

As a result, there are still very few programmes in relation to need and even fewer tailored to the Czech or Slovak environments. The development of specific educational materials in Czech and Slovak lags far behind the need.

The providers

One of the activities of the PHARE project has been to conduct a review of major existing providers of health sector management development. The details of this review are found in Resource Guide I, but several general conclusions can be drawn from this work with implications for future development.

While respective ministries of health have both been criticised for not producing a comprehensive management development plan to date, the absence of central edicts has created the framework for a "free-market". The lack of "directives from above" detailing the organisation, content, and official providers of health management training services has allowed, and in fact required, enterprising individuals in a variety of settings to assume new leadership responsibilities. The pluralistic initiatives which have emerged are beginning to result in the creation of a marketplace with several competing options of health management training, for purchasers to consider.

Provider organisations tend to fall into one of four general types - traditional publicly owned post graduate institutes; established universities with previous experience of medical training or teaching management disciplines (e.g. business

management, economics); newly created institutes, often quasi-independent units of a university or other health related organisation set up specifically for this purpose; and, despite the lack of formal legislation, foundations or associations and other private organisations set up to provide management development.

Most are still quite dependent on foreign partnerships at this stage and most are facing significant barriers as they try to develop programmes:

* lack of trained staff and appropriate curricula at existing public training centres (postgraduate institutes, economics and medical faculties).
* lack of financial resources to support the redevelopment of existing public institutions or the creation of new private/foundation based training centres, and
* low priority that health sector management development has commanded in the national budget allocation processes.

These supply side challenges are beginning to be addressed by development of direct linkages between Czech and Slovak institutions and international management training centres. Foreign partners/investors have been attracted to this marketplace because of:

* the unique opportunity to participate in unprecedented national health reform programmes;
* perceived entrepreneurial opportunities; and,
* the availability of donor and lender financing for interventions.

Particularly when supported by health ministries, requests for assistance in this area have been favourably received by major international donors and lenders such as the European Community's PHARE and TEMPUS programme and the United States Agency for International Development, as well as foreign foundations like Project Hope.

While present training capacity is limited, significant collective experience has been gained to date. Programmes are presently operating and others being planned which can provide the basis for future national and regional developmental strategies.

A critical priority for all provider programmes is the need to develop in country trainers and educators as a first step. A variety of methods are being tried in each Republic. Some examples follow:

* The City University of Bratislava, a foundation based programme established in 1991, is taking open learning materials on health sector management developed by the Open University in the UK and translating these for use in Slovakia. Using foreign faculty and tutors, they have involved a critical set of about 100-150 health professionals from various levels of management in a training process. About thirty individuals from among this group have been identified who can begin to customise the materials to the Slovak reality and then act as support faculty for the next round of teaching. Eventually, the programme should result in fully adapted materials and a core of independent Slovak faculty.

* The Health Management School in Bratislava is using a different approach and has received TEMPUS funding for direct training of faculty from a variety of other teaching institutions and associations who wish to become health sector management teachers/trainers. Foreign partners from Holland and Belgium serve as training faculty. Potential trainers take courses in the West and then co-teach equivalent courses in country.

* Three MBA programmes in the Czech Republic are planned to begin in autumn 1993. Each is training/retraining faculty from selected technical universities, existing business faculties and some high level health service managers by having them co-teach courses with foreign counterparts and participate in exchange fellowships abroad for varying periods of time. This model is being used by the MBA programme at the Masaryk Institute (with Sheffield University in UK), the Czech Management Centre in Celovice (with the University of Kansas in the US) and at the Praha International Business School (with the University of Manchester in the UK, EADA in Barcelona and a consortium of US Business Schools who have formed an international advisory board).

* Many enterprising managers have been honing their applied management skills and potential consulting skills by taking short courses offered by national and international groups (Vernirovice, Medum, PHARE/King's Fund College, Project Hope/Wharton School of Management) and returning to become trainers in their own localities.

Overall, the provider side is developing, but it is apparent that the time is critical for clarity about priorities for government and foreign investment if those resources

that are available are to meet the major needs. It is also important that government works with other interests to establish standards, if not for specific programmes, at least for providers to assure that those efforts that are supported are of acceptable quality.

4.3 FRAMEWORK FOR A COMPREHENSIVE PATTERN OF HEALTH SECTOR MANAGEMENT DEVELOPMENT PROGRAMMES

Over the medium term, a comprehensive approach to developing effective health sector management will need to combine a wide range of modern methods including:

- on-the-job training by other good managers in the same organisation who have themselves been trained for this mentoring role;
- distance learning programmes with appropriate materials;
- learning networks which regularly bring together individuals or teams from different places;
- action learning and organisation development programmes with specific change objectives in particular agencies or districts; and
- a variety of off-the-job educational programmes meeting particular requirements.

This increasing variety of opportunities (and the development of the in-country capacity to supply them) is illustrated in Figure 6.

In order to plan to meet current and future needs, it is helpful to identify both the different target groups requiring management training and the different kinds of programme which may be relevant to their needs.

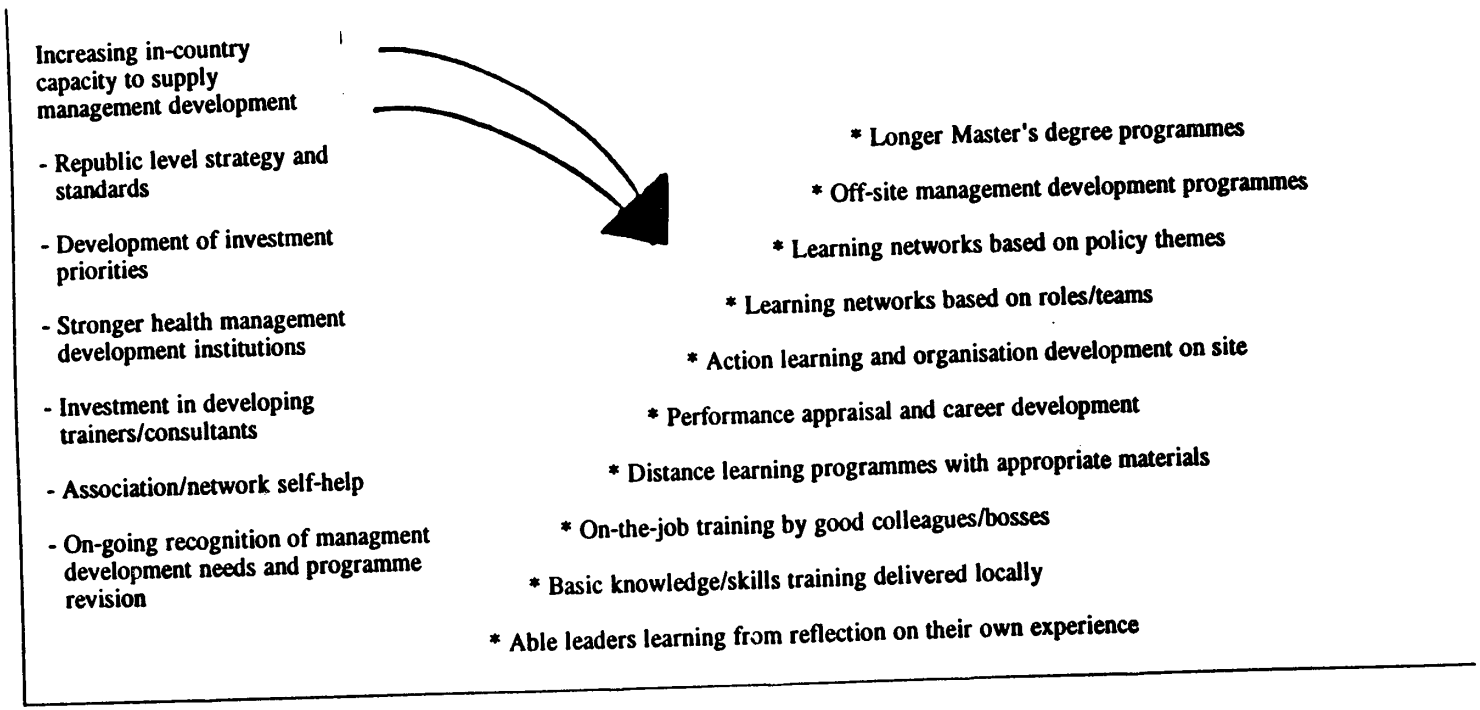
A framework for this analysis is presented in Figure 7.

This distinguishes the following target groups:

Directors: Hospital directors, insurance company branch office directors, district authority health department directors.

While these individuals will have different specific responsibilities, the common issues they face will be "leading" their organisations internally - assuring the development of an effective management team, setting goals and priorities for programmes and resources, and assuring that these are met. They will also be taking on a newer role in the pluralistic system of managing up and out - relating to the leaders of other organisations in their locality and influencing government policy. This role change is significant and often stressful. Individuals need not

FIGURE 6 **GROWTH IN MANAGEMENT DEVELOPMENT OPPORTUNITIES**



1992 Increasing variety of opportunities and increasing linkage to achieve individual, organisation and systems development 1995

FIGURE 7

MANAGEMENT DEVELOPMENT PROGRAMMES

TARGET GROUPS	ACADEMIC PROGRAMMES	SKILLS TRAINING	LEADERSHIP TRAINING	ORIENTATION TO HEALTH SECTOR	CONTINUING MANAGEMENT EDUCATION	TRAINING THE TRAINERS	CONSULTING SKILLS
Directors	#	✓	✓		✓	#	#
Senior Managers	#	✓	✓		✓	#	#
Functional/ Departmental Managers		✓	✓		✓	#	
Entry Level Managers		✓		✓			
Future Directors	✓		✓		✓		
Clinical Managers		✓	✓		✓		
Health Professionals				✓			
Academic Faculty	✓			✓		✓	#
Trainers/ Developers				✓	✓	✓	#
Organisational Consultants				✓	✓	✓	✓

If interested for own career development

only skill building, but on-going mechanisms for support and continual learning from their own experience in the new role.

Senior Managers - Individuals on the executive teams of hospitals, insurance companies, etc. who may in future assume director roles. The major learning needs are updating technical knowledge in their specialism and becoming comfortable as part of a management team taking responsibility for the overall organisational performance, not just the performance of their particular technical area. They must also learn how to lead their own staff and develop younger managers within their technical area.

Functional/Departmental Managers - These are the so-called middle managers in most organisations - those who run information services, central supplies, pharmacy etc. Some may be health professionals and others may be general managers. The focus of their development must be on general management skills, interpersonal relations, and ongoing updates in technical areas of work.

Entry Level Managers - these will be individuals entering lower levels in the health sector after appropriate educational qualification. Many countries approach this group in two ways--basic entry level orientation and skill building development programmes for all - and so called "high flyer schemes" that identify applicants, usually university or master's degree graduates, who have potential to be future directors or senior managers. These individuals are offered a specially designed training and mentoring programme usually organised at a national or regional level.

Clinical Managers - health professionals - doctors, nurses, etc. usually in provider organisations whose major role will be managing other professionals, supervising the quality of clinical practice and managing or working with others who manage basic financial and personnel resources within the provider units.

Health Professionals - these are individuals who are practising clinicians, but their daily decisions about patient care generate resource use. It is important that they understand the basic operations of the health care system and the resource implications of their decision making.

Academic Faculty - individuals with existing specialisms who can contribute to the education and training of health sector managers and health professionals. They

may or may not be familiar with the health sector and this fact will have different implications for their own development as faculty in these programmes.

Trainers/Developers - individuals with backgrounds as faculty, teachers and trainers outside the health sector, managers from outside the health sector, and, very importantly, experienced health care managers and health professionals who seek to assume part-time or full-time teaching or training roles in health sector management development programmes or as organisational consultants.

Organisational Consultants - individuals with health sector management experience or experience in management and organisational consulting in business or service sectors outside health. They will need special preparation to serve as consultants to top managers in the health sector on overall organisational change programmes.

And the following types of management development programme:

Academic Programmes - increasingly health sector senior managers are likely to be university graduates and one would expect that the masters in business administration (or equivalent) with or without a health specialism will become the predominant special academic preparation. In the future these programmes will usually take 2-4 years, depending on the scheduling around work commitments, are labour intensive and expensive, The typical cost now in the Czech Republic and Slovakia ranges from 25,000 to 50,000 crowns or more. These will continue to be centred in national institutes or university departments.

Skills Training - these are usually programmes on topics of importance in a technical specialism (e.g., financial management) or in more general management skills (time management, human relations and communications skills, managing people) needed by all who will assume management responsibility.

These are best provided through some combination of classroom learning or distance learning with supervision and "on the job" training or supervision. Programmes are often designed to meet the particular needs of an organisation or a level of individual in an organisation and should increasingly become the responsibility of individual units or district and regional centres.

Leadership Training - these are often programmes that combine knowledge and skills training with learning modes that provide for personal development of participants through so called "action learning", stressing the use of small groups, "on the job" observation and mentoring by trainers/organisational consultants. They may also involve exposure to international or cross sector comparative management experiences.

Orientation to the Health Sector - valuable as an induction for individuals entering health sector from other sectors and health professionals who may have an interest in management, but are unfamiliar with how the health sector works.

Continuing Management Education - these are likely to be market lead short courses for information updates in topics of interest. They may become part of an on-going accreditation system for managers.

Training the Trainers - basic skill building tailored to the type of teaching/training role the individual will play. There is a continuum from the more academic, classroom teaching methods involving curriculum development, lecture, use of case studies and small group work and tutorials to the more action learning type models, using group techniques to help managers explore their own learning needs and work with each other to solve problems, in the light of their own real experiences.

Consulting Skills - these programmes would involve long term partnerships with experienced organisational consultants (likely to be foreign initially) for individuals with health sector or management backgrounds who seek a new career direction in consulting to senior managers about overall organisational change problems.

As can be seen from the more detailed review in Resource Guide I, a variety of programmes are currently emerging to meet some of these requirements. These spontaneous initiatives from different potential providers should continue to be encouraged as part of the necessary pluralism in the supply of management development opportunities.

Resources in the market can probably continue to support short programmes of topical interest... e.g. on health services financing, personnel management, etc... and outside subsidies may continue to be available for some senior managers to

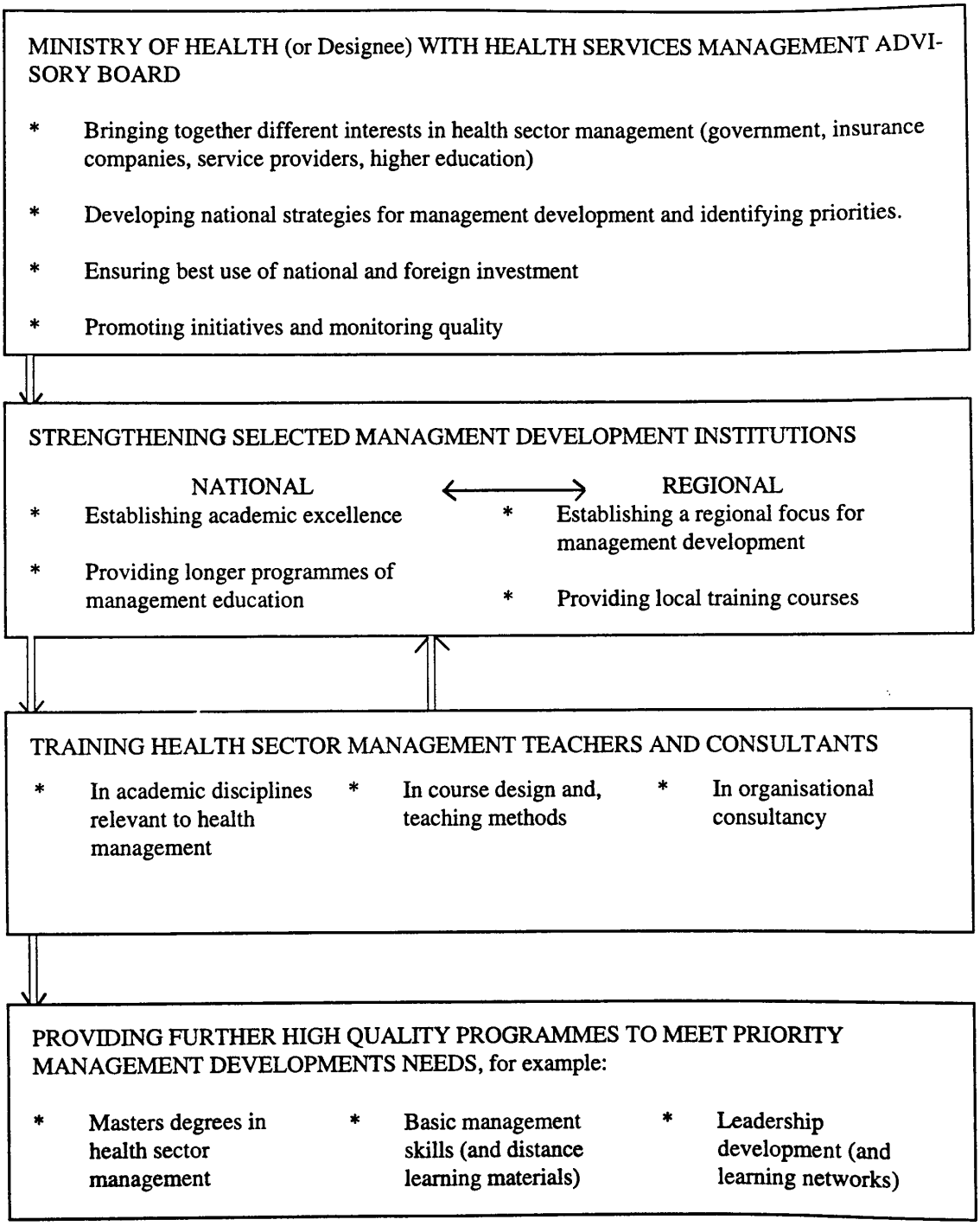
make foreign exchange visits and for some training of trainers in organisations that have established international partners.

However, our analysis of management development needs and our survey of existing in-country supply, suggests these initiatives are likely to fall considerably short of what each Republic now requires. In particular, there is a major need to strengthen the in-country capacity for designing and delivering health sector management development programmes and to target this capacity on managers and programmes which reflect priorities agreed between government and relevant health sector interests. Our recommendations to meet these needs are summarised in Figure 8.

Our proposals to implement these recommendations take into account the likelihood that the environment for the health sector, and therefore for health sector management development, will continue to be characterised by

- uncertainty and change
- severe resource constraints, which may worsen
- increasing pluralism, autonomy and diversity in the functioning of health financing and delivery organisations which will make central guidance from government more difficult.

Figure 8 STRATEGY FOR STRENGTHENING IN-COUNTRY MANAGEMENT DEVELOPMENT CAPACITY AND MEETING PRIORITY NEEDS



4.4 RECOMMENDATIONS FOR NATIONAL ACTION

Recommendation I - A Health Services Management Advisory Board should be established by the Ministry of Health in each Republic.

Such an action will communicate the importance of health services management to the success of the reforms and give the efforts of provider organisations credibility. It can also send a message to foreign investors that this area is a priority for continued development and investment.

The purposes of the Board should be:

* to assure that broad advice and expertise are available to the ministry in developing national strategies (or at least identifying national priorities) for foreign and governmental investment in health sector management;
* to advise on standard setting for the various types of management development providers or programmes;
* to involve the key stakeholders in health sector management development who will be critical in effective implementation of any development efforts;
* to assist in the monitoring of any initiatives that are undertaken.

The Board should be small (10-12) members and include leaders of the insurance companies, hospitals and other provider associations, key professional groups, representatives of the higher education sector and outstanding managers and health professionals actively practising in the health sector.

The ministries should take the lead in convening such a group and in deciding the best approach to managing any national efforts - whether through a senior official of the ministry or by designating another organisation (a university, institute or hospital) with appropriate expertise and credibility to manage such efforts.

This recommendation reflects the belief that, in an increasingly pluralistic system, the market will eventually support a number of providers of management development. The role of government is to assure their quality and to assure that initial investments are made in priority areas needed for the most effective development of the health sector.

This Final Report on the PHARE health sector management project and the Summary and Recommendations to each health ministry could provide the basis for the initial agenda for the work of the Board and its consultation with other interested parties, on priorities for action.

Recommendation II. The Ministry of Health (or its designee) with the Board should take the lead in promoting further development of (a) national and (b) regional institutions as leading centres for management and organisation development in the health sector, with the teachers, libraries and educational equipment required to achieve a high reputation with current managers.

Given the significant need for health management training at different levels and the limited supply of relevant training opportunities, the current challenge is to balance the fact of scarce resources for developing the organisational infrastructure needed for high quality management development institutions with the wider philosophy of encouraging pluralism, competition and diversity.

The best strategy would seem to be one that combines support for one (or more -depending on resources) national centre(s) for health sector management development which can over time, develop both an academic and more applied capability and investment in a small number of more modest regional initiatives.

Starting from the survey of existing initiatives in Resource Guide I and the views of interested parties in each Republic, the Boards or their project managers should seek to identify promising initiatives and explore the sponsoring organisation's capacity and commitment in order to identify the most promising focus for further investment.

(a) **The national centres.** The development of national centres of <u>academic excellence</u> in health management disciplines could be based either on:

- an existing health sector training institute, taking account both of strengths and weaknesses in long-established institutions; or

- a higher education institution with a good reputation in business management and the capacity to extend this reputation in the health sector.

From different starting points, both of these options would require initial investment in new programmes (e.g. masters degree programmes with a strong emphasis on the academic disciplines most relevant to health sector management and oriented towards the relevance of this teaching to managerial practice) and the development of teachers for these programmes. The chosen institutions should seek to develop partnerships with institutions and faculty in other countries where there is already significant experience of similar programmes.

(b) The regional centres. The development of regional (or more local centres) possibly with links to the national centres (e.g. as one source of teachers and for advice on course design), would provide a regional focus for management development and aim to considerably extend the volume of appropriate applied management training (e.g. for senior and departmental managers already working in the health sector).

These more modest training centres might be based in existing health facilities or linked educational institutions, and developed with the support of leading health sector managers in the region. For example, leading managers in each of the PHARE project pilot districts have shown a strong interest in establishing such centres in their districts to serve a wider geographical area.

The development of the selected national and regional centres can be promoted through:

* The Ministry with advice from the Board designating these centres as preferred providers (i.e. seeking to ensure their services are in demand) and thereby contributing to their fee income;
* giving priority to their staff members in the opportunities available for training health sector teachers (Recommendation III, below)
* subsidy from the health ministry (and perhaps other management training purchasers) in exchange for attention given to developing programmes to meet national priorities (Recommendation IV, below)
* favoured access to investment from any further foreign assistance, which might appropriately be directed over a 3 year period to ensuring that core faculty, basic equipment, library and teaching materials are available.

At the same time, other public and private management development initiatives can be encouraged to test their value in the 'market' i.e. by whether they attract people

seeking training, although the Ministry, with advice from the Board should consider how adequate quality standards can best be established.

Recommendation III: The Ministry of Health, advised by the Board should seek to promote appropriate investment in high-quality training for selected groups of people in (a) academic disciplines relevant to health sector management; (b) applied management development; and (c) organisational consultancy skills.

By far the most important success factor in the development of these initial centres will be the quality of the faculty and teachers. Provision of high-quality training for those who are or can be faculty and teachers and for other members of what will hopefully become a future network of management consultants with a primary interest in the health sector is a crucial part of infrastructure development. Three complementary but distinct areas needing investment are:

- advanced education for teachers and research workers in disciplines which inform health sector management (e.g. management and organisation theory, human resources, management information systems, health economics, public health);

- further training for current and potential health sector management teachers in course design and management skills teaching methods;

- advanced training for organisational consultants to work in the health sector.

Depending on the amount of available international assistance, strategic decisions will be needed in allocating investment across the three areas to build on existing strengths in each Republic.

(a) **Advanced academic training.** Further encouragement should be given to the most able candidates, drawn from existing managers, teachers and research workers to pursue relevant post-graduate training both in the Czech Republic and Slovakia, and through scholarships to leading universities and business schools elsewhere in Europe. (Resource Guide II provides a guide to suitable programmes in disciplines relevant to health management in the United Kingdom). Some of these people with advanced academic training should form the core of faculty initially in the national 'academic' centres or join existing business and management faculties, developing a

health specialism within what are now purely business oriented teaching programmes. Some may also wish to join the regional/local pilot health sector management development institutions proposed above. A critical mass of such faculty will eventually permit the development of new centres.

(b) **Training for management trainers.** International assistance funds should be sought to extend in-country 'training the trainer' programmes for health sector management teachers. There is a need to re-orient and strengthen existing health sector management training, particularly to deliver basic skills programmes and develop teaching on new topics in the management curriculum (e.g. business planning, quality assurance, more sophisticated financial management techniques, human resource management, etc).

This project might be implemented through identifying one well-regarded existing teacher training or management training institution or a coalition of such institutions with the necessary capacity to manage these programmes. An experienced project manager should be identified to work with suitably equipped foreign partners for these programmes.

The in-country and foreign partners should provide training programmes in the first year combining:

* a series of short courses for actual or potential management teachers, delivered on a modular basis, which demonstrate techniques of appropriate course design and materials development, model an "adult learning/action learning" approach to the teaching of particular topics and skills and support selected teachers in developing their practice;

* involvement in a range of opportunities for newly trained or experienced faculty and international partners to deliver new courses together to health sector managers (see Recommendation IV). Initially the international partners may lead, but the goal would be to phase out the necessity for all outside involvement;

* linking these teachers in an "Association of Health Sector Management Developers" to provide support, mutual aid and develop higher quality teaching practice.

In each Republic , these programmes might aim to recruit ten to fifteen people per year for three years, with diminishing use of international faculty as in-country teaching resources are strengthened.

Recruitment might be on the basis of competition, giving preference to people with suitable qualifications or experience in health sector management, health professionals or individuals already involved in health sector management training.

Opportunities should be sought for the most able teachers in each cohort to participate in international faculty development programmes and/or work as visiting faculty in the best foreign health sector management development institutions.

This kind of in-country capacity is important and differs from that to be developed in the academic centres, because individuals with this more applied training capability are committed to learning in the field, closer to health service providers and financing agencies. Their ability to provide short courses and design on-site programmes especially suited to the needs of these agencies will be of critical value to individuals leading the reforms. The location of some individuals in the initial pilot centres will facilitate local working and new developments based on real management needs.

The applied knowledge and skills they can provide are especially relevant to promoting the radical shift from an administrative to a managerial culture in the health sector which is fundamental to all other aspects of management development.

(c) **Training in organisational consultancy.** International assistance should be sought to develop a mainly in-country 'training for health sector consultants' programme.

Again suitable institutions and project managers should be identified to commission qualified foreign partners to develop a formal "training for consultants" programme combining:

* an intensive induction course and subsequent training on methods of process consultation, health sector organisation theory and management and organisation development skills;

* initial experience working as a partner to a more experienced consultant, followed by more autonomous but supervised practice;

* arrangements for continuing reviews of experience and further skill training;

* participation in a learning network providing support and mutual aid.

Such programmes might aim to recruit and work with a total of about 10 people in each Republic. This work would include supervised practice and follow up, extending over a two year period.

Recruitment should be competitive and seek involvement of individuals with considerable organisational, management or teaching experience who wish to shift into this different career track. It would be reasonable to expect these individuals to eventually charge for their services and develop other consultants to expand the available resource.

Recommendation IV. Through these and other means the Ministry of Health, advised by the Board should seek to ensure the availability of further high quality programmes to meet priority management development needs.

In the light of the framework presented in Section 4.3 and assessments of the strengths and gaps in current in-country management development initiatives, the Ministry of Health, advised by the Board should seek to identify national priorities for further programmes and use its influence to ensure these are addressed. Our analysis suggests three priorities for early attention.

(a) **Masters (or equivalent) degree programmes in health sector management** for people preparing for or already involved in health management careers. In both Republics there are current and proposed initiatives to provide longer term academic programmes, designed to lead to accredited qualifications. These are all at an early stage of development and require further attention to ensure:

* appropriate training of faculty (Recommendation III, above)
* arrangements for assuring quality.
* accessibility to potential students in different parts of the two Republics.
* opportunities for some programmes to be taken on a part-time basis by practising

managers and potential managers.

* funding is available to make these programmes affordable both to students preparing for careers in health sector management and for practising managers.

(b) **Basic health sector skills training programmes**, particularly addressed to practising middle managers in different agencies and professions and supported by Czech/Slovak distance learning materials.

There are a substantial number of people notably in the hospitals (chiefs of departments, directors of economics, directors of nursing) but also the polyclinics and health insurance company offices who need to accept increasing managerial responsibility in the very unfamiliar context of the reforms. Their success in doing so will be very important to the success of more senior managers in leading these organisations in the new health system and to the more junior managers they supervise or professionals they lead in implementing necessary changes on the ground.

There is a related and even larger requirement for some basic management training for professionals establishing themselves in private practice (e.g. as general practitioners).

There are already some initiatives to meet these training needs (e.g. the training programmes for their own staff provided by the general health insurance companies) and the needs of private practitioners are attracting some interest from commercial agencies.

There remains, however, a large requirement for low cost, accessible middle management training. The PHARE project has suggested priority areas for specific training of target groups of middle managers in each of the key sectors of the health service - the insurance companies, districts, hospitals and primary care (detailed in Chapter 2).

The number and types of programmes to be sponsored should be selected to meet critical needs and maintain momentum on training and development over a two year period while the training centres and faculty infrastructure are being developed.

Programmes can be held in the regional training centres, in host hospitals with conference facilities, etc. in a wide enough variety of geographic areas to provide reasonable opportunities for access from most parts of the Republics. Courses would be fairly consistently designed and delivered in the topic areas selected, in effect creating a travelling training capacity.

Some faculty should be those who are in training (Recommendation III noted above), along with local health service managers who can serve as role models for the particular target group of participants being trained, and appropriate foreign experts where possible.

An important resource to these (and other) programmes would be the development of relevant educational materials, some of which could also be used for self-study and distance learning. The lack of suitable materials in Czech and Slovak is currently a major weakness in health sector management education and although material in English and other Western European languages is becoming more accessible, its value is limited both by the language barrier itself and the need for careful selection of material which is really relevant to the challenges being faced. It is also expensive and time consuming to translate and adapt foreign materials to the Czech and Slovak environment.

Both the training of teachers/trainers and the development of short courses should be used therefore to gradually develop a systematic collection of relevant educational materials for wider distribution.

It is suggested that selection of target groups and specifications for the training services be written in consultation with the Health Services Management Advisory Boards. A subgroup could also be used to review and select successful proposals and monitor quality.

(c) **Further development opportunities for the most senior health sector managers which combine high quality short courses and small learning networks.**

Successful implementation of the reforms depends critically on the management skills of the directors of hospitals, polyclinics and insurance company offices as well as district authority health department directors. They face very substantial

challenges and most have little time for training. Nevertheless, many would benefit considerably from high quality management development and continuing support.

Because these individuals are at the executive level, they should be reasonably clear on their needs, but may not have either the financial sponsorship or knowledge of the opportunities available to meet those needs.

It is suggested that a sum of money be set aside for development of hospital directors, district directors and insurance company directors to finance in country and some out of country experiences - short courses in academic institutions, exchange visits with international counterparts or professional conferences.

Individuals in these categories would be advised of the availability of these funds and an application process would be developed. The guidelines for such a programme could be approved by the Health Services Management Advisory Boards and managed by the national centres, one of the pilot centres or another designated by the ministry.

Project management would involve some personal/professional diagnosis of the needs of those senior managers applying; knowledge of available resources to meet those needs; and follow up evaluation of the effectiveness of the experience for future use by others.

The centres and institutions involved in discussion with these managers might also seek to establish small learning networks (i.e. five to eight managers, probably with similar roles) which meet for two to three days at regular intervals spread over twelve to eighteen months. Wherever possible, these learning networks should have their work facilitated by a trainer with consultancy skills, including as soon as practical the professionals participating in the "training for consultancy" programme (Recommendation III (c)).

The provision of these opportunities will be limited by resources but the aim might be to offer everyone in director level appointments the opportunity to participate in some elements of this programme in the next two years.

5. IMPLICATIONS FOR DEVELOPING MANAGEMENT INFORMATION SYSTEMS AND RECOMMENDATIONS FOR NATIONAL ACTION

5.1 MAJOR PROBLEMS IN EXISTING INFORMATION SYSTEMS

5.2 A NEW APPROACH TO HEALTH SECTOR MANAGEMENT INFORMATION SYSTEMS

5.3 RECOMMENDATIONS FOR NATIONAL ACTION

5.1 MAJOR PROBLEMS IN EXISTING INFORMATION SYSTEMS

Introduction

The project team's original proposals argued that the dual foci of the PHARE project on health services management development and information systems development were inextricably intertwined. It is impossible to have good management without good information, but on the other hand, it is impossible to design effective information systems without first clarifying organisational missions, critical success factors and the management processes to be used. In periods of major health systems change, such as the situation in the Czech Republic and Slovakia in the past year, the time needed to establish new approaches to management will, of necessity, limit progress in designing really useful information systems.

While initial work could be done by information specialists to set up computer systems for basic financial tracking or administrative purposes or perhaps even venture into developing clinical information systems, a failure to involve the users - the managers and health professionals in the services - will ultimately make these systems less effective.

Ideally, joint planning between information specialists and managers and clinicians should proceed from the beginning, but the world is rarely this rational and managers, doctors and nurses face competing priorities for their time. Many also do not understand information systems issues. It is thus natural that specialists in information systems will wish to move ahead with developments in their area.

This chapter is written separately in acknowledgement of the facts of information systems development in complex environments, but it ends with recommending ways forward for improving management information systems which increasingly seek to integrate management development and information systems development at all levels from the health ministry to the individual general practitioner's office.

The data on which we base our observations about the current reality in use of information systems in the Czech Republic and Slovakia and these recommendations for action are drawn from extensive field work in three pilot districts, two Republic level workshops bringing together managers and information

specialists from [illegible] and national level, consultation with information specialists in the two ministries, and discussion with leading managers and specialists involved in two one-week visits to Barcelona to study health sector information systems (organised by the Instituto de Estudios Superiores de la Empresa). (These seminars and study visits are described further in Educational Programme Report 2).

A diagnosis of problems to be addressed

Arising from these observations, we have identified seven major problems affecting the development of the management information systems required for the success of health sector reforms in the two Republics.

(i) Effect of environmental changes

The changes in the relationships between the ministries, the insurance companies and the providers have meant that the insurance companies are less and less dependent on the ministries of health. Therefore there is a danger that management information systems will be developed differently by each agency. The fact that the ministries have not been fully involved in the recent changes in the insurance company information systems is a clear example of this problem.

More generally, rapid political changes are having a great impact inside health sector organisations, generating uncertainty and sometimes antagonism which makes it difficult for managers and information systems specialists to agree a common agenda.

(ii) Confusion between health system design, management and information system problems

Problems in the overall design of the health system have created conflicts for management which add to the usual managerial problems that institutions meet in coping with change. The lack of clear understanding about which problems are due to defective design and which due to poor management creates a sense of frustration, thus blocking possible solutions. Too frequently, it is considered that the availability of computer equipment (confused with information management) will solve problems that are not, in fact, information system issues but design, management, and operational ones. A particular instance of this problem is the

search for computerised turnkey systems with the hope that they will deal with the flaws in health system design and management.

It is very tempting in a project like this to try to overcome management difficulties with equipment. The introduction of new equipment would have made the project more visible at the first stage, but in our opinion would not have been very valuable.

Consider a very simple example:

At present most hospitals manage their own inventories of drugs in a decentralised way. Each department keeps its own inventory and when the inventory levels are low, a new order is issued from the department to the local pharmacy store. These requisitions are, at present, the most accurate data source about drug usage by department. No information exists on the investment in drugs for the whole hospital at a given point in time.

A straight "informatisation" of this process would call for the installation of a computer in each department/ward that could do the same task, but in a faster and probably, more accurate way. However, the trend in most Western hospitals is towards increasing the centralisation of the pharmacy function in the hospital, with most of the drug deliveries being made daily from the central pharmacy to the patient room (through the nurses) in amounts required by the doctor for the patient on that particular day.

This ensures a patient-based tracking of drugs used, better control of the medication by the clinical pharmacist who can check for incompatibilities, and, usually, large reductions both in inventories of drugs in the hospital and in the purchasing costs (since hospitals can deal directly with pharmaceutical companies, thus saving on intermediary costs and at the same time negotiate bulk prices).

Admission procedures in hospitals reflect a similar situation. At present, patients are admitted and discharged by department. In Western hospitals it is usual for admissions and discharges to be centralised. Again, this change in procedures will never be the result of an "informatisation" of the present system, but rather must be made by management.

The introduction of computers must be the result of an information system design that is developed in parallel with management changes in the operational procedures (and administrative circuits) of the units.

(iii) **Skills to run the basic transactional modules (financial accounting, inventory, resource utilisation, patients flows and files...) are weak or non-existent.**

Until very recently, individual provider units have not had a clear and independent identity. Therefore the need for strong economic, administrative and managerial capacities in units was not felt under the old system. Timely completion of the required forms and reporting of requested data to the centre was sufficient.

Additionally, people have not in the past been able to choose their provider. Consequently, provider institutions have not had any incentive to improve services to attract patients.

Furthermore, under the old system, additional resources were allocated often according to the providers' ability to manipulate the system, rather than local needs. The new system will hopefully reward those who deliver a better service in a more cost-effective way. This takes good management, service orientation and leadership.

Now, most providers (hospitals and general practitioners subject to privatisation) realise the need to improve their skills in these areas. Unfortunately, the former structure has not developed managers with these skills within the health system. They will have to be imported or developed internally. Both approaches face several problems:

* Internal development requires time that was not allowed for in the schedule of reforms.
* Importing managers from other "non health" sectors would require salary levels above those paid in the health sector and, also, would require competing for a scarce resource in the nation's labour market.
* Importing managers from other industries may put the focus of management on economic issues, thus giving clinical healthcare issues lower priority.

(iv) **Changing definitions of the roles of different parties**

There has been a changed focus for the role of the ministries of health: from providing health care to a policy making, planning and control role. The provision of health care is being progressively decentralised and privatised. The financing of the system is being delegated to (eventually several) insurance companies.

Concern for the improvement of health status, access and proper care are central policies in the two Republics. This concern is translated into legislation, stating that a safe environment and the reduction of illness are matters of public concern. Therefore, the achievement of these goals is not left to the free choice of individuals. Quite the opposite, public policy aims to ensure that all citizens are protected from health loss and from economic damage resulting from poor health. Such protection is to be made available through legal, structural and operational arrangements that are equitable, technically correct, financially sound and cost-effective.

These policies do not necessarily require a centralised and unified system, as experience in most Western societies show.

Planning, organisational and financial schemes exist where multiple private and public agents are assigned specific tasks. The design of such pluralistic systems is, however, difficult and challenging. Incentives and control mechanisms have to be carefully installed and counter-balanced. Health systems, where market forces can be expected to influence the allocation of resources and stimulate demand, require a very specific managerial approach.

In future, it is likely that the ministry of health's role will concentrate on the following:

* Leadership in health policy, including public health and health services planning;
* Legislation: market rules and control;
* Equity and solidarity assurance;
* Health education: population and professionals;
* International relations.

Obviously these major strategic activities will have to be supported by well designed and properly run information systems.

Similarly, to implement the new financing arrangements, the insurance companies need strong and accurate information in several areas:

* The population has to be identified not only by demographic criteria, but in relation to its financial contribution to a social security scheme.
* Companies and other contributors need to be identified and monitored to ensure correct and punctual payments.
* The combined effect of a market orientation, of privatisation, and devolution will generate a tremendous volume of information built on the units of payment and on the flow of funds from the insurance companies to the providers.

(v) Persistence of attitudes from the former system

Previous managerial practices have continued, leading to the reliance on compulsory regulations as a way of defining what needs to be done and how.

There have been some unrealistic expectations of power relationships in the new situation which reflect a lack of understanding about working in a democratic environment, where negotiation is required to accommodate the interests of different parties.

(vi) Information accumulation versus effective and efficient information systems

There has been a multiplication of data collection requirements by different institutions (Health Insurance Company, UZIS, etc.) in addition to the information required for normal operational management. Data should be collected as close as possible to where the original data is generated. It is best if individual general practitioners and hospitals can do it along with their normal activities. They may need some motivation to collect this information, but, even so, this is better than creating a separate parallel organisation to collect it.

There has been a tendency to give priority to collecting and transmitting data at a set date as opposed to an emphasis on its usefulness and accuracy. Individuals at different levels of the organisation prefer to submit the required data on the specified date, even if such data has to be "estimated".

To be useful, the data must be accurate, or at least the managers should know the degree of accuracy. We did not find ways of guaranteeing accuracy in the existing system. It seems likely that individual doctors or hospitals provided "top of the head" estimates rather than the real figures. Obviously, statistics based on unreliable data are misleading and of little use.

Most data producers or transmitters, when asked how the information would be used were not able to provide a clear answer. Under these circumstances, individuals are not motivated to collect accurate and useful data. In some instances, this is made worse by defective operating procedures. This is the case, for instance, in the current practice of hospital departments to delay the communication of information about discharges for some days. This practice generates wrong statistics but fits with the previous tendency to reward high bed occupancy.

There is also an absence of a clear client orientation in the institutions handling health data. In a market oriented society, usefulness can be measured by the willingness of customers to pay an appropriate price for the service. It is our impression that the institutions handling data processing and statistics have not yet identified a set of "customers" interested in the services they provide. If those customers exist, they may not value the service enough to justify the high costs of collecting, processing and distributing this information.

In past times - due to full-employment policies - it may be true that collecting and processing data was cost free. This is not so now, especially if the time required by the doctors/hospital administration to fill in the forms is included in the cost. Some state health institutions lack market orientation, and further enlarging their human and technical resources will not solve this problem.

Information is transmitted mainly in one direction, without any useful feed-back to the providers of data. Since the data provided is not fed-back to those who produced them in a useful form, there is a tendency to "tease" the system by not providing all the data, or by providing "funny" data to see if the existing control system is able to catch the "errors".

(vii) **There is no well defined body of knowledge in the health management area.**

External sources (i.e. association of health economists, medical chamber section on health policy) are not yet established for developing, sharing and disseminating knowledge of effective management practice.

The rapid increase of unco-ordinated and duplicated initiatives in management information systems produces the risk that future legislation or centrally developed standards will conflict with applications already developed.

5.2 A NEW APPROACH TO HEALTH SECTOR MANAGEMENT INFORMATION SYSTEMS

Criteria for health management information systems design.

In the design of a health management information system (HMIS) strategy, the needs and utilities of the different "clients" of the system should be considered. The utility that every client will perceive from such a system will be based on a subjective ratio between what benefits the systems provides to him/her and the costs of its utilisation.

We will briefly explore these utility functions for the main clients of the HMIS.

(i) **Patients, their families and the general population**

The patients (and the general population as an aggregate of patients) will perceive the outcomes of the care provided, and will evaluate also the process by which the health service is delivered. They will compare the results with the costs, which include the payments made directly for health services (deductions from salaries to pay for the compulsory insurance) or indirectly through taxes, and the costs incurred (in a general sense) in getting the service. These might include the repetition of investigative procedures, the length of stays in hospital, etc.

In mathematical terms, the utility function for patients is the following:

$$\text{Value} = \frac{\text{Outcomes + Delivery process}}{\text{Price paid (directly and indirectly)} + \text{Other related costs}}$$

A good HMIS should aim to increase the perception of value by the patients, by assuring, among others, the following objectives:

* A single identification of patients throughout the system, in the delivery of health care in all settings (hospitals, general practicioners, etc.) and in the payment of the insurance premiums, etc. This can be easily accomplished in the Czech Republic and Slovakia since the use of the birth number is common for all purposes. It would be a pity if some information systems are developed which do not include this unique identification.

Information should be patient-based at its lowest possible level. Aggregation based on pathologies, geographical considerations, etc. should be built on the individual patient based data.

* A single (or at least a shared) record of patient history. Personal health information must flow between hospitals, general practitioners and insurance companies, subject to security and confidentiality safeguards. This will allow an authorised doctor to review the history of the patient and avoid duplicating investigative procedures.

* Enabling the priorities for health programmes established by the ministry or the insurance companies to be based on the needs of the population as suggested by the aggregate records.

* Make information on waiting lists and quality of care available to the policy makers so that more equitable resource allocations can be achieved.

(ii) Professional staff

The value function takes the form of compensation and other related benefits divided by the effort the professional puts in. In mathematical terms:

$$\text{Value} = \frac{\text{Economical compensation} + \text{Other benefits}}{\text{Effort} + \text{Time spent}}$$

Obviously, there is a lot to be done in demonstrating the uses of HMIS to help medical professionals improve their perception of value. A list of some of the objectives of the HMIS for medical professionals includes:

* Highlighting the work done in diagnosis and care by making the information for each patient-doctor encounter available on patient records.

* Providing data on the status of the population in the area of interest (including structure, health needs, morbidity profile, etc) and on the available resources, thus enabling better targeting of funds.

* Providing information on the results (clinical and financial) of the services he/she provides compared against those of similar professionals/departments in the same area, or nationwide, to help the professional focus the available resources in an efficient way.

* Providing data (subject to confidentiality) to allow their use in medical research.

* The information demanded by the system, and provided by the health professionals, should be derived from operational systems as far as possible. Professional time should be devoted to care, not compiling statistics. Therefore, the data should be obtained from the systems that the professionals use in their day-to-day work.

(iii) Managers and administrators

The utility function here is related both to the results obtained for the population compared to the investment (and expenditure) made, and also to the equity of the overall health system.

The HMIS should have the following objectives when viewed from the managers point of view:

* Improving the availability of the information which is needed to understand health needs which are to be met through contracting.

* Reducing overhead costs in information collection and increasing its reliability and timeliness.

* Allowing the tracking of health indicators to monitor, review and redistribute resources to improve the performance of the system and its quality.

* Allowing comparisons between service providers to identify the most efficient ones. The practices of the best providers should be rewarded and copied to other sites.

In the past the collection and processing of information from the providers by the ministries of health did not meet the needs of the other stakeholders. They did not perceive any added value in the provision of the information required by the ministry's institutions. The central information system was not seen as a useful resource by the providers of data, who were thus not motivated to supply accurate, timely and useful data. This was probably because of: (1) lack of feedback to the providers, (2) lack of focus on the information that can be of help to providers in times of cost control and now privatisation, and (3) a feeling of data being used exclusively for control by a superior body.

Elements in future management information systems: Examples

(i) Health services providers

In earlier project reports, a strong emphasis was placed on the need for management information systems (MIS) development by health services providers.

Important aspects of health sector reform which require MIS development include:

* Large numbers of providers will become independent/private.
* The number of patients attracted will be the combined result of competition and planning.
* Provider income will not be determined by centralized budget allocations but will be the result of their activity priced at pre-determined rates. These rates will either be negotiated or imposed by the funders.
* Financial viability will be the combined result of revenue generated by increased activity and cost efficiency.
* An increased emphasis will have to be put on the control of costs.
* Administrative procedures will have to be improved in order to ensure activities are invoiced.
* Hospital departments will have to develop clear targets for activity and expenditure.
* Hospital managers will need good data regarding activity levels, productivity, costs, case mix and efficiency of individual providers, departments and units.

During the project, we have stressed that MIS development must be based on a clear understanding of the organisation's mission and critical success factors. This is applicable at the institution, department and individual levels. The previous

points summarise the critical success factors relevant to providers. That is to say, the stated activities are those that will have to be performed well in order to survive in the new health care system.

As an example of the type of structure that an MIS for a hospital can take, we provide here a brief description of the main modules:

(a) **Patient identification and invoicing applications**

* Admissions, occupancy, and discharges. Systems should be oriented toward the identification of the patient, as well as the recording of basic data (e.g. length of stay) necessary for invoicing procedures.

* Outpatient appointments and visit control. Systems should be oriented toward the planning of outpatient visits and recording of activities performed.

* Invoicing. Systems that use the information generated by the above systems should generate automatically the required invoices to third party payers.

(b) **Financial applications**

* Financial accounting. Through the input of income and expenditure related data these applications produce the standard financial statements required by law (balance sheet and income statement). At the start of development, the entries to this system are performed manually. As the system becomes more complex it is feasible to connect this application to those that generate the basic transactions (purchasing, permanent inventory, accounts receivable, etc)

* Supply related applications (purchasing of materials, drugs, fixed assets, etc.) These applications support the activities of the organisational units responsible for the acquisition, maintenance, and internal distribution of these items.They may include databases of providers, updates on prices, records of requests issued, permanent inventory, accounts receivable, and the internal destination of supplies by departments.

* Staff related applications. These applications are aimed at providing information about the structure, changes, and allocation of human resources. They start with the creation of a personnel database, incorporating periodic or discretionary incidents (sick pay, sanctions, rewards, etc), and eventually the monthly payroll. Supplementary outputs may include levels of expenditure on personnel by department.

(c) Other operational support systems

The main objectives of these systems are to support, speed up, and make more efficient the day-to-day operational tasks of each department and also improve communications between them when needed.

* Laboratory. Systems to support and facilitate patient appointments, physician orders, scheduling of samples, workload distribution within laboratories,result grouping, printing and distribution, and associated statistics regarding demand profile, consumption, etc. by physician or by main diagnostic categories.

* Radiology. These are the same as for laboratory.

* Pharmacy. These are the same as described in the supply support systems. Eventually these systems can also support the introduction of more advanced distribution procedures (unidose).

* Medical records. Linked with the admissions and outpatient systems, they support the sequential numbering of medical records, their storage, and retrieval.

* Maintenance. These include the register of legally required and/or periodically scheduled maintenance operations, register of suppliers and provide legal proof of tasks performed.

* Dietetics and food services. Specification of medically required diets and support for the operation of the kitchen.

* Nurse scheduling, blood bank operations, emergency room operations, operating theatre scheduling, etc.

(d) **Operational integration**

The applications described so far now can be complemented by a communications network which enables physicians and nurses to interact with the departmental applications by filing their requests through this network.

Additionally, physicians and nurses can retrieve information from the system (e.g. laboratory results, patient status, etc.) by electronic means.

(e) **Information integration applications**

* Economic management control. This system can be developed as soon as finance and operational support systems have been installed. The main objective is to provide a comparison of budgets and expenditure based on actual performance.

* Medical information. Through the availability of computerized and coded discharge summary information, the hospital management and the medical staff can extend this information for planning and research.

It is very important to realise that planning and financing authorities can benefit particularly from these two last applications, since they provide the basis for comparison of performance, efficiency, quality of care, case mix severity, etc. This type of information is much more relevant to their missions than the mere statistical collection of raw activity data.

(ii) **Insurers**

Throughout our consultancy and teaching in both Republics, we have stressed that the new financial flows give insurance companies a central and critical role in the improvement of information systems with particular reference to beneficiaries identification and the financing of health services providers.

(a) **Beneficiaries identification**

Many health systems, either public or private, use the initial contact with patient to incorporate into the data bases relevant personal as well as health related information.

From an organisational point of view a complete identification of customers, their families and their demographic data facilitates the planning of health care. Demographic trends can be identified and used to plan the future expansion or reduction of facilities. Additionally, it may be possible to base provider payment systems on capitation data.

In future stages of development, adequate physical supports, (identity cards with magnetic or electronic storage systems) can speed up administrative contacts between patients and the system, provided that adequate reading points are available in clinical and administrative facilities. Experience elsewhere can serve as models for the introduction of this type of arrangement. (Members of the study groups which visited Barcelona in March 1993 were able to examine an ambitious project of this type).

From a health policy point of view, the gathering of selected health status and life-style data can be extremely helpful in designing health programmes, by identifying social, geographical, occupational and other sorts of population segments with specific diseases and risk factors.

In many countries, insurance companies have collected only limited information from their beneficiaries, for example, by collecting only information relevant to premiums. Where this happens, the opportunity for avoiding duplication of data bases is lost, forcing other authorities to invest time and resources in collecting their own information.

The information collected from the administrative procedures by which citizens are included in the insurance company register of beneficiaries can be used to provide information to public health authorities. For example, the register of beneficiaries at district level can be used by district health department officers to monitor vaccination coverage, screen workers in risky occupations, identify women for breast cancer screening, stimulate

blood donations, and, in general, define target groups for preventive intervention. Issues of confidentiality and reserved access must be considered at the time of establishing these systems.

(b) Financing health services providers

We cannot emphasise strongly enough the scale of the changes required by the new financing arrangements. As far as information systems are concerned, the new financing arrangements are the most important agent of change.

* Former vertical information flows, collected for national statistics, will look modest in relation to the quantity of information that payment systems will generate.

* Health care providers will be forced to generate information that supports their invoicing procedures.

* Insurance companies will be able to design contractual agreements with providers where specific information can be requested.

* Planning authorities at the ministry level can fulfil their information needs better by incorporating specific requirements in these contractual agreements.

Close collaboration between health ministries and insurance companies is needed and strongly recommended. Otherwise, duplication of resources and of information flows will occur, institutional relationships may deteriorate and common objectives may not be recognised.

* Insurance companies can also use their contractual strength as purchasers to force providers to change the way they process information internally. Since insurance companies will be paying large sums of money based on the invoices sent by providers, they can demand that particular information is provided with the invoices.

Thus ministry and insurance companies can force hospitals and other providers to formulate and execute plans regarding their administrative, financial and health care related activities.

It is strongly advised that contractual agreements and payment methods seek to:

* provide the right incentives to providers
* do not stimulate unnecessary treatment or care
* do not stimulate the overuse of technology where this is not required
* are easy and cheap to administer
* prevent fraud

Examples of Good Practice

Our work has shown the considerable potential for integrating new ideas into day-to-day practice. Managers, in general, have not had the chance to support their work with information tailored to their needs. However, when exposed to new ideas or to specific solutions, they immediately try to implement these.

Professionals in electronic data processing departments are knowledgeable about technical issues. However, a greater awareness of the need to work on the "service to the internal customer" should be fostered. The only concern is that newly created private companies are able to attract staff away from the health care system by offering higher salaries than those available in the health sector.

Two examples of interesting initiatives follow:

(a) The cost centre project in Slovakia

The "cost centre project", developed by the institute for creating the health insurance company in Slovakia is an example of a good initiative with which we worked.

This project was designed to provide a rational quantitative base for resource allocation and rate setting through the generation of hospital cost data in a unified reporting system.

Several important policies were reflected in the project objectives. The most important one, in our opinion, was that the project could be interpreted as a message from central authorities, that:

* the financing authorities were putting an effort into basing their decisions on real data and to comparing hospitals' levels of efficiency .

* hospital managers were going to have to focus their efforts on attaining acceptable comparative cost levels at the departmental level.

At the time of their introduction, these two ideas were relatively new and congruent with the plan to move towards a new system for financing the health care system.

Hospital managers, at least those able to interpret the message, realised that their future income was going to be based on the information they could provide. Therefore, it was in their best interest to co-operate fully in the project and use it as a first step towards establishing an internal cost control system.

Other managers simply took the project as another central initiative, where hospital participation was required only for the time the study was being conducted. They made no effort to take advantage of the first step and make management control permanent.

As we have said during the PHARE project, quality and truthfulness of data is a vital issue. This is still the case. The cost centre project provided a good opportunity to spot problems in the whole network and in particular hospitals. Thus, a path was set in order to establish priorities for the whole system of management control and information systems improvement.

The cost centre project deserves recognition in terms of its objectives. In terms of execution, central authorities and the technical team responsible probably relied too much on providers readiness to co-operate on the assumption that the project had been ordered and that everybody was going to obey. The project was probably not "sold" well enough, but imposed as

a new obligation. The central team was skeptical about the technical competence of most of the hospital managers. This should have resulted in some preliminary training and the participation of hospitals representatives in some sort of project steering committee.

The cost centre project could have served many purposes. One of these was design of a reimbursement system which was tested during the first quarter of 1993 and had some very positive elements. This system had the advantages at a time of serious financial constraints, of not simply fixing rates but also incorporating volume controls.

Its merits should certainly be compared with the alternative points system which has the disadvantages of:

* requiring a lot of record keeping from doctors
* providing incentives for unnecessary care and being difficult to audit

(b) Local information system development in the Czech Republic

In the Czech Republic, the project team was able to follow the development of information systems in some of the institutions in the pilot districts.

The insurance company branch in the northern pilot district was equipped with an HP computer and some software being developed for them by a company in Praha.

When the project started, the concern was the establishment of a reliable way of transmitting claims from the different providers to the insurance company. Some of the big hospitals in the area were already transferring the data via diskette, but most of the small providers (including the pharmacies) presented claims on paper.

Once the basic transmission problems were solved, the insurance company branch started concentrating on the analysis of the data provided, compiling statistics, for instance, on drug prescribing by doctor and specialty in the local polyclinics. These statistics proved very helpful in detecting outlyers in provider performance, both for the insurance company itself and for the

managers of the provider institutions, who had never before had a tool to help them manage better.

The availability of information allowed a change in focus. At the start, the focus was to "get the papers processed", but later it became to "find out what improvements can be achieved". The jobs assigned to the staff changed to more analytical and less transaction-related tasks. An increase in drug prescriptions could be noted and several common "abuses" of the system immediately spotted. It is estimated that 20-25% reduction in drug consumption could be achieved by proper controls on prescription patterns.

The insurance company branch can move to build on these basic systems. For example, once they have the administrative system for processing the prescriptions that were brought twice a month from the city pharmacies, they can change the prescription form to include not only the name of the patient but also his/her birth number and a code for the main diagnosis. This will allow further analysis of consumption by patients and by diagnosis.

Similarly, the main hospital in this pilot district had already started its own internal MIS project. With the help of a computer specialist, the chief administrator and director of the hospital launched a departmental level profit centre project. Each department was charged its related expenses (salaries, drugs, etc) and was credited the income equivalent to the points claimed to the insurance company.

This system proved to be very efficient in motivating the heads of departments to monitor accurately the procedures performed on patients. When the first results were available some departments were shown to be money-losers, and their chiefs were asked to explain the reasons. This motivated them to keep better accounts since a money losing department was in a weak position when applying for new equipment or new personnel.

Drug distribution in the same hospital is another example of the changes brought by use of information. When the PHARE project started the hospital only had information on the purchases of drugs by the different departments, but not on the actual consumption nor on the inventories

available at each ward. During the project a centralised hospital pharmacy system was implemented. This allowed closer control on consumption and a release of funds from drug inventories.

5.3 RECOMMENDATIONS FOR NATIONAL ACTION

This analysis of the problems in existing information systems and the evidence of initiatives among managers and information specialists suggests a wide range of possibilities for developing better management information systems including:

* Training managers in basic managerial skills (see Chapter 4)
* Development of models of management/operations in key areas
* Creation of standards of good practice in administration
* Pilot site based integrative HMIS development with participation of all stakeholders (insurance company, providers, local authorities, hygiene stations, etc.)
* Pilot projects for patient/insured identification magnetic card
* Development of an association of health information professionals.

If these initiatives are to lead in time to a co-ordinated national strategy for health management information systems in each Republic, we make three main recommendations:

Recommendation I. Creation or strengthening of an advisory body attached to each health ministry and composed of managers and information systems technicians.

The members of these advisory bodies should be recruited from different levels and institutions within the health system and also from outside the sector, both inside the country and abroad.

These advisory bodies would serve as **consensus development forums** in each Republic. Among their responsibilities it is proposed that they promote innovation through:

* ensuring dissemination of both national and international literature
* organising forums to debate the main health information systems issues
* fostering the creation of an association of professionals interested in health information systems
* serving as the starting point for the development of a White Paper on health

information systems at the Republic level

* acting as Steering Committees for facilitating priority pilot projects.

Recommendation II. Pilot HMIS development projects should be established at different levels (national and local) and in different parts (insurance companies, hospitals, general practices) of the health system designed to demonstrate best practice and promote common solutions.

These projects should each aim to:

* Identify needs for HMIS in the different areas and the possible benefits to be achieved.

* Obtain valuable information with which to establish a thesaurus, minimum data sets and conventions for data recording, coding, transmittal, etc. to be used nationwide.

* Focus on common approaches and solutions to HMIS implementation, avoiding duplication and thus reducing the effort of every provider.

* Offer 'demonstration models' from which others in the system can learn.

The following pilot projects should be considered:

(a) General practices. During the last year, the PHARE project team has come across several initiatives by general practitioners and paediatricians who have developed their own management information systems. These should be analysed and discussed with other general practitioners and software developers to agree a set of minimum standards. These standards will ensure that general practitioner applications collect all the necessary data on their operational tasks and that these data can be easily transmitted to other HMIS (e.g. the insurance companies, UZIS, etc.).

(b) Hospitals. Similarly, each hospital visited during the PHARE project had developed some sort of information system to meet its own internal management requirements as well as the communication needs of the insurance companies. The requirements for data at other institutions, such as UZIS, had

generally not been taken into consideration. The HMIS pilot projects should consider the needs of large teaching hospitals as well as those of small county or town hospitals, with emphasis on guidance and support to improve patient care and to reduce the administrative burden of providing information required by the other higher organisations (insurance companies, UZIS, etc.).

The project will establish the communication standards and the set of minimal data to be transmitted for each different occasion of hospital stay.

(c) Insurance Companies. The insurance company district offices should be the focus of the third pilot project. A model HMIS should be developed to investigate several relationships:

- the relationship of the insurance companies (as purchaser of services) with the providers (general practitioners, hospitals, pharmacies, etc.);
- the relationship of the branch insurance companies with the central insurance company;
- the relationship of the branch insurance companies with the payers (enterprises and employees).

Again, a model system should be developed and a set of communication standards and minimal data sets will be established.

(d) Public health information system. This pilot project should aim at making health information about the population of the district available to the health related agencies in the district (and at the national level) in an aggregate way. The objective of the project is to define the data required by each of the health agencies (providers, local authorities, ministry, etc.) to pursue their missions and establish the procedures to provide them in a reliable, timely and efficient way.

Recommendation III. Development of a national information network

A system of population data bases (maintained at the district level) needs to be introduced. The records should contain a minimum (but updated) set of data to each person in the system: birth number, name, address, sex, employer number, and the selected general practitioner.

These data bases must be shared between districts to reduce the duplication of records and the correct linking and billing of health events.

The introduction of the network will be preceded by a compilation and coding of a data dictionary and thesaurus of clinical terms and groupings. This will enable data on, for example, symptoms and diagnosis, to be transferred and understood by any computer in the system and will facilitate research on practices to improve efficiency and quality in delivery.

Obviously, a framework for security and confidentiality must be incorporated into the development of this network.

A set of quality standards for HMIS, for example, in line with the ISO 9000 guidelines could also be developed across the national health system.

6. MANAGING FOR BETTER POPULATION HEALTH

6.1 MANAGEMENT FOR HEALTH GAIN

6.2 COLLABORATION TO IMPROVE HEALTH

6.3 IMPLICATIONS FOR NATIONAL AND LOCAL ACTION

6.4 ADDENDUM: AN ILLUSTRATIVE PATHWAY TO HEALTH

6.1 MANAGEMENT FOR BETTER HEALTH

Introduction

The main thrust of the PHARE project has been to improve the quality of management and information systems related to health care. This must, however, include attention to how health service managers contribute to improving population health. This chapter draws lessons about strengthening management commitment to improve population health from across the work in the two Republics and makes recommendations for national and local action, and for relevant management training.

Health services managers must consider the health needs of the population they serve and assure the effectiveness of the treatments they offer so as to maximise the health improvement achieved by their investment. At the same time they must recognise that they are important as advocates for population health and will often have opportunities for leadership in the development of health improvement strategies involving other agencies at the local and Republic levels.

The Czech Republic and Slovakia face serious problems concerning the health of their populations. Life expectancy has been falling over the last ten to fifteen years, due largely to the high levels of coronary heart disease, strokes and cancers. Although these diseases are common in other developed countries, elsewhere prevention and treatment programmes have reduced their impact on morbidity and mortality. Tackling these population health problems should be considered a high priority and could have an important bearing on other serious issues facing Governments and local managers.

These diseases and premature deaths result in:

at national level
- direct costs of health care.
- direct costs of sickness benefits, pensions and support payments
- loss of trained and experienced workers.

at local level
- demand for acute health care services
- demand for rehabilitation services
- demand for social care.
- loss of trained and experienced workers.

Improvements in health will result in economic and social benefits as well as the obvious humanitarian ones.

The contribution of health sector management

Health service managers are at present preoccupied with the implementation of the reforms and the pressing financial problems facing their services and institutions. Many of the managers who have been involved with this project at both local and national levels have, however, seen the importance of their strategic role. It is accepted that the aims of health services are:

* to prevent the development of disease whenever possible
* to diagnose and treat existing disease as effectively and efficiently as possible
* to reduce the impact of disease and disability by comprehensive rehabilitation services
* to provide support and comfort to people with incurable illnesses.

These goals have to be achieved within the constraints of limited financial and human resources. The manager therefore has the duty to assess the whole range of services which might be provided, and if necessary select those which will give the best health return ("health gain") for the "health kroner."

The insurance companies are at present also, understandably, preoccupied with the establishment of their new functions and administrative systems. They too, however, will have to begin considering their strategic role as "purchasers" of health care. Their financial resources will not be sufficient to meet all the demands made on them. Their selection of the services which they will fund should be determined by their assessment of the effectiveness of the services concerned in achieving the health improvements set out above.

Health care interventions can be categorised, simplistically, according to

- the Importance of the condition involved
- the Cost of the intervention
- the Effectiveness of the intervention.

In constrained systems, it is reasonable that only "important" conditions should be treated - those which are serious, life-threatening, incapacitating or with high prevalence. The interventions available can then be assessed according to cost and effectiveness. In most cases, the information available is inadequate, so the best that can be done is to designate them as "high" or "low".

Figure 9

Effectiveness

Cost	High	Low
High	√	X
Low	√ √	?

The good manager, who seeks to achieve maximum health gain will ensure that all the "low cost, high effectiveness" services are available and supported. In the Czech Republic and Slovakia, there is an excellent record in these services, such as immunisation and ante-natal care, and it is essential that they are safeguarded.

The "high cost, high effectiveness" services also represent good economic investment. Examples of this category are hip replacement, properly selected coronary artery surgery and oncological treatment of some leukaemias.

The most difficult managerial challenge is to prevent expenditure on "high cost, low effectiveness" services, which use significant resources without improving the duration or quality of life of the recipients. These include much radiotherapy and oncology treatment for lung cancer, some drug treatments and heart surgery where proper selection criteria have not been applied. There is often a good deal of pressure to expand these services, with emotive arguments put forward in support. Managers should ensure that they obtain expert, independent advice on the scientific evidence about such services before deciding on their future development or on major new expenditure. To be successful in this area, insurance companies and hospital directors will have to work together to ensure that ill-informed market pressures or pressure by certain medical specialists do not result in the waste of significant sums of money.

6.2 COLLABORATION TO IMPROVE HEALTH

Health improvements in the population are not achieved by health care alone. Health status is also affected by:

- health promotion programmes
- social services
- environmental attention:
  - physical - air, water pollution
  - economic - poverty, employment
  - social - education, housing

Health care managers are clearly not in a position to affect all these matters but they can be more effective if there is a general context for co-operation on improving population health.

Diagnosis of current challenges

(i) **Responsibilities**. At the moment the responsibilities for the health status of the population and its improvement are not always clear. At government level, the ministries of health have a lead responsibility and have access, through their information services, to the demographic data which enable them to monitor progress. At the present time, they face two main problems in tackling this part of their work;

- Many of the determinants of the health of the population (education, environment, income, housing) are not the responsibility of the ministry of health and there is not effective inter-ministerial collaboration for the development of population health strategies.

- The top political and policy priority of the ministers of health is, understandably, the restructuring of health services and the introduction of the new organisational and financial arrangements.

At the local level, there is little clarity about responsibility for co-ordinating efforts to improve population health. It is shared between civic heads (mayors), district

health departmental directors, hygiene stations and health services (hospitals and primary care). Each of these has a vital role to play, but their efforts need co-ordination and the recognition of a common framework for action which will encourage synergy rather than duplication and will produce the best possible health outcomes from the available resources.

(ii) **Structures.** The existing organisation of health services and their relation to hygiene and epidemiology services have emerged historically. In the latter, high levels of work and commitment of staff have been achieved in most places we have visited. It is essential that good services are maintained, especially in the fields of disease prevention (immunisation, screening services). The structures do not, however, always lend themselves to a more holistic approach to population health.

At present the relationships and levels of communication between staff responsible for the planning, management and delivery of health care, health promotion, social support and environmental services are inadequate. Management and committee structures do not bring together all the people who can contribute to policy making at the Republic level or to the solution of operational and strategic problems at the local level.

(iii) **Education and Training**

Professionals - Education in public and population health does not form a large part of the basic training of health professionals. In addition, the institutes of public health are not integrated into the university and medical education systems, which reinforces the separation of population health and patient care interests. There are few opportunities for multi-disciplinary education and training for health professionals or for multi-sectoral training involving people from the different departments and agencies which influence population health and well-being.

The Public - The citizens of the former CSFR lived for many years in a system which did not encourage participation in the planning and development of public services nor in exercising choice in the use of such services The development of health care management systems which take account of user views and encourage public participation (a key aspect of the WHO 'Health for All' strategy) will

therefore require considerable public education and empowerment. This will need constant support and reinforcement from health professionals and managers (most of whom are equally unprepared for public involvement). This is likely to be a slow process during which citizens will acquire knowledge (about health, the factors which influence health and the systems of provision of health and related services), they will acquire skills (in assessing information and negotiating with service providers and planners) and they will develop new attitudes (of self-confidence and recognition of consumer rights).

Education along these lines, in 'good citizenship', is vital if the population is to take part in the development of pluralistic systems, which require effective consumers if they are to be successful. Managers will have to support and encourage such developments and to learn to cope constructively with them. For example, they should provide the opportunity for public involvement in local purchasing decisions by the insurance company and involve patients in the assessment of services provided by hospitals and clinics.

Local Examples

Population health improvements require the adoption of compatible health policies at national and local levels which are "owned" by key participants. This is a long term objective. However, the WHO 'Health for All' strategy has already been adopted in principle at national level in both Republics and its main tenets are supported implicitly at local level.

International experience shows that this is an enhancing strategy - it can build on existing work and does not diminish previous efforts.

In order to assist the pilot districts to develop health strategies within this framework two multi-sectoral workshops were arranged (October 1992, Slovakia; December 1992, Czech Republic) by the project team.

These workshops brought together colleagues from district authorities, hygiene stations, hospital and primary care services, employers and teachers. As a result, some multi-agency projects have been established and others are being discussed,

suggesting the potential for significant progress in improving health and services typically for little cost. There is scope however for improving multi-agency planning and strengthening project management to overcome barriers between different agencies. The experience (and its documentation) available from other parts of Europe in establishing projects to tackle specific issues (accidents, alcohol) and in adopting a "settings" approach (healthy schools, healthy hospitals, healthy workplaces) should assist these and similar local initiatives.

A useful framework for planning joint action is included as an addendum (Chapter 6.4).

6.3 IMPLICATIONS FOR NATIONAL AND LOCAL ACTION

National Action

(i) Health Policy

The Czech Republic and Slovakia are both establishing broad health policies. There is a need to review these policies in the light of recent evidence on the health status of the population and to identify the contributions which will be required from each government department and from non-governmental agencies.

Expert assistance, for example from the World Health Organisation, European Region, may be helpful in this process. Some countries have found the targets approach set out in the 'Health for All' strategy useful, and this should be considered by ministers and their advisers.

(ii) Investment appraisal

Considerable sums are already invested in the various health, social, environmental and economic services which contribute to improvements in population health. The present economic situation requires that all investment decisions are appraised and, where possible, this process should take account of the health benefits or potential harmful effects on population health produced by each activity. (It is recognised that there is not always satisfactory evidence or information to achieve this aim.)

(iii) Organisational structures

The organisational structures at national government levels should bring together the people responsible for funding and provision of health care with the people responsible for population health and hygiene service policy and resource management. The organisational position of the key national advisory institutes (including health information and public health), their relationships with senior ministry officials and with external academic (university) departments should also

be reviewed to ensure that government has access to the best information to inform decision making.

(iv) **Education, training and research**

The further development of health improvement programmes, health service management and information systems must be underpinned by sound epidemiological and statistical theory. The existing institutions (institutes and university departments) are important in education and training and provide several good courses. Some of them could, however, be improved further by more cross-fertilisation to develop a broader view of health and a more comprehensive understanding of the roles and contributions of different parties. Exchange programmes should be encouraged either for individuals or as long-term links between departments to increase the pace of dissemination of information and experience.

The national reforms should be monitored and evaluated. This requires health services research skills and the development of suitable research programmes in both health management and population health.

Local Action

(i) **Health policy**

Most districts do not at present have a comprehensive health policy which is accepted by all the relevant local agencies. The process of production of such a policy can in itself generate considerable energy and commitment to health improvement and often identifies some projects which can be rapidly implemented at minimal cost, through reorientation of existing services.

Discussions on health policy development for a district should involve senior policy makers from the civic authorities, housing and education departments, hygiene stations, health professionals and the public. The precise arrangements will of course vary according to local circumstances.

Information on the health status of local people is necessary in order to establish the priority action areas for the local health policy. There is a great deal of European experience and documentation of health policy development at the local level which can assist those embarking on this task. (For example, there is a long British tradition of annual reports on the health of the district population which are widely publicised).

Once agreed and disseminated, the local health policy forms the framework within which the further development of services, management and information systems can take place.

The local health policy will of course reflect the national priorities, but work on such a policy does not need to await formal endorsement of the national health policy.

(ii) Public involvement

The development of a local health policy which will be effective requires the involvement of local people. They should have the opportunity to discuss with managers and professionals their perceived health needs and develop ideas to meet those needs. The public themselves are a considerable resource for population health improvement.

Further implications for health sector management development

(i) Academic health service management programmes and management development programmes offered to working managers should include an introduction to basic population health status data and principles of epidemiology.

(ii) These programmes should also include a focus on the quality of services. They should aim to teach health professionals and insurance company directors about clinical, organisational and consumer quality assurance, including audit. This is an important aspect of the market approach and may determine the future

success of provider institutions. In addition, high quality clinical and organisational services are essential for an economically efficient organisation. Insurance companies will need to include quality standards in contract arrangements.

(iii) A third and related focus of management development needs to be study of ways of achieving new patterns of health services. Initial cost reductions can be achieved in hospital services with improvements to patient care by reductions in length of in-patient stay and better use of some specialist facilities. This requires consideration of present clinical practice and development of appropriate support in the community. However in the longer term, decisions about service configuration should be based on population need, effectiveness data and economic realities. The change process must be carefully managed and will require:

* close co-operation between central and local health officials
* involvement of insurance companies
* careful planning at local level by those responsible for hospital, primary care and social support services.

(iv) Senior health service managers, civic leaders and public health officials should be supported as teams for out-country visits to 'Healthy Cities', perhaps concentrating on those which are part of the formal WHO project and are in central Europe (Karnas, Pecs) to discuss and gain information from colleagues on the practical implementation of health improvement policies in an urban environment. Foreign assistance should be invested in such programmes.

(v) University departments with an interest in contributing to population health studies should be encouraged to improve contact with existing academic institutions in the Republics and abroad with a view to developing their capacity for health services research and evaluation.

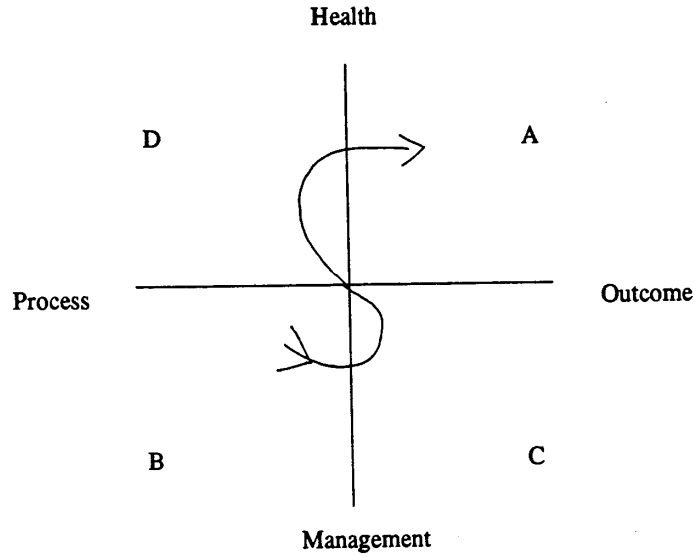
(vi) Foreign assistance should be sought to provide for a formal review of the functions of hygiene stations, with a view to supporting:

* rationalisation of activities

* further development of health promotion, prevention and environmental improvement programmes
* better integration with other services and agencies at the local level.

6.4 ADDENDUM : AN ILLUSTRATIVE "PATHWAY" TO HEALTH

Figure 10



The achievement of health outcomes (reduction in death rate, or lower incidence of disease) may take a long time. It is often difficult or impossible to relate the contribution of one specific project to improvements in health status. This model helps to identify the essential intermediate steps towards health improvement and to help individuals and groups to position their work and projects on the pathway.

A is the health outcome which is to be achieved. This can be identified by the analysis of the health status of the population and the selection of priorities for action. The World Health Organisation "Health for All" strategy sets out targets for Europe, the British Government has put forward targets for England in "Health of the Nation" and many English districts identify local targets in their annual reports.

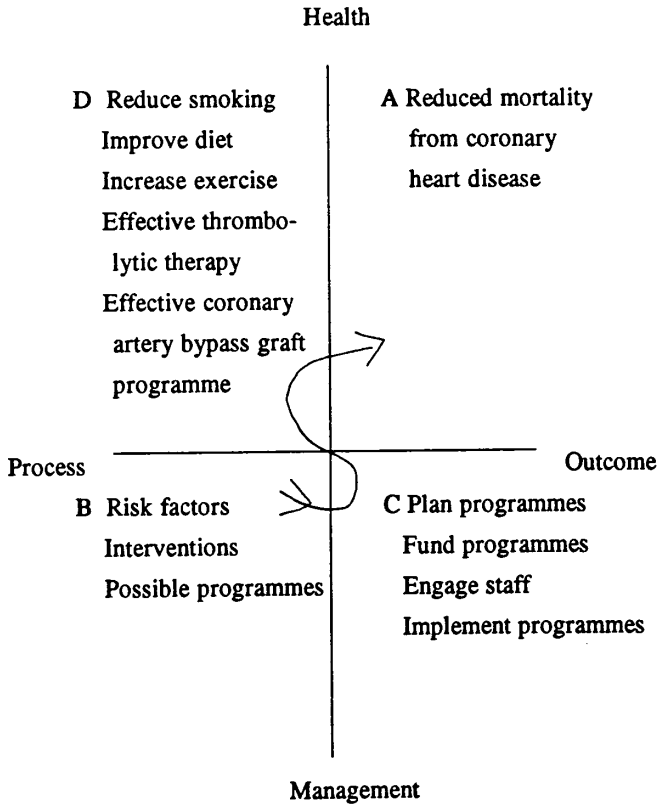
B is the "management process" quadrant, which requires analysis of the evidence about the health outcome selected in A in order to determine risk factors, to assess possible interventions and to identify other agencies or individuals which may need to be involved.

C is the "management outcome" quadrant. This is the segment where plans are agreed, resources (financial and other) identified, staff engaged, and the programme implemented.

D is the "health process" quadrant, in which, if the programme is successful, patients receive treatment, or people change behaviour (stop smoking, increase exercise) or services are reorientated to improve access and uptake. The evidence acquired in B enables one to make reasonable assumptions that these changes will contribute to the achievements of the goals in A.

The process can then begin again, as a cyclical activity with gradually improving standards.

Figure 11 **Example**



A Coronary heart disease identified as a major cause of morbidity and premature death.

B Evidence shows effectiveness of primary prevention (smoking, diet, exercise): important contributions are also made by timely thrombolytic therapy and well-selected cardiac surgery; comprehensive programmes require the involvement of health professionals, educators, leisure services, etc.

C Planning and implementation of, for example:
- smoking reduction programmes for hospital staff/local factory staff
- smoking education projects in schools
- thrombolytic therapy programmes for patients admitted to hospital with myocardial infarcts, with monitoring of "door to needle" times
- coronary bypass surgery, with selection for treatment determined by best scientific evidence on outcomes.

D Evaluation of programmes implemented in C, to show changes in smoking rates, or achievement of treatment standards.

Appendix - The PHARE Health Sector Management Project 1992/1993

Introduction

An expert mission from the European Community visited the CSFR in September 1991 to assess challenges facing the health sector and discuss with Health Ministry representatives from the Czech and Slovak Republics priorities for investment from the PHARE programme (the CEC's main form of assistance to economic and social reconstruction in Central and Eastern Europe). A specification was agreed for an initial one-year project on developing management capacity and information systems in the health sector. The contract to undertake this project was awarded by competitive tender to the King's Fund College, London and work began at the end of March 1992.

The King's Fund College is the largest independent centre dedicated to health services management development in the United Kingdom, with a long established reputation for independence and extensive international experience. The College assembled a multi-disciplinary project team from its own staff and colleagues from two other institutions, the Institute de Estudios de la Empresa, Barcelona (a leading European Business School with particular expertise in management information systems) and the South East Institute of Public Health, Tunbridge Wells (an applied research centre specialising in strategies for improving population health).

Project Aims

The specification summarised the aims of this project as being to 'strengthen health sector management and health information systems in the CSFR by providing training and technical assistance at the District level and by preparing for enhanced capacity in management training and information system implementation at the Republic level'. It was expected that this first year's work would provide the basis for 'a larger follow-on project...to further develop management skills and information systems and to support the health sector reform process in other ways'.

The specification required that these aims be addressed through:

* working with managers in three pilot districts (identified by the health ministries) to understand the challenges they face in achieving radical transformation in national health systems;

* assisting these managers in short-term action to improve management and information systems through on-site consultancy and providing a range of training opportunities;
* working with officials at the Republic level and in relevant training institutions to assess the existing in-country capacity for management and information systems development;
* using all this experience to identify ways of strengthening this in-country capacity in 1993 and beyond.

Project Approach and Strategies

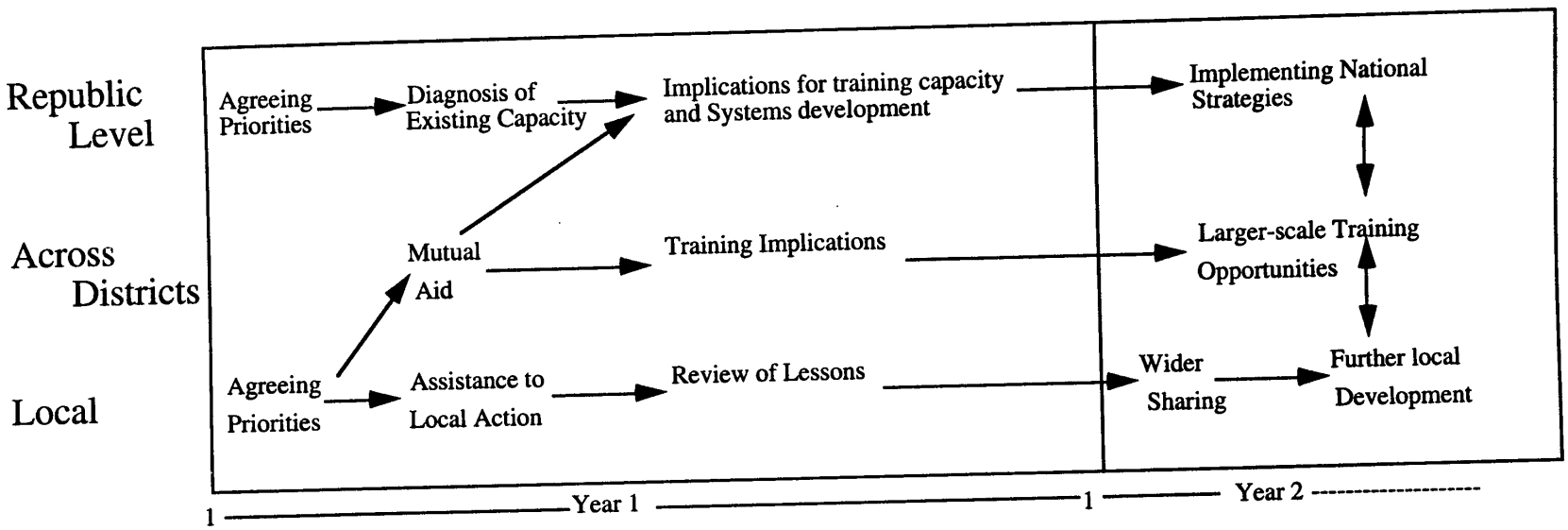
In its proposals to meet this specification, the King's Fund College set out to go beyond Western knowledge transfer through an approach based on partnership with local and Republic-level leaders and a commitment to assisting them in finding effective ways of making progress in their situation. This approach involved:

* responding to the priorities identified by Czech and Slovak leaders;
* strengthening the capacity of people and organisations to resolve problems themselves rather than offering 'external' solutions;
* learning from experience through widespread dialogue between people at different levels and in different parts of the changing health systems;
* focusing effort not just on diagnosis but also on action so that the benefits of the project could begin to be demonstrated in the first year; and
* emphasising outcomes through a continuing concern with the relevance of better management to better health.

The College proposals identified a project strategy which set out to work 'from the bottom upwards' in relating local challenges to future national strategies for management and information systems development in each Republic (as suggested in Figure 12). That is, the project started from detailed work at local level, sought to test and develop ideas from this work through intermediate level activities (e.g. training events and conferences) and use this experience (and a parallel survey of existing in-country capacities) to inform Republic-level proposals for the future.

In practice, the project team had to adapt this strategy to the turbulent and rapidly changing situation in the two Republics over the year from April 1992, including:

Figure 12: RELATIONSHIPS BETWEEN PROJECT ACTIVITIES OVER TIME



* difficulties for the health ministries in identifying suitable pilot districts;
* changes in policies and personnel following the elections in June 1992;
* problems in identifying partners for the project at the Republic level;
* differences in understanding of the project between local and central levels;
* division of the former CSFR; and
* changing ministry priorities for future PHARE support.

Main Activities

Reflecting this strategy and the project team's efforts to overcome these difficulties, the main activities carried out to meet the project's aims can be summarised under five headings:

(i) Assisting pilot districts in addressing current challenges; developing local strategies for managing change

* Continuing programmes of consultancy and training were undertaken with three pilot districts (Litomerice and Pisek in the Czech Republic, Trencin in Slovakia) designed to increase understanding of management and information system challenges and assist managers in addressing these challenges.

* In each case, project team members visited the district on seven or more occasions over a period of nine to twelve months, meeting a significant cross-section of local managers and clinicians, providing consultancy, arranging local seminars and workshops and reviewing progress.

* In each district, a plan was agreed to focus project effort on local priorities which included:

  - cross-agency collaboration in implementing reforms
  - insurance company leverage in shaping the pattern and quality of local services
  - improving hospital efficiency and effectiveness
  - privatisation and the development of primary health care
  - rethinking management information systems
  - multi-sectoral strategies for health promotion

always with the aim of strengthening the local management capacity to address these and other challenges.

* Leaders from each district also participated in out-country training programmes on health sector leadership in London (November 1992) and management information systems in Barcelona (March 1993).

(ii) **Sharing lessons across districts; preparing leaders for managing transformation**

* a series of seven seminars and workshops were arranged to share lessons across districts and promote local/central dialogue on key issues, including:

  - defining the management agenda;
  - managing for quality;
  - management information system design and development;
  - multi-sectoral action for health policy goals.

* This work culminated in the first Brno health management conference (March 1993) in which managers from both Republics discussed common challenges and the way forward for health sector reform. (See Educational Programme Report 3)

* Altogether more than 300 managers contributed their experience to educational events at local and national level.

(iii) **Strengthening in-country capacity for management and information systems development**

* A survey was conducted into strengths and needs among potential higher education and other suppliers of management development opportunities. (See Resource Guide I)

* Seminars were organised in both Republics (Bratislava, February 1993, Praha February 1993) to discuss strategies for strengthening in-country management development capacity.

* An in-country workshop (Praha, March 1993) was organised to demonstrate methods for training management trainers.

* Out-country training opportunities were arranged for twenty people with roles in management training or information systems development.

* Workshops were organised in both Republics (Bratislava, December 1992, Praha, January 1993) to examine strategies for information systems development. (See Educational Programme Report 2)

* Consultancy was offered to people with leadership roles in new management development initiatives (based in post-graduate medical institutes, universities and independent training networks).

* A basic allocation of health management literature were supplied to five centres for future management training.

(iv) Reinforcing project initiatives through out-country study visits, management training and English language teaching

* The King's Fund College offered twenty-two national and local leaders a three-week leadership development programme in London (November 1992) including one week as guests of British health sector colleagues. (See Educational Programme Report 1)

* The Instituto de Estudios Superiores de la Empresa offered twelve national and local leaders one week visits (March 1993) studying management and information systems in the Catalan health system. (See Educational Programme Report 2)

* The College and IESE arranged seven individual study visits for national health sector leaders including a review of different approaches to health sector management development in the U.K.

* The project produced a guide to post-graduate study in health management and information systems at U.K. universities. (See Resource Guide II)

* English language tuition was provided at three Czech and Slovak centres for participants in the out-country training.

* Some longer-term exchange relationships were established between people and institutions in the two Republics and the U.K.

(v) **Assisting Republic-level diagnosis of management and information system challenges; establishing medium-term strategies for management and information systems development**

* The project team conducted diagnostic interviews and subsequent discussions with a cross-section of national officials in the health ministries, insurance companies, national institutes and education centres, and met health ministers on five occasions.

* Office equipment was supplied to each ministry to assist efficient project management.

* Lessons from the project work and their implications at national level were reviewed regularly with the project co-ordinators appointed by each health ministry.

* Building on proposals in earlier reports, our final report to each health ministry includes detailed recommendations for ways of establishing national strategies for management and information systems development.

* These recommendations are the topic for proposed national seminars in each Republic.

Final Report

Contents of the final report, **Better Management, Better Health** bringing together lessons from the project and recommendations for the future are as follows:

* EXECUTIVE SUMMARY AND RECOMMENDATIONS

* LESSONS FROM THE PHARE HEALTH SECTOR MANAGEMENT PROJECT.

1. Introduction
2. Managing health sector reform : an overview.
3. Managing change in health services at the local level : experiences in three pilot districts.
4. Implications for health sector management development and recommendations for national action.
5. Implications for developing management information systems and recommendations for national action.
6. Managing for better population health

Appendix : The PHARE Health Sector Management Project, 1992/1993

* RESOURCE GUIDE I : THE IN-COUNTRY HEALTH MANAGEMENT TRAINING MARKETPLACE

* RESOURCE GUIDE II: POSTGRADUATE STUDY IN HEALTH MANAGEMENT DISCIPLINES IN THE UNITED KINGDOM.

* EDUCATIONAL PROGRAMME REPORTS.

1. DEVELOPING HEALTH SECTOR LEADERSHIP (November, 1992)

2. DEVELOPING MANAGEMENT INFORMATION SYSTEMS (March 1993)

3. RECOMMENDATIONS FROM THE BRNO HEALTH MANAGEMENT CONFERENCE (March, 1993)

Key Personnel

Czech Republic:

Health Ministry)	PhDr Jan Jaros (3/92-10/92)
Project Co-ordinator)	RnDr Alexandra Kralova (12/92 onwards)

Slovakia:

Health Ministry)	Ing Peter Krnac (3/92-8/92)
Project Co-ordinator)	MuDr Branislav Koren (8/92 onwards)

Joint Project Administrator: Mgr Eva Stricova

Project Team:

King's Fund College	Ms Sheila Damon, MA, MSc, MSc, MSc C.Psychol Dr John Mitchell, MB, MRCP Dr David Towell, Dipl in Management, MA, PhD
Instituto de Estudios Superiores de la Empresa	Professor Antonio Garcia Prat, MSc Professor Jaume Ribera, MSc, PhD
South East Institute of Public Health	Dr June Crown, MA, MB, B Chir, MSc, FFCM
Project Liaison:	Mrs Zuzana Feachem, BSc, MSc
Project Secretary:	Mrs Urannie Small

The project team also acknowledges the valuable advice and assistance of many colleagues, particularly Franklin Apfel, MD, Jo Ivey Boufford, MD, Johannes Maarse, B.Polit Sci, PhD, Peter Mumford, BSc, MBA and Magda Rosenmoller MD.

KINGS FUND COLLEGE

Better MANAGEMENT Better HEALTH

The health sector management project was the first investment by the European Communities PHARE programme in supporting the transformation of health services in the Czech Republic and Slovakia. Between April 1992 and April 1993 the project provided initial technical assistance in developing health sector management and information systems. Its aims have been to work with managers in the two Republics in seeking to understand the challenges of achieving radical transformation in national health systems; support these managers through on-site consultancy and a range of training opportunities; and use this experience to identify ways of strengthening the in-country capacity for management and information systems development in 1993 and beyond. The project has been undertaken by the King's Fund College, London in collaboration with the Instituto de Estudios Superiores de la Empresa, Barcelona and the South East England Institute of Public Health.

Contents of Final Report:

Executive Summary and Recommendations

Lessons from the PHARE Health Sector Management Project

Resource Guides:

I The In-country Health Sector Management Training Marketplace

II Postgraduate Study in Health Sector Management Disciplines in the United Kingdom

Educational Programme Reports:

1 Developing Health Sector Leadership (November 1992)

2 Developing Management Information Systems (March 1993)

3 Recommendations from the Brno Health Management Conference (March 1993)

Copies of each part of this Report are available from the International Co-operation Department in the Czech and Slovak Health Ministries or directly from David Towell at:

The King's Fund College
2 Palace Court, London W2 4HS
Tel: 071-727 0581 Fax: 071-229 3273