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

EXECUTIVE SUMMARY AND RECOMMENDATIONS FROM THE PHARE HEALTH SECTOR MANAGEMENT PROJECT TO THE HEALTH MINISTRY OF THE CZECH REPUBLIC

KINGS FUND COLLEGE

1 June 1993

Dear Colleagues

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

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

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

Its aims have been to:

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

The project was funded from April 1992 until April 1993. During this period the six members of the project team spent between them more than twelve months visiting the three pilot districts (Litomerice, Pisek and Trencin) and the two capitals, meeting a wide cross-section of local and national health sector leaders; more than three hundred managers contributed their experience to educational events and forty-five managers participated in study visits to Spain and the United Kingdom organised by the project.

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

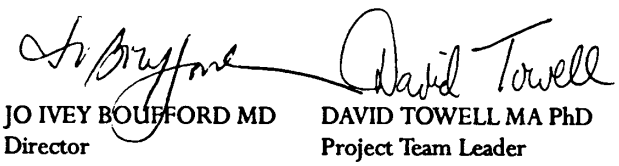
This report draws together lessons from their experiences and the full range of project activities for wider discussion. It is addressed to managers in other districts seeking to develop their own responses to similar challenges, to experts in management development and management information systems,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

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

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

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

Yours sincerely



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BETTER MANAGEMENT - BETTER HEALTH

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BETTER MANAGEMENT, BETTER HEALTH

The health sector management project was the first investment by the European Communities PHARE programme in support of 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; to support these managers through on-site consultancy and a range of training opportunities; and to use this experience to identify ways of strengthening the in-country capacity for management and information systems development in 1993 and beyond.

Lessons from this project are described in the final report. We summarise this work here and bring together our recommendations for further strengthening health sector management and information systems in the Czech Republic. This summary is particularly addressed to relevant officials in the health ministry and representatives of other agencies at the national level (health insurance companies, associations of health care providers, professional chambers, institutions of higher education and others specialising in management development and information systems design) who share an interest in, and responsibility for, health services management.

The recommendations in this report have benefited from helpful comments on an earlier report from officials in the Czech health ministry. Further information about the PHARE project and the other parts of the final report are available from PhDr Alexandra Kralova in the international co-operation department of the health ministry.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

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I INTRODUCTION AND RATIONALE

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

The original proposals for reform in the Czech Republic recognised that investment in management infrastructure – to get the right things done well – was critical to the success of these reforms. As the PHARE project was to show in more detail, pluralism and decentralisation required a radical change in management practice away from the administrative centralism characteristic of the previous system. Managers were needed who could provide leadership for change and mobilise the support of other staff. They would need new skills to define the goals of more autonomous organisations, improve efficiency and operate in a more competitive environment. They would also need new tools, especially effective information systems with a new focus on gathering information relevant to management tasks, particularly the requirements of new funding arrangements.

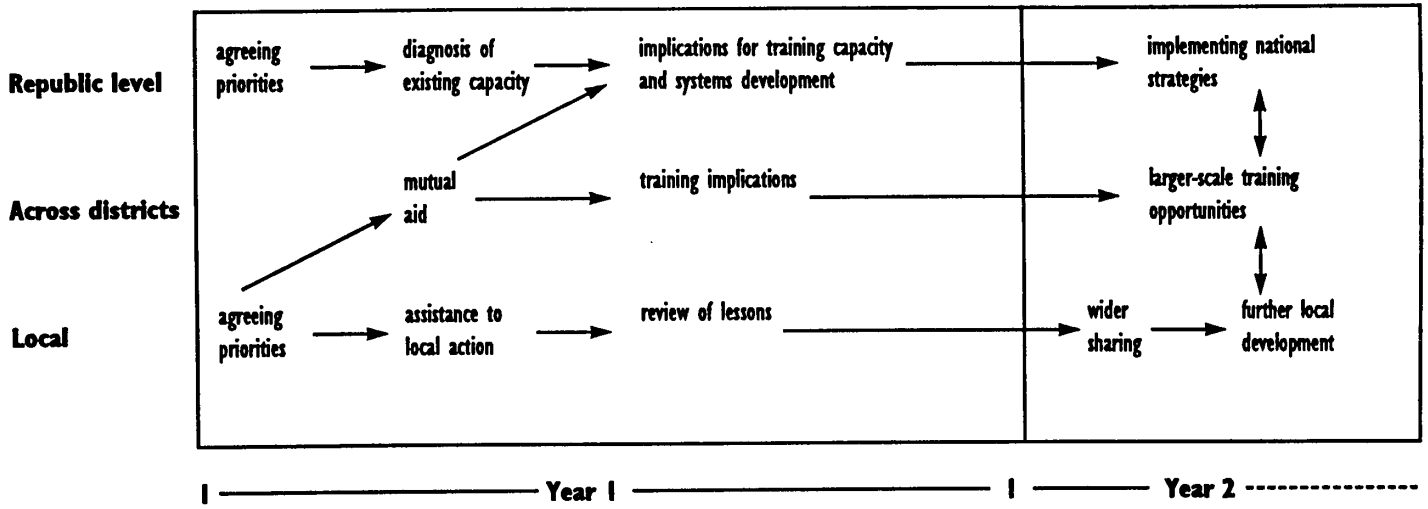
The health minister at the time appreciated that this radical change in management and the way managers are prepared, would take several years to accomplish. It was agreed with CEC representatives that the PHARE programme could make a useful contribution to meeting this challenge through an initially modest one-year project to develop a plan for health sector management and information systems. The contract to undertake this project was awarded by competitive tender to the King's Fund College and work began at the end of March 1992.

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

The specification required that these aims be addressed through:

- working with managers in three pilot districts (Litomerice and Pisek were identified by the Czech health ministry) to understand the challenges they face in achieving radical transformation in national health systems;
- assisting these managers in short-term action to improve management and information systems through on-site consultancy and providing a range of development opportunities;

Figure 1 Relationship between project activities over time



- working with officials at the Republic level and in relevant training institutions to assess the existing in-country capacity for management and information systems development; and
- using all this experience to recommend ways of strengthening this in-country capacity in 1993 and beyond.

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

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

The College proposals identified a project strategy which set out to work 'from the bottom upwards' in relating local challenges to future national strategies for management and information systems development in each Republic (as suggested in Figure 1). That is, the project started from detailed work at local level, sought to test and develop ideas from this work through intermediate level activities (for example, training events and conferences) and use this experience (and a parallel survey of existing in-country capacities) to inform Republic-level proposals for the future. In practice, the project team had to adapt this strategy to the turbulent and rapidly changing situation over the year from April 1992, including:

- initial difficulties for the health ministry in identifying suitable pilot districts;
- changes in ministry personnel, policies and priorities following the elections in June 1992;
- differences in understanding of the project between local and central levels; and
- problems in identifying senior and consistent project co-ordination at the Republic level.

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

Over the year, four members of the project team spent between them more than seven months visiting the pilot districts and Praha, meeting a wide cross-section of local and national health sector leaders; nearly two hundred Czech managers contributed their experience to educational events and thirty managers participated in study visits to Spain and the United Kingdom organised by the project.

As the final report describes in detail, a very important outcome from this work has been the wide range of actions taken by these managers to improve health services in their localities and, we believe, to increase their capacity for informed leadership in future.

II THE IMPORTANCE OF MANAGEMENT AND INFORMATION SYSTEMS IN NATIONAL STRATEGIES FOR HEALTH SECTOR REFORM

The project experience confirms the importance of strengthening management infrastructure as a critical means of achieving the health sector reforms.

In the Czech Republic, the idealism which inspired these reforms was combined from the outset with an equal sense of urgency. There is no doubt that in both scope and speed the changes envisaged would constitute a very bold programme of reform in any national health system. In the particular situation of the Czech Republic, where there are concurrent strategies for the wholesale transformation to a market economy, major constitutional change and severe economic problems, they pose a formidable set of challenges.

In meeting these challenges, the health sector has been able to draw on significant assets. These include:

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

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

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

Success in achieving large-scale change depends on:
– the clarity with which ends and means are related in the design of reforms themselves;
– the design of effective arrangements for implementation; and
– the capacity of leadership (both nationally and locally) to manage transition.

To date, the design of the reforms has followed an uncertain trajectory as national agencies have responded to initial weaknesses and confronted new pressures. Implementation has relied heavily on combining legislative change (defining new structures, their functions and relationships) and market incentives (intended to promote policy goals through the transactions between more autonomous purchasers and providers).

Equally if not more important, is the need to establish the management infrastructure required to promote decentralisation and ensure effective implementation in the new pluralist system. The health sector is one of the largest employers in the Czech economy; it consumes a significant proportion of the gross national product and its services intimately affect the lives of the whole population. Just as in the wider restructuring of the economy, good management and management information are essential.

Management in this sense represents a fundamental change from what existed prior to 1989. Among the most important aspects of this change are the shifts shown in Figure 2.

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

The precise implications of this radical change vary according to the distinctive functions of each agency in the new pluralist system (for example, health ministry, insurance companies and provider units) and at different levels in their internal organisation. For a wide variety of managers there is an urgent need for high quality management training designed to equip them with confidence in their own capacity for leadership and the skills necessary to operate successfully in the new health sector environment.

In each agency there is also an urgent need to establish information systems which provide the tools required for effective and efficient performance of their own new functions, while taking account of the needs of related agencies.

In the Czech Republic, a significant start has been made on meeting these requirements and there are useful initiatives on which to build (see Resource Guide I). In the light of existing capacities and the limited resources which are likely to be available, this report examines what is now required to strengthen the in-country capacity for management training and develop better management information systems for the future.

III DEVELOPING HEALTH SECTOR MANAGEMENT AND RECOMMENDATIONS FOR ACTION

Meeting these challenges effectively requires a fundamental change in traditional methods of training health sector managers and full discussion of the priorities for investment in management development opportunities from the limited resources. This discussion needs to start from a clear framework for analysis.

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

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

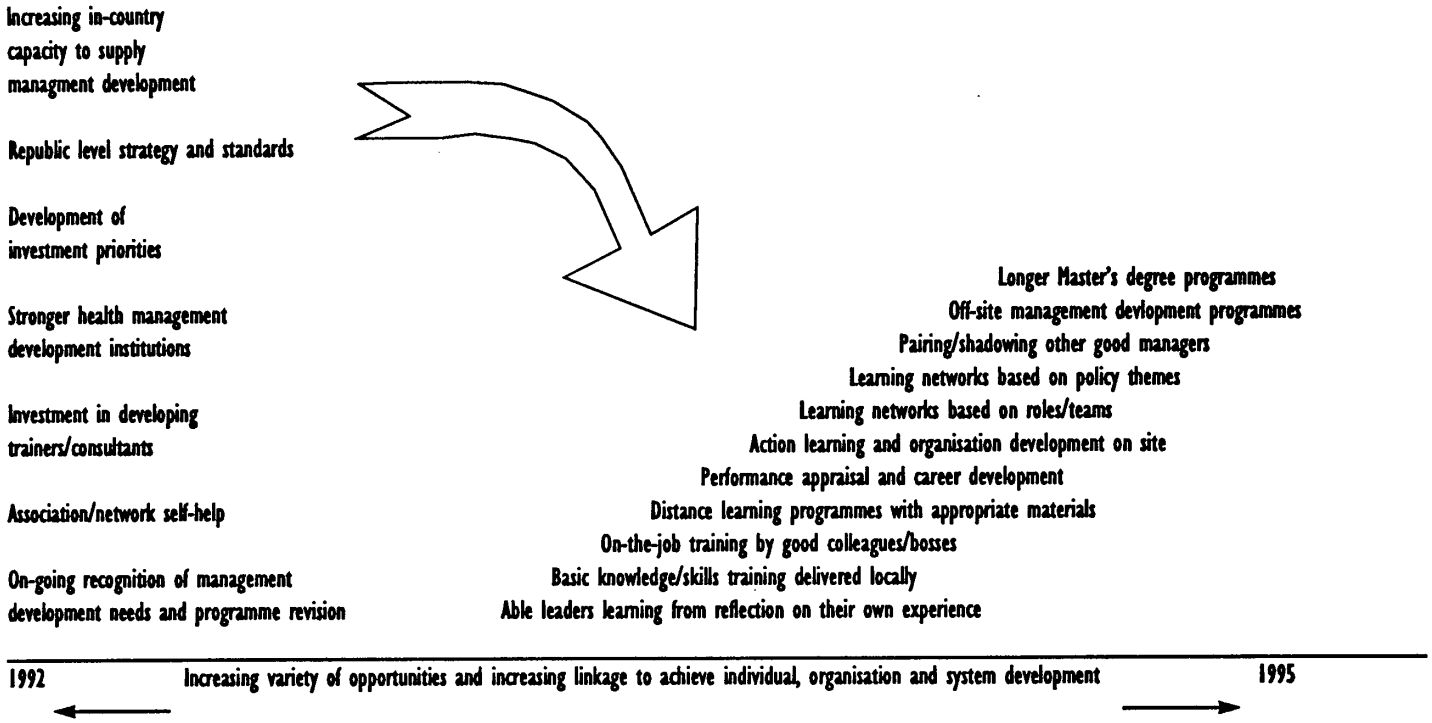
This increasing variety of opportunities (and the development of the in-country capacity to supply them) is illustrated in Figure 3.

In order to plan for current and future needs, it is helpful to identify both the different target groups requiring management training and the different kinds of programme which may be relevant to their needs. A framework for this analysis is represented in Figure 4.

This distinguishes the following *target groups:*

DIRECTORS: Hospital directors, insurance company branch office directors, district authority health department directors. While these individuals will have different specific responsibilities, the common issues they face will be 'leading' their organisations internally

Figure 3 Growth in management development opportunities



and relating to the leaders of other organisations. Individuals need not only skill building, but on-going mechanisms for support and continual learning from their own experience in the new role.

SENIOR MANAGERS: Individuals on the executive teams of hospitals, insurance companies, etc. who may in future assume director roles. The major learning needs are updating technical knowledge in their specialism and becoming comfortable as part of a management team taking responsibility for the overall organisational performance, not just the performance of their particular technical area.

FUNCTIONAL/DEPARTMENTAL MANAGERS: These are the middle managers in most organisations – those who run information services, central supplies, pharmacy etc. The focus of their development must be on general management skills, interpersonal relations, and ongoing updates in technical areas of work.

ENTRY LEVEL MANAGERS: These will be individuals entering lower levels in the health sector after appropriate educational qualification. Many countries approach this group in two ways – basic entry level orientation and skill building development programmes for all, and so called 'high flyer schemes' that identify applicants who have potential to be future directors or senior managers.

CLINICAL MANAGERS: Health professionals (doctors, nurses, etc.) usually in provider organisations whose major role will be managing other professionals, supervising the quality of clinical practice and working with others who manage basic financial and personnel resources within the provider units.

HEALTH PROFESSIONALS: Individuals who are practising clinicians, but their daily decisions about patient care generate resource use. It is important that they understand the basic operations of the health care system and the resource implications of their decision making.

ACADEMIC FACULTY: Individuals with existing specialisms who can contribute to the education and training of health sector managers and health professionals. They may or may not be familiar with the health sector and this fact will have different implications for their own development as faculty in these programmes.

TRAINERS/DEVELOPERS: Individuals with backgrounds as teachers and trainers outside the health sector, managers from outside the health sector, and experienced health care managers and health professionals who seek to assume training roles in health sector management development programmes.

ORGANISATIONAL CONSULTANTS: Individuals with health sector management experience or experience in management and organisational consulting in business or service sectors outside health. They will need special preparation to serve as consultants to top managers in the health sector on overall organisational change programmes.

And the following types of *management development programmes:*

Figure 4 Management development programmes

Target groups	Academic programmes	Skills training	Leadership training	Orientation to health sector	Continuing management education	Training the trainers	Consulting skills
Directors	#	✓	✓		✓	#	#
Senior managers	#	✓	✓		✓	#	#
Functional/ departmental managers		✓	✓		✓	#	
Entry level managers		✓		✓			
Future directors	✓		✓		✓		
Clinical managers		✓	✓		✓		
Health professionals				✓			
Academic faculty	✓			✓		✓	#
Trainers/ developers				✓	✓	✓	#
Organisational consultants				✓	✓	✓	✓

If interested for own careers development

ACADEMIC PROGRAMMES: It is likely that the masters in business administration (or equivalent) with or without a health specialism will become the predominant special academic preparation for graduates aiming for senior health management positions. In the future these programmes will usually take two to four years, depending on the scheduling around work commitments, are labour intensive and expensive. These will continue to be centred in national institutes or university departments.

SKILLS TRAINING: These are usually programmes on topics of importance in a technical specialism (for example, financial management) or in more general management skills (time management, human relations and communications skills), needed by all who will assume management responsibility. These are best provided through some combination of classroom learning or distance learning with supervision and 'on the job' training.

LEADERSHIP TRAINING: These are often programmes that combine knowledge and skills training with learning modes that provide for personal development of participants through so called 'action learning', involving the use of small groups and mentoring by trainers/organisational consultants.

ORIENTATION TO THE HEALTH SECTOR: Valuable as an induction for individuals entering the health sector from other sectors and health professionals who may have an interest in management, but are unfamiliar with how the health sector works or managers who need to understand the broader reforms.

CONTINUING MANAGEMENT EDUCATION: These are likely to be market-led short courses for information updates on topics of interest. They may become part of an on-going accreditation system for managers.

TRAINING THE TRAINERS: Basic skill-building tailored to the type of teaching/training role the individual will play. There is a continuum from the more academic, classroom teaching methods involving curriculum development, lecture, use of case studies and tutorials to the action learning approaches which use group techniques to help managers explore their own learning needs and work with each other to solve problems, in the light of their own experiences.

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

Initiatives to meet some of these requirements are already emerging in the Czech Republic. As Resource Guide I describes in more detail, there is evidence of a growing market for health management training linking the requirements of 'purchasers' (that is, senior managers in the insurance companies and health services providers, or associations of such managers) with new training options from 'providers' (that is, traditional post-graduate institutes, established universities and newly-created educational institutions in the public or private sectors), often with links to foreign institutions. For example, the project survey identified

three masters in business administration programmes with a health sector specialism due to begin in the autumn of 1993.

These spontaneous initiatives from different potential providers should continue to be encouraged as part of the necessary pluralism in the supply of management development opportunities. However, our analysis of management development needs and our survey of existing in-country supply, suggest these initiatives are likely to fall considerably short of what the Republic now requires.

In particular, there is a major need to strengthen the in-country capacity for designing and delivering health sector management development programmes and to target this capacity on managers and programmes which reflect priorities agreed between government and relevant health sector interests. Our recommendations to meet these needs are summarised in Figure 5. (Further details of these recommendations including proposed arrangements for implementation and suggestions for educational programme design are provided in Chapter 4 of the Final Report.)

RECOMMENDATIONS FOR NATIONAL ACTION

RECOMMENDATION 1

A health services management advisory board should be established by the Ministry of Health.

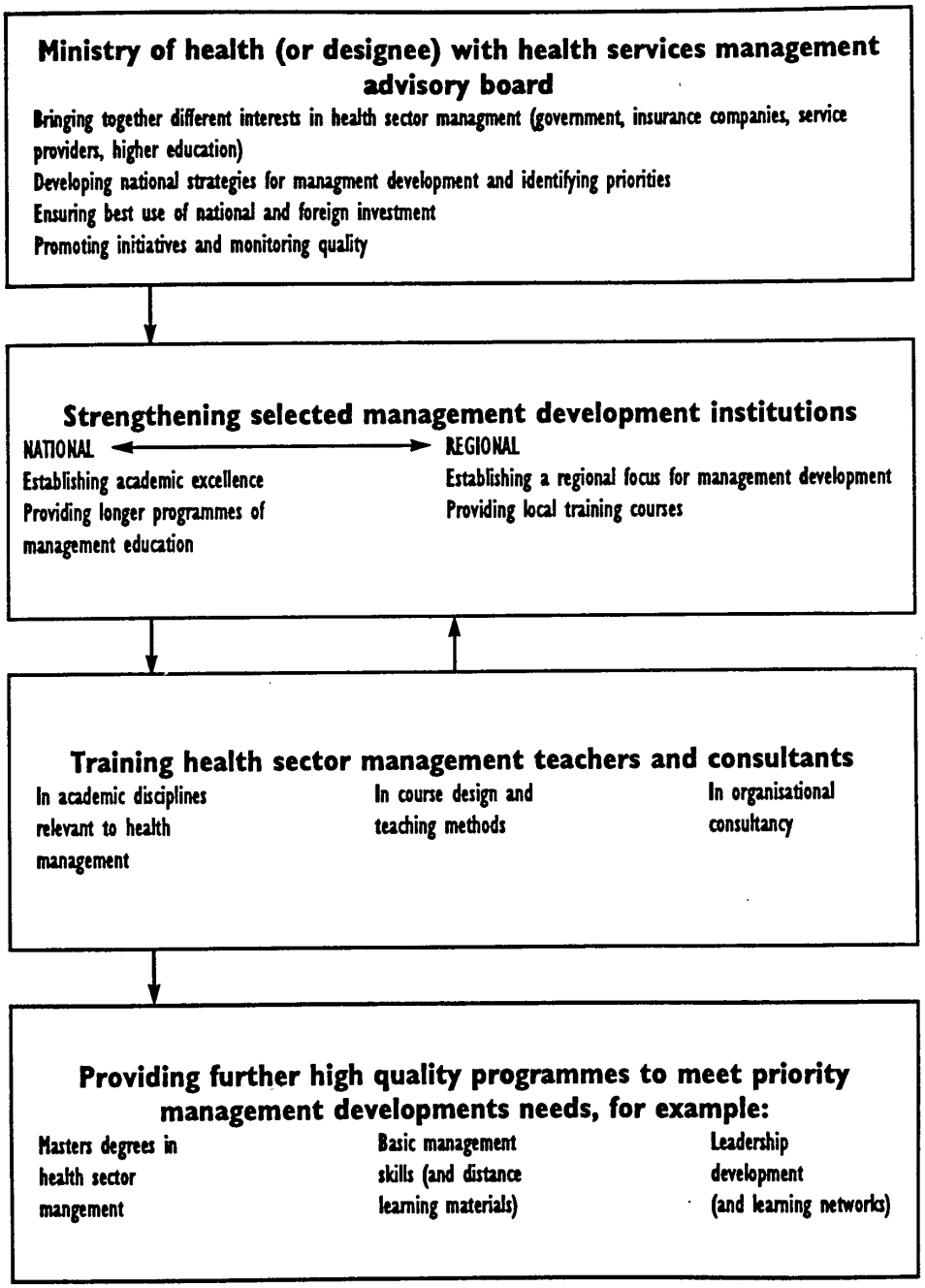
Such an action will communicate the importance of health services management to the success of the reforms and give the efforts of provider organisations credibility. It can also send a message to foreign investors that this area is a priority for continued development and investment. The purposes of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

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

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

The ministry should take the lead in convening such a group and in deciding the best approach to managing any national efforts – whether through a senior official of the ministry or by

Figure 5 Strategy for strengthening in-country management development capacity and meeting priority needs



delegating this responsibility to another organisation (a university, institute or hospital) with appropriate expertise and credibility to serve as project co-ordinator on behalf of the ministry.

This report could provide the initial agenda for the work of the ministry with the Board and its consultation with other interested parties on priorities for action.

RECOMMENDATION II

Advised by the Board, the Ministry (or designated organisational representative) should take the lead in promoting further development of (a) national and (b) regional institutions as leading centres for management and organisation development in the health sector, with the teachers, libraries and educational equipment required to achieve a high reputation with current managers.

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

- an existing health sector training institute, taking account both of strengths and weaknesses in long-established institutions; or
- a higher education institution with a good reputation in business management and the capacity to extend this reputation in the health sector.

From different starting points, both of these options would require initial investment in new programmes (for example, masters degree programmes with a strong emphasis on the academic disciplines most relevant to health sector management and oriented towards the relevance of this teaching to managerial practice) and the development of teachers for these programmes.

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

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

RECOMMENDATION III

Advised by the Board, the Ministry of Health (or project co-ordinator) should seek to promote further investment in high-quality training for selected groups of people in (a) academic disciplines relevant to health sector management; (b) applied management development; and (c) organisational consultancy skills.

By far the most important success factor in the development of these initial centres will be the quality of the faculty and teachers. Provision of high-quality training for potential faculty and teachers and for other members of what will hopefully become a future network of management consultants with a primary interest in the health sector is a crucial part of infrastructure development.

(a) Advanced academic training. Further encouragement should be given to the most able candidates, drawn from existing managers, teachers and research workers to pursue relevant postgraduate training both in the Czech Republic and through scholarships to leading universities and business schools elsewhere in Europe. (Resource Guide II provides a guide to suitable programmes in disciplines relevant to health sector management in the United Kingdom).

(b) Training for management trainers. International assistance funds should be sought to extend in-country 'training the trainer' programmes for health sector management teachers. There is a need to re-orient and strengthen existing health sector management training, particularly to deliver basic skills programmes and develop teaching on new topics in the management curriculum (for example, business planning, quality assurance, more sophisticated financial management techniques, human resource management). This kind of in-country capacity is important and differs from that to be developed in the academic centres, because individuals with this more applied training capability are committed to learning in the field, closer to health service providers and financing agencies. Their ability to provide short courses and design on-site programmes especially suited to the needs of these agencies will be of critical value to individuals leading the reforms.

This project might be implemented through identifying one well-regarded existing teacher training or management training institution or a coalition of such institutions with the necessary capacity and employing an experienced project manager to work with suitably equipped foreign partners.

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

(c) Training in organisational consultancy. International assistance should be sought to develop a mainly in-country 'training for health sector consultants' programme. Again, suitable institutions and project managers should be identified to commission qualified foreign partners to develop this programme.

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

RECOMMENDATION IV

Through these and other means, the Ministry of Health (or designee) advised by the Board, should seek to ensure the availability of further high quality programmes and educational materials to meet priority management development needs.

In the light of the framework presented above and the Board's own assessments of the strengths and gaps in current in-country management development initiatives, the Ministry of Health (or project co-ordinator) should seek to identify national priorities for further programmes and use its influence to ensure these are addressed. Our analysis suggests three priorities for early attention.

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

- appropriate training of faculty (Recommendation III, above);
- arrangements for assuring quality;
- accessibility to potential students in different parts of the Republic;
- opportunities for some programmes to be taken on a part-time basis by practising managers and potential managers; and
- funding is available to make these programmes affordable both to students preparing for careers in health sector management and for practising managers.

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

There are a substantial number of people notably in the hospitals (chiefs of departments, directors of economics, directors of nursing) but also the polyclinics and health insurance company offices who need to accept increasing managerial responsibility in the very unfamiliar context of the reforms. There is a related and even larger requirement for some basic management training for doctors establishing themselves in private practice (for example, as general practitioners).

The PHARE project has suggested priority areas for specific training of target groups of middle managers in each of the key sectors of the health service – the insurance companies, districts, hospitals and primary care (detailed in Chapter 2 of the Final Report).

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

(c) An important resource to these (and other) programmes would be the development of relevant educational materials, some of which could also be used for self-study and distance learning. The lack of suitable materials in Czech is currently a major weakness in health sector management education and although material in English and other Western European languages is becoming more accessible, its value is limited both by the language barrier itself and the need for careful selection of material which is really relevant to the challenges being faced. Both the training of teachers/trainers and the development of short courses should be used,therefore, gradually to develop a systematic collection of relevant educational materials for wider distribution.

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

Successful implementation of the reforms depends critically on the management skills of the directors of hospitals, polyclinics and insurance company offices as well as district authority health department directors. They face very substantial challenges and most have little time for training. Nevertheless, many would benefit considerably from high quality management development and continuing support.

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

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

The training centres involved in discussion with these managers might also seek to establish small learning networks (that is, five to eight managers, probably with similar roles) which meet for two to three days at regular intervals spread over twelve to eighteen months.

IV DEVELOPING HEALTH SECTOR MANAGEMENT INFORMATION SYSTEMS AND RECOMMENDATIONS FOR ACTION

Information is an essential tool for good management at all levels from the health ministry to the individual general practitioner's office. The design of effective information systems depends however on first clarifying organisational missions, critical success factors and the management processes to be used in each part of the health system. The two foci of the PHARE project on health services management development and information systems development are therefore inextricably intertwined.

The further development of management information systems in the Czech Republic needs to address several problems arising both from the rapid changes required by the health sector reforms and from weaknesses in traditional practices:

- The radical changes in the functions of different agencies (including the health ministry, insurance companies and provider units) require careful specification of their new missions and the development of information systems to meet these new requirements.
- There is a possibility that management information systems will be developed differently by each agency, risking expensive duplication and lack of co-ordination.
- There is a common tendency to identify a health system design or management problem as an information system problem with a tendency therefore to expect computer equipment to solve problems that are really operational in nature.
- Skills to run the basic transactional modules (for example, financial accounting, inventory, patient flows) are weak because these and other skills were not required in the past.
- Existing information systems are heavily biased towards the timely collection and transmission of data, not to its usefulness and accuracy.
- There is also an absence of a clear client orientation (that is, a concern with feeding back useful information to meet the needs of 'customers') in the state institutions handling health data.

To address these problems, a new approach to health sector management information systems (HMIS) design is required. In designing the HMIS strategy, it is essential to consider for each main 'client' the ratio between what benefits the information system provides and the costs involved in its use. Clients here should include:

- **patients** and the general population (where objectives will include the unique identification of individual patients throughout the health system and the aggregation of data to permit health priorities to be based on population needs);

- **professional staff** (where objectives will include making information on each patient-doctor encounter available on patient records, while limiting professional time spent on information recording); and

- **managers** (where objectives will vary according to the particular agency but include providing information on health services performance to encourage improvements in quality and efficiency).

The health sector reforms require significant investment in the development of management information systems by both health services providers and the insurance agencies.

In order to function effectively in the new health system, **providers** (for example, hospitals) need to attract patients, control costs, ensure activities are recorded and invoiced, develop targets for activity and expenditure at the departmental level, and monitor other aspects of performance. These requirements provide the basis for defining critical success factors.

The main elements of appropriate hospital management information systems (described in detail in Chapter 5 of the Final Report) should therefore be built up, over time, to include:

- patient identification and invoicing systems;
- financial systems;
- operational support systems;
- operational integration through a communications network; and
- the integration of information for financial management and service planning.

The new methods of financing health care give **insurance companies** a central role in improving information systems, particularly in the two areas of:

- identifying beneficiaries (where relevant data on the population of beneficiaries can be very useful in health services planning and health promotion initiatives); and
- financing health services providers (where insurance companies can use their contractual relationship with providers to request information for planning).

Close collaboration between the health ministry and insurance companies is required to avoid duplication of resources and information flows.

There is considerable interest in health sector management information system development in the Czech Republic, both insurance companies and large providers have already made significant investments and there are knowledgeable technical experts. There is also scope for a wide range of further initiatives.

If these initiatives are to lead to a co-ordinated national strategy for health sector management information systems, we make three main recommendations.

RECOMMENDATION V

Strengthening the Health Information System Advisory Council attached to the Health Ministry.

In an earlier report, the project team proposed the creation of a health information system advisory council, composed of managers and information systems technicians and recruited

from different levels and institutions within the health sector and also from outside the sector, both inside the country and abroad.

This Advisory Council would serve as consensus development forum for the Republic. Among its responsibilities it was proposed that it promote innovation through:

- ensuring dissemination of both national and international literature;
- organising forums to debate the main health information systems issues;
- fostering the creation of an association of professionals interested in health information systems;
- serving as the starting point for the development of a White Paper on health information systems at the Republic level; and
- acting as a Steering Committee for facilitating priority pilot projects.

The comments of Ministry officials on this proposal suggested that advisory teams already established at the Ministry could serve most of these functions and that significant progress is already being made in:

- distributing literature through the 340 medical libraries and information centres;
- organising professional forums; and
- establishing a professional association (linked to the European Association for Health Information and Libraries).

In building on this progress it will be important to ensure that the perspectives of health services managers and health professionals (that is, in the insurance companies and health services providers) are fully represented in further work to co-ordinate developments in management information systems, particularly in steering the pilot projects proposed in Recommendation VI and ensuring lessons from these projects are widely used throughout the health system.

RECOMMENDATION VI

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

These projects should each aim to:

- identify needs for HMIS in the different areas and the possible benefits to be achieved;
- obtain valuable information with which to establish a thesaurus, minimum data sets and conventions for data recording, coding, transmittal, etc. to be used nationwide;
- focus on common approaches and solutions to HMIS implementation, avoiding duplication and thus reducing the effort of every provider; and
- offer 'demonstration models' from which others in the system can learn.

The following pilot projects should be considered:

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

(B) **Hospitals**. Similarly, each hospital visited during the PHARE project had developed some sort of information system to meet its own internal management requirements as well as the communication needs of the insurance companies. The requirements for data at other institutions, such as UZIS, had generally not been taken into consideration. The HMIS pilot projects should consider the needs of large teaching hospitals as well as those of small county or town hospitals, with emphasis on guidance and support to improve patient care and to reduce the administrative burden of providing information required by the other higher organisations (insurance companies, UZIS, etc.).

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

(C) **Insurance companies**. The insurance company district offices should be the focus of the third pilot project. A model HMIS should be developed to investigate several relationships:
– the relationship of the insurance companies (as purchaser of services) with the providers (general practitioners, hospitals, pharmacies, etc.);
– the relationship of the branch insurance companies with the central insurance company; and
– the relationship of the branch insurance companies with the payers (enterprises and employees) .

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

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

RECOMMENDATION VII
Development of a National Information Network

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

These data bases must be shared between districts to reduce the duplication of records and ensure the correct linking and billing of health events.
The introduction of the network should be preceded by a compilation and coding of a data dictionary and thesaurus of clinical terms and groupings. This will enable data on, for example, symptoms and diagnosis, to be transferred and understood by any computer in the system and will facilitate research on practices to improve efficiency and quality in delivery. Obviously, a framework for security and confidentiality must be incorporated into the development of this network.

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

V NEXT STEPS

Reflecting the approach adopted by the project team throughout the last year's work, we expect Czech readers of this report to test our analysis and recommendations against their own experiences with a view to identifying the most useful lessons for improving health sector management. In particular, we hope that officials in the health ministry and other relevant agencies will use the recommendations here as a stimulus to their own debate about how best to build on the momentum already established so as to strengthen national strategies for developing management and information systems.

In addressing this report initially to the health ministry, we understand that the health sector reforms require new ways of policy-making which incorporate the principles of pluralism and decentralisation. We expect therefore that examination of our recommendations will involve representatives of other key agencies (insurance companies, health services providers, educational institutions and professional chambers) and seek views from the local level (for example, representatives of the project pilot districts).

In this context, the health ministry and its partners will need to make a judgement about how far the health ministry should play a leadership or facilitative role in establishing these national strategies (for example, through the proposed health services management advisory board and the health information systems advisory council). In the light of priorities agreed through these or other forums, the ministry and its partners will also need to identify the possibilities for further foreign investment (including from the PHARE programme).

The health sector reforms were stimulated by the major problems in population health and serious deficincies in health care which the Czech Republic inherited. **Better management** is required to provide the leadership required to address these problems within the resources available and ultimately therefore to achieve **better health.**

APPENDIX: PROJECT PERSONNEL AND REPORTS

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

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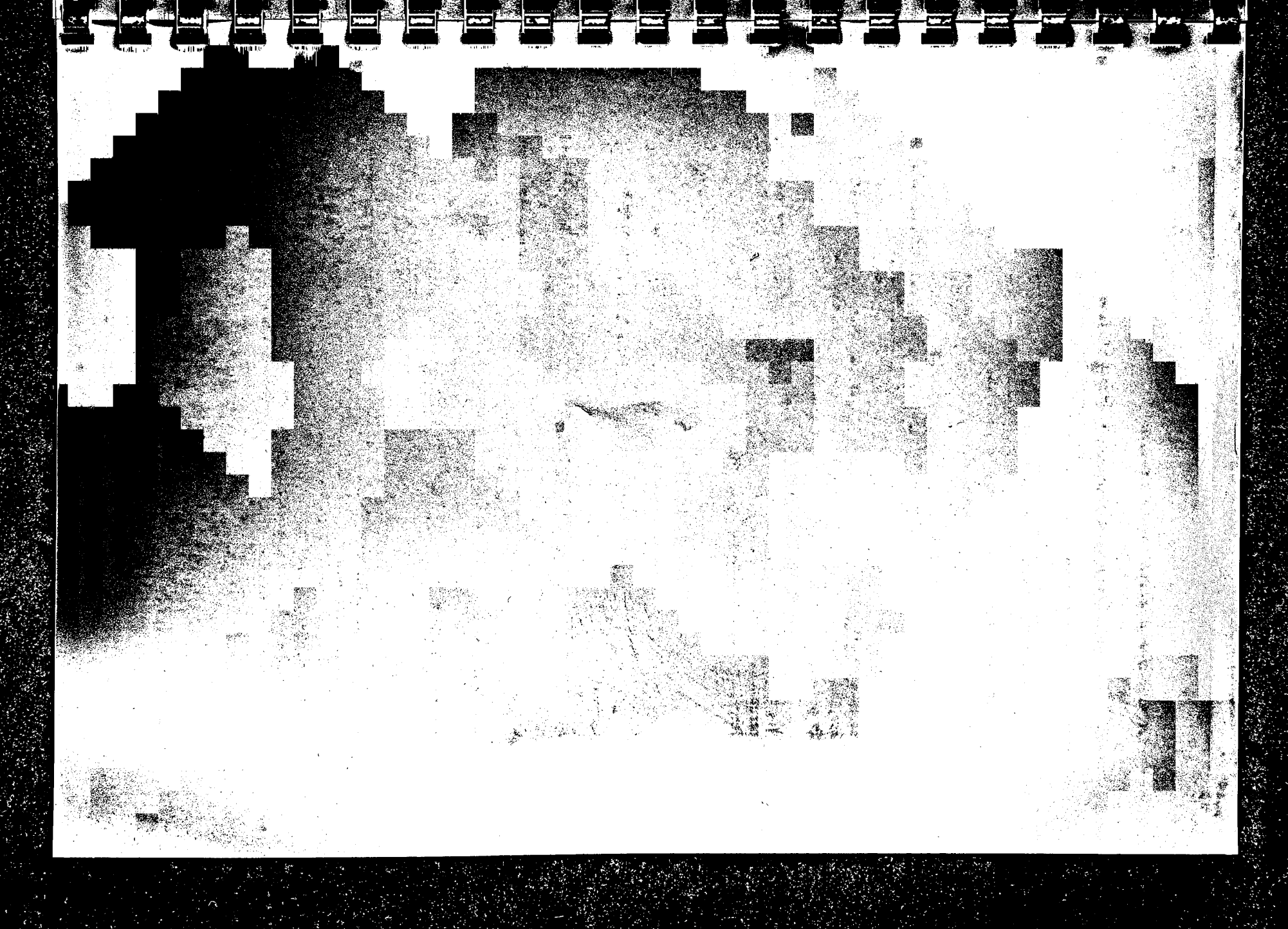

Better MANAGEMENT Better HEALTH

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:

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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