Better MANAGEMENT Better HEALTH

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

EDUCATIONAL PROGRAMME REPORTS

1. **Developing health sector leadership**
2. **Developing management information systems**
3. **Recommendations from the Brno health management conference**

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FINAL REPORT ON THE PHARE
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EDUCATIONAL REPORT I

Developing health sector leadership
A report on an educational programme for Czech and Slovak managers (London 1992) and review (Brno, March 1993)

FOREWORD

The Czech Republic and Slovakia have inherited from the past major problems in the state of population health and serious deficiencies in the ways health care is provided. Both Republics are seeking to address these difficulties through radical reforms in the health sector including new financing arrangements, decentralisation and privatisation.

These reforms present massive challenges to the people both nationally and locally who have accepted responsibilities for managing the transformation in health care. Fortunately, many able and committed people have accepted these challenges and are working hard to make progress in both Republics.

It is recognised in the wider restructuring of the economy that the quality of management is a vital factor in commercial success. In the health sector, better management is also essential to:

- provide leadership for change;
- ensure best possible use of resources;
- ensure sustained attention to improving the quality of health services; and
- operate successfully in a pluralistic and decentralised system.

Accordingly, in the autumn of 1991, the European Community agreed with Health Ministry representatives that a modest initial investment from the PHARE programme should focus on developing health sector management and information systems.

This PHARE health sector management project ran from April 1992 until April 1993. The project involved:

(i) Work with leaders in three pilot districts to establish local strategies for managing change, and

(ii) Work at the Republic level designed to strengthen future arrangements for management and information systems development.

As part of this project, two intensive management development programmes were organised which combined opportunities for study in Western Europe with in-country training.

In November 1992, the King's Fund College hosted a three week leadership development programme in Britain in which twenty-two Czech and Slovak managers had the opportunity to explore the management of change in the light of other European health sector experience.

These managers were drawn from the pilot districts and from the national level in each Republic. They reflected the pluralism in new arrangements, by including representatives from the health ministries, general insurance companies, district authorities, hospitals, primary health care and related agencies concerned with population health and health information.

Four months later, the participants met again in Brno to review how lessons from the programme had been applied in their jobs and to share their experience at a wider conference for health sector managers which attracted more than 80 people. This paper reports on this leadership development programme and the ways managers used their experience to address challenges in their own work.

One theme of the leadership development programme was the development of management information systems. The teaching on this topic was undertaken by the College's project partners, the Instituto de Estudios Superiores de la Empresa, who subsequently organised two national workshops in Bratislava and Praha (in December 1992 and January 1993 respectively) for policy-makers, managers and technical experts with a particular interest in health sector management information systems and two one-week study visits to Barcelona on the same topic in March 1993. Lessons from this programme are the subject of Educational Programme Report 2 in this series.

The main approach to management development used by the King's Fund College starts from the situation of participants and seeks to help them explore ways of managing better which build on their ideas and experiences. These programmes rely less on formal teaching than was common in the CSFR and more on interactive methods, case studies and direct study of management practice.

In a short report, it is not possible to do justice to the wealth of discussion in the leadership development programme, still less what people learnt directly from observation of British health services. This report is however intended as a useful 'aid to memory' for participants in this programme as they seek to apply lessons in their own jobs. The Report may also be useful to other people in similar roles in the two Republics as they consider how best to meet the challenges of implementing the health sector reforms. There is an urgent need to expand the literature on health sector management in Czech and Slovak so that those accepting, or aspiring to leadership roles can compare their experiences with other people and learn from each other how to make management more effective. The College is therefore publishing this Report as one contribution to this literature.

David Towell
King's Fund College
May 1993

DEVELOPING HEALTH SECTOR LEADERSHIP

CONTENTS

1. HEALTH SECTOR REFORM : THE NATIONAL CONTEXTS

The King's Fund College leadership development programme was designed to address senior managers' needs in implementing health sector reform in the two Republics. In addressing the inheritance from the past, both Republics are developing a new vision of social welfare and redefining the relationship between individuals and the State. In the health sector, the proposed goals include:

- improving population health through stronger programmes of health promotion and disease prevention;
- ensuring universal access to basic health services;
- shifting the balance and improving the efficiency of services through strengthening primary health care, integrating different elements of provision and rationalising facilities;
- improving the quality of services; and
- promoting greater patient choice and public confidence in health services.

These aims are being pursued through major system changes which combine:

- new approaches to raising and distributing finance, particularly through health insurance arrangements;
- new forms of ownership and greater autonomy for provider units;
- decentralisation in decision-making; and
- encouragement to private practice;

There are some differences in the detailed arrangements between Republics (for example, in proposed payment systems and in the pace of privatisation) and these national policies are still evolving (for example, through further legislation). In both Republics however these changes can be understood as seeking a radical redistribution of previously monopolistic and centralised functions to appropriate levels and agencies in a well-balanced pluralistic system.

The matrix represented in Figure 1 provides a framework for identifying the mission and key tasks of different agencies and at different levels in this pluralistic system.

This framework:

(i) draws attention to aspects of system design which are not yet fully defined (e.g. the role and authority of local democratic authorities in shaping health policy);

(ii) points to the nature of the transactions required between different elements in the new systems;

FIGURE 1 **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

(iii) suggests the considerable expansion of demands on management and management information systems.

Experience suggests that the ways each agency (e.g. the insurance companies; more autonomous hospital and primary medical care providers) carry out their functions in the new systems are likely to be evolutionary. With existing management capacity and tools, it will take time (possibly several years) to establish the range of activities required to maximise the benefits of the new arrangements even when these are well-designed.

A major challenge to managers is to ensure that the key goals of reform remain central to the management agenda while attention is addressed to the financial and organisational questions involved in this transformation.

This challenge is itself made more difficult by the need for managers to cope with significant uncertainties arising from continuous political debate about the design of reforms, economic pressures and wider changes in the two Republics. Indeed, in rational descriptions of health sector changes, it is important not to underestimate the anxiety and conflict which leaders at all levels are experiencing and the impact of these stresses on their capacity to pursue a clear agenda for change.

Observations in the two Republics and indeed the lessons from international experience of public sector reform (e.g. Western privatisation programmes) suggest that this transformation represents much more than a change in policies, structures and procedures: more fundamentally, it requires significant changes in what is meant by management in the health sector.

Among the most important strands in these management changes are the shifts:

FROM ADMINISTRATION	TO MANAGEMENT
Dependence on central direction	Exercising leadership to meet local needs
Following monopolistic administrative controls	Addressing competitive 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 responding to 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

As Figure 1 suggests, the precise implications of these changes vary according to both the type of organisation in the new system (e.g. local authority, insurance company, provider units and health-related institutes) and at different levels in these organisations.

2. CHALLENGES IN MANAGING IMPLEMENTATION

Against this background, the King's Fund College programme provided opportunities for participants to clarify the challenges facing different agencies and explore appropriate managerial responses to these challenges. It also encouraged individuals to review their own roles in providing leadership for change.

In general terms, the Czech and Slovak managers typically found satisfaction in the fulfilling nature of their jobs and the opportunities to contribute to shaping new arrangements and gaining greater autonomy. The three greatest difficulties in this period were identified as lack of clarity in the design of the new systems, problems in financing of health services and in arrangements for privatisation.

In more detailed work with colleagues in similar roles, participants identified the main challenges for management in their agencies. Over the three weeks of the programme they also worked together to suggest ways of addressing these challenges in the Czech and Slovak situations. To summarise their main concerns and recommendations:

(i) HEALTH MINISTRIES

Challenges:

* At the Republic level, Health Ministries (with other parts of Government) face unparalleled demands in converting the principles of health reform into detailed legislation and procedures, securing implementation of new arrangements and monitoring the impact of change;

At the same time, Ministries are having to:

* redefine their own functions in a demonopolised system and find new ways of working which promote effective decentralisation;
* Ensure successful implementation of the reforms through both directly controlled and newly independent agencies;
* Establish the health insurance agencies;
* Establish the conditions for successful provider privatisation;
* Redefine the needs of their health and management information systems taking into account new functions;
* Monitor and improve the quality of services during the period of transition; and
* Promote, evaluate and disseminate the lessons learned from local initiatives.

Recommendations:

Faced with these challenges, it appeared important that Ministries:

Invest effort in strengthening their own management capacities particularly so as to provide clear and consistent messages to all other agencies involved in implementing the health sector reforms;

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

Play a leadership or co-ordinating role in creating national strategies for management and information systems development, particularly through strengthening the in-country capacity for providing good quality management training.

(ii) INSURANCE COMPANIES

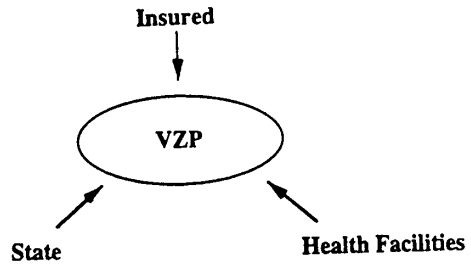
Challenges:

* There is a major task in creating new organisations, including recruiting and training staff, and establishing basic management systems (e.g. for pricing services, collecting premiums, arranging payment to providers and monitoring performance);

* Establishing these new arrangements on a short time-scale and with central policies still emerging is proving very demanding: managers are finding it often necessary to improvise in order to cope with day-to-day problems;

* More fundamentally the insurance companies have to work at the intersection of three powerful pressures - and find ways of articulating the different requirements of:

  - the insured person - wanting necessary health care
  - health services providers - wanting sufficient income
  - the state - wanting to contain costs of health care



* Locally, the insurance company branch offices need to clarify how they can best contribute to the optimal transformation of the local health system, particularly in a period when the legislation and procedures necessary for the insurance companies to act as selective purchasers of services have not been established.

Recommendations:

Both locally and nationally, the insurance companies should take steps to make their work more visible to the insured people - and to build public understanding of the opportunities, choices, and constraints which need to be faced in the development of affordable health care;

Within the national health insurance companies, there need to be better links between the branches (with their experience of local health services problems) and the centre (with its role in policy-making);

Further work is required to clarify policies on the connection between health and social insurance, the arrangements for supplementary health insurance, the relationship between different insurance companies and the optimum ways of charging and paying for services;

Insurance companies should co-operate with the professional associations to define appropriate standards for clinical practice;

In addition to their role in financing health provision, the insurance companies should seek to play an active role in influencing health policies and the pattern of health services by:

- co-operation between the insurance companies and the local agencies concerned with population health;
- 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;
- working to establish a proper 'gate keeping' role for general practice which

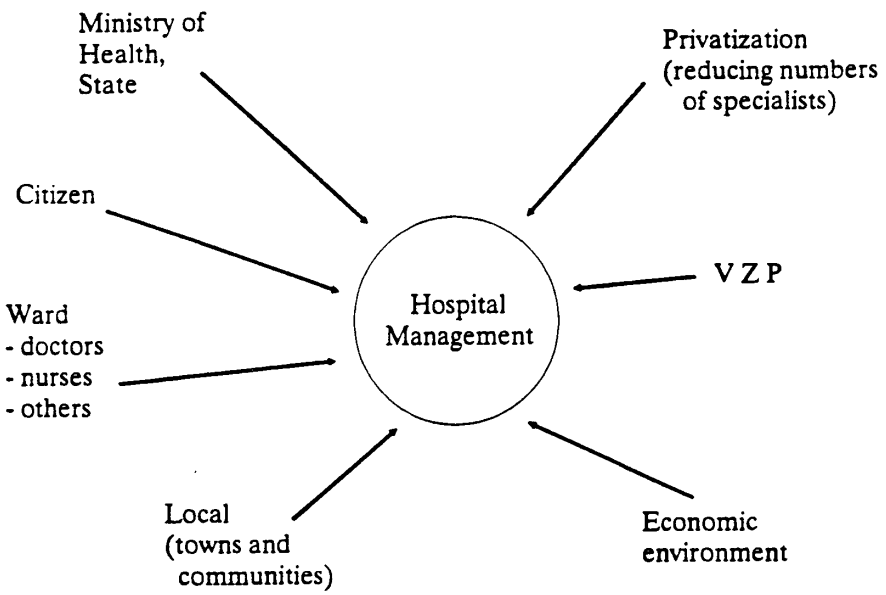
would make it possible to oblige patients to go through general practitioners to reach secondary services (except in areas, such as emergency treatment, which would need to be defined).

The insurance companies need to take a leadership role in considering the appropriateness of their information systems and how they link with the requirements of other agencies (e.g. government, population health agencies and service providers).

(iii) HOSPITALS

Challenges:

* Leadership at a time of radical change requires an increasing capacity to look both inwards and outwards to balance a wide range of demands and pressures;



* In meeting these demands, leaders (e.g. hospital directors) can feel isolated and lacking in support;
* Within the hospital, there are typically conflicting interests among employees, insecurity and a lack of understanding of the need for change;
* Privatisation and new funding arrangements require significant changes in organisation, management and management information systems to improve

efficiency;

* There is considerable scope for improving the quality of care (notably in respect to the rights and dignity of patients);
* There is a need both to establish a strong management team and improve delegation of responsibilities downwards within the hospital with appropriate feedback.

Recommendations:

Hospital managers need to look outwards to work with a variety of partners to get the best from changing opportunities:
  - with the local insurance companies on synchronisation of costs and evaluation of treatment procedures;
  - with towns and communities on the co-ordination of activities which promote health;
  - with new forms of ownership which enable appropriate forms of privatisation;
  - with other providers to ensure effective patterns of treatment and care;
Similarly, looking inwards, managers need to work with staff in:
  - developing management capabilities;
  - decentralising authority and responsibility;
  - humanising and improving the quality of care;
  - strengthening their own capacity for leadership (e.g. in standing by their opinions and learning how best to motivate colleagues);
  - introducing procedures, budgetary arrangements and information systems which contribute to improving both effectiveness and efficiency.
Nurse managers also emphasised the importance of improving the quality of nursing care by:
  - encouraging new attitudes;
  - accepting more responsibility and increasing the status of nursing;
  - distinguishing different levels of nursing work according to educational and skill requirements.
During 1993 a central aim must be to develop strategies for future hospital services which reflect their clinical strengths, patient needs and likely resources and which define the implications of these strategies for financial viability, future staffing requirements and the rationalisation of facilities.

(iv) GENERAL PRACTICE

Challenges:

* With greater autonomy, general practitioners have to develop and maintain good relationships not only with patients but with many elements in the local health system (hospitals, insurance companies, local authorities, medical chamber, other colleagues);
* New arrangements imply a change in the nature of the doctor-patient relationship to reflect the greater autonomy of patients;
* General practitioners need to reconsider their ways of working with other general practitioners (for example, in joint practices), nurses and emerging home care services;
* They also need to widen their role to manage their practice and its financing, in a period when there is considerable uncertainty about funding.

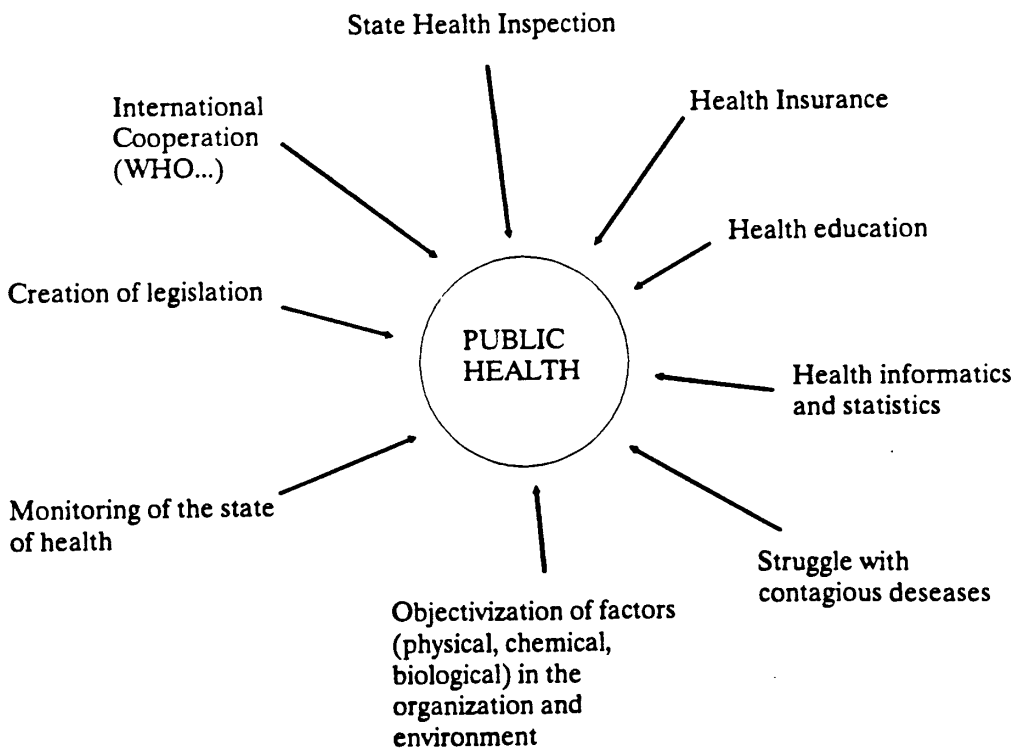
Recommendations:

Privatisation means that general practitioners need to accept the responsibility of becoming the managers of "small businesses", marketing services, business planning and establishing administrative support systems;
Important to the developing role of independent general practitioner will be greater emphasis on the 'gate keeping' role to more specialised services;
Attention needs to be given to the development of joint practices (permitting some sub-specialisation among partners) and the contractual basis for such practices;
Effective primary care requires not just good general practice but the complementary development of other community health and social services which together permit a shift in the balance of treatment and care towards the community.

(v) POPULATION HEALTH AGENCIES (particularly Institutes of Hygiene and Epidemiology)

Challenges:

* For maximum effectiveness, the 'public health' function needs to review its priorities and ways of working in relation to a wide range of demands (illustrated in the diagram);
* Central to this change of function is a shift from mainly inspection activities to a stronger role in monitoring the state of population health and promoting better health;
* This in turn requires rethinking the organisational structure of 'public health' institutions.



Recommendations:

A new role for public health institutions is required which gives priority to:
  - assessing the state of population health in relation to living conditions;
  - developing effective programmes of health education;
  - working in close co-operation with local government and other sectors;
The organisational focus for these activities should be revitalised institutes of hygiene and epidemiology at the district level;
There should be more initiative at the local level and better communication between centre and periphery in relation to Republic-level initiatives;
These efforts should be supported through better-designed information systems for national health promotion programmes;
There is also scope for improving international co-operation in public health and speeding up the harmonisation of policies with other European countries;

In a similar way, the health officials of district authorities are having to come to terms with quite a new role and find new approaches to exercising influence (rather than control) over local health policies, through:

drawing on the information and expertise of the hygiene stations and health information institutes;
establishing new collaborative arrangements for multi-sectoral action on important health promotion issues like reducing smoking and accidents;
exercising leadership in improving the co-ordination of health and social care, particularly for elderly people.

COMMON PRIORITIES across all four groups include the need for:

New relationships between the centre and periphery in each Republic's health systems which promote both informed policy-making at the centre and considerable decentralisation in health services management;
Local managers who actively grasp the opportunities for change and provide the leadership required to reshape local provision;
A fresh emphasis on developing new relationships with the people, as patients, insurance payers and citizens;
Systems to assure adequate quality of all health care;
Proper recognition of the impact of the reforms on each element of the health system and the need to review functions, organisation and management (including

financial management) requirements;

Major attention in each agency to the new relationships required with other agencies in a decentralised, pluralist health system and enhanced skills in working with both competition and co-operation;

Clear identification of the mission of each agency, its relationship to the mission of other agencies and the possible benefits of a common definition of their information requirements;

Considerable capacity among managers and professional leaders to cope with the uncertainties of change and improvise workable solutions during the period of transition;

New personnel policies and human relations skills which promote staff support for change.

3. COMPARISONS WITH WESTERN EXPERIENCE:

Observations on the United Kingdom

Participants in the King's Fund College programme spent a week as guests and observers of the British health system. Small teams visited Wales to examine policy-making and management at the national level and examined management and service delivery in four English districts with different characteristics - a northern industrial town (Sheffield), a major University region (Oxford), a western rural county (Gloucestershire) and a southern seaside town (Brighton).

At the time of these visits the British health system was two years into major national reforms involving:

- the separation of arrangements for purchasing health care from the agencies responsible for provision,
- the creation of more autonomous providers of both hospital and community health services; and
- the introduction of some competition among providers within the tax-financed state health sector.

Participants drew two general lessons from their observations during these visits:

* Clearer recognition that there are strengths and weaknesses in all national health systems which mean that many are in a state of flux as policy-makers search for optimum arrangements.
* Fuller understanding that major change takes time, depends on effective management and typically has to cope with people's behaviour lagging behind the formal requirements of the new arrangements.

More specifically, participants highlighted eight aspects of current British experience with relevance for implementing change in the two Republics:

(i) The separation of 'purchasing' from the provision of health care has assisted the purchasing agencies in Britain in developing the provision of services to meet the health needs of the local population. The purchaser's role in population need assessment, contracting with providers and monitoring quality all have potential lessons for health insurance companies if they are to assume a more strategic role in the reformed Czech and Slovak health systems.

(ii) Following the White Paper on The Health of the Nation, this attention to population health status is reflected in longer-term strategies for prevention and health promotion, embracing multi-sectoral action (for example, on the causes of cancer and coronary heart disease at both national and local level).

(iii) In comparison with the typical experience in the two Republics, most British services are characterised by a strong commitment to 'putting the patient first'. This commitment is reflected in policies (e.g. The Patients' Charter), professional attitudes (e.g. respect for the individual), arrangements for getting patients' views on services (e.g. using questionnaire methods) and in everyday practice (notably the efforts to provide a home-like environment in hospitals, encourage visiting and abolish unjustified regulations).

(iv) Quality of services is an important concern of British managers (e.g. through the contracting process and through quality assurance arrangements), professional groups (e.g. through the development of clinical audit), and patient representatives (e.g. through the monitoring visits of Community Health Council members).

(v) The concern with improving effectiveness and efficiency in British health care is reflected in changing patterns of services and innovative clinical practices, particularly the growing emphasis on day surgery, ambulatory treatment and care for people (e.g. the elderly) in their own homes. This requires, however, a well developed system of primary health care and related community services.

(vi) The introduction of a decentralised and responsive health care system in Britain has involved considerable investment in management at all levels, the delegation of authority and encouragement for initiative. There are also extensive opportunities for management education and development;

(vii) Information systems have been developed which start from examining what information managers need and use. Increasingly these management information systems address questions of quality as well as quantity and cost.

(viii) Managers in Britain recognise that health care is an issue of considerable public and political concern, and this is reflected in the extent of press and television attention to health services issues. One lesson here is that health agencies themselves have a significant role in contributing to public understanding and expectations.

THEMES IN WESTERN HEALTH SECTOR MANAGEMENT

During their programme, Czech and Slovak managers heard a series of contributions on development of health sector management in other Western systems and had access to a selection of the Western management literature. They identified a series of themes in this experience and literature with relevance to the Czech and Slovak health sectors:

* Assessing health needs. The introduction of market systems brings with it a requirement for explicit choices about the services to be purchased, which should be based on people's preferences and evidence about the improvements to health they will provide. It is therefore important that health services managers are able to obtain better evidence about the health needs of people they serve and the effectiveness of available interventions.

* Health care reforms in Europe. The Czech and Slovak reforms are two among several current efforts to rethink national health care systems in Europe. Under the auspices of the World Health Organisation, a working party is comparing experiences across Europe and has proposed a set of guiding principles for health care reform. These principles have relevance to managing transformation in the Czech Republic and Slovakia.

* Developing social health insurance systems. The health insurance arrangements being introduced in the two Republics have distinctive features but there is considerable experience of social health insurance schemes elsewhere in Europe. These schemes take different forms and have different problems, for example, in setting premiums and establishing payment (reimbursement) mechanisms. Particularly interesting is the shift away from a largely administrative role for insurance companies towards more active management of the companies' relationships with both the subscriber and service provider markets.

* Management in a pluralist system. The introduction of market mechanisms, like the recent reforms in the U.K., also have major implications for the management of provider agencies (e.g. hospitals), as they increasingly move towards contracts with funding agencies in which they receive 'agreed money for agreed work'. Greater provider autonomy brings greater responsibilities and greater risks for their managers and the need, therefore, for new approaches to planning,

budgetary control and the relationship between managers and clinicians. These changes have further implications for the functions of leadership in a turbulent environment especially in highly competitive market environments like in the United States of America.

* Managing strategic change. A major function of senior managers in these situations is to provide leadership for their agencies' strategies and gain the support of staff for change. There is a need however to clarify the meaning of strategy when it is difficult to predict the future and to identify key elements in developing effective strategies for achieving change.

* Management development for health care interfaces. An important characteristic of health care systems is the presence of numerous organisational boundaries (and therefore interfaces) between different elements of these systems (e.g. payers and providers) and different aspects of provision (e.g. hospital and primary health care). Management in these systems requires managers to develop new approaches to working across these interfaces and new skills in negotiation and other means of 'lateral' influence. These new approaches and skills need to be learnt.

* Setting up hospital audit. There are many elements in any serious approach to improving the quality of health services. In some British hospitals, for example, medical and other professional staff have gone about organising a continuing process of clinical audit, as one contribution to improving the outcomes of clinical practice.

* Collaboration between nurses and doctors. The rapidly changing and increasingly complex world of health care requires that doctors, nurses and the institutions which educate and employ them review the traditional doctor-nurse relationship and make it a more collaborative one, i.e. based on the recognition of inter-dependence. This has benefits for doctors, nurses and patients.

* Managing primary care. There is increasing recognition in Westerm systems of the importance of developing an effective pattern of primary health care, both to improve services to patients and to get better value from the necessarily constrained total expenditure on health care. It is instructive to compare, for example, the British model of primary health care (based on family practitioners

and their teams serving a defined practice population) to the more complex situation of the United States.

* Involving local people. There are a wide variety of reasons why any health system needs to find ways of listening to the views and learning from the experiences of the people who, as patients, use services and, as subscribers and/or taxpayers, contribute to their costs. The separation of purchasing and provision of health care makes it particularly important for the purchasing agencies to involve local people and subscribers in their work and there are many ways in which district purchasing authorities are trying to do this more effectively.

4. EVALUATION AND APPLICATION

(i) Participants' assessments of the November 1992 leadership development programme

Participants were asked to complete an evaluation questionnaire at the end of the programme at the King's Fund College. This section groups and summarises the participants' actual responses to individual questions.

Question A: What has been most valuable to you in this three week programme?

* The value of looking in depth, and with openness at another health system

"An opportunity to see the function of health care with all the pluses and minuses. Sincere indication of all deficiencies, which we should prevent."

"Getting to know the reality in other country. Problems are everywhere, at different levels, to different degree. Solutions are different and possible to use (adapted to local situation)."

"Finding out that even the country with such a tradition in democratic system have in many areas of the health care problems similar to ours."

"Practical visits at places of work, opportunity to see working practices and work organisation."

"Compare the attitude towards the patient here and at home, mainly at children wards."

"Most valuable was the opportunity to see and compare the conditions in the health care here and at home. I had the opportunity to compare for the first time. We have found out about a lot of new things, which we are currently undergoing, for us totally new."

"The fact that some of the changes we fear can be of benefit. Strict regulation of some activities, conditions, etc cannot be justified."

* Realisation of common problems and challenges in different health systems

"Perfect health system does not exist. It is important to be aware of the imperfection and admit to it and with this knowledge to adopt a solution. I mean real solution, not pretend-solution. I am not sure, if the host country follows that direction."

"Realisation that problems in the health care and its structure are in every country and we are nothing special with our problems."

"Realisation that it is necessary to adhere to financial discipline and budgets in any society."

"Recognition that changing the health system is a long term matter, which does not depend on the structure as much as on the people, who work under this structure."

"Legislation is important, most important however is to support people's activities and give them opportunity to take part in management."

"Realisation that we have to apply own effort in order to solve our problems, under the constraint of economic and political conditions."

"There is obvious effort to change the attitude and the relationship by both sides. I value very highly the status and the progress in health improvement."

* Attitudes towards staff and patients

"I have confirmed to myself that it is necessary to change mainly the attitude towards the patient. Nurses theoretical knowledge is of good standard, but the attitude towards the patient must be changed."

"Due to the changes, which are happening at home, this will be necessary to influence most."

"Necessity to change approach to the patient and his position in the health care system to his/her benefit."

"Surprising was the nurses status, which is completely different. Nursing care is totally separated, the nurse has therefore much more responsibility."

* Attitude towards participants' roles as leaders and insight into how to work more effectively in the future

"It gave me the opportunity to think about myself and to realise that, if I want to change something, I must start with myself."

"I learned to think about the substance of the problem and I have realised that it is very important to stop and consider next concrete action."

"Programme enabled me to stop and sort the problems, find the priorities and evaluate the solution to problems from more viewpoints."

"Opportunity to look at same problem from different points of view."

"Confrontation of own knowledge, views and plans with the course experiences, which lead to modification and clarification for my own future work."

"The lectures often confirmed my feelings and views about management and methods of solving problems. At the same time I have gained a great self-confidence for the future and independent dealing with problems in management."

"Confirmation that many things can be resolved without finances, just through good work organisation."

"During my university studies I took as one of the main subjects "Systems Theory" where studies theoretical issues regarding system types, their function and rules (later synergistic theory). This course enabled me to

realise the usefulness and validity of this knowledge for the role of manager as a person managing certain system."

Question B: If you were to meet today with a colleague in a similar role to your own, what would be the key lesson you would want to pass on.

* Comparing health systems internationally

"You should not have such a strong feeling of lagging behind the rest of the world."

"Health support is always limited financially. Ideal and definite solution does not exist."

"Health politics must be essential part in the work of national health insurance."

* Healthcare Leadership

"Focus on the humanisation of the health care - see a person behind every patient."

"The patient comes first."

"Before you start looking around you, look at yourself."

"Necessity to set priorities, objectives of the activity with need sometimes to stop and evaluate up to date actions."

"Do not despair, there are no problems impossible to solve".

* Information systems development

"That it probably will not be realistic to monitor costs per department, with the staff numbers and the technology we have."

"Information system designed from lower to higher levels must allow sharing of information between health services as well as between facilities."

Question C: What do you think will be the benefits of this three weeks to your organisation?

* Participants' own methods of working

"I have learned that it is necessary occasionally to stop, revise the approach and set the priorities for further work."

"I will think again over my plans."

* Influence the methods of other managers

"I will try to teach acquired knowledge to colleagues working with me on the same problem and in so doing to influence style of further work."

* Development of ideas while on the programme

"Change in the organisation status in the regional structure."

"Probably, in accordance with the new health system concept, it will come to restructuring the hygiene and epidemiology in respect to organisational structure and job description."

"Effort to find a solution to organisation's debt."

"Preserving of what is good at home."

"I hope that I will succeed in influencing too technocratic organisation management system in the direction of health care politic."

* It is too early to know the answer to this question

"It is to be seen."
"I would like to answer this question after some time."
"Time will show."
"Practice will show."

Question D: Participants were asked how their understanding of management has changed, below are some of their responses:

A year ago I thought management was	Now I think management is
I did not know the basis.	To know how to approach problems, analyse them and find optimal solution not only with one's own help, but by involving other people on the team, which takes part in solving the problem.
to put forward own ideas.	continuous co-operation with others, but in the end result evaluate and be responsible alone.
hard.	even harder.
mainly a thing of intuition.	mainly a thing of intuition and knowledge.
organising people and things.	co-operating with people when organising things.
carrying out the directives from the centre.	hard creative work where we must take decisions based on information, as well as feelings and intuition.
I did not think about it.	difficult but interesting.
kind of art.	kind of art and theoretical knowledge.
something impossible to learn.	it is necessary to learn the management.
work with people is demanding, it	the same.

requires a whole person, intelligent,
sensitive, playful, educated 'technician',
'expert', 'artist'.

management and decisions about others. myself as well.

(ii) **Applying the lessons: reflections from the March 1993 review**

Participants from the London Leadership Programme were invited to a review workshop in Brno (March 1993).

The purpose of this meeting was for participants to discuss their progress since November, review some of the lessons from the London programme, and identify ways to continue development as health sector leaders.

In the workshop participants were asked what were some of the key lessons from the November programme based on their experience since.

* Leadership

"It is essential that I learn to solve problems in my workplace without waiting for direction from the 'center' or for directions from more Senior Managers."

"The programme has increased my self-confidence to manage. I am now more sure of how to manage change."

"I have seen the need to put knowledge and ideas into practice, and have begun to do this."

"I learnt in London new methods of management and problem solving, which involve people. In the past I would not have done this, now I try to."

"There is a need for us to change our attitude as leaders, which became clear to me in England. It is important if we are to progress for leaders to take risks even if they do not know the consequences."

"It is necessary for this relationship between doctors, nurses and patients to be a concern of leaders in healthcare. In the past this has not been seen as important."

"It was very instructive to see other types of control and management of health care services in England, and to see other methods of managing changes in healthcare in action."

* Communicating

"There is a need to improve communication between healthcare staff, this especially needs attention, particularly between the public sector and the fast growing private sector."

* Nursing

"The new roles and responsibilities of nurses in England had many lessons for the Czech and Slovak health systems."

* Cost Effective Care

There is great potential benefit in concentrating management effort within health facilities on making health care operation more cost effective. It can release money for other important developments without affecting the quality or outcome of the service.

* Home Care

Participants were challenged by examples in England of health care being provided at the patient's own home for conditions that required the patients staying in hospital in the Czech Republic and Slovakia. The quality of life for the patients was high given the condition, and participants wanted to develop home care in their own localities.

Participants were asked what success they had had in putting into practice what they had learnt in the London programme. Their responses included the following

which illustrate the great variety of impact the programme has had on participants, their organisations and the services they provide:

"Included the staff in management decision making."

"Improved the quality of care, despite major changes and problems in the health system."

"Despite significant budget cuts, the system did not collapse."

"Developed new services, particularly piloting home care."

"Changed bed allocations in our hospital, to make the service more efficient and moved some services to out-patients only."

"Moved out-patient services to private sector."

"The first GPs in the district going private, others now applying."

"Decrease the number of beds and the number of employees in the hospital, without directions from the 'top'."

"Moved from research and theory of management to practical action."

"Special institutes sustaining health promotion activity."

"Working with people differently inside and outside the hospital."

"I have transferred some of my responsibilities to others without worrying, and have given them goals."

"Begin work to clarify doctors' and nurses' roles and responsibilities."

"I am now more effective at negotiating."

Some of the major difficulties they have encountered since their return include:-

"The need to adapt to meet central directives."

"The developing competition between public and private health services, where they are not learning to work together."

"Low budgets."

"The insurance companies not functioning properly."

"Difficulties in developing principles and practice of home care."

"Difficulty of reaching agreement in negotiation with other institutions in a district."

None of these difficulties were surprises to participants but they recognised that they had been able to bring about change despite these and other problems.

Continuing the process of review

The diagrams below were introduced to the participants to illustrate the way in which they had been working in the leadership programme and provide a method to sustain their own personal development and that of the organisation they represented.

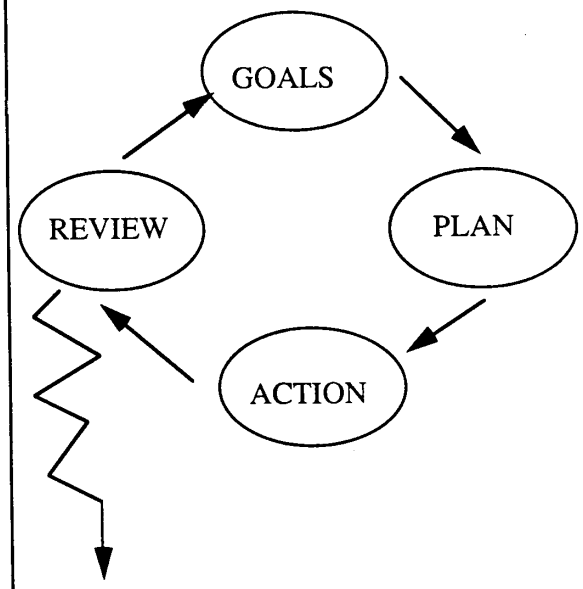
At its simplest, this method involves Setting Goals; Planning Action; Taking Action and Review (See Fig. 2).

If we were all entirely rational people; machines with no emotions, this would be quite adequate as a model of how we work. Fortunately we have emotions, feelings and passion. We therefore have to create a more extensive model of change for individuals and organisations.

A common weakness of the model in Figure 2 is that if review occurs at all, it often leads into blaming others for disappointments, negative criticisms or personal despair (See Figure 3).

FIG 2

FIG 3



Blaming
Negative Criticism
Despair

FIG 4

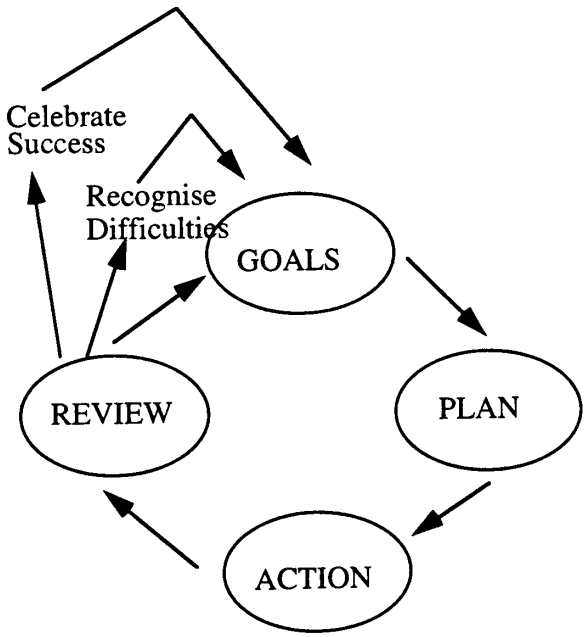
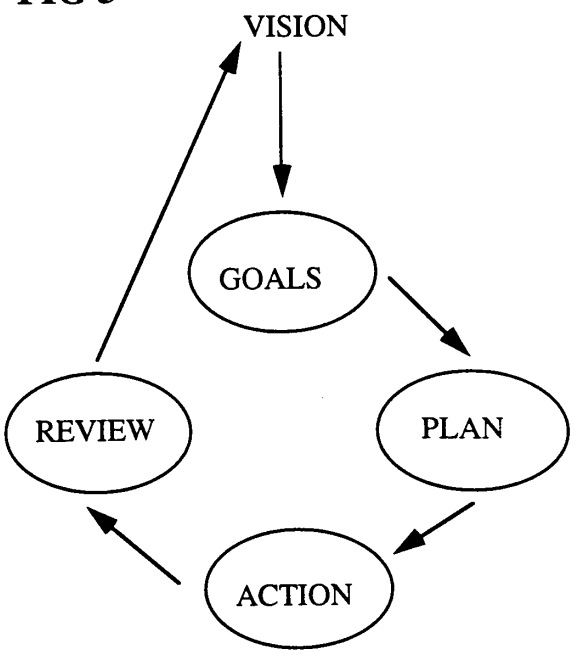


FIG 5



It is harder to undertake reviews where Success (however small) is acknowledged and celebrated and where Difficulties are identified and analysed without recourse to blame (See Fig. 4).

If reviews take this form there is greater opportunity to set more realistic goals for the future, taking true account of experience.

When goal setting, it is often very helpful to step back from the immediate problem and review how the individual or organisation wishes to be different in the medium term (maybe 1-3 years), building a concrete picture or Vision of the future. This could be in terms of the clinical services to be developed, the organisation to be established or the values or culture to be created. This sets a context to test the value and purpose of shorter term actions and enriches the goal setting process (See Fig. 5).

For the individual and the organisation it is also important to review the values that are influencing choice and risk taking. What is of importance to this organisation; for example for a hospital, is the generation of new services for patients more important than generating a profit, or is the sustaining of current employment levels more important than improving the quality of services. These factors underpin the criteria used in decision making.

The result of these 'humanising factors' in managing change and development can be seen in Fig. 6.

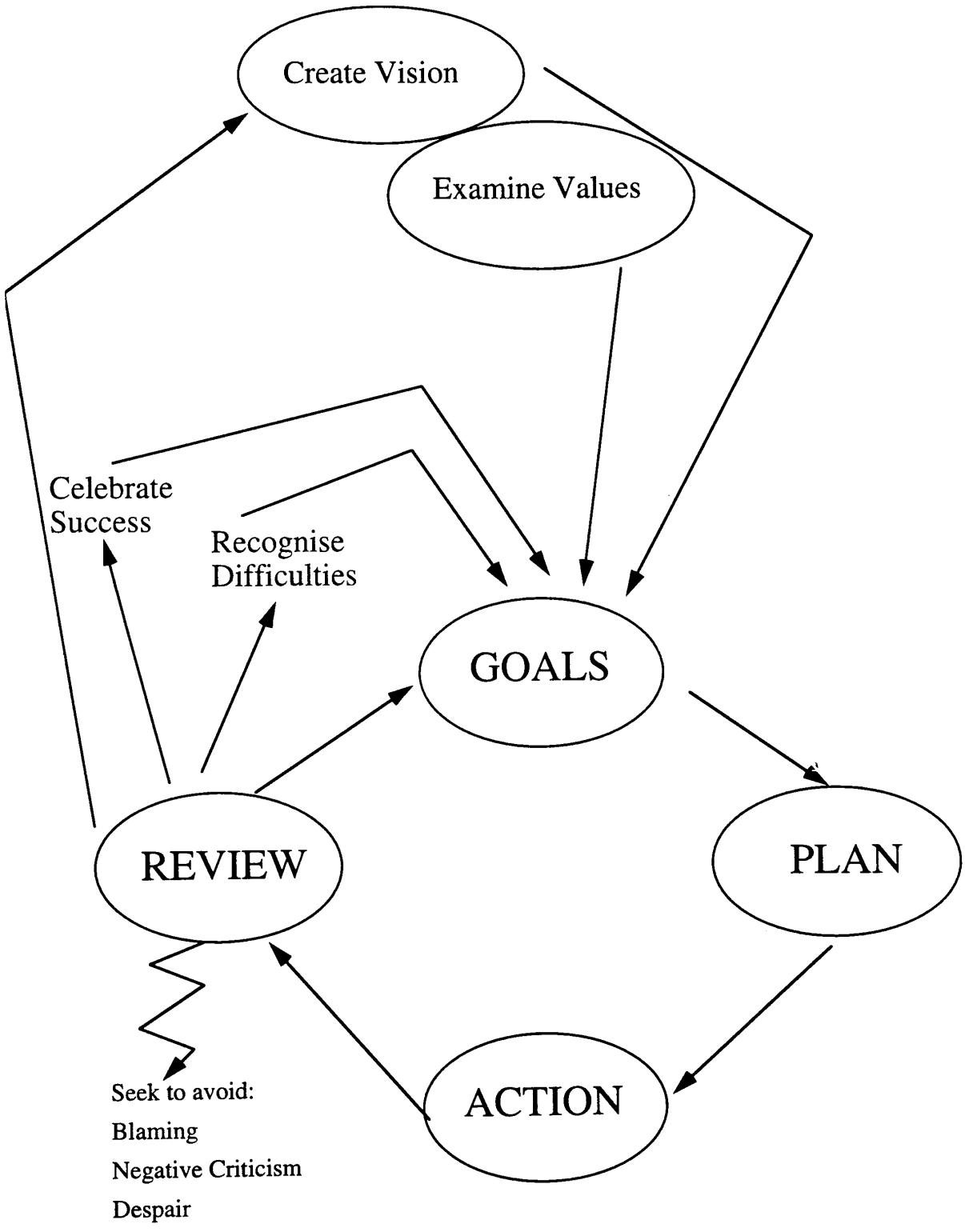
Looking Ahead

Participants were asked what two or three achievements they would be hoping to celebrate were another review to be organised in March 1994.

Among their responses were the following:-

> "To have survived within the State budget and sustained the good in our health service."

FIG 6


Create Vision
Examine Values
Celebrate Success
Recognise Difficulties
GOALS
REVIEW
PLAN
ACTION
Seek to avoid:
Blaming
Negative Criticism
Despair

"To have saved money on big issues, such as energy, payments to mothers, medicines, reduce 'special' money, release some employees, close some departments or wards."

"To have built a new network of out-patient and primary care doctors."

"Check the purpose of privatisation, monitor progress and sustain standards of care."

"To have found ways of keeping an interest and concern for patients' needs."

5. FURTHER READING

(i) Published papers discussed during the Leadership Development Programme.

* Crown, J. "Needs Assessment"
  British Journal of Hospital Medicine
  Vol. 46, November 1991, pp.307-308

* Health Care in Transition - Report on the First Meeting of
  the Working Party on Health Care Reforms in Europe.
  World Health Organisation,
  Regional Office for Europe, Copenhagen, 1992

* Boufford, J.I. "Managing the Unmanageable"
  International Journal of Health Planning and Management
  Vol. 6, 1991, pp.143-154

* Mintzberg, H. Crafting Strategy
  Reprint No. 87407 from the Harvard Business Review, 1987

* Hunter, D. "Managing the cracks: Management development
  for Health Care Interfaces"
  International Journal of Health Planning and Management
  Vol. 5, 1990, pp.7-14

* De Lacy, G., Jacyna, M., and Chapman, E.
  "Setting up Hospital Audit" Hospital Update
  September 1992, pp.670-676

* Fagin, C. "Collaboration between nurses and doctors"
  Nursing and Health Care, September 1992, pp.354-363

* Grumback, K and Fry, J. "Managing Primary Care in the United States and
  in the United Kingdom"
  New England Journal of Medicine,
  Vol 328, No. 13, 1993, pp.940-945.

(ii) Relevant publications from the King's Fund

* King's Fund College The Commissioning Experience
London, King Edward's Hospital Fund, 1992

* Jacobs, B. The Nation's Health: A Strategy for the 1990s
London, King Edward's Hospital Fund, 1991

* Ham, C. Health Check: Health Care Reforms in an International Context
London, King Edward's Hospital Fund, 1990

* Carle, N. Managing for Health Results
London, King Edward's Hospital Fund, 1990

* Parston, G. Managers as Strategists: Health Services Managers Reflecting on Practice
London, King Edward's Hospital Fund, 1986

* Wall, A. Ethics and the Health Services Manager
London, King Edward's Hospital Fund, 1989

* Sanders, D. Variations in Hospital Admission Rates: A Review of the Literature
London, King Edward's Hospital Fund, 1989

* Jost, T.S. Assuring the Quality of Medical Practice: An International comparative Study
London, King Edward's Hospital Fund, 1990

* Shaw, C. Medical Audit: A Hospital Handbook
London, King Edward's Hospital Fund, 1989

* Hughes, J. and Humphrey, C. Medical Audit in General Practice: A Practical Guide to the Literature
London, King Edward's Hospital Fund, 1990

* Stocking, B. Medical Advisers: The Future Shape of Acute Services
London, King Edward's Hospital Fund, 1992

* Taylor, D. Developing Primary Care: Opportunities for the 1990s
London, King Edward's Hospital Fund, 1991

* Hughes, J. and Gordon, P. An Optimal balance: Primary Health Care and Acute Hospitals in London
London, King Edward's Hospital Fund, 1992

* Hughes, J. Enhancing the Quality of Community Nursing
London, King Edward's Hospital Fund, 1990

* Salvage, J. Nurse Practitioners: Working for Change in Primary Health Care Nursing
London, King Edward's Hospital Fund, 1991

* Towell, D. and Beardshaw, V. Enabling Community Integration
London, King Edward's Hospital Fund, 1991

* Shearer, A. Who Calls the Shots? Public Services and how they serve the people who use them
London, King Edward's Hospital Fund, 1991

(iii) Recommended books on management

Beckhard, R. and Pritchard, W.
Changing the essence: the art of creating and leading fundamental change in organizations
London: Jossey-Bass, 1992

Bennis, W.
Onbecoming a leader
London: Collins, 1988

Blackwell, E.
How to prepare a business plan
London: Kogan Page, 1989

Boss, R.W.
Organisation development in health care
Woking: Addison-Wesley, 1989

Caple, T.
Preparing people for change: a handbook for trainers and managers
Bristol: NHSTA, 1990

Garner, L.H.
Leadership in human services: how to articulate and implement
a vision to achieve results.
London: Jossey-Bass, 1989

Harvey-Jones, J.
Making it happen: reflections on leadership
London: Collins, 1988

Kotler, P. and Clarke, R.N.
Marketing for health care organisations
Englewood Cliffs, USA: Prentice Hall, 1987

Mintzberg, H.
Mintzberg on management: inside our strange world of organizations
New York: Collier/MacMillan, 1989

Mooney, G.
Economics, Medicine and Health Care
London: Harvester Wheatsheaf, 1992

Pedler, M., Burgoyne, J. and Boydell, T.
A Manager's Guide to Self Development
London McGraw Hill, 1978

Porter, M.E.
Competitive advantage: creating and sustaining superior performance
New York: Collier/MacMillan, 1985

Schein, E.
Process Consultation
Wokingham, England: Addison-Wesley, 1987

Schon, D.A.
Educating the reflective practitioner
London: Jossey-Bass, 1987

APPENDIX: PROGRAMME AND PARTICIPANTS

Programme aims and arrangements

The PHARE health sector management project in the CSFR aims to contribute to the success of new health systems by improving the managerial capacity to implement major reforms. The main focus of project work is within the two Republics at both local and Republic levels. This management development programme at the King's Fund College is designed to reinforce current initiatives within the two Republics by offering twenty-two people the opportunity to explore together how major change can be achieved in the light of other European experience.

Participation

Invitations to participate in this programme are being issued to suitably qualified people at the Republic level nominated by the Project Co-ordinators of the two Health Ministries and by representatives of health sector agencies in the three 'pilot districts' in which project work has so far been concentrated: Litomerice, Pisek and Trencin.

It is intended that participants should have leadership roles in managing health sector transformation and reflect the pluralism in new arrangements, i.e. by representing the interests of government, general insurance companies, local authorities, hospitals, primary health care and related agencies concerned with public health and information. A few places have also been reserved for people with management training responsibilities in the two Republics.

Language

While some understanding of English will clearly be an asset in visiting Britain, the programme is being organised so as not to exclude non-English speakers. Classroom presentations will be translated, group discussion will be in Czech/Slovak and interpreters will be available to assist in visits to health sector agencies.

The programme is also offering English-speaking preparation opportunities for participants with some English who wish to practise before coming.

Aims

In both Republics, health sector leaders face the double challenge of achieving significant improvements in health care through a major change in systems for organising and financing health services.

The central aim of this programme is to assist participants in increasing their capacity to manage this transformation successfully:

- in their roles as leaders in different agencies
- as participants in 'lateral' networks which link different agencies
- as participants in wider networks which link Republic and local action

It is intended that the Programme will increase understanding of management in health care and be useful in strengthening subsequent efforts to tackle problems in participants' own managing.

The educational approach adopted by the College starts from the situation of programme participants and seeks to draw on their ideas and experiences in exploring better ways of managing.

In this Programme, participants will also be encouraged to draw lessons from the experience of major change in other health systems, particularly recent reforms in Britain. Faculty will assist in drawing out principles for effective management in times of rapid change and identifying useful management tools.

Opportunities will be provided for participants to:

- seek assistance in addressing questions of individual interest; (Individual Consultancy)
- work with colleagues with similar jobs (e.g. hospital director) on common challenges, (Role Groups)
- work with colleagues from the same geographical area (e.g. Pisek) on local agenda; (Local Groups)
- work with colleagues at different levels in the same system on wider

implementation questions; (Republic Groups)
and to exchange ideas across these different boundaries.

Design

In advance of the November Programme, participants will be invited both as individuals and as representatives of particular networks to identify key leadership questions they hope to address through the Programme.

In Britain, the three weeks are organised as follows:

Week One: 9-13 November, King's Fund College
Exploring the nature of positive leadership for change in the CSFR in the light of wider European experience

Week Two: 16-20 November
On location as guests of provincial and local health systems to study British health care management in practice

Week Three: 23-27 November, King's Fund College
- Using the principles developed in Week One and lessons from Week Two in developing more detailed strategies for managing transformation in the CSFR and considering how best to apply these ideas "back home".

After the Programme it is hoped participants will take the lead in organising relevant follow-up activities designed to share lessons and promote positive action within the CSFR.

Czech and Slovak Participants

Czech Republic

MUDr Antonin Cernohorsky	Department of Clinical and Primary Care at the Czech Health Ministry, Praha
PhDr Vlastimil Fikr	School of Public Health, Institute for Postgraduate Medicine, Praha
PhDr Blanka Slavikova	Institute of Social Medicine, Praha
RNDr Ales Svarovsky	Institute of Social Medicine, Praha

Litomerice

Ing Vlastimil Fibich	Hospital Director, Roudnice
MUDr Miroslav Jiranek	Hospital Director, Litomerice
Ms Mariela Krebsova	Chief Nurse
MUDr Stefan Mates	General Practitioner
MUDr Jana Sterbova	Director, Insurance Company

Pisek

MUDr Karel Kukleta	Director, Insurance Company
MUDr Pavel Pohorsky	Director, Polyclinic and General Practitioner
MUDr Petr Pumpr	Hospital Director

Interpreter:

MU Dr Ivana Podropska	Diabetologist, Litomerice

Slovakia

MUDr Juraj Karovic	Deputy Director of Institute for Introducing Health Insurance, Bratislava
MUDr Priska Rupcikova	Department of Hygiene and Epidemiology at the Slovak Health Ministry, Bratislava
RNDr Jozef Pivacek	Research Institute of Medical Informatics, Bratislava

Trencin

MUDr Natasa Gullerova	Deputy Hospital Director
Ing Alzbeta Nebusova	Head of Economics Department
MUDr Olga Polekova	Head General Practitioner
MUDr Pavol Simurka	Head of Paediatrics Department
Ms Anna Vaculikova	Chief Nurse

Rimarska Sobota

MUDr Dusan Bares	Medical Officer, Institute of Hygiene and Epidemiology

Interpreter

Dr Henrietta Kajabova	Slovak Academic Information Agency

Programme Staff

Directors:

Mr Peter Mumford, BSc, MBA, Fellow in Organisation Development
Dr David Towell, MA, PhD, Fellow in Health Policy and Development

Contributors:

Ms Sandra Andrews, Director of Finance, Bromley Joint Purchasing Authority
Dr Jo Ivey Boufford, MD, Director, King's Fund College
Dr June Crown, MA, MB, B Chir, MSc, FFCM, Director, South East Institute of Public Health
Ms Sheila Damon, MA, MSc, MSc, MSc, C, Psychol, Fellow in Organisational Behaviour
Ms Eva Lauermann, BSc (Hons), Fellow of the College
Professor Hans Maarse, Department of Health Policy and Administration, University of Limburg
Dr John Mitchell, MB, FRCP, Fellow in Health and Clinical Management
Professor Antonio Garcia Prat, MSc, Instituto de Estudios Superiores de la Empresa, Barcelona
Professor Jaume Ribera, MSc, PhD, Instituto de Estudios Superiores de la Empresa, Barcelona
Mr John Smith, BA, MA, Deputy Director Finance & Information & Fellow in Public Service Management
Dr Robin Stott, Medical Director, Lewisham Hospital, London

Interpreters: Ms Teresa Hesounova, PhDr Henrietta Kajabova, MUDr Ivana Podropska, MUDr Ljuba Stirzaker, Mgr Eva Stricova, Mr Edward Strouhal

Hosts in England and Wales include:

Dr M Bailey, General Practitioner, Severnvale Surgery, Cheltenham
Miss M Bull, Chief Nursing Officer, The Welsh Office
Mr P Colclough, Chief Executive, Gloucester Health Authority
Ms M Harris, Director of Operations, Cheltenham General Hospital

Mr G Harrhy, Chief Executive, South Glamorgan Health Authority

Dr Alison Hill, Director of Public Health, Buckinghamshire Purchasing Agency, Whitchurch

Dr D Hine, Chief Medical Officer, The Welsh Office

Ms Liz Jayne, Co-ordinator, Healthy Sheffield 2000

Mr M Jenkins, General Manager, Mid Glamorgan Family Health Services Authority

Dr Keith Levick, Chief Executive, Sheffield Children's Hospital

Mr Tony Mapplebeck, Chief Executive, Sheffield Health Authority

Mr Bob Nicholls, Chief Executive, Oxford Regional Health Authority

Ms Helen Orton, Purchasing Directorate, Sheffield Health Authority

Dr Ljuba Stirzaker, Specialist in Public Health Medicine, Oxford Regional Health Authority

Mr George Walker, General Manager, Sheffield Family Health Services Authority

Dr G Williams, Director of Public Health, Brighton Health Authority

Schedule

WEEK ONE

Monday 9th November

Travel by air from CSFR to London, Heathrow Coach to Bayswater. Register at Embassy Hotel (150 Bayswater Road, London, W2 4RT. Tel. No. 071 229 1212, Fax. 071-229 2623).
Walk to King's Fund College (2 Palace Court, London, W2 4HS. Tel. No. 071 727 0581, Fax. 071-229 3273).

5.15pm **Welcome and Introduction** — Peter Mumford, David Towell

* Welcome to Britain and the College
* Introducing Programme Staff and Participants
* Aims and Arrangements for the next three weeks
* Getting maximum benefit from the Programme
* Working across language and other barriers
* Ensuring a comfortable and interesting stay

6.30pm *Buffet Dinner*

7.30pm **Getting to Know Each Other**
An introductory exercise for Participants and Programme Staff to begin establishing working relationships.

9.15pm *Session Ends*

Tuesday 10th November

9.00am *Programme Forum*

9.15am **Hearing from the Different Localities**

Working in locality groups, participants will have an opportunity to share their news and experiences of working in the Czech and Slovak Health System. Key themes from this discussion will be presented to the whole group.

10.45am *Coffee*

11.15am **An introduction to the British Health System** — John Smith

A presentation on the evolving pattern of health care in Britain, how it is organised and financed, and how the system is changing in the light of recent reforms.

12.45pm *Break for Lunch at 1.15pm*

2.15pm **The Experience of Working in the Changing British Health System** — Robin Stott

A senior manager will discuss the changing demands on him and his personal experience of working in the British health system.

3.45pm *Tea*

4.15pm **The Experience of Working in a Changing Health System** — David Towell, Peter Mumford

We will look at experiences participants have had of trying to fulfil their role and their aspirations in the Czech and Slovak health system.

5.45pm *Session Ends - Break for dinner at 7.00pm*

8.00pm **Leadership, Management and Administration** — Peter Mumford

A presentation and discussion on the development of management in the British health service, attempts to move away from a centralised

bureaucracy and the impact on people working in the system.

9.00pm *Session Ends*

Wednesday 11th November

9.00am *Programme Forum*

9.15am **What Do I Want From This Programme?**
Individuals will be helped to clarify for themselves how they can best use this Programme.

10.45am *Coffee*

11.15am **Managing People in Organisations** — Eva Lauermann
A case study which explores the management of an organisation that has lost sight of its purpose.

12.45pm *Break for Lunch at 1.15pm*

2.15am **Managing Changing Organisations** — Eva Lauermann
An introduction to the management of people in health services, drawing on UK experience and current issues in the Czech and Slovak Republics.

3.45pm *Tea*

4.15pm **Assessing Health Needs** — June Crown
A guide to how population health needs can be identified and the role of need assessment in influencing the pattern of health services. Discussion on how and where health need assessment should influence the development of British, Czech and Slovak health services.

5.45pm *Break for Dinner at 6.15pm*

7.00pm **Managing with Money** — Sandra Andrews

A presentation and discussion of how one manager has taken the opportunity of the UK health reforms to use money more effectively in providing health services.

9.00pm *Session Ends*

Thursday 12th November

9.00am *Programme Forum*

9.30am **Managing Pluralism : Lessons from International Experience** — Hans Maarse

Drawing on wider Western experience, this session will explore distinctive management opportunities and challenges in health systems characterised by insurance funding, privatisation and the growth of pluralism.

10.45am *Coffee*

11.15am **Managing Pluralism : Lessons from International Experience** - Continued — Hans Maarse

Further exploration of changing roles and relationships associated with privatisation.

12.45pm *Break for Lunch at 1.15pm*

2.15pm Open session

3.45pm *Tea*

4.15pm **Health Care 2001** — Peter Mumford, John Mitchell

Participants will use a simulation of future negotiations about health services requirements

to explore relationships among different parties in a pluralist system.

5.45pm *Break for Dinner at 7.00pm*

8.00pm **Refining Local Agendas** — David Towell, John Mitchell, Toni Garcia

Working in groups from the same localities, participants will have an opportunity to review what they have learnt from the week and what they now hope the Programme will help them and their 'back home' colleagues to address more effectively.

9.30pm *Session Ends*

Friday 13th November

9.00am *Programme Forum*

9.30am **Information as a Tool for Management** — Toni Garcia

A presentation on the development of relevant information systems as tools for managerial decision-making and exploration of how information can be utilised effectively.

10.45am *Coffee*

11.15am **Preparation for Week Two** — Peter Mumford, David Towell

Introduction to the aims of the visits to different parts of Britain in Week Two and description of host agencies.
Establishing 'visiting teams' and team discussion of their agenda for enquiry.

12.45pm *Break for Lunch at 1.15pm*

2.15pm **Preparation for Week Two** - Continued — Toni Garcia
Visiting teams share agendas with whole group. — David Towell
Discussion of ways of maximising the value of the visits.

3.15pm *Tea*

3.45pm **Review of Week One and Planning Week Three** — Peter Mumford
Participants meet in pairs to review the week's experience against their individual agendas and identify priority themes for further work. — David Towell
Pairs share key points with whole group.

4.45pm *Session Ends*

Friday Evening *Dinner and cultural entertainment in London*

Saturday 14th/Sunday 15th November

Participants will be able to get to know Britain better through optional visits and entertainment organised by the College and/or explore London for themselves.

WEEK TWO

Monday 16th November

8.30am Final briefing at the College for visiting teams.

9.15am Leave London for host locations:

* Brighton
* Gloucestershire
* Oxfordshire/Buckinghamshire
* Sheffield
* Wales

Late Morning Arrive at Host Locations. Register at Hotels.
Welcome from Hosts.

Lunch with hosts

2.00pm Introductions between hosts and participants.
Briefing on location and relevant health sector agencies.
Reviewing team agendas and programme for week.

Tuesday 17th-Friday 20th November

Host agencies are organising opportunities for members of the visiting teams to:

- visit different agencies and services in the area;
- discuss policy, management and delivery issues with local leaders; and in Wales with Ministry officials;
- spend time with people in jobs similar to their own, seeing British management in practice;
- review with other team members each day what is being learnt from their observations;

Building on the framework established in Week One, it is expected that these visits and discussions will provide opportunities to explore in practice:

- the current pattern of health services and how this is delivered in different settings (hospitals, primary health care centres, home care services);
- the work of clinicians and how this is managed;
- the influence of users on service delivery and development;
- the use of management and clinical information systems;
- the ways quality is defined and maintained
- developments in the purchasing of health services and the need for new roles and capabilities;
- inter-agency negotiation and collaboration among purchasers and providers;
- the role of health services as part of wider strategies for health promotion and prevention;
- what agency leaders are learning about the dynamics

of reform in Britain and successful strategies for managing change.

Friday 20th November - Afternoon

Review

Participants in the visiting teams will be encouraged to review their impressions and lessons from British health care with their hosts and the people they have met through the week.

Friday evening and Saturday 21st November

Participants will be able to get to know another part of Britain better through optional entertainment and visits organised by the College.

Sunday 22nd November

Morning *Travel back to London*

1.00pm *Lunch*

Afternoon *Optional tourism organised by College*

7.00pm *Dinner and free evening*

WEEK THREE

Monday 23rd November

9.00am **Welcome and Introduction to Week Three** — Peter Mumford, David Towell

9.30am **Lessons from the Visiting Teams**
Visiting teams will have an opportunity to draw out key lessons and impressions from Week Two with their colleagues.

10.30am *Coffee*

11.00am **Lessons from the Visiting Teams** - Continued

Each visiting team to give brief presentations to the whole group on lessons and impressions from their visits to host organisations.

Discussion.

1.00pm *Break for lunch at 1.15pm*

2.15pm **Lessons for Role Groups** — David Towell, Peter Mumford

Participants with similar responsibilities will meet in their 'role groups' to share lessons for their own roles in the Czech and Slovak Republics from the local visits.

Role groups will be invited to share briefly key lessons and further questions with the whole group.

3.45pm *Tea*

4.15pm **Lessons for Locality Groups**

Participants from the same localities will meet to share lessons for their own efforts to manage transition in systems and services.

6.00pm *Break for Dinner at 7.00pm*

8.00pm **Patient Perspectives on the British Health System**

Participants will be invited to prepare a short presentation which captures their perspective of what it might be like to be a patient in the British health system.

9.30pm *Session ends*

Tuesday 24th November

9.00am *Programme Forum*

9.30am **Population Health and Public Accountability** — June Crown, David Towell

Building on the examination of Needs Assessment in Week One, this session will present ideas and tools for relating the local pattern of health services to population needs.

By comparison with British experience, participants will be invited to consider further how in the CSFR health services might be shaped to meet different local needs and the roles of different agencies in achieving this.

10.45am *Coffee*

11.15am **Population Health and Public Accountability** - Continued — June Crown, David Towell

This exploration will continue with attention to the further question of how far health sector agencies in a pluralist system should be accountable to the public and in what ways.

12.45pm *Break for Lunch at 1.15pm*

2.15pm **Leading Strategies for Change** — Sheila Damon

Building on ideas developed in Week One, this session will present a fuller framework for managing and leading change in health systems and services.

3.30pm *Tea*

4.00pm **Leading Strategies for Change** - Continued — Sheila Damon

Using Czech and Slovak examples, participants will work in groups to develop strategies for tackling particular problems.

5.30pm *Break*

An Evening of English Hospitality!

Wednesday 25th November

9.00am *Programme Forum*

9.30am **Personal Development Review** — Peter Mumford, Sheila Damon

This is an opportunity for participants to review the roles, priorities and aspirations they have within their own health systems. Participants will be encouraged to consider what changes they may wish to make and work together on common themes.

10.45am *Coffee*

11.15am **Personal Development Review** - Continued — Peter Mumford, Sheila Damon

12.00am *Break for Lunch at 1.15pm*

2.30pm **Managing People** — Eva Lauermann

An opportunity to explore issues concerned with managing people and situations at work, through exercises and examination of participant's own experiences.

OR Visit to Private Health Insurance Company.

3.45pm *Tea*

4.15pm **Managing People** - Continued — Eva Lauermann

5.45pm *Break for Dinner at 6.30pm*

7.30pm **Lessons from America** — Jo Boufford
A personal view of working as a health care leader in the United States.

9.00pm *End of Session*

Thursday 26th November

9.00am *Programme Forum*

9.30am **Developing Management Information Strategies** — Jaume Ribera, Toni Garcia
Building on earlier work, presenters will develop a framework for diagnosing information needs and designing low cost management information systems. Participants will then work in groups to sketch the requirements for useful management information systems in Czech and Slovak contexts.

10.45am *Coffee*

11.15am **Developing Management Information Strategies** - Continued — Jaume Ribera, Toni Garcia
This work will continue and groups will share key proposals with the whole group.

12.45pm *Break for Lunch at 1.15pm*

2.15pm **Management in Practice** — Jaume Ribera, Toni Garcia
In this session we will draw out key lessons from the programme through a practical exercise in management.

3.30pm *Tea*

4.00pm **Lessons for the Czech and Slovak Republics** — Peter Mumford, David Towell
Participants from each Republic will meet together to summarise key lessons from this three weeks'

work for implementing health sector reforms in their Republic, possibly highlighting:

- personal lessons and insights
- lessons they are taking back to their own organisations
- ways of supporting other local leaders in developing the capacity to manage change successfully
- implications for central/local relations in the developing systems

5.30pm *Session ends*

7.00pm *End of Programme Dinner*

Friday 27th November

9.15am **Learning, Application and Evaluation**
Participants will work individually and in groups to consider the next steps in their development strategies and ways of sharing lessons from this Programme with relevant colleagues.

June Crown
Sheila Damon
Toni Garcia
John Mitchell
Jaume Ribera
David Towell

10.15am *Coffee*

11.00am **Learning, Application and Evaluation**
- Continued
Participants will be invited to evaluate this Programme as a contribution to health sector leadership development in the CSFR.
Finally participants and Programme staff will share hopes for the future and say farewell.

12.15pm *Break for Lunch at 12.30pm*

Early Afternoon Coach to Heathrow for return flights to the CSFR

Better
MANAGEMENT
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HEALTH

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

EDUCATIONAL PROGRAMME REPORT 2

Developing management information systems
Programme design and participants in the IESE national seminars (December 1992; January 1993) and study visits (March 1993)

INTRODUCTION

As part of the PHARE health sector management project, the management information systems experts in the project team, Professor Toni Garcia and Professor Jaume Ribera (both from the Instituto de Estudios Superiores de la Empresa, Barcelona) led national health management information system seminars in each Republic and organised visits for twelve Czech and Slovak management and information systems experts to study aspects of the Catalan health system.

This paper reports on the design of these two seminars and describes issues of interest to participants in the Barcelona study visits.

CONTENTS

HEALTH MANAGEMENT INFORMATION SYSTEMS SEMINAR - STUPAVA - December 14th and 15th, 1992

I. PARTICIPANTS

- Ministry of Health
  MUDr. Rupcikova. Head of Epidemiology Department

- Health Insurance Company
  Dr. Karovic. Deputy Director

- Research Institute for Medical Informatics
  Dr. Rusnak. Deputy Director
  Dr. Pivacek

- Institute of Health Information and Statistics (UZIS)
  Dr. Ondrejka. Director
  Ing. Uvacek
  Ing. Svitkova
  Doc. Volna

- National Institute of Hygiene and Epidemiology
  MUDr. Krizanova
  Ing. Nemeth

- ILF
  Dr. Schwarzova
  Ing. Krnac

- Institute of Hygiene and Epidemiology. Trencin
  Dr. Holla

- Trencin Hospital
  Dr. Gularova
  Dr. Obeda
  Dr. Polekova
  Dr. Simurka
  Ms. Vaculikova

- Health Insurance Agency. Trencin
  Dr. Paliatka

- Institute of Medical Cosmetics
  Dr. Haid

- Institute of Hygiene and Epidemiology. Rimavska Sobota
  Dr. Beres

- PHARE Project Adminstrator
  Mgr. Stricova

- PHARE Project Team
  Prof. Garcia
  Prof. Ribera
  Dr. Mitchell

II. OBJECTIVES

The main objectives of this seminar were the following:

- To familiarize participants with a methodology to solve information systems (MIS) problems from a managerial perspective, i.e. related to the mission and the vision of the institution.

- To clarify the stages of MIS analysis required before a hardware decision needs (or can) be made.

- To provoke inter-sectoral/inter-institutional discussion in a non-threatening environment.

III. PROGRAMME

First session: SASA. This case is an introductory case presenting the situation of an auction company in Madrid. The participant is asked to define the critical success factors (CSF) of the company and to develop an analysis of the information system needed to help achieve them.

a) Define business. Identify stake-holders.

b) What is the mission of the business. Development of performance indicators to evaluate the success

c) Definition of the Critical Success Factors (CSF).

d) Basic Idea on how Information Technologies can help improve performance on CSFs.

e) Define existing Business Activity Sequences (BAS) of the business.

f) Critique and improvement of the BAS. Concept of added value/cost.

g) Information needed in each step of the BAS.
   - Operational vs. Supporting activities

- Information process sequences vs. Decision intervals
- Level of knowledge about the process
  * Observable - Evaluate
  * Controllable - Factors to influence
  * Improvable / Optimizable

h) Specify Information System Procedures
- Data flow diagrams: output and input definition
- Data dictionaries
- Entity - relationship models
- Data processing descriptions
- Data base design

Second session: Nemocnice Svate Klary (case study)

Previous methodology applied to a hospital with three different businesses (social security, private insurance and private patients) facing changes in the environment and organizational problems.

Third session: The Spanish system: structural and information systems evolution

Fourth Session: Mapping missions, CSF and information requirements in the Slovak Health System

IV. COMMENTS ON THE EVOLUTION OF THE SEMINAR

a) This was the first seminar to be offered in-country (following the London educational programme, November 1992) and we did not do a good job of communicating the objectives, thus resulting in a group with mixed expectations and non-homogeneous level of knowledge on MIS.

b) The methodological approach presented in a theoretical way on the first day did not match the expectations of most participants, specially those that had not attended the London programme nor had had any previous contact with the Project. Participants seemed to be looking for "quick informatic solutions" tied to their particular tasks in the present. Furthermore, the proposed case

discussion method was new to many of the participants who were more used to sit and listen to proposed solutions.

This situation was somehow frustrating both for participants and leaders. Despite this, a decision was made by the project team to proceed with the original program.

c) On the second day of the seminar, participants were asked, as planned, to identify missions of the different stake-holders present in the Slovak health system. Thus, ministry, insurance company, district authorities and providers were to define their reason for existence and also their most critical functions and objectives. Once this process was accomplished, information requirements and interrelations had to be mapped.

It was difficult for some participants to produce clear views on their agencies' contributions when considering the real nature of their current jobs. Probably because of this, some participants left the seminar at the time these issues were to be discussed.

d) In the last part of the seminar, where participants had to discuss with other stake-holders the interrelations in terms of information, it appeared that:

- no provision was made from central administrative levels to provide information to lower level providers of health care

- some discussions started in such a way that some participants were trying to look for a way of justifying the information they are now collecting, thus revealing a clear sense of feeling threatened by the recent and coming events

- some participants reported being approached by others who, in the past, had been reluctant or even had refused to cooperate or share information; these old behaviours seem to be being replaced by a more "cooperative-we need to sit down and talk" approach. (Can this be one of the measures of success of this seminar?)

HEALTH MANAGEMENT INFORMATION SYSTEMS SEMINAR - ZVIKOV - JANUARY 21ST AND 22ND, 1993

I. PARTICIPANTS

- FN Hradec Kralove Dr. Milan Elbl
- Batlova nemocnice Zlin Dr. Prehnal p. Lumobir Machovec
- Stredisko aplikovane kybernetiky Benesov Ing. Jan Martinek
- UZIS Mgr. Jiri Holub Mgr. Zuzana Kamberska
- NsP Kladno MUDr. Alice Baumannova
- nemocnice Pardubice Ing. Radim Petras
- FN Olomouc MUDr. Jiri Petr
- nemocnice Pisek Dr. Pumpr Ing. Janovsky
- nemocnice Bulovka Ing. Frantisek Novak
- Fakultni nemocnice Praha 2 Ing. Cestmir Holy
- vyp. stredisko Hradec Kralove Ing. Milan Svoboda
- nemocnice usti nad Laben Dr. Pavel Zubina
- prednosta klinicke hematologie Olomouc Doc. Jindrak, CSc.
- FNI Ing. Sedlak
- nemocnice Trebic Dr. Jan Lhotsky
- NsP Pribram Ing. Jaroslav Kaluz
- nemoncnice Vsetin Ing. Martin
- vypocetni stredisko Praha 9 Ing. Karel Vavra
- ministerstvo zdravotnictvi CR RnDr. Karel Neuwirt Dr. Martin Malinak
- Special guest/interpreter Frantisek Osanec
- Interpreter Zdenek Krpal
- PHARE Project Team Prof. Ribera Prof. Garcia

II. OBJECTIVES

- To familiarize participants with a methodology to solve information systems problems from a managerial perspective, i.e. related to the mission and the vision of the institution.

- To clarify the stages of MIS analysis required before a hardware decision needs (or can) be made.

- To provoke inter-sectoral/inter-institutional discussion in a non-threatening environment

III. PROGRAMME

The program was slightly modified after the previous experience of teaching it at Stupava. However, the objectives remained the same.

Introduction (before lunch first day, since we started very late)

Brief introduction of the professors and the participants. Distribution of name tags. Asked to find similarities with the jobs of other participants in order to create a team later on.

Presentation of the program. Explained why we will use cases and that we will be very flexible with the timetable, adjusting it as we move along.

Presentation of three working schemes for management information systems:

(1) Operations diagram on three levels: (a) operative, (b) decision-making, (c) policy-making and resource-allocation. Data/Information flow among them.

(2) Diagram on systems, structure and people.

(3) Management control systems cycle: Plan, Do, Check, Act.

First session (immediately after lunch) Your job

The participants were asked to take a piece of paper and answer the following questions:

(1) A description of the task of the department they are working in.

(2) Why does this department exist? What is its purpose? Its objectives?

(3) Define a set of measures to evaluate the department. I.e. if you go on leave of absence for a year and when you return your successor tells you the things are now much better/worse, how would you evaluate the truth of the statement.

(4) What is the information that you get now that is useful to your job (refer also to question 3)

(5) What is the information that you do not get yet but that would be very useful to your job.

(6) What information do you provide to others. How do they use it?

After their individual answers, small teams met to agree ideas in common. Finally each group made a presentation and the rest questioned some of the points they made.

We concluded with a few comments on the presentations: the importance of measuring results, the easiness of defining success by looking at inputs and process, and the necessity of focusing on actual results achieved by the internal/external customers. Several examples provided by the participants included: (a) input: (equipment available, number of beds, number of surgeons, etc), (b) process (number of procedures performed, length of stay, etc), and (c) outcomes (deliveries, number of iatrogenic infections, etc).

One of the groups came up with a measure of success of the information system department: intensity of use of its work. This provoked an interesting discussion.

Second session (second half of the afternoon and the after-dinner session): SASA (case study on auction company, already described in the Stupava seminar summary)

The SASA session continued over in the morning of the second day. It was concluded with a little lecturette on: Customer satisfaction as a measure (first law of services) and the difficulty of evaluation (scale of Zeithalm).

Third session (morning of the second day): Nemocnice Svate Klary (case study)

Previous methodology applied to a hospital with three different businesses (social security, private insurance and private patients) facing changes in the environment and organizational problems.

The alternative-criteria matrix. How to use nominal voting techniques to achieve a "consensus" agreement.

Fourth session: This was intended as a final open discussion session, but we ended up answering questions about the Catalan and Spanish system, which proved quite interesting to the participants.

IV. COMMENTS ON THE EVOLUTION OF THE SEMINAR

a) This seminar was similar to the one already offered in Stupava, but much of what we learned there was applied here: we were very keen to shape the expectations of the participants and also to provide more directed discussion. These changes seemed to improve the participants' perception of the usefulness of the seminar.

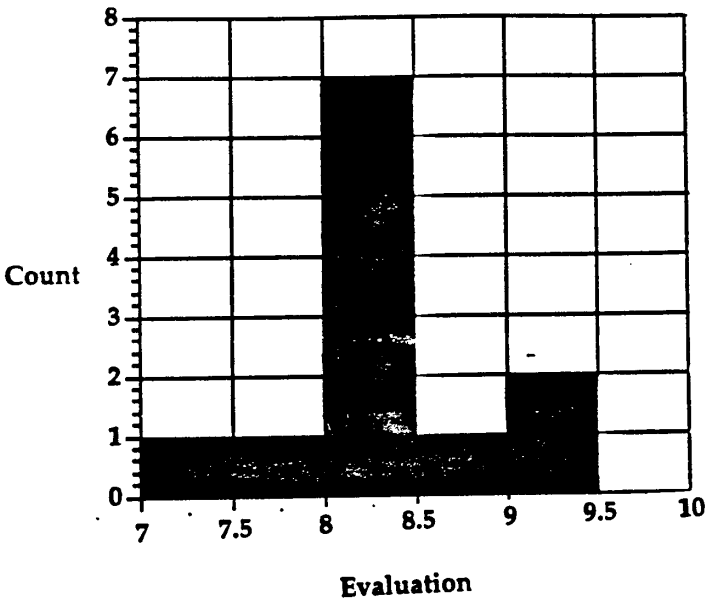
b) The seminar was considered quite successful with encouraging comments from some of the participants. This was quite satisfactory given the initial expectations, the Stupava experience and the fact that only Dr. Pumpr was known to us (in addition to the people from UZIS and Dr. Neuwirt).

c) The group was very good with highly motivated people who worked on the cases very well. When separated in small teams they grouped in three teams: central people, directors-managers-administrators, and people in charge of information systems. The second group had some difficulties in focusing their efforts, but after a while they also got good results.

d) During the seminar there appeared some small tension between the managers group and the central group.

e) At the end of the seminar, we asked the participants five questions, including:

- Evaluate the usefulness of this seminar on a scale of 0-10



- If we were to do this seminar again, would you advise your colleagues to attend? Everybody answered positively.

STUDY VISIT - BARCELONA
1ST GROUP : 15TH TO 19TH MARCH
2ND GROUP : 22ND TO 26TH MARCH

Participants

1st. Group	2nd. Group
Marian Obeda	Maria Alexandrova
Branislav Koren	Marian Hojsik
Petr Pumpr	Pavel Brezovsky
Vlastimir Fibich	Karel Neuwirt
Zuzana Kamberska	Ludmila Subertova
Rudolf Pechlat	Miroslav Jiranek

OBJECTIVE

As an additional element to the consulting and teaching activities performed in the Management Information Systems area, a study trip for managers, planners and information systems experts was planned

The main objective was to expose Czech and Slovak professionals to:

- a different health system, characterized by a clear separation between financing and provision, with a multiplicity of public and private agents, cooperating and also competing;

- its main organizational, financial and planning challenges;

- a wide sample of information systems, covering very different elements of a health system.

Participants were offered an intensive program, combining introductory and concluding sessions with selected site-visits and meetings with Catalan managers and experts in their work-places.

Beyond these objectives, participants could also explore and get acquainted with Western attitudes toward authority, competitors and information. There was also the possibility of discussing common management challenges.

Personal contacts may become the basis of future cooperation and sources of mutual technical support, common projects and sharing of experiences.

CONTENT

1. REGIONAL MINISTRY OF HEALTH. GOVERNMENT OF CATALONIA

(i) **Catalan Institute of Health, Information Systems** Unit (ISU): participants were shown two of the major projects that are being now introduced in the health system

* Insured identity card: to be distributed among all inhabitants of the region as the main source of administrative information for the system. Applications are being planned in order to use the information collected in the process of using the card for payment to primary care doctors, access to primary care services, access to hospital services, etc.

* Primary Care Network Information System: a region wide information system, combining centralized maintenance of basic registers and decentralized execution of patient and professional functions.

ISU is responsible also for the maintenance and development of other applications created in the past which are fully operational today:

* Centralized Register of Personnel: A complete data base of all permanent and temporary workers of the "Catalan Institute of Health" employing some 34.000 employees on a permanent basis. Individual registers with all personal, professional and administrative information enable hospitals and districts to have access to a very powerful amount of information. Information is updated on a decentralized scheme, although central control is kept mainly on economic questions: no new employee can be introduced in the monthly payroll without central permission. Also, timely data on monthly payments is rapidly accessible.

* Centralized accounting and accounts payable system: The Catalan Institute of Health operates on a yearly budget approved by the Catalan parliament. Hospitals and primary care districts use this application to register all their

expenditures in the legally approved format. As a source of additional information, a permanent and updated status of the debt situation regarding suppliers is maintained from the decentralized level. This is later linked with the Ministry of Economy, which is the institution responsible for executing payments.

* Pharmaceutical consumption system: Drugs prescription from primary care doctors are billed monthly by the Associations of Pharmacists. The ISU introduces this information to the main computer and decentralized primary care districts and regional authorities control billing. At the same time, very detailed profiles of consumption by prescribing doctors are elaborated, thus allowing for a very efficient control of "over prescribers". Information at the individual doctor level reports economic volume, type of drugs, possible non-compatible drugs per patient, etc...

(ii) **Catalan Institute of Health.Management Control Unit**

The General Directorate of the Catalan Institute of Health has been working over the last six or seven years in order to define the information needed at the top of the organization in order to perform a timely and accurate management control of the 12 hospitals and 35 primary care districts under its governance. This Management Control Unit has done a very good job by analyzing all ongoing informatic applications and extracting from them the relevant data.

Participants had the chance to explore how this process had been conducted and which are the criteria used in order to select, prioritize and present the data in a selective and decision-making oriented manner. Relationships between the central unit and those existing at the decentralized level were also analyzed and participation-communication strategies were explained.

(iii) **Ministry of Health. Catalan Health Service.**

The Catalan Health Service has been recently created by integrating several former units of the Ministry. It is the organizational unit responsible for the financing of the Catalan health sector. It does not hold any operational responsibility for any provider. Its main mission is to develop the Parliament approved "Health Plan" and execute it mainly through contracts with providers.

Among its technical tools for strategic development and control of the system it uses several information systems. These are examples of some of those explained to participants in the study tour:

* Minimum Data Set Project: All contracted hospitals in the publicly financed network record individual discharge summaries, using ICD-9-CM coding. These coded discharges are sent in magnetic support to the Ministry. The Ministry uses this data in order to perform statistical analyses on key performance indicators. This information is used to guide the contracting policies and reflects changes in the case-mix and efficiency of individual providers. Participant hospitals are fed-back with their indicators, compared to those of other hospitals.

  Future plans include the re-processing of discharges through a case-mix software (DRG,PMC), in order to make information comparison easier and useful for management purposes.

* Central Register of Transplants: In the last decade a very aggressive policy in order to encourage transplants, specially kidney transplants, was introduced. The need emerged for a tight control of accredited transplant units as well as of waiting lists. Specific information strategies were put in place for kidney, marrow bone and liver transplants

* Health Plan Information Strategy: A task force was created in order to prepare the information base for the Catalan Health Plan. This task force performed a census of all general and particular sources of information and published the appropriate guide for all management levels to use. This guide gives detailed information about objective, scope, periodicity and author of all health related information bases in the country

(iv) **Emergencies System.**

Participants could see an example of an extremely successful unit where critical care operations are performed with the support of an information system. The Emergency System's mission is to facilitate prompt access to critical care to those patients in need following a request from a health care unit or professional, most frequently a hospital. Operations are based on a network of connected stations with critical care transport.

Information used during operations is used to plan services, make judgements on appropriateness of requests, evaluate receiving units' performance, estimate demand along the day, week and seasons according to social habits, etc...

2. CONSORCI HOSPITALARI DE CATALUNYA. (Catalonia Hospital Consortium)

Organizers arranged this visit in order to expose participants to a very common reality in western countries: individual providers joining an association in order to influence policy decisions, elaborate joint strategies in order to gain negotiating strength with suppliers, organize joint services in order to benefit from larger scale in the running and management of certain common services. etc...

3. FUNDACI AVEDIS DONABEDIAN

A very interesting private initiative put up by a group of doctors and economists interested in strengthening quality in our hospitals. The Fundaci Avedis Donabedian is active in developing accreditation standards for hospitals. It has been contracted by the Ministry to design and process the accreditation questionnaire that all hospitals willing to contract with the Catalan Health Service have to comply with. Information collected in the process is extremely helpful in order to determine levels of structural as well as operational quality of care in hospitals.

The Fundaci maintains a very good data base on quality control publications, performs a large variety of training activities and is frequently asked to consult with different public administrations.

4. BARCELONA CITY INSTITUTE OF PUBLIC HEALTH

A very active organization in charge of several responsibilities in the Public Health information domain. Its activities range from vaccination control, to control of food markets, water and atmospheric pollution. Periodically it conducts what is reputed to be the best health status survey in Spain. With a sample of some 25,000 families in the city it portrays the health status of the population, with

supplementary information on economic status, educational level, health related habits, etc...

This is the organization acting for Barcelona in the Healthy Cities WHO project.

5. CATALAN INSTITUTE OF HEALTH. BARCELONA PRIMARY CARE AUTHORITY

(i) "Josep Maluquer Primary Care Centre"

The Primary Care System of Catalonia is moving from an old scheme towards a new one.

In summary, general practitioners and pediatricians used to be assigned a population of approximately 2000 adults and 1500 children under seven, respectively. Payment was based on number of family-heads assigned and practice was done on a two-hour daily schedule, in addition to home-calls. Professionals used to practise individually, with a high level of pharmaceutical consumption, and low use of ancillary services, which determined a high ratio of referrals to extra-hospital specialists (in Spain this is an intermediate level before access to hospitals' outpatient clinics is allowed).

This model is progressively being substituted by a team-practice formula, where Primary Health Teams are assigned a certain geographical area of around 20.000 inhabitants. General practitioners and pediatricians are required to work as a unit, with a high degree of interaction with the nursing staff. A Primary Care Medical Record exists for every patient and preventive as well as curative activities are to be performed in the Team's catchment area. Professionals are paid on a salary basis, although differences are allowed depending on different parameters such as socio-economic status of the catchment area, population structure, distance to be covered, etc.. These Teams have decreased dramatically the expenditure in drugs consumption while, at the same time, increased the usage of laboratory and radiology. Referrals to specialists are also much lower and patient satisfaction has also been surveyed to be higher.

At the Jose Maluquer Primary Care Centre both models coexist for different catchment areas.

The methodology used to design, distribute and make the Primary Care Medical Record useful is particularly interesting. This is obviously a very important information element both for daily clinical practice as well as for epidemiological and planning purposes. The Team is also a "client" of information produced by itself or by other elements of the system. Thus, information monitoring levels of consumption of any sort is made available, as well as demographic information and individual based data. The latter is extremely useful where patients and families with health and social problems are contacted by the Team's nurses or social workers in order to tackle problems and provide support.

5.2. BARCELONA PRIMARY CARE AUTHORITY. CENTRAL OFFICES

This is the management unit responsible for the planning and operation of primary and specialist extra-hospital care for the city of Barcelona (1.7 million inhabitants). It also decides on patient-flows to hospitals, dealing yearly with an approximate number of 80,000 referrals.

The technical staff of the Authority explained the information system it uses for managerial and planning purposes. It is a system started in 1982 and has evolved into a very complex and ambitious system.

Information is collected from the centres regarding activity and periodic evaluations are conducted in order to verify quality of information and possibilities of simplication. In general terms all data is collected at the moment operations and incidences occur (appointment of visit, visit, laboratory orders, radiological studies, etc). No special purpose collection is made, thus preventing personnel having to spend part of their time filling forms specially made for the information system.

Other sources of information are the entry access modes to the centralised Register of Personnel, pharmaceutical consumption and accounting applications. The Authority can use this centralised system for its daily operations and has access to several outputs.

The Authority uses all these sources for monitoring the process of primary care transformation explained previously. Comparisons among old and new primary care centres are possible for evaluation.

A different system exists whereby the 80,000 referrals each year are investigated. In the particular case of surgical referrals, some 40,000, the Authority has developed an information system which is fed by the folowing sources:

- contracted hospitals periodically update their supply capacity in terms of quantity of patients and pathologies
- the unit in charge of daily decisions matches these capacities with demand coming from primary care centres and, mostly, extrahospital specialists
- monthly performance of hospitals is collected from the bills reception unit at the Ministry
- all of these inputs are then used in order to prevent waiting lists increasing and reward hospitals with better performance profiles
- patients are then referred to closest or minimum waiting list hospitals

6. OTHER HEALTH CARE PROVIDERS

(i) Fundacio Puigvert.

This is a specialist urological-nephrological hospital that was deemed as interesting for three main reasons:

- it is one of the pioneering hospitals in the development of a managerial culture and the introduction of sophisticated information management control systems;

- it is one of the few contracted hospitals where doctors are allowed to admit private patients, in addition to the patients admitted under public funding;

- in the recent times it has proved to be one of the most advanced hospitals dealing with medical record based clinical documents.

(ii) Hospital Mutua de Terrassa

This is another interesting example of a hospital belonging to a private insurance company which holds a contract for admitting publicly financed patients. It is implementing a vertical integration strategy, developing independent units for primary care, acute care and chronic care patients.

From the information systems point of view, it has successfully tested an American made fully integrated software package for hospitals. The insurance company owns an information systems company that sells its services to the hospital. This company has reached an agreement with a USA contractor and software developer, introducing some applications as they were originally designed. However, other applications have been reformed in order to match local legislation or procedures.

7. SOFTWARE COMPANIES

Czech and Slovak professionals need to be exposed to the marketing strategies of software selling companies. Two very different companies were chosen and hospitals where their products were installed were visited.

(i) Centre de **Calcul de Sabadell/Red Cross Hospital**

Red Cross Hospital is a county-intermediate hospital where Centre de Calcul de Sabadell (CCS), a local information systems company, has introduced its software for hospitals. Participants had the opportunity to discuss design, implementation and operational results with representatives of both the hospital and the company.

(iv) **Shared Medical Systems/Hospital Clinic**

Hospital Clinic is a large top level hospital linked with the University of Barcelona Medical School. It is one of the largest and best hospitals in Spain, with large teaching and clinical programs in kidney, liver and marrow bone transplants, open-heart surgery, etc... With 1000 beds and some 4000 employees it is reported to have high levels of excellence in research and in most of the specialities it offers.

Back in 1983 an American software company was contracted to install its information system. This was a fully American system and the hospital had to go through a long process of adaptation. Applications are now being fully interconnected and the system includes many department based applications. A large and well staffed computer centre has been set up.

8. CONTRACTS

Mrs. Roser Artal, head of the contracts unit of the Ministry of Health was invited to chair the closing sessions for both groups participating in the study trip. Mrs.

Artal is an economist who has done extensive practical work in the process of designing, negotiating and monitoring the more than 200 contracts that are now in existence.

The topics she introduced were extremely relevant for the audience since many technical and political elements that have been present in the development of the Catalan system can be traced to their equivalents in the Czech Republic and Slovakia.

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Better MANAGEMENT Better HEALTH

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

EDUCATIONAL PROGRAMME REPORT 3

Recommendations from the Brno health management conference (March 1993)

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Dear Colleague

BETTER MANAGEMENT, BETTER HEALTH

Report on the Health Management Conference, Brno 29-30 March 1993

I and my colleagues greatly enjoyed the opportunity to share with you and other participants in the discussions at Brno. We hope the Conference provided an effective means for considering how best to manage current changes in Czech and Slovak health care. We also hope that the Conference has contributed to strengthening mutual assistance networks among managers facing similar challenges.

With this letter I am sending a short report on the Conference, including:

* a summary of the recommendations from the six working groups
* a list of participants, with contact addresses

All of us hope there will be future opportunities for sharing ideas on the contribution of management to achieving better health services, and better health.

Our best wishes for the success of your efforts.

Yours sincerely

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CONTENTS:

SUMMARY OF RECOMMENDATIONS

The Brno conference combined formal presentations to the whole conference by invited speakers with intensive work in groups of 10-15 participants on important challenges facing Czech and Slovak managers. These working groups addressed six main topics, in each case beginning with a 'diagnosis' of the challenges and then sharing ideas and experiences to identify practical recommendations for future progress. These recommendations were reported back and discussed by the whole conference.

Group discussion was in Czech and Slovak, as were the reports. The following summaries have been prepared by the Western contributors, who were listening to the discussions through interpreters and were therefore 'handicapped' in gaining a complete understanding. Nevertheless we hope these summaries will be helpful both as an aid to memory for the managers present at Brno and as an interesting record of the discussions for other managers facing similar challenges.

1. HEALTH INSURANCE AGENCIES AND THE RELATIONSHIP WITH PROVIDERS

The first working group was composed mainly of Czech participants and focused on the recent evolution of the health insurance system in the Czech Republic. Participants included representatives from many levels in the health system: health services providers, district branches of the general health insurance company, the central office of the insurance company and the health ministry.

Discussion began from specific practical problems raised by local participants but then moved to system-wide dilemmas where participants from the national level led the debate.

Challenges

* Privatisation is creating a large number of new partners for the insurance companies (hospitals, polyclinics, private doctors, pharmacies, opticians, spas etc.) and requiring tremendous efforts to establish and maintain good communication with all of them.

* There is a widespread feeling of uncertainty: several different proposals for further development of the health reforms have been produced in a short period.

* People perceive that the way policies are being created allows vested interest groups to influence decisions in their own favour.

* The ultimate goals of privatisation seem unclear and the costs involved may be underestimated.

* The nature and extent of health care benefits which are going to be publicly financed remains unclear.

* Several aspects of the health insurance and financing system require review. These include the contribution levels for payers, the system for recording activities and the organisation of billing and financing.

Recommendations

Major improvements are required in the following areas:

- formulation of the health insurance plans and the benefits to be covered;
- clear incorporation of the insurance funding into the total financing of health care;
- clarification of the role of different agencies in the insurance system and improved communication between them;
- consideration of better ways of financing the work of health services providers, including development of contracts, establishing fair prices and encouraging productivity/efficiency.

It was agreed that in addressing these issues it is important:

(i) To develop the health insurance system in a way which starts from the interests of patients and promotes attention to the quality of services and to ethical considerations.

(ii) To develop procedures which clearly identify and deal successfully with the related but partly independent questions of:
- billing for activities
- cost control
- quality control

(iii) To recognise the differences between:
- issues in designing the system
- managerial and operational problems
- technological problems

2. HOSPITALS : IMPROVING QUALITY AND EFFICIENCY

This group's discussion and recommendations focused on the role of hospital managers in ensuring their hospitals are successful within a more decentralised and insurance-funded health system. A particular concern was how to combine economic viability with improvements in the quality of care experienced by patients.

Challenges

Hospitals are typically at an early stage in achieving major changes in management and performance. There is scope to learn from each other about how best to meet these challenges. Slovak managers can also learn from Czech colleagues about the impact of insurance company payments using a points system because there has already been a year's experience of this sort of system in the Czech Republic.

In both Republics there is a need to:

- increase understanding of the new requirements and involve doctors, nurses and other staff in achieving necessary changes;

- improve the systematic information available to managers so that the basis for decision-making can be made more visible;

- rethink the services which hospitals should provide in the light of other hospital services in the same area, the expansion in private medical specialists and changes in general practice.

Recommendations

In meeting these challenges, each hospital needs to develop its own strategy for the future. Key elements in these strategies should include:

(i) Agreeing the purpose of the hospital in the local health system and identifying the services which it is most important to sustain or develop, having regard to local health needs and the new funding arrangements.

(ii) Developing new management arrangements through delegation of responsibility and authority to departments and involving medical and nursing staff in improving both efficiency and quality.

(iii) Establishing useful management information systems which provide an increasingly good analysis of each department's performance and costs. It would also be very useful to managers to have more comparative information - showing how performance compares with hospitals elsewhere.

(iv) Giving greater attention to the quality of services through a range of initiatives including:
- developing clinical audit;
- improving the status of patients and their families ('humanising the hospital');
- considering how best to integrate care between the hospital, ambulatory and home care services.

(v) Creating opportunities for the training of medical and nursing managers and providing other ways of sharing experiences between people facing similar challenges in different hospitals.

3. PRIVATISATION AND THE DEVELOPMENT OF EFFECTIVE PRIMARY CARE

This group discussed the effects of privatisation on the ability to maintain and further develop effective, high quality primary care. Despite a stated policy priority to strengthen primary care as the foundation of the reformed health care system, there is as yet little evidence that the needs of primary care providers are being considered in the reform process. Rather, the reform agenda continues to be dominated by the needs of the acute hospital.

Challenges

Historically primary care providers - largely GPs and pediatricians - in the Czech and Slovak Republics have been at the low end of the medical power structure, with low status in the Medical Chamber and poor organisation as an association of physicians. Because one can become a GP after medical school and two years of work in a hospital, it has often become a "specialty by default" for those who are unable to enter a specialty training programme. Due to the large number of physicians, it has become increasingly unclear whether or not physician graduates interested in primary care will have jobs when they complete their training.

The new health care reforms seem to place a policy emphasis on strong primary care and prevention as the keys to a healthier population and a more cost-effective and patient responsive health care system. The belief is that privatisation will "free up" primary care physicians to be more efficient. The ability of patients to choose their own primary care doctor will lead to constructive competition, improved patient responsiveness and quality of care, as poor providers fail in "the market".

The discussion raised serious questions about whether the act of privatisation would, in and of itself, achieve these ends. Most felt that the potential freedoms

would be useless unless some serious steps were taken to address historical problems in primary care practice so that a "new primary care" can emerge.

Recommendations

Attention is urgently needed to address unanswered questions that are crucial to the development of effective primary care in a privatised system:

* what is primary care? Is it a service provided by a certain category of doctor, e.g., a general practitioner or a paediatrician or is it a system of care with certain characteristics that must be met, regardless of who provides the service (for example, first contact care, continuity of care over time, comprehensive services directly or through managing referrals etc.)?

  If no clear definition is given to primary care, the tendency will be that anyone practising outside the hospital calls himself a primary care provider, and, without criteria, it will be difficult, if not impossible to ensure the appropriate nature and quality of services.

* Are primary care providers in the Czech and Slovak Republics going to be "gatekeepers" into the health care system for patients or can the public self-refer directly to specialists or hospitals? This is a critical policy decision that will have enormous effects on costs and appropriate use of the health care system.

It was noted that in the United Kingdom where patients can only be referred for specialty and hospital care by their GPs, only 10-15% of all patient encounters with the GP result in a referral. In the United States, the most effective prepaid managed care systems (HMOs) refer 30% of patients to specialists, and, in fee for service private practice, over 60% of patients are referred to specialists.

* How will the new insurance system support and "grow" primary care? In a market system, services that are well reimbursed are the ones that flourish. Attention must urgently be paid to assuring adequate financial incentives for primary care practice and administrative and capital reimbursement systems that are realistic for the small practice office.

Up to now, it appears that most of the concerns of the insurance systems have focused on the needs of the acute care hospital. There is great uncertainty among primary care doctors about the 'points system' so they feel at great risk in maintaining or increasing their income under privatisation. It is not yet clear how primary care doctors will be able to afford to acquire, rent or renew premises and equipment needed for practice under privatisation schemes. The paperwork required of primary care doctors to cope with the insurance system is overwhelming as, without administrative support, they must process claims for multiple companies using different forms in order to receive payment.

* How will doctors be properly trained and "accredited" to practice primary care? Mechanisms must be developed to assure quality under the new privatised system as it becomes much more heterogeneous with multiple small, relatively independent practice units.

  Because there is no history of general practice specialty training, a policy commitment to primary care must be accompanied by an investment in design, recognition and implementation of specialised graduate medical education programmes to retrain existing GPs and keep them up-to-date with the latest developments. Finally, in the proposed privatised system for primary care, who will assure quality? The insurance companies will verify that practices exist and that there are enough of them, but the Medical Chamber may need to be involved in accrediting these practices.

Primary Care under Privatisation - A Possible Model

While the group realised that policy and politics would ultimately determine the future directions for primary care, they offered a model for reform that would be attractive from their point of view.

(i) An association of Insurance Contracted Physicians could assume responsibility for the administration of insurance claims, information handling, and negotiations with the insurance companies over covered

benefits and payments (e.g., procedure lists, pharmaceuticals and health aides covered) on behalf of physicians in primary care.

(ii) Independent surgeries should be sold for a symbolic price (20,000 crowns) with free transfer of equipment more than five years old and graduated payments over a period of time for other, newer equipment.

(iii) Polyclinics should develop systems through which physicians could buy or lease surgeries there. A formula could be developed for cost sharing on space use, equipment use, and shared administrative overheads for running the facility and administrative support for the practices. The physicians favoured a 80% profit/20% to running costs split; the administrators doubted this would be financially viable, but both agreed some collaborative problem solving might lead to arrangements of mutual benefit that could be proposed to the insurance companies.

4. STRENGTHENING NURSING LEADERSHIP

This group's discussion focused on:

a) Comparing the historical and "future" role of nursing leadership in hospitals;
b) Identifying three important challenges facing nurse leaders in the Czech Republic and Slovakia; and,
c) Proposing action steps that could be taken in the next year to meet these challenges.

a) Hospital Nursing Directors - Role characteristics

Historically, the nursing director has:

* been a subordinate of hospital director;
* been responsible for nursing care quality;
* been the professional manager of subordinate nurses;
* had no financial decision-making power;
* been responsible for personnel selection and recruitment; and,
* been responsible for all auxiliary staff.

The group envisaged the future nurse director/leader as:

* being at the same level as the hospital director
* being responsible for implementation of the "nursing process";
* directly managing subordinate staff;
* making decisions related to the allocation of financial resources related to the provision of care;
* being responsible for the recruitment of all levels of nursing staff; and,
* not being responsible for auxiliary staff.

b) Major challenges facing nurse leaders include:

1) Enhancing professional (including doctors' and nurses') and public understanding of the role of nurses and the importance of the nursing process.

2) Extending the theoretical knowledge base and practical skills of nurses; and,

3) Developing nursing documentation methodologies and training nurses to use them.

Recommendations

Suggested action steps included:

1) Role/image enhancement - there is a need to educate medical/hospital directors as to the importance of the nursing process and have them initiate a training programme with medical and nursing staffs in all hospital departments. Some in the group, while acknowledging the importance of a sympathetic director, argued for building on informal intra- and inter-departmental ("horizontal") relationships within the hospital.

Health insurance regulations in the Czech Republic allowing for direct reimbursement to nurses for home care was felt to be a very significant step. While reimbursement is at present financially inadequate, a new "door" has been opened which will allow nurses to demonstrate their skills and advocate for nurses and nursing.

2) Training - there is a need to continue support for and enhance involvement in the variety of post-secondary school, private, postgraduate, baccalaureate, masters, and doctoral programmes initiated during the past two years.

3) Nursing Documentation - there is a need to encourage demonstration projects on nursing documentation. Services where good communication patterns and an understanding of the potential contribution of nursing to quality care amongst doctors and nurses exist should work on developing some uniquely Czech/Slovak nursing documentation standards.
Brno and Martin nurses noted that such projects were underway in their hospitals.

5. POPULATION HEALTH AND THE ROLE OF PUBLIC HEALTH AGENCIES

This group agreed that the national and local objective should be to improve the health of the population. Although much of the evidence is poor, it is clear from mortality data that Czech and Slovak citizens are less healthy than most European neighbours. Life expectancy is shorter and there are excess premature deaths from coronary heart disease and cancers. Concern was also expressed about other factors which affect population health such as the physical environment (air, water), education and employment levels.

The challenges which were identified at the district level included:

(a) Locally-based information is inadequate so it is sometimes difficult to provide a statistical basis for local health programmes. Regionally-based information would be more scientifically valid, but would not have the local impact needed for district projects. Even when information is available, the people do not always believe it.

(b) A key issue is to generate citizen motivation and to improve communication skills with the aim of, for example, moving from the existing levels of knowledge about the health effects of smoking towards behaviour change which will improve health.

(c) Districts would welcome a clear statement from Government on health policy. A "Health for All" medium-term plan would provide support for district initiatives, would give a legislative framework and would increase public awareness of health matters. A central strategy should also include proposals for the future development of hygiene stations, identifying the functions which should be retained and those which might be changed.

Recommendations

Several organisational matters need to be addressed:

(i) The role of the district authority health department director needs clarification, including assigning authority to the director to identify and implement solutions to health problems.

(ii) Collaboration between district health department director, hygiene stations and other professionals needs to be improved.

(iii) Local committee structures need to be revised: at present there are many different arrangements but none provide an adequate structure for effective health promotion programmes.

(iv) The organisational balance in districts between preventive and treatment services needs to be reviewed: preventive services should not be seen as the sole responsibility of hygiene stations. There is a need to develop a broad based and active approach to health promotion, as opposed to passive prevention.

6. DEVELOPING IN-COUNTRY HEALTH MANAGEMENT TRAINING CAPACITY

This group's discussions focused on:

(a) Reviewing desirable characteristics of in-country health management training programmes (long term, short term, and consultancy).

(b) Identifying obstacles to the development of in-country health management programmes; and,

(c) Describing health management training and consulting activities in which they themselves were presently engaged or were planning to initiate in the near future.

Challenges

Obstacles identified to the development of health management training programmes included:

* Lack of enabling legislation for non-profit organisations and official acceptance of a Czech/Slovak Master's degree;
* Lack of funding for public sector programmes;
* Lack of publications, materials, handouts, curricula;
* Lack of regional trainers and training opportunities; and,
* Lack of functional integration between relevant training departments and schools.

Recommendations

The group considered that desirable characteristics of health management training programmes included:

(i) <u>Long term programmes:</u>

* that programmes provide a broad base of general business management training, with a strong economics focus;

* that programmes be accessible for managers from all parts of the country; i.e. residential facilities be available;

* that courses be taught in Czech and/or Slovak

* that competence be certified through examination;

* that studies lead to internationally recognised degrees such as Master of Business Administration;

* that schedules allow for participation by working managers;

* that programmes provide appropriate training for large numbers of both top and middle level managers;

* that programmes are affordable for health professionals in public, non-profit and private sectors;

* that programme curricula be culturally sensitive and faculty knowledgeable regarding realities of health sector reform;

* that programmes selectively train trainers to enhance in-country capabilities.

(ii) Short programmes:

* that programmes focus on introducing general and specific management concepts;

* that programmes be process oriented, emphasising approaches to problem solving rather than "formula" solutions;

* that programmes be offered on national, regional, and district levels;

* that programmes be used to foster the development of local, regional, national and international assistance networks;

* that programmes provide training for a wide variety of manager categories;

* that programme curricula be culturally sensitive and faculty knowledgeable regarding realities of health sector reform.

(iii) Consultancy:

* that initiatives have an organisational or locality focus;

* that initiatives are problem oriented;

* that initiatives use culturally sensitive consultants well oriented to the realities of health system reforms in Slovakia and/or Czech Republic.

Two planned programmes described

* The Institute of Social Medicine in the Czech Republic is planning to offer health management training through social medicine departments in medical schools and possibly other centres. They plan to work with Czech Medical Chamber. An affordable, interrupted, modular type training programme offered in Czech uniquely designed for the reality of the current Czech health system is being conceptualised. Developers believe this will address some of the shortcomings of foreign sponsored courses which tend to be expensive, taught in English, inaccessible to the working manager, and utilise case material at times inappropriate for Czech reality.

* Health Management Consultancy Service - a Pisek management group is proposing to develop a health management consultancy service that can provide management training to hospital and community based mid-level managers in an intensive format at the work site. The proposed programme aims to address the lack of mid-level management training and the logistical and economic difficulties faced by institutions wanting to train large numbers of their staff at one time.

GENERAL CONCLUSIONS

In his introduction to the Brno conference, MUDr Stanislav Vachek suggested that the health managers' slogan should be "progress not perfection". This theme was reflected in the spirit of the conference as participants identified how in a very difficult period for the two Republics it was possible to make progress by:

* accepting the responsibility for solving problems;

* having the confidence to take initiatives;

* trying to learn from both successes and mistakes;

* providing support to each other; and,

* always looking for better ways of doing things.

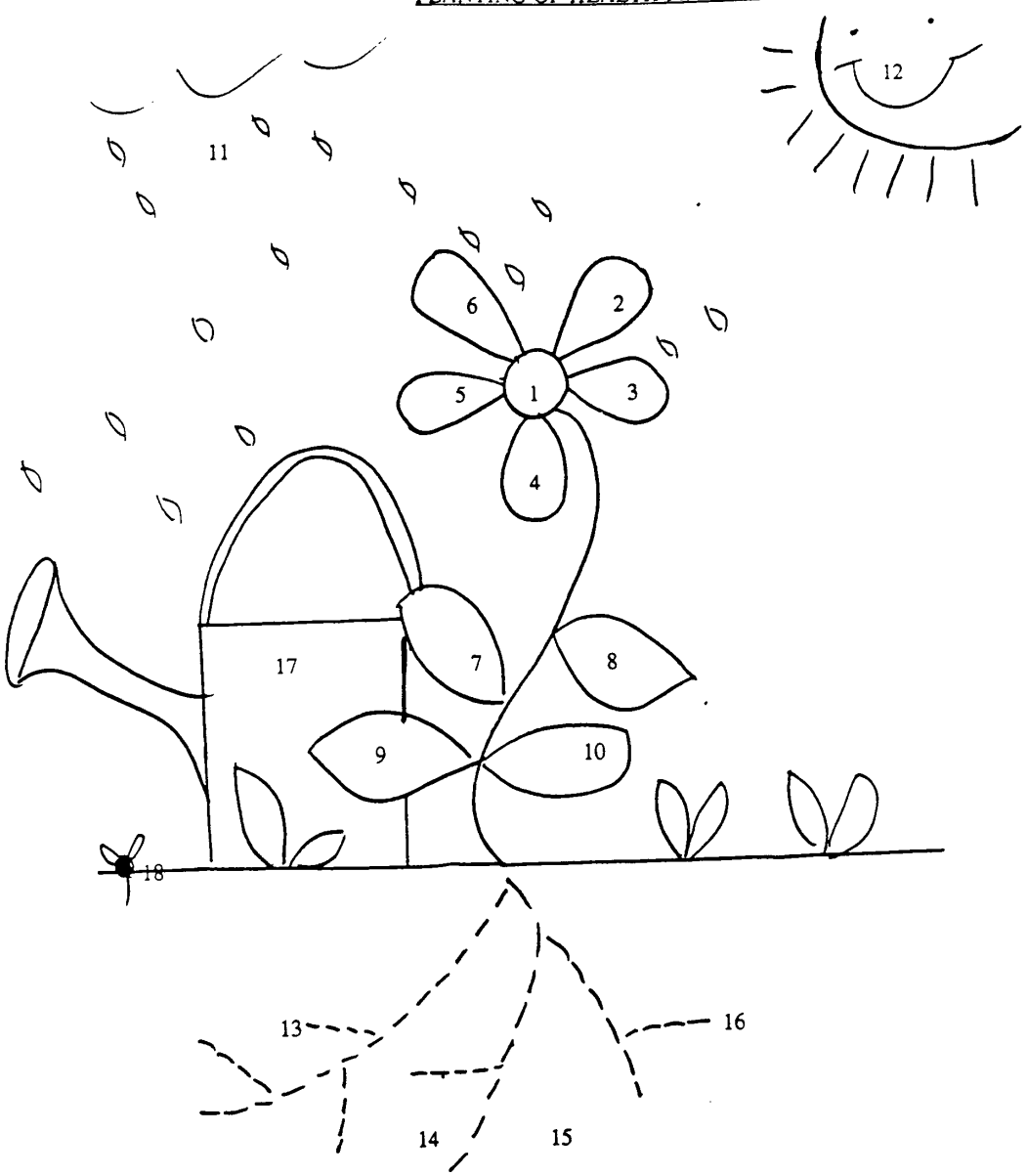
The experience of health sector reform suggested the importance of new approaches to achieving large scale change which are consistent with the philosophies of decentralisation and pluralism. These new approaches require managerial leadership with these five characteristics together with further opportunities for:

* lateral dissemination of ideas and innovations (i.e. through conferences like this one, through mutual aid networks and through health management journals); and,

* better central - local dialogue (i.e. between policy-makers at national level and local managers)

One group presented to the conference an image of health management as a growing flower which was already starting to bloom but required careful nurturing over the coming years to develop its strength for the challenges to come. Perhaps similar conferences in future will help both to support and demonstrate that growth.

PLANTING OF HEALTH MANAGEMENT



1. HEALTH
2. PROBLEMS
3. PRIORITIES
4. PLANS
5. ACTION
6. REVIEW
7. SKILLS
8. KNOWLEDGE
9. EDUCATION
10. TRAINING
11. MONEY
12. HUMAN VALUES
13. LEGISLATION
14. TRADITION
15. LAW SYSTEM AND GOVERNMENT
16. DEMOCRACY
17. GOVERNMENT
18. EDUCATION FOR FUTURE

"BETTER MANAGEMENT, BETTER HEALTH" Health Management Conference, Czech Republic and Slovakia

5.00 pm 29th March until 9.00 pm 30 March 1993
Venue: (IDVPZ) Health Care Educational Centre Brno

Organised by the King's Fund College, London in collaboration with Czech and Slovak participants in the PHARE health sector management project.

Languages : Czech and Slovak (with English translation when required).

Participation: Up to 80 senior managers, invited on the nomination of current participants in the PHARE health sector management project.

Background: In both Republics, the success of health sector reforms will depend considerably on the quality of managers in the different agencies (Insurance Companies, Hospitals, Primary Health Care, Local Authorities, Hygiene Stations, Health Information Institutes) which make up the new system, as well as managers at the Republic level (e.g in the Health Ministries and General Insurance companies). These managers face many common and complementary challenges in implementing the reforms and improving the quality of health services during a difficult period of transition. This Conference is designed to bring managers from different agencies and places together to share lessons on how these challenges can best be tackled.

Aims:

* To highlight the importance of good management in achieving successful implementation of health sector reforms.
* To promote discussion of the key challenges facing managers in 1993 and how these can best be tackled.
* To draw lessons for the future development of health sector management and information systems.
* To strengthen mutual assistance networks among managers facing similar challenges.

Programme

The style of the Conference is participative and the programme will combine:

- Conference presentations from Czech/Slovak and Western contributors.
- Workshop presentations and discussion (among groups of 20-25 people with similar interests)
- Problem-solving groups (of 6-10 people) sharing experience of tackling particular challenges.

Topics:

Important themes of the presentations and discussion are likely to include:

- the role of local leadership in implementing the reforms
- the nature of management in decentralised and pluralist systems
- improving quality and efficiency in hospital services.
- developing effective primary health care
- strengthening nursing leadership
- making information a tool for effective management.

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PHARE Conference, BRNO - 29.-30.3.1993

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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:

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