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Leadership and management through financial crisis and uncertainty

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Health care executives face many challenges in today's world of financial crisis and uncertainty, including coping with resources and overwhelming demand, securing access to quality health services for the whole population, and ensuring value for money. Ultimately, it is leadership, good policy making, and skillful management that are instrumental in setting priorities, introducing incentives, and marshalling scarce resources effectively. A critical part of addressing the health challenges most countries face today is improving leadership and managerial capacity to deal with the complexity of modern health systems and almost continuous change brought about by new discoveries and procedures.

As suggested by the contributing authors of this issue of the *World Hospital and Health Services Journal*, management has different dimensions. It occurs at different levels of the health system in the following forms: a stewardship role at the senior policy level, a governance role at the organizational level, line management of client services at the level of individual facilities, and clinical management at the level of the patient. There are also different schools of thought about effective management techniques – command-and-control bureaucratic approaches, business school approaches, new public sector management approaches, and the invisible hand of markets. There are significant cultural differences in management as well – American, British, Chinese, East European, French, Indian, Japanese, Latin American, Middle-Eastern, and Russian.

The authors explore ways of making management more results oriented. They examine the special challenges of managing complexity and change and review empirical evidence on the degree to which current thinking about "good management practices" has been applied to different health problems both in the advanced market economies of North America and Europe and in lower- and middle-income countries.

Furthermore, the issues and policy options that managers face at the national level differ significantly from those faced by managers working at the regional or local levels. In examining management approaches it is useful to distinguish four different levels of management, each with a specific focus:

- Macro or stewardship level (management of strategic policies and institutions at the national, provincial / state, or regional level of the health care system).
- Meso or governance level (executive management of large organizations or networks of public health programs, hospitals and clinics).
- Micro or operational level (line management of client services).
- Household or individual level (clinical management of patients).

In a well-functioning health system, there is a good deal of interaction and complementarities between these different levels of management and, at the same time, a clear division in responsibilities and accountability. In poorly functioning health systems, there are significant gaps and overlaps. At the macro level, policy makers of large national health services may become overwhelmed with micro-level decisions associated with a large cadre of health workers who are civil servants or the procurement problems of nationally run supplies and stores. At the micro-level, clinicians and directors of local facilities may be overwhelmed by the added tasks imposed by excessive bureaucratic procedures that have little to do with the clinical care given to patients or operation of the facility in which they work.

The International Hospital Federation (IHF) is launching an initiative to mobilize health care executive associations from around the world to work together on designing and implementing a competency framework, acceptable to all that could become the benchmark for evaluating health care decision makers' leadership and management skills. Everyone interested in participating in this initiative is invited to contact the IHF secretariat and come to the 2013 World Congress in Oslo. The Federation is committed to helping its members manage quality health services in these times of financial crisis and other uncertainties. ❑

Managing the myths of health care

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ABSTRACT: Myths impede the effective management of health care, for example that the system is failing (indeed, that is a system), and can be fixed by detached social engineering and heroic leadership, or treating it more like a business. This field needs to reframe its management, as distributed beyond the "top"; its strategy as venturing, not planning; its organizing as collaboration beyond control, and especially itself, as a system beyond its parts.

Myths abound in management, for example that senior managers sit on "top" (of what?), that leaders are more important than managers (try leading without managing), and that people are human resources (I am a human being).

Myths abound in what is called the system of health care too, not least that it is a system, and is about the care of health (mostly it is a collection of treatments for disease). Combine these two sets of myths, as is increasingly common these days, and you end up with the mess we now face in the world of health care.

Let us begin with the myths of managing now prevalent in health care and then turn to some reframing that may help to escape this mess.

Myth #1: The health care system is failing. Speak to people almost anywhere in the world and they will tell you how their system of health care is failing. The truth is quite the opposite: In most places in the developed world, health care is succeeding – expensively. In other words, success is the problem, not failure.

Consult almost any statistic. We are living longer, losing fewer infants, and so on, in large part because of advances in treatments. The trouble is that many of these are expensive, and we don't want to pay for them – certainly not as healthy people through our insurance premiums or taxes. So health care services get squeezed, and it looks like the system is failing. In fact, as we shall discuss below, the problems are not in the health care services themselves so much as in the consequences of our interventions to fix this ostensible failure. We consider three interventions in particular: social engineering, leadership, and business practice.

Myth #2: The health care system can be fixed by clever social engineering. The system is broken so the "experts" have to fix it: usually not people on the ground, who understand the problems viscerally, but specialists in the air, such as economists, system analysts, and consultants, who believe they understand them conceptually. Thanks to them, in health care we measure and merge like mad, reorganize constantly, apply the management technique of the month, "reinvent" health care every few years, and drive change from the "top" for the sake of participation at the bottom.

Do all this and all will be well, we are told. But is it ever? In particular, at this so-called bottom, the real experts struggle to cope with the pressures, not least from these very "solutions," most of which seem to make things increasingly convoluted.

What if, instead, we came to appreciate that effective change in health care has to come largely out of the operations, and diffuse across them rather than forced down into them? Consider, for example, the changes in recent times that have made the greatest differences, not only in cutting costs – that's the easy part – but also in improving quality. Day surgeries have to be near the top of that list. This idea came from engaged clinicians, not detached social engineers.

Myth #3: Health care institutions as well as the overall system can be fixed by bringing in the heroic leader. New leadership can certainly help, at least when it replaces a leadership that was worse. But what does effective leadership mean in a field where the professionals have so much of the power? In hospitals, for example, physicians are usually far more responsive to their own hierarchies of professional status than the managerial hierarchies of formal authority. Hence what can be called "heroic leadership", so fashionable now in business (witness the whole system of bonuses), can be bad for health care, let alone for business itself. Far more necessary is what can be called engaging management: managers who are deeply and personally engaged so as to be able to help engage others.

Myth #4: The health care system can be fixed by treating it more as a business. This is a particularly popular prescription in the United States. Perhaps no country on earth treats health care more as a business, or is more encouraging of competition in this field. But given America's current state of performance – far more expensive than anywhere else, with overall quality rankings that are mediocre – shall we take this as testimonial to the wonders of competition and business practices in the field of health care?

The United States spends about 31¢ of every health care dollar on administration; Canada, with much less competition and far less of a business orientation in health care, spends about 17¢, and achieves better measures of quality. To quote from an article in the *New York Times*: "Duplicate processing of claims, large numbers of insurance products, complicated bill paying systems

and high marketing costs [plus all the "paperwork required of American doctors and hospitals that simply do not exist in countries like Canada or Britain"] add up to high administrative expenses" (Bernasek 2007). In the name of competition, American health care in fact suffers from individualization: every professional and every institution for his, her, or itself.

So again, let's try it differently: Health care functions best as a calling, not a business; as such, it needs greater cooperation, not competition, among its many players and institutions. Physicians may be well paid, but these are smart people capable of earning large incomes elsewhere. What keeps many, if not most, of them in health care is the sense of service. This applies equally, if not more so, to the nurses, who don't earn that kind of money, and many of the managers too. What happens to health care as a calling when it is seen as "one-stop shopping", hospitals as "focused factories", patients as "customers" and "consumers", and physicians as "industry players" (as described by Herzlinger 2006)?

Myth #5 and 6: Health care is rightly left to the private sector, for the sake of efficiency. Health care is rightly controlled by the public sector, for the sake of equality. Take your choice, according to the country in which you live. In fact, if you live where the services are largely public, you hear a great deal about the private sector (as in Canada now). And if you live where they are largely private, then you hear a great deal about the public sector (as in the recent debates in the United States Congress). That is because nowhere in the world today can the field of health care function without serious involvement of both government controls and market forces.

Many Americans, and not only on talk radio shows, are sharply critical of the role of the state in health care. In two influential publications, Porter and Teisberg were highly dismissive of the state as a player in this field. Their book *Reforming Health Care* (2006) referred to government-controlled regulations as "never a real solution" (although it certainly is in most developed countries). Concerning the unsatisfactory performance of American health care over many years, they claimed in their related *Harvard Business Review* article (2004) that "while this may be expected in a state-controlled sector, it is nearly unimaginable in a competitive market." (Again, the facts suggest exactly the opposite.)

Of particular importance is that many of the most important services in health care come from neither the public nor the private sector. Canada and the United States sit near the two extremes on this issue, yet the vast majority of hospitals in both countries are in the plural sector, namely in the form of organizations that are owned by no-one (so called "voluntary" in the United States), and that includes the most prestigious. Efficiency and equality certainly matter in health care, but hardly more so than quality, which often seems to be delivered best by organizations that are autonomous – controlled neither by the state nor owned by private shareholders. Presumably this helps to reinforce the engagement of their professionals with regard to their sense of calling.

Of course, all the sectors have a role to play in health care: the public sector, largely to maintain a certain level of equality (as in the new American legislation) as well as in regulation; the private sector, significantly to provide supplies and equipment as well as some of the more routine services; and the plural sector, for the delivery of many of the key professional services, including research. (And the latter might well include pharmaceuticals. In the twentieth century, arguably the three most significant pharmaceutical developments – penicillin, insulin, and Salk vaccine – all came out of not-for-profit laboratories.)

The Myths of Measurement and of Scale Measurement is a fine idea, as long as it does not mesmerize the user. Unfortunately, it so often does: both managers who rely on it for control and physicians who believe that being "evidence-based" always has to trump being "experienced-based." Management and medicine alike have to balance these two in order to be effective. Unfortunately, too much of health care at both the administrative and clinical levels has been thrown out of balance by their obsessions with measurement.

In the management of health care, the frustration of trying to control rather autonomous professionals has led the administrators and social engineers to a reliance on measurement. And this, it should be noted, is no less prevalent in private sector control by insurance companies and HMOs, etc, than in public sector control by government agencies.

The problem with measurement is that, while the treatments exist in standard categories – certain medications for manic-depression, particular forms of angioplasty for various heart conditions, etc. – their outcomes are often not standard, and therefore can be tricky to pin down by measurement. That is because we as individual patients are not standardized, and so our treatments have to be tailored to our individual needs and conditions.

It is often said that "If you can't measure it, you can't manage it." Well, who has ever adequately measured the performance of management? (Don't tell me it can be done by looking at a stock price.) In fact, who has ever even tried to measure the performance of measurement itself? I guess we must conclude therefore that neither management nor measurement can be managed.

So what can be done if we cannot rely wholly on measurement? That's easy: use judgment. Remember judgment? Can you imagine medicine without judgment? Well, then, I suggest that you not try to imagine management without judgment either.

Measurement favors large scale; in fact scale is measurement. So a society mesmerized by measurement is a society obsessed with large scale. Hence the small hospitals are the ones that get closed. Herzlinger wrote in her 2006 *Harvard Business Review* article that "Health care is still an astonishingly fragmented industry. More than half of the US physicians work in practices of three or fewer doctors; a quarter of the nation's 5,000 community hospitals and nearly half of its 17,000 nursing homes are independent." But what is wrong with that? She added that "You can roll a number of independent players into a single organization…to generate economies of scale". Picture that!

Notice the term: economies of scale. Not effectiveness of scale but economies of scale. Too much of the management of health care has come to be about using scale to reduce measurable costs at the expense of difficult-to-measure benefits.

I am not trying to make the case that smaller is always more beautiful, only to plead that bigger is not always better. Scale, too, has to be judged, especially for its impact on performance. Health care as a calling works best in units that are as humanly small as the best of technology allows. This, in fact, seems to hold true even in pharmaceutical research. To quote Roger Gilmartin when he was chief executive of Merck: "Scale has been no indication of

the ability to discover breakthrough drugs. In fact, it has been the other way – you get bogged down" (Clifford, 2000).

All of this suggests that it is time for some reframing in the management of health care. What follows is not social engineering so much as a suggested set of guidelines.

Reframing management: As distributed beyond the "top"

As noted at the outset, management on "top" is a myth. Aside from that ubiquitous chart, and those famous bonuses, what is management on top of exactly? Indeed, in hospitals, "top" managers often sit on the ground floor (perhaps to be able to make a quick getaway). Seeing yourself on top of an organization all too often means not being on top of what is going on in that organization.

Should these top managers have the power to make decisions about the purchase of expensive equipment, independent of the physicians who use them? That hardly makes more sense than leaving those decisions to the physicians themselves. These are not financial decisions or technical decisions but hospital decisions, and so require collaboration on the part of managers and physicians. And, make no mistake about it, involvement in such decision making places the physicians squarely in the realm of management – as soon as we get past the notion that management is something practiced only by people called managers. Many health care organizations require "distributed management", which means that managerial activities be performed by whoever has the necessary skills, knowledge, and perspective to carry them out most effectively – and that often means collaboratively.

Reframing strategy: As venturing, not planning

If you want to understand what strategy means in a professional organization such as a hospital, stay away from almost all the strategy books. They tell you about strategic planning from the top; recognize instead strategic venturing at the base.

If strategy concerns the positioning of products and services for users, then in a hospital the services are specific kinds of treatments for specific diseases. And where do these come from? Rarely from any "top" management and rarely in any planning process. They come mostly from the venturing activities of professionals: concern about a new disease here, championing of a new treatment there. In other words, the strategy of a hospital is largely the sum total of the many ventures of its professional staff. So here, especially, is where we see distributed management: Professionals on the ground, who are not managers, are responsible for most of the strategic initiatives in health care.

Sure there are other, more conventional strategies determined at large – for example about what services to offer and where to locate them. But much of that is built into the structure and history of the institution.

Hospitals may engage in strategic planning, but a great deal of this, in my experience, doesn't amount to much. Too often it is just another indication of what can be called "the administrative gap" – the disconnect between the machinations of management and the operations of clinicians (Mintzberg 1994, 2007).

Reframing organization: As collaboration beyond control, communityship beyond leadership

With management as distributed and the strategy process as venturing, the nature of most health care organizations can be better understood. The prevailing model in business is what can be called the "machine organization": top-down, hierarchically-focused, control-oriented, numbers-driven, and outputs-standardized. Managers rule. But a very different model, that can be called the "professional organization", is more common in health care: expert-driven, skills-oriented, and highly oriented to pigeonholing, which means getting the client into the right box (mania, hernia, etc.) so that the most appropriate intervention can be applied.

Such pigeonholing describes the great strength of the professional organization as well as its debilitating weakness. The professionals get used to operating in their own pigeonholes, as free as possible of the influence of their own colleagues, let alone the controls of the managers.

Unfortunately, as human patients we are sometimes square pegs forced into these round holes. Some of us have this habit of getting illnesses that cut across the disease categories, or worse still, that don't fit them well (as in auto-immune diseases). Then we require interventions that cut across the pigeonholes, which are often resisted by medical specialists used to operating within them. In other words, we need collaboration from people who are mostly inclined to avoid it.

How to organize around this problem? The inclination has been to use solutions designed for the machine organization – centrally-imposed control systems, performance measures, financial incentives and the like, or else expecting managers up the hierarchy to force the professionals to collaborate. But these hardly work well with independent professionals. Resistance to collaboration in the professional organization will more likely be overcome by drawing on the professionals' sense of calling, and enhancing their organization as a community of service. Put differently, when people are committed to their organization, and not just to their own profession, they are more likely to collaborate effectively. A good sense of this can be had from some comments made by Atul Gawande in one of his *New Yorker* articles on health care:

> The Mayo Clinic… is among the highest-quality, lowest-cost health-care systems in the country. A couple of years ago, I spent several days there as a visiting surgeon. Among the things that stand out from that visit was how much time the doctors spent with patients. There was no churn – no shuttling patients in and out of rooms while the doctor bounces from one to the other…
>
> The core tenant of the Mayo Clinic is "The need of the patient first" – not the convenience of the doctors, not their revenues. The doctors and nurses, and even the janitors, sat in meetings almost weekly, working on ideas to make the service and the care better, not to get more money out of patients. …decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers. It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors' goal in patient care couldn't be increasing their income. …almost by happenstance, the result has been lower costs (2009: 14–15).

Reframing scale: As human beyond economic

None of the guidelines suggested above are helped by large scale – not community, not engagement, not collaboration, not closing the gap between administration and operations. Nor does large

scale help to humanize the practice of medicine.

There can, of course, be technical reasons to favor large scale, for example, in order to purchase necessary expensive equipment. This suggests that we should no more reject large scale than embrace it. But the unfortunate fact is that, because of our mesmerization with measurement, far too often we embrace large scale, conveniently forgetting the human factors.

Imagine if we made small scale the default position, so to speak – in other words put the onus on the proponents of large scale, in health care institutions as well as in health authorities, to make their case for scale on social grounds, judgmentally as well as numerically, beyond the technical and economic grounds.

Reframing managing style: As caring more than curing

Nursing, focused on care, may be a more appropriate model for managing than medicine, focused on cure. Our health care institutions, in other words, require care more than cure: the engagement of their managers to help them function more smoothly, rather than having the power of heroic leaders to run around fixing things.

There was a cartoon once that showed a group of surgeons around a patient on an operation table, with the line "Who opens?" In medicine, we know who opens; in management often we do not – not even if someone should open. That is why management has to be a fundamentally cooperative practice, of a style far from heroic leadership. Managing in health care should be about devoted, continuous, holistic and preemptive care more than interventionist, episodic, narrow and radical cures.

Reframing health care itself: As a system beyond its parts

I opened this article with the claim that we do not have a system of health care so much as a collection of disease treatments. Even my own examples have come largely from the latter. (Hospitals, it should be remembered, account for only about 30 percent of health care expenditures.) Especially the promotion of health, but also the prevention of disease, are muscled aside by our focus on the treatment of disease, even though investment in the former can be far more cost-effective.

An ad appeared some years ago for SAP Canada, headed "This is not a cow." It showed a picture of a cow, with lines drawn where it would be quartered, with the text: "This is an organizational chart that shows the different parts of a cow. In a real cow the parts are not aware that they are parts. They do not have trouble sharing information. They smoothly and naturally work together, as one unit. As a cow. And you have only one question to answer. "Do you want your organization to work like a chart? Or a cow?"

Why can't health care work like a cow: why can it not be a true system of cooperation and collaboration? Note that the parts of a cow are not "seamless." They are distinct, necessarily so. But in a healthy cow, they work together harmoniously. Can this happen in health care? I believe so, and have been working with colleagues for some years to that end. Our management and medical schools at McGill University have teamed up to create a masters program for health leadership that seeks to encourage all of these guidelines (www.mcgill.ca/imhl). It brings practicing managers from all over the world in all aspects of health care – hospitals, community care, public health, government ministries, etc., most of them with clinical backgrounds – together in an ongoing forum that meets periodically over a year and a half to address the major issues of health care. These include:

- The Gap Issue: How to bring the administration of health care closer to the operations, connecting it for support beyond control?
- The Collaboration Issue: How to get the different parts of health care working in greater cooperative harmony?
- The Engagement Issue: How to enhance engagement through the promotion of human scale beyond economic scale?
- The Sector Issue: What are the appropriate roles of the three sectors, especially the plural sector that sits between the now dominant public and private sectors?
- The Performance Issue: How to balance the intrinsic needs for efficiency, equality, and quality in health care?

We have been especially struck by the natural propensity of managers in such a program to work together on such issues, reaching out beyond their own personal needs and those of their institutions, into their local communities and out to the needs of health care in general. On a number of occasions, groups in the class have brought into our forum key issues of concern in their communities, to enable the class to address them in a process we call "friendly consulting".

A group of managers from Quebec, for example, invited the three commissioners of a major government health care commission into the class for a workshop on some of these issues. And two physician managers from Uganda brought our classroom to a conference they organized in Kampala for 60 health care managers from seven African countries, on the subject of how to scale up their management infrastructures.

What this has made clear is that an immense amount of energy and goodwill exists in the field of health care, to work collaboratively to render it more effective, on both the local and the global levels. We just need to get past the myths. ❑

Henry Mintzberg is faculty director of the International Masters for Health Leadership at McGill University (www.mcgill.ca/imhl), and is completing a monograph under the same title as this article.

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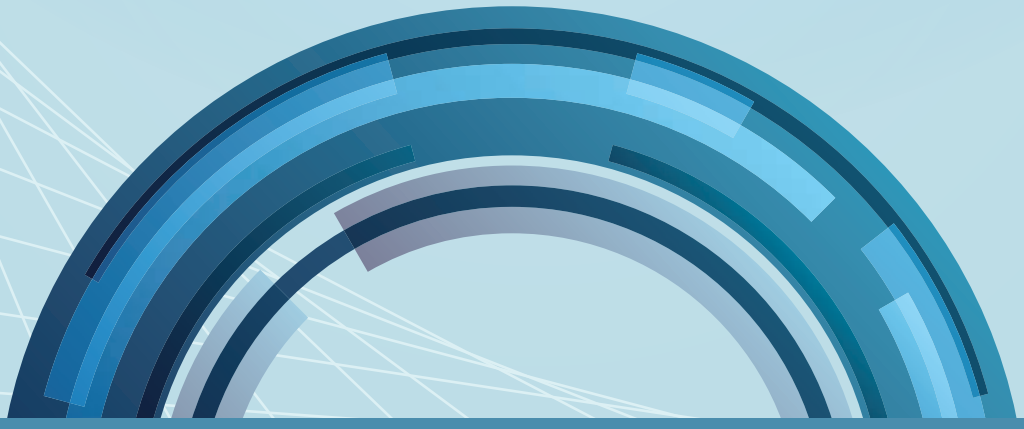

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Health leadership and management competencies: A systemic approach

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ABSTRACT: The achievement of national and international health goals requires better-performing health systems. Strengthening leadership and management of health systems thus becomes essential for achieving greater efficiency and responsiveness, ultimately improving health outcomes.

Building a global framework of core competencies for leadership and management needs to be approached with systems thinking and methodologies akin to complexity science that takes into account all components and levels of the health system and the possible interactions between them that influence outcomes. The results will have important policy implications for national health authorities seeking to strengthen management capacity and building transformational leadership in health systems.

The achievement of national and international health goals requires better performing health systems. Available resources or even additional resources will not necessarily improve performance or translate into interventions that improve population health and well-being. Strengthening leadership and management of health systems thus becomes essential for achieving greater efficiency and responsiveness, ultimately improving health outcomes.

The World Health Report 2010 listed the ten leading sources of inefficiency in health systems. A quick review of the list, from a manager's perspective, will lead to the conclusion that lack of good leadership and management lies at the heart of the problem. Further on, the report states that between "20-40 percent of resources spent on health are wasted, resources that could be redirected towards achieving universal coverage". The report also points out that universal coverage is not solely an issue of more money (which is important) or removing barriers to access (also very important), but "[ensuring] resources are used efficiently". It is evident, thus, that the solutions will require tough decision-making by health system leaders and managers (WHO 2010).

In the Region of the Americas, the concern for improved efficiency and management of health care delivery systems has been stated in various regional initiatives and calls for action (PAHO 2007 and 2009; Gov of Chile 2007). Lack of managerial capacity has been blamed for most health system inefficiencies and considered a "binding constraint" to improving health care services delivery (WHO 2007). Ministers of health often seek technical support from the Pan American Health Organization/World Health Organization (PAHO/WHO) and other agencies to train health managers, hoping to increase their knowledge and competencies, only to find that there are no quick fixes.

Most health systems in the region are faced with questions regarding the managerial workforce: how to train them? Which incentives to use to improve their performance and retain them? Which management skills are necessary? On the other hand, in many countries of the region, health managers are often not recruited based on their competency for the job or through transparent selection processes, but through political appointments. These political nominations lead to situations where, whenever a minister of health is removed or a government changes, all managerial positions are also changed, aggravating the lack of continuity and inefficiencies that such practices produce.

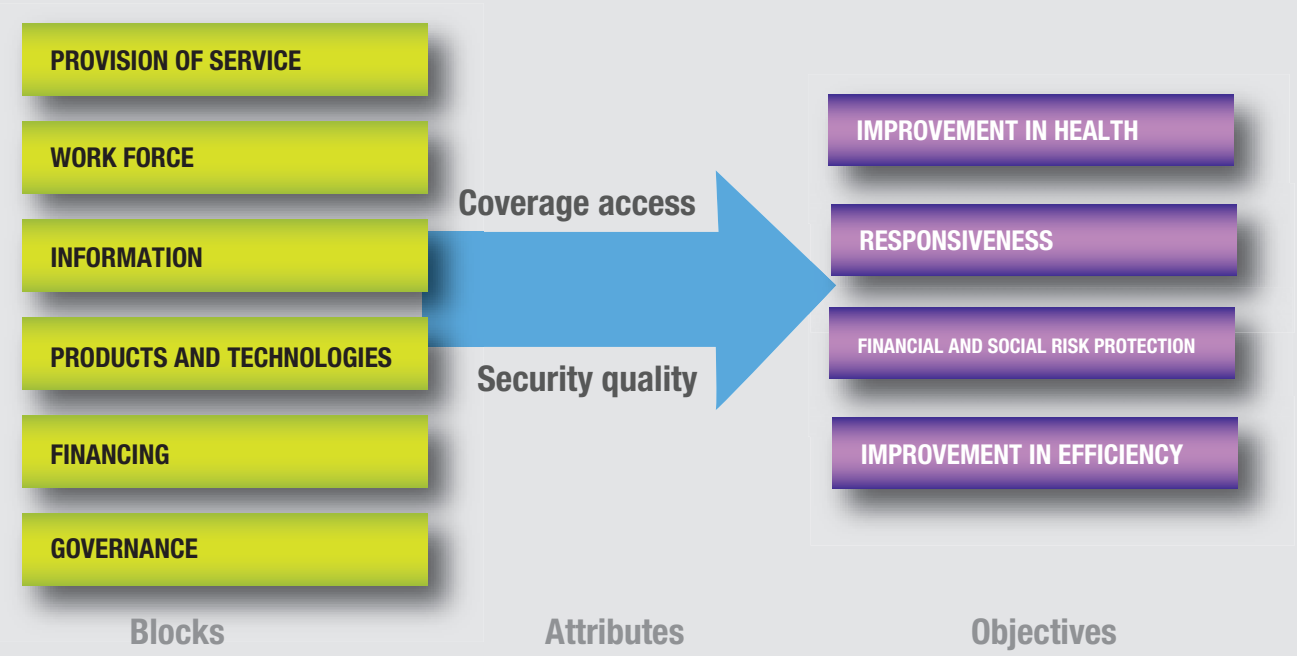
Health managers are also faced with many challenges. Above all, those related to their limited skills in important managerial functions (human resources, financing and accounting, conflict resolution, etc.) and limited knowledge of health systems and the many factors that influence systemic performance. In addition,they often lack the means and enabling conditions to manage effectively. These include, among others, limited data for informed decision making; lack of methodologies, tools, guidelines and information on good practices; and the absence of capacity-building opportunities. Effective management is not only dependent on the manager, but also on the policies, structures, organizational culture, and national or local context (WHO 2005).

Finally, a new issue of concern in the region is the emerging number of academic institutions providing training at the master's degree level in health systems or health care management. More and more authorities in health and education are expressing concerns about quality (accreditation) and the great diversity of curricula. Most disquieting is the lack of consistency between the training curricula and the health systems transformations that most countries are engaged in (Mollis 2003, UNESCO 2009).

Discussion

In health systems, as in any "complex adaptive system" (NAPCRG 2009; WHO 2009), transformations in one component of the system require changes in the other components to ensure that the system is balanced and sustainable. As stated by Peter Senge "to understand the most challenging managerial issues requires seeing the whole system that generates the issues" (Senge 1990). Thus, building a framework of core competencies for leadership

Figure 1: Health systems: components, attributes, objectives



Source: Adapted from WHO 2009. Systems Thinking for Health Systems Strengthening

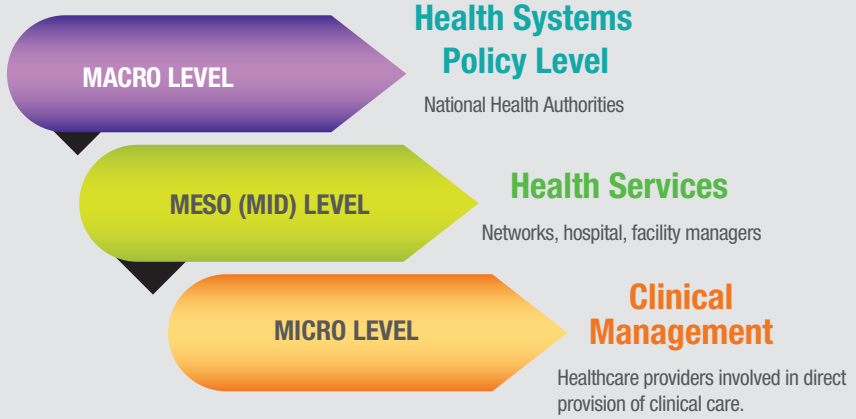
and management in health systems needs to be approached from a systemic point of view.

WHO defines health systems as all organizations, people and actions whose primary intent is to promote, restore or maintain health (WHO 2000). For a health system to function adequately, all of its components must be aligned with its attributes to achieve the desirable objectives (Figure 1). In addition, it is widely recognized that health systems management occurs at three different levels (Figure 2). The macro or policy level refers to the overall governance of the system and, under the leadership of the national health authority, designs and implements policies, regulations, and strategies for the achievement of national health goals. The meso level, which includes management of health services networks and facilities, is responsible for the health of populations and the provision of people-centered services that respond adequately to the needs, expectations, and preferences of the population. The micro level encompasses health care providers (working in teams or individually) involved in the direct provision of clinical care (Ortún 1998).

With this systems framework in mind it is important to consider that changes to management and leadership in one component of the system or at a given management level will undoubtedly trigger or require changes in the rest of the system to maintain viability.

In 2007, WHO presented a conceptual framework for building leadership and management capacity. The framework tries to respond to the question of "What conditions are necessary for good leadership and management[1] at the operational level?" (Figure 3). The emphasis is on two major objectives: 1) availability of capacity (adequate number of managers who in turn have appropriate competencies) and, 2) ability to utilize capacity (better critical management support systems and clear rules, and an enabling working environment). This framework, although a step forward, fails to account for leadership and managerial decisions that are beyond the "operational level" and that are needed to ensure these conditions. In other words, from a systems perspective, the success of the WHO framework will also require that leaders at the macro level have the appropriate competencies and conditions to put forward and implement decisions that influence management at the

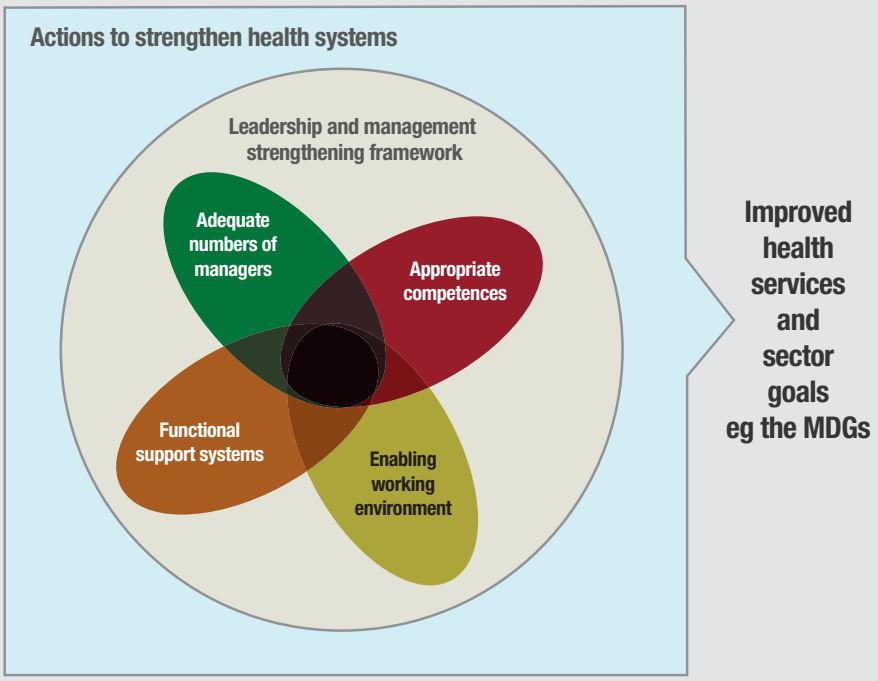
Figure 2: Health systems: management levels



Source: Adapted from Ortún (1999).

[1] Definition: "Good leadership and management are about providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources" (WHO 2007).

Figure 3: The WHO framework: conditions for successful managerial processes



Source: Adapted from WHO 2009. Systems Thinking for Health Systems Strengthening

operational level (WHO, 2007).

This leads to the notion that there are "appropriate competencies" specific to each of the three levels of management: macro, meso, and micro. Leaders and managers at the macro or policy level are increasingly faced with the need to be knowledgeable of the global health context and agenda. To a greater extent, health issues take on global characteristics and countries are required to participate in debates and decision-making that affect international health. Leaders and managers working at this level should develop competencies in global public health such as negotiation skills, knowledge of global health security issues, understanding of global health governance, intercultural sensitivity, etc.

At the meso level, the leading objective in the Americas and in many other regions of the world is the integration of health care delivery services based on a Primary Health Care approach. More and more, countries are implementing policies, and passing legislation and other regulations to put in place strategies for integrated health service delivery networks to improve the coordination of care and the efficiency and effectiveness of service delivery. Managers at this level will need to develop or enhance their skills to manage large organizations with different types of health facilities and acquire new competencies for interacting with and leading teams that span the first level of care, specialized care, and social services.

At the clinical or micro level, integrated health service delivery is based on a renewed and stronger first level of care, with multi-disciplinary teams that coordinate care along the continuum of services and interact with specialized care and social services to address the needs of the populations they serve. In hospitals, care is evolving from the traditional fragmented specialist based model, to models of care organized around processes and using clinical pathways and evidence-based medicine to treat persons and not diseases or organs. Clinicians are called to provide care to individuals with increasing knowledge and access to information who demand to be part of the decision-making process relating to their health or that of their families. Other health professionals, most prominently nurses, are progressively playing new and more complex roles in health care provision, including management, which require new outlooks in managing human resources. All these changes entail new skills, knowledge, and behaviors, (Shortell 2006), in other words, new competencies that go beyond the traditional.

It is widely accepted that effective health systems depend greatly on having "the right people in the right places" (PAHO 2007a; Filerman 2003). In that same line, effective leadership and management of health systems, requires that individuals who lead have the "underlying characteristics" that allow them to perform and render results that ensure efficiency and effectiveness. (Ross Baker 2003)

To the question of whether there is a need or a place for an international framework of core competencies in health leadership and management, the authors argue that such a framework is urgently needed and will be very useful in achieving at least three major purposes:

1. The framework would be useful to national health authorities in providing normative guidelines for training and continued education of health managers and establishing certification programs to build a critical mass of leaders and managers that will allow for better selection and appointment processes.
2. Such a framework would allow academic institutions to streamline programs for training health managers to ensure correspondence between curricula content and the needs of modern health systems.
3. It will allow managers to build career paths that progress from one level to another, while others may choose to enhance their competencies and specialize in management of a specific level of the system.

At the international level there is a wealth of solid work on competencies for leadership and management in health (NHS 2010; ACHSM 2012; CCHSE 2005). Also, there is extensive work on competencies for the public health workforce (AJPH 2008; PAHO 2012). Filerman's cautionary note that these competencies are both essential and complementary but not the same is still very valid. Any new developments should build on this solid foundation and need not attempt to reinvent the wheel. However, a core framework agreed upon and accepted by an international consensus of health systems stakeholders will absolutely need to include the following tenets:

- A health systems approach that includes knowledge and skills for global health and that goes beyond leadership conceived only for physicians, but including all health professionals.

- Competencies that builds leaders and managers with an ethos for leading organizations in continuous transformation.
- Competencies for building systems that are people-centered and based on Primary Health Care values and principles.
- An approach that combines competencies both for public health and management of healthcare delivery services.

Conclusion

At the global level, and even more so in the Region of the Americas, an internationally accepted framework of core competencies for leadership and management in health, based on wide consensus, is needed and would be useful in guiding policy makers and national health authorities.

New health challenges demand that the development of and agreement on these competencies be conducted applying clear systemic approaches and methodologies akin to complexity science that takes into account all components and levels of the health system and the possible interactions between them that influence outcomes. The results of such a process will have important policy implications for national health authorities seeking to strengthen management capacity and building transformational leadership in health systems.

The ultimate result of applying such a framework should be to improve efficiency and management performance in the health system with the critical goal of improving people's health and well-being. ❑

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Leadership and globalization: Research in health management education

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ABSTRACT: The impact of globalization on graduate health care management education is evident, yet challenging to quantify. The Commission on Healthcare Management Education (CAHME) recently authorized two research studies to gather specific information and answer important questions about accredited graduate programs in the USA and Canada. Two surveys provided the most comprehensive data impacting international health management education efforts by 70 programs. An inventory was made of 22 countries; information was compiled on 21 accrediting or quality improvement organizations. Observations on leadership and the demand for qualified health care professionals is discussed in terms of accreditation, certification, competency models, outcome assessment, improving quality, and the impact of globalization on higher education.

Global transformation impacts all sectors of the economy and health care landscape, providing unique challenges and opportunities to rethink business strategy. A borderless world in higher education provides mobility of students and faculty to enhance and reshape the global academic landscape. New opportunities exist for growth and innovation in accreditation, certification, graduate education and professional development of health care professionals. This is especially true given the demand for well-trained leaders and managers who appreciate the importance of managing cost, controlling access to care, increasing quality of care, and having clinical outcomes linked to quality management. Educating and training of health care executives remains a priority for most countries that recognize the need for effective leadership, efficient management structures, competency development, evidence-based management, increased economic competitiveness, and maintaining international reputation.

Overview of research

The Commission on Accreditation of Healthcare Management Education (CAHME) in the USA recognized the need to survey CAHME accredited programs. With funding from the Aramark Charitable Fund, two research studies (PHASE I & II) were authorized to gather specific information and answer important questions impacting graduate healthcare management education in the USA. Each study had a domestic and international initiative methodology.

The PHASE I study conducted in 2011 was structured to:

- Examine the supply and demand for professionally trained healthcare administrators in sixteen countries.
- Provide a summary of the health systems.
- Use an expert panel to provide opinions, advice, and access to information.
- Assess the extent of international health care management education activities of CAHME accredited programs and describe involvement in international health administration education.
- Prepare recommendations for future research for Phase II and Phase III.
- Suggest ideas for conferences, presentations, and other venues to disseminate the results of the projects.

A domestic survey composed of 39 items was sent to all CAHME accredited programs. Out of 72 programs surveyed, 66 responded with a 91.67 percent response rate. An international study was conducted to identify university and other providers of programs that lead to a credential that is recognized by the health services delivery system/community as attesting to the completion of a course of study that is appropriate preparation for management practice. Countries were analyzed regarding the economy, political status, and the health care environment. For each country in the educational provider section of the survey, specific data was collected on educational institutions, programs, affiliations, degrees offered, program duration and other identifying information. The 16 countries included Austria, Brazil, Chile, France, India, Israel, Mexico, Philippines, Saudi Arabia, Singapore, South Africa, Spain, Sweden, Turkey and The United Kingdom.

The PHASE II study built on findings from the PHASE I study to examine four areas. First, six additional countries (Germany, Ireland, Czech Republic, South Korea, Netherlands and Colombia) were added bringing the total to 22 countries. Second, in-depth telephone discussions were held with directors (PDs) of CAHME accredited programs to gather information on global centers, courses, international research, partnerships and faculty. Third, accreditation programs in business, medicine and public health were surveyed to identify domains that pertain to health services

administration sponsorship, processes and memberships. Fourth, a strategy to implement international demonstration site visits using the 2013 CAHME Accreditation criteria was developed. This included identifying relevant CAHME criteria that can be used outside of the USA under some type of external review such as certification.

During the telephone survey, 40 CAHME-accredited PDs were contacted who in the PHASE I study identified international program/faculty involvement. Twenty-six PDs (65 percent) responded to the survey. The survey addressed the following questions:

- Does your college/university have a global center through which health care management education is delivered?
- Do program faculties have grants with international focus?
- Are any of your faculties involved in international research studies?
- Does your graduate program have any international health care management partnerships with other countries?
- Does your program teach any courses at foreign universities?
- Listing of courses taught internationally.
- Does your program offer a track or concentration in international health management education?

Survey findings and observations (Phase I & II)

The PHASE I study revealed several key findings, including the following:

- Approximately 30 percent of CAHME programs have international involvement of some type.University-based partnership models have been identified as a venue for different types of educational endeavors from courses, workshops/seminars, short courses, certification courses, and lectures. Faculty activities include international grants, international research, projects, publishing in international journals, and encouraging study abroad. There is a high probability these types of activities will increase. A limited number of faculty hold visiting faculty appointments at universities outside of the USA and Canada.
- Approximately 30 percent of PDs reported that their graduate programs provide study abroad, student exchanges, faculty exchanges, online graduate courses, and service learning opportunities abroad. One program reported having a university or college global center through which health care management education is delivered. A limited number of programs have faculty who take sabbatical leaves abroad and faculty who serve on editorial boards of international journals. Very few PDs reported subsidizing international journals, but provided in kind resources to these journals.
- CAHME programs are involved in many countries but the focus seems to be on Asian, Middle Eastern and Western European countries. Joint degree programs of study are rare and very few PDs report having campuses located in other countries. There are a variety of different courses being taught in international settings (mainly or mostly business administration and public health), but few courses in health management education or concentrations in health management education. A limited number of programs teach courses at foreign universities and only 10 PDs reported that they marketed programs to students in specific countries or had a specific international marketing strategy.
- The number of programs having courses on global health care management is very small. Only four PDs reported offering a certificate in international health care management. However, several programs have foreign graduates who are alumni and help recruit new students.

> A domestic survey composed of 39 items was sent to all CAHME accredited programs. Out of 72 programs surveyed, 66 responded with a 91.67 percent response rate.

The PHASE II survey focused on specific international health management areas: global centers, research, courses, study abroad and partnerships. The following are among the key findings of the PHASE II survey:

- All contacted programs had some type of international activity. The areas of involvement and intensity of activity varied across programs.
- Of the 40 programs studied, with 26 programs responding, 11 of 26 programs (42 percent) reported offering study abroad. The majority of programs (82 percent) use elective courses to offer study abroad. This survey showed that most study abroad occurs in Asian countries (China, Vietnam, Thailand, India) followed by Western Europe (Germany, Italy, France), Eastern Europe (Slovakia), Middle East and Africa. On the average, most graduate programs offered study abroad for the length of two weeks.
- In the area of research, 69 percent of programs had faculty involved with some type of international research, and this research was focused in specific areas of quality, education and clinical aspects of healthcare delivery. At present, 10 of 26 programs are involved in Africa followed by China, France, Taiwan, India and South America. Eleven of 26 (42 percent) programs conduct research with other universities, and 12 of 26 (46 percent) programs receive external funding for conducting research from grant sources.
- Global health management courses were offered by 38 percent of the programs (10 out of 26). The courses were focused on comparative health systems, delivery of care, general management with the majority focused on public health. Only a few had courses specific to global health management. Most courses are offered in the USA and three of 26 programs (12 percent) offered global health management courses outside of the USA. 73 percent of programs teach these courses in the classroom and 27 percent use a blended style in teaching courses (In class and Online). The dominant teaching method is lecture with projects.
- 46 percent of programs (11 of 26) reported having international partnerships with another country. The majority of partnerships focus on research and teaching. The location of these partnerships are in China, Germany, Costa Rica, France, Taiwan, Korea, Slovakia and other Eurasian countries. 50 percent of these partnerships involve other universities and occur because

of specific faculty international interests in a country.

Based upon observations of the 22 study countries, we conclude that it is helpful to visualize the status of the education system for health administration and the place of health administration careerists in the service delivery system in terms of the degree of alignment between the two. The situation analysis of the countries can be arranged from those that are highly aligned to the less aligned. In the highly aligned situation most, if not all, of the senior positions in the public and private health services delivery systems are either occupied by individuals with recognized credentials in the field, and/or the credential is a distinct advantage for appointment or promotion. Also in the highly aligned situation, the health systems administration education system is closely articulated with the recognized competency needs of the system and is producing a sufficient number of graduates to meet a substantial portion of the demand. There is a high degree of professional identity and credential holders are likely to remain in the field.

The other end of the spectrum – that is, when the degree of alignment is low between the education system for health administration and the place of health administration careerists in the service delivery system – often reflects low recognition of management degrees/credentials in other sectors. Overall recognition of the value of the credential is limited, usually to a few large government hospitals in capital cities and large private providers. The credential is rarely cited in position qualifications, there is little professional identity among administrators, there is not a career path associated with the credential, and individuals with the credential often move to other kinds of higher paying organizations. There are few programs and usually there are a small number of students, reflecting the limited market.

A review of 21 accrediting or quality improvement organizations suggested that the most developed and active areas are business followed by public health and medicine. The 2013 CAHME Criteria and Standards were successfully used in an international site survey visit at St. Elizabeth University in Bratislava, Slovak Republic in April 2012. A panel of five international experts determined that the majority of new CAHME criteria could be applied outside of the USA and used in another country. A strategy and plan of action is identified for a PHASE III study for CAHME. Specific steps with timeframes have been provided to initiate demonstrate site visits in 2013.

Conclusions

Globalization has impacted graduate education in the USA. The number of international students enrolled in graduate education in the USA is significant. Career opportunities for graduates with multi-national corporations, NGOs and international organizations appear to be increasing. The global competencies needed by future students are constantly changing placing pressure on graduate programs in health management education to re-examine the importance of accreditation, competency models and specific competencies, demonstrated knowledge and skills and placement following graduation.

In most of the countries from which data was collected, it appears that professional education for health administration is not yet seen as a key to producing necessary managerial competence and leadership. There is growing recognition that clinical competence is not the same as managerial competence, but also that there are many clinicians with little or no managerial training who are successful managers and leaders. That makes it difficult to change the culture, even in the context of improving system performance. It does appear that in most of the study countries professional administrators are gaining status over poorly trained or performing physicians who do not see themselves as administrators.

Developments in the education sector, including public health and business administration, as well as health administration education are also converging to set the stage for expanded recognition of credentials in the field. A global expansion of public health schools and programs started about ten years ago will most likely continue in both developed and emerging countries. At the same time, there is a recognition that traditional approaches to public health education have failed to deliver the management skills necessary to improve system performance. In addition to responses addressed in this report, medical schools are expanding community medicine and health systems related courses and specialties. Both are fueled by the world-wide growth of health economics and health services research.

Globalization of health management education continues to mature in response to the need to assure access to healthcare services in every country, addressing the demand for cost effective care, and improving quality of care. The issues of cost, access and quality are global and are driving the need for trained leaders and managers who can improve the performance of health systems and in particular effectively manage care across public and private sectors.

The growth of the health care management in the next decade and beyond will be in the cities of the emerging economies. Most of these countries are either engaged now in universal health coverage or are moving in that direction. There is an opportunity to contribute to their efforts to improve health system performance through strengthening managerial competencies and professionalism. The success of such a contribution is dependent upon recognition of the need for maximum country ownership, or at least participation in improvement efforts and their resistance to the perceived imposition of foreign behavioral expectations.

Our opinion is that a well-conceived and developed process for external recognition/ certification based on broadly applicable criteria may have traction if focused on global health management, leadership development, quality and improved outcomes across the continuum of care. Such certification can focus on professionalism, competencies, teaching methods and processes within higher education. Certification can be used to promote assessment of student outcomes, impact on managerial practices, as well as promoting program resource and faculty development. In other words, it may accomplish the same objectives as accreditation, without all of the administrative and regulatory complexity. If it is properly designed to have international legitimacy, certification is likely to be widely accepted.

The expectation is that the health administration field's recognition, stature and support will grow at an increasing pace across the study countries. This would be in response to the consensus among governments, planners, donors and all other global promoters of health services that the key to improving health status is not more money: It is to improve the performance

of health services, and the key to that improvement is competent management and strong leadership. ❑

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West, Daniel J., Filerman, Gary, and Ramirez, Bernardo. 2011. International Healthcare Management Education. Phase I. Report Commission on Accreditation of Healthcare Management Education (CAHME). http://www.cahme.org/Resources/FINAL%20REPORT%20_%20International%20Study%20.pdf. The Report for Phase II will be available from CAHME at: http://www.cahme.org/Reports.html

Leadership and management quality: Key factors in effective health systems

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ABSTRACT: The effectiveness of health care systems in the developing world is related to the quality of their leadership and management, yet that factor has been neglected by academics and funders. Based on replicable existing models, the article proposes an approach to strengthening local management training institutions.

The quality of leadership and management skills is a key determinant of health systems effectiveness, especially so in the developing world. Yet neither academics nor development funders have devoted much attention and resources to the issue.

The article touches on three questions:

- Why is quality management important to health outcomes?
- How can management quality be improved in developing countries?
- What is an effective way of enhancing local management education capabilities in the developing world?

> One of the key determinants of developmental outcomes in all sectors is the quality of management. That factor has been neglected by academics as well as by development funders and implementing organizations

Management matters

Why have health-related Millennium Development Goals not been achieved? According to the World Bank, despite progress in reducing child mortality, "more than 100 countries remain off track, and only a few of them are likely to reach the MDG target by 2015". Similarly, in improving maternal health, 94 countries are "off track or seriously off track", and "the number of countries seriously off track has increased" (World Bank 2011).

One of the key determinants of developmental outcomes in all sectors is the quality of management. That factor has been neglected by academics as well as by development funders and implementing organizations. Yet, ongoing research shows the importance of management quality on outcomes. Researchers have been tracing over time the performance of medium and large firms in India, which, to varying degrees, adopted improved management methods. "The early results have been startling – when these firms adopted these basic management practices they obtained massive improvements in productivity… For example, most firms previously had no quality measurement systems, so the same production defects would persist for long periods of time. Introducing systems to measure quality defects and analyze the data enabled forms to correct the causes of defects quickly, reducing average defect levels by over 50 percent min the first three months alone… [If] these firms fully adopted the modern lean management practices that are in common use in developed countries, they could potentially increase their productivity by up to several hundred percent" (Bloom et al. 2010).

Recent research indicates that efforts to improve management quality may also improve health outcomes. In a study of 1,194 hospitals in the United Kingdom McKinsey concludes that "Hospital-specific management practices are strongly related to a hospital's quality of patient care and productivity outcomes…. [This] research shows that improved management practices in hospitals are associated with significantly lower mortality rates…" (Dorgan et al. 2010).

The case of Nairobi Hospital illustrates how better leadership and management practices can help to improve outcomes in a developing country's health sector. "Facing stagnant growth, increasing costs of care, and high staff turnover, Nairobi Hospital was risking closure. The institution needed strong leadership to come in and turn it around. Dr Mailu and his team were able to do this through improved processes, investment in infrastructure, improved quality of care, and strengthened organizational decision-making. Some approaches included increased use of ICT, outsourcing non-core business functions, convincing the hospital board of the importance of making investments, and empowering the work force. On the point of investments, Dr Mailu articulated the importance of balancing profitability and accessibility. Surpluses are not caused by price increases, but cost containment and efficient management practice. Managing health care organizations effectively is critical; hospitals are

businesses that have to be run efficiently. Dr Mailu concluded by saying that the application of sound management and leadership skills was key to Nairobi Hospital's success, and success in health care translates to higher quality care and better health outcomes." (Mailu 2010).

Enhancing management and leadership quality

As an important factor determining health outcomes, local management and leadership quality should be an integral part of ongoing efforts to strengthen health systems. There is evidence of the need for enhancing the management capabilities of the health workforce. A survey of 800 health professionals in Kenya, Nigeria and Senegal, carried out in 2009 shows strong perceived needs for training in financing (e.g., accounting and budgeting, resource allocation, conducting cost-effective analyses, resource development and mobilization, etc); health policy (e.g., developing quality frameworks, quantitative and qualitative data interpretation skills, etc); and in health management (e.g., leadership, communications, accountability and reporting, human resource management, etc.) (Fine 2009).

Well-designed leadership and management training programs can improve performance and outcomes. There have been numerous examples of training activities with significant impact. For example, teams enrolled in a Leadership Development Program (LDP) conducted in collaboration with EngenderHealth's ACQUIRE Project, in Kigoma Province, Tanzania, increased the number of new clients by 20 per cent to 80 per cent. In 2003, three district teams in Egypt increased the number of new visits by 36 per cent, 68 per cent, and 20 per cent respectively. Local health professionals then used their own resources to expand the program to all 185 health facilities in the Aswan Governorate. In Ghana, a six-month LDP was conducted in the Central Region. Given the success of this program, the Ghana Health Service found funds to scale up the LDP to the other nine regions of the country beginning in 2009 (Dinkin and Taylor 2009).

More recently, a study using a quasi-experimental design focused on the impact of a leadership development program in Kenya. The study tracks measurements of health service indicators from 2008 to 2010 in districts and facilities where the LDP was delivered to 67 teams and a comparison group where LDP was not delivered. The study shows strong positive impact of LDP both at the district level and for individual health facilities. The study tracked health indicators such as fully-immunized children under the age of one, women who delivered with a skilled birth attendant; and pregnant women who had four or more antenatal care visits. Strikingly, the average coverage rate for these selected health indicators improved from 54 to 67 percent where LDP had been delivered, while coverage remained unchanged at 45 percent in districts where LDP had not been delivered (Management Sciences for Health 2010).

In most OECD countries there is an abundant supply of high-quality educational institutions providing leadership and management training for the health sector, notably schools of public health. These schools feed into well-established career streams such as hospital administrators. This is unfortunately not the case in the majority of developing countries. There, typically, schools of public health teach administration rather than (problem-solving) management, and career streams for professional administrators are not deeply embedded into health systems; rather, hospitals and other health services institutions are often run by medical personnel with little or no management training.

In some developing countries, local business schools are beginning step into this space, some in collaboration with schools of public health or medical schools. Why business schools? Because good business schools develop important competencies that are highly relevant to the effective management of facilities and services in the public, not for profit, and private sectors. Among these are leadership, teamwork, strategic foresight and strategizing, and sound business planning. Perhaps most important, good business schools hone problem solving skills, an ability systematically to appraise major challenges, quickly identify the root causes, and weigh the advantages and drawback of different solutions.

Strengthening such professional competencies is an essential complement to current efforts to decentralize the delivery of health care. Furthermore, when provided to highly motivated professionals, such education, with further nurturing, can produce "agents of change" capable of thinking "outside the box", in terms of systemic change and organizational innovation (Fine 2009, p.4). The cost of such courses may seem expensive, but represents a very small fraction of the amounts organizations can save as a result of more effective leadership and management.

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Strengthening the capacity of local management schools

Only a few developing country management schools have the capability to deliver courses "producing" change agents. One example is Kenya's Strathmore Business School's Executive Healthcare Management Program (EMPH). It targets senior health care professionals from the private and public sectors, who are primarily responsible for medical and financial performance of health care organizations. It is also suitable for those who lead in the healthcare support industry and non-governmental organizations involved in health care delivery.

Strathmore Business School (SBS) was established relatively recently, and offers a good example of how local capabilities can be developed. SBS grew out of Strathmore University's school of accountancy, a highly-respected institution. Being part of a private university, SBS enjoyed a greater of freedom to innovate, than is generally available to government universities. SBS's links to a first-tier European business school (Spain's IESE) were crucial in developing its faculty. SBS is a member of the Global Business School Network (GBSN) and of the Association of African Business Schools, both of which have contributed to faculty development by facilitating access to worldwide relevant expertise. Similar examples of successful institutional capacity-

building can be found in other Kenyan business schools and in other developing countries, but very few resources are being allocated by local governments and external funders to this end.

In conclusion, the quality of leadership and management (hence leadership and management education) are key factors in effective health systems. A comprehensive framework for enhancing health management in developing countries entails changes at three levels: elevating the value of health management and leadership; increasing health management training capacity; and creating incentives within the health system to seek management training (Global Business School Network 2007). ❑

Mr Pfeffermann worked for 40 years at the World Bank Group as a development economist. He was Chief Economist for Latin America and the Caribbean (1979-87) and the Chief Economist of the International Finance Corporation, the World Bank's private sector development arm (1988-2003). He is the founder and CEO of the Global Business School Network, a non-profit organization whose mission it is to build management education capacity for the developing world.

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[1] There are many reasons for this neglect. In particular, the distinction between training individuals and strengthening institutions is critical. Institutional capacity-building is far more conducive to long-term sustainability than the training of individuals. However, the two are often conflated, to the detriment of institutional capacity-building.

Health and hospital reform in Australia – A local health district's perspective

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ABSTRACT: Health and hospital reform is not new on the international stage. Increasing demand for health care services due to aging populations and the increased burden of chronic disease, continued advances in medical technology (including the rapid expansion of information systems) and ever growing community expectations mean that the health care expenditure of most health systems is growing at a rate greater than GDP (OECD 2008). Most countries appear to be grappling with how they can create a sustainable health system for the future. This article provides an overview of reform occurring within the Australian and New South Wales (NSW) Public Healthcare Systems, which includes devolution to Local Health Districts, a smaller and more focused Ministry of Health, increased transparency and funding reform. The article examines the challenges this reform presents for Local Health Districts and how these challenges are being addressed locally. This reform has also highlights the competencies that are required of chief executives and other senior executives in health in managing and leading these complex health organizations.

Australia has universal health cover. The Australian Health System consists of a mix of public and private sector health services and a range of funding and regulatory mechanisms. Australia has 1,340 hospitals, 752 public hospitals accounting for 68 per cent of hospital beds (57,772) and 588 private hospitals accounting for about 32 percent of beds (28,000 private hospital beds (2009–10 data)). Around 64 percent of surgery in Australia is performed in the private sector (Productivity Commission 2009). Australia's health system is financed through a combination of income tax, a specific income levy (the Medicare Levy) and private financing by individuals through private health insurance premiums and out of pocket payments. Almost 70 percent of the total health expenditure in Australia is funded by government.

Over the past 12 months, the Public Health System in New South Wales has been implementing one of the largest, most complex and most significant reforms that has occurred in the last 25 years in any jurisdiction in Australia.

This has been done while the Australian Commonwealth, State and Territory governments reached agreement to implement a National Health and Hospitals Network which aimed to reform health care delivery in Australia (Commonwealth of Australia 2010). The Agreement sets out the shared intention of these arms of government to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

The reforms aim at achieving better access to services, improved local accountability and transparency, increased clinician engagement, greater responsiveness to local communities and a stronger financial basis for the health system into the future through increased Commonwealth funding.

A central requirement of this reform was the establishment of Local Health Networks, the aim of which was to decentralize public hospital management and increase local accountability to drive improvements in performance. Consistent with the recommendations of the Special Commission of Inquiry – Acute Services in NSW Public Hospitals, NSW (Garling 2008), Local Health Networks are accountable for treatment outcomes and responsiveness to patient's needs and make active decisions about the management of their own budgets.

NSW was the first state to introduce Local Health Networks (now Local Health Districts) with work on the transition commencing in mid 2010. On 1 January 2011, eight large area health services were reorganized into 15 Local Health Network and three state-wide Specialty Networks, administered by Chief Executives, supported by Governing Councils and grouped into Clusters providing shared services in areas requiring critical mass and expertise.

With the change of State Government in March 2011, decision making was even further devolved. Local Health Networks became Local Health Districts (LHDs) on 1 July 2011 and the governance structure changed with the introduction of LHD Boards, to whom the Chief Executives are accountable. LHD Board members are appointed by the Minister. The Board is chosen to have a mix of skills including medical expertise, financial and risk management, and local community and clinician representation. Responsibility for control and management of the day-to-day operation and performance of the LHD or specialty network is vested in the Chief Executive. The aim of LHDs is to devolve resources and decision making so that those closest to patients can make more decisions about the best health care for patients.

As outlined by Foley (2011) the themes of the new governance arrangements for NSW Health are:

- Devolution of authority and responsibility to LHDs with NSW

TABLE 1: SYDNEY LOCAL HEALTH DISTRICT BOARD REPORTING PACK: CHIEF EXECUTIVE REPORT – BALANCED SCORECARD

Finance and Management	MTH T	MTH Bud	MTH Act	MTH Var	YTD T	YTD Bud	YTD Act	YTD Var	F/C	Notes
GF Revenue		11,927	9,777	18.02%	↓	152,090	153,648	-1.02%	-5.02%	1
GF Expenditure		152,703	159,457	4.42%	↓	1,161,895	1,174,076	1.05%	0.65%	2
NCOS		140,777	149,680	6.32%	↓	1,009,805	1,020,428	1.05%	0.00%	3
Patient Fees		5,664	6,314	-11.47%	↑	62,309	67,455	-8.26%	-11.77%	
Recurrent Trade Creditors > 45 days (< 10%)	-	-	-	-	↑	-	0.02%	-	0.00%	
Patient Fee Debtors Chargeable > 45 days (< 5%)	-	-	-	-	↓	-	3.19%	-	5.00%	
Patient Fee Debtors Compensable & Ineligible > 150 days (< 5%)	-	-	-	-	↑	-	1.94%	-	5.00%	4
Cost Weighted Seps. % previous month YTD	-	-	-	-	-	-	-	-	-	
Capital works expenditure		1,912	1,912	0.00%		3,501	3,501	0.00%		
Coding Timeliness (95%)		95%	100%	5%	↑	95%	88.89%	-6.11%		5
ALOS (overnight)		6.36	6.17	-0.19	↓	6.17	6.29	0.12		6

People	MTD T	MTD Target	MTD Act	MTD Var	YTD T	YTD Target	YTD Act	YTD Var	Notes
Staff Numbers FTE		-	8537	-		-	8367.7	-	
# Workcover Claims /mth		44	45	2.3%	↑	485	428	-11.7%	
Workforce Turnover %		-	0.60%	-	↑	-	1.02%	-	7
Premium Staff Usage: Agency		-	111.9	-	↑	-	129.2	-	8
Premium Staff Usage: Overtime		-	235.7	-	↓	-	236.3	-	
Premium Staff Usage: Casual		-	177.2	-	↓	-	178.3	-	
Sick Leave FTE**		-	2.91%	-	↓	-	2.66%	-	
Leave Liability ***		-	906	-	↓	-	906	-	9

** Target = 5% reduction from same period previous year. Will be updated for future report

Safety and Quality	MTH T	MTH Target	MTH Act	MTH Var	YTD T	YTD Target	YTD Act	YTD Var	Notes
SA-BSI		2	0.44	-1.56	↑	2	0.94	-1.06	
CDI		-	3.06	-	↑	-	1.41	-	10
ICU CLAB infections		0	0	0	↑	0	12	12	11
Rapid Resp. Calls		-	15.23	-	↑	-	13.44	-	12
Cardio-Resp. Arrests previous month		-	0.39	-	↑	-	7.18	-	13
Incorrect Procedures		-	0	-	↑	-	7	-	14
Complaints Mgt <5 days		100%	100%	0	↑	100%	N/A	-	
Complaints Mgt <35 days		80%	76.27%	-3.73%	↓	80%	N/A	-	
Unplanned/Unexpected readmissions		<2.81%	3.23%	0.42%	↓	<2.83%	2.99%	0.17%	15
Cancellations on Day of Surgery		-	90	-	↓	-	842	--	
Mental Health readmissions<28 days		10%	2.73%	-7.27%	↓	10%	3.6%	-6.4%	
ED re-presentations (48 hrs)		-	3.30%	-	↑	-	3.70%	-	

Patient Flow	MTH T	MTH Prior Yr	MTH Act	MTH Var	YTD T	YTD Prior Yr	YTD Act	YTD Var	Notes
Mental Health ED>24hrs (0%)		2	5	3	↓	37	43	6	16
ED Triage 1 (100%)		100%	100%	0%	↑	100%	100%	0%	
ED Triage 2 (80%)		82.42%	74.54%	-7.87%	↓	84.53%	82.39%	-2.14%	
ED Triage 3 (75%)		68.46%	60.36%	-8.10%	↓	68.64%	66.46%	-2.18%	17
ED Triage 4 (70%)		69.32%	72.51%	3.18%	↑	71.41%	73.08%	1.67%	
ED Triage 5 (70%)		88.37%	88.76%	0.40%	↑	88.88%	88.49%	-0.39%	
ED <4hrs(70%)		45.27%	51.81%	6.54%	↓	46.62%	48.28%	1.66%	18
ED <8 hrs (80%)		61.62%	73.96%	12.34%	↓	63.22%	71.76%	8.54%	
OST <30m (90%)		67.14%	66.81%	-0.33%	↓	65.70%	68.47%	2.77%	19
Acute Seps <24 hrs		5,364	5,800	436	↑	57,974	59,381	1,407	
Acute Seps – overnight		5,947	6,310	363	↑	63,524	64,485	961	
O/due Elec. Surg. Cat 1 95%		0	1	1	↑	0	5	5	20
O/due Elec. Surg. Cat 2 95%		0	4	4	↓	3	16	13	20
O/due Elec. Surg. Cat 3 95%		0	7	7	↑	2	44	42	20
Available Beds		60,135	61,053	918	↓	634,088	651,369	17,281	
Bed Occupancy		89.73%	91.10%	1.37%	↑	89.73%	89.08%	-0.65%	
Theatre Utilisation (80%)		N/A	79.55%	-	↑	N/A	73.16%	-	21

* Not a target. Denotes performance for same month previous year

↓ Denotes deterioration in performance from previous 3 months

↑ Denotes improvement in performance from previous 3 months

KEY: Performing | Underperforming | Not Performing

1 SLHD Finance, Risk and Performance Committee Meeting Monday 2nd July 2012

Source: Sydney Local Health District May 2012.

Ministry of Health (MoH) and LHDs moving to a purchaser-provider relationship. LHDs have responsibility and accountability for managing all aspects of hospital and health service delivery for their local district under a service agreement between the MoH as purchaser and systems manager/regulator and the LHDs as providers of health services. Expectations of LHDs are now clearly laid out in the new Performance Framework which is intended to allow LHDs maximum autonomy to determine how the expected performance is achieved. It is intended to create transparency of expectations but also to leave LHDs free to identify other areas of performance important for local communities and clinicians.

- ✚ Changed role and structure for the MoH providing Westminster functions of supporting the Minister and Government, regulatory functions (such as licensing, and other public health legislation), public health functions (disease surveillance, control and prevention) and system manager functions in statewide planning, purchasing and performance monitoring. Reducing duplication of functions and stepping back from operational matters has allowed the Ministry of Health to focus on its role as system manager, purchaser and regulator and coordinating the public health function. The Ministry of Health is 25 percent smaller than the previous Department of Health.
- ✚ Strengthening of four "Pillars" developed in response to Garling (2008) to enable them to more effectively support LHDs (Agency for Health Innovation (ACI), Clinical Excellence Commission (CEC), Health Education and Training Institute (HETI) and Bureau of Health Information (BHI).
- ✚ Increased clinical leadership, engagement and support through the LHDs and CEC and ACI.
- ✚ Investment in education and training with the restructured HETI having an expanded focus on clinical and non clinical leadership development and undergraduate and vocational training in addition to postgraduate training.
- ✚ Greater transparency and utility of health information with the BHI having a role as the independent expert in analysing and reporting patient outcome information to the public and clinicians.
- ✚ Realising the potential of statewide services (Health Support Services (HSS) and Health Infrastructure (HI)) through developing stronger customer focus and contestability of pricing. HSS provides linen, food payroll warehousing procurement recruitment and other shared services to public hospitals and health services while HI supports LHDs with capital works project planning and delivery.

The NSW Health System is complex requiring cooperative working relationships between each and every entity to ensure that is works effectively and achieves positive outcomes. NSW Health has developed Instruments such as Service Agreements

between the MoH and LHDs, Inter-District Agreements between LHDs and Service Level Agreements between Statewide entities and LHDs to try to encapsulate the spirit and obligations of key service relationships.

Further reform occurred on 1 July, 2012 with LHDs being allocated funding using a combination of funding based on activity and block grants. The new system aims to give clinicians richer information for patient care, greater involvement in funding decisions and better clarity on the costs associated with delivering the services.

Sydney Local Health District (SLHD) was established on 1 January 2011 as one of the 15 Local Health Districts in NSW Health. SLHD covers 126 square kilometres in the centre and inner west of Sydney and has a population density of 4,210 residents per square kilometre (ABS 2006). It is responsible for providing health care to more than 530,000 people. The District is characterised by significant socio-economic diversity, with pockets of both extreme advantage and extreme disadvantage. SLHD has a long history of providing tertiary and quaternary health care services to patients from other parts of NSW, including the provision of education and training, clinical leadership, telemedicine and outreach clinics to rural areas. Over 25 per cent of overnight admissions to SLHD wards in 2009/10 were for patients residing in other Sydney LHDs, 8 per cent were for NSW patients residing outside Sydney and 3 per cent for interstate and overseas patients.

SLHD has a well-established reputation for excellence in the provision of health care services and for managerial and fiscal responsibility. The District has strong and well recognised leadership roles in research, education and in the provision of high quality tertiary and quaternary clinical services. SLHD has a strong academic culture with the research and education enterprise enhanced by its unique relationship with the University of Sydney and seven Medical Research Institutes that are located within the District. Health promotion and the provision of high quality health care to its local community are also integral to the District's role.

Despite its strengths, like other Districts in NSW, SLHD has faced many challenges during this period of significant reform. The reform of NSW Health provides valuable lessons on the challenges and opportunities in transitioning from highly centralized models of health service governance to the significantly more decentralized models of LHDs.

These challenges and strategies taken to address them include:

- Ensuring business and clinical continuity during the transition to the new governance structure. To do this, a transition governance committee was established with regular reporting on progress to the Board and to NSW Health.
- Establishing robust clinical and corporate governance structures to support the new Districts, including effective enterprise risk management. Clinical and corporate governance structures were established within the first few months and have continued to evolve as the organisation has matured.
- Clarifying roles, responsibilities and accountabilities. With the changes in organizational structures, new role descriptions were developed for over 2,000 staff.
- Ensuring effective change management. Processes were put into place to ensure that staff were engaged, with regular communication via a range of media. A monthly newsletter, *Healthmatters* and the District's website ensures staff are well informed. Staff and key stakeholders have been actively engaged in the District's strategic planning processes.
- Establishing effective relationships with the re-formed Ministry and Pillars. SLHD has invested significant resources in establishing these relationships including inviting MoH representatives to be on District Committees and ensuring that SLHD is actively engaged on MoH Committees and Taskforces.
- Ensuring that senior executives and managers are adequately equipped and have the competencies to effectively manage and lead these new organisations. SLHD has continued to strengthen its management training through its linkage with the University of Tasmania and, in particular, through the further development of the Institute of Innovation and Health Service Management which aims to achieve excellence in health service management through the delivery of high quality post graduate education management programs, leading edge research into health services management and identification and support for health services managers of the future. SLHD has also established an executive development program supported by an Associate Professor in Health Services Management. HETI is also developing a Leadership Program for the NSW health system which is based on evidence and best practice which will be accessible to our staff.
- Ensuring robust and transparent reporting. SLHD has worked closely with its Board to develop a Board Reporting Pack which aligns with the MoH and District's Service Agreement. An external consultant was engaged to assist the District to review international best practice and to develop a reporting pack that was user friendly and enabled effective monitoring of the District's Performance on all major indicators. This external support has given the Board additional confidence regarding the robustness of the reporting framework. Further work is occurring to enhance the District's reporting at a facility and clinical unit level.
- Facilitating increased clinician and community input into decision making and strategic planning. SLHD is continuing to build on a long history of effective clinician engagement and involvement in the planning, delivery and management of its health services. This has been achieved through the development of both formal and informal structures that support clinician engagement. SLHD has the benefit of having a strong and effective clinical stream management structure which has been in place for many years. Clinical Directors provide strategic leadership across the network and work closely with the senior management to ensure that services are appropriate and are meeting the needs of the local population. SLHD has also been working with its community to review its Community participation framework.
- Adapting to a changing political environment. As with all changes of government, the last 12 months has seen a realignment of priorities within the state and within NSW Health. SLHD has responded effectively to these changes which are reflected in the District's strategic directions.
- Preparedness for the new Commonwealth and State funding model. SLHD and its predecessors have had a reputation for sound financial management. Given this, SLHD was particularly concerned about the implications of the new funding reform on its financial position and has engaged external consultants to review its preparedness for the new funding reform. Over the next two years SLHD will work with

local clinicians to ensure that the service agreements are met and the new funding model is delivering clinical services where they are needed.

The recent NSW Commission of Audit (2012) noted that NSW has already achieved significant reforms in health. The first phase of the health reforms has seen the implementation of new governance arrangements across the NSW health system.

The challenges that Health Reform in NSW has presented for LHDs, have also highlighted competencies that chief executives and other senior executive in health need to develop in order to effectively manage and lead these complex health organizations. Not surprisingly, these competencies are consistent with those identified in the Pan Canadian framework, National Health Service Framework and the Health workforce Australia Draft Framework. These include but are not limited to:

Strategic direction

- Ability to set clear direction and communicate a compelling vision for the organisation.
- Effective strategic thinking and decision making.
- Innovation and ability to encourage, plan and implement strategies and service improvements.
- Commitment to the NSW Public Health System and to the MoH CORE Values.
- Responsiveness to community needs.

Building organizational capabilities

- Ability to manage organisational change and maintain business and clinical continuity during a period of significant change.
- Building and maintaining an effective, dynamic and innovative team.
- Ability to support and give confidence to the Board.
- Effective management of relationships with Chair and Board members.
- Effective information and communication management.
- Credibility with clinicians and managers.
- Effective clinician engagement and involvement in decision making.
- Ability to develop a learning organisation.
- Ability to inspire trust and loyalty of staff.
- Valuing staff.
- Ability to promote workforce diversity.

Organizational effectiveness

- Ability to manage complex, multi-site services with a significantly smaller executive team.
- Ability to develop corporate and clinical governance structures quickly to support the effective operation of the organisation and being prepared for these to evolve over time.
- Sound business judgement.
- Managing performance at all levels of the organisation.
- Effective enterprise risk management.

Financial performance

- Ability to manage effective financial function and enforce appropriate financial controls.
- Ability to adapt to new funding regimes.
- Effective Resource Management.
- Ability to analyse and monitor trends, financial literacy and quantitative problem solving skills.
- Ability to engage clinicians and managers in financial management.

Leading effective relationships with the Ministry and external stakeholders

- Effective interaction with the community, patients and the public.
- Ability to support the development of organisational competencies in partner organisations.
- Ability to develop and maintain effective partnerships with the Ministry, Pillars and other Districts.
- Ability to development strategic partnerships with other organisations including Medicare Locals.
- Ability to develop effective governance arrangements with partner organisations for shared projects.

In conclusion, the Health Reform that is occurring within NSW Health, with its newly implemented devolved governance structure, provides a solid foundation for improved transparency, accountability and engagement in the planning and delivery of world class health services and infrastructure. The real challenge for Local Health Districts and their Executives is to embrace these reforms and to continue to develop competencies that enable them to effectively lead and manage the innovation and changes necessary to support the reform and develop sustainable health systems delivering high quality health care for the future. ❑

Teresa Anderson has over 30 years experience in the public health system as a clinician, manager and board member. She has extensive experience in the management of health services and is currently Chief Executive, Sydney Local Health District.

Barry Catchlove has more than 40 years experience in health care, covering a range of clinical, medical administration and board appointments. He is a Fellow of the Senate, Sydney University, Chair of the Senate's Safety and Risk Management Committee and a Member of the Nominations Committee. He was appointed National President of the Australian Hospital Association and Chairman of the Australian Council of Healthcare Standards. He is a Fellow of the Royal Australasian College of Physicians and the Australian College of Health Service Executives.

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Current situation of health care in India and corporatization in emerging economies – what is the way forward?

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ABSTRACT: In this study, we examine the management and operational problems faced by different categories of health care delivery platforms such as corporate hospitals, medium level private hospitals and public hospitals in Mumbai. Some suggestions are made and we believe many of the short falls or limitations that exist in the current set up can be removed and a way forward can be made in alleviating the suffering of vast majority of humankind living in our mega cities. Three major issues emerged as far as a public health system is concerned – that is shifting of trained health manpower from the public system to private or corporate hospitals, severe strain on the public health system's infrastructure and support services compounded by lack of accountability as far as management and governance are concerned

Providing a western concept of an institutional or hospital-based health care delivery mechanism in India dates back to British era which started around 1757 AD, while the system of providing health care by trained medical practitioners in traditional medicine through well established small community-based dispensaries or welfare health clinics existed from AD 405. The first organized medical college to train local students in the western concept of medicine started in 1817 in Calcutta, the then capital of British India (Datta 2009).

Major changes in health policy occurred after India achieved independence from colonial rule through setting up of various national expert committees on health and subsequently their recommendations were implemented to the extent possible under both national and state level administrative control (Bhore Committee 1946).

Although the impact of major scientific advances i.e., the discovery of antibiotics, vaccines, etc. that began in late 19th and early 20th century in the western world, were seen in India in the form of major reduction in death rates and a population explosion as well as higher longevity of the population, but it remains below the standard achieved by the western or developed countries (Schlipkoter and Flahault 2010).

Hospital care and its management as a specialty has evolved over last years and is still emerging in developing countries like India. A well-coordinated approach is required for a smooth and effective delivery of quality health care and services in the shortest possible time in a home environment or comfort. A rapid expansion of hospitals is required so that health care can reach the needy across the country at an affordable price.It is also felt necessary to integrate various systems of medicine including complimentary system into one evidence-based system so that beneficiaries can avail the best of everything under one roof as per their choice and preferences without compromising on the modern quality of health care and its usefulness in reducing morbidities and illnesses (Ahmed 2010). The developing world including India has yet to achieve major success as far as providing quality health care is concerned in terms of all the major vital indicators such as maternal mortality, infant mortality, deaths due to TB, Malaria, diabetes, hypertensions, and cancer etc (Rao 1963).

This study focused on the current status of health care in Mumbai, which is one of the largest metropolitan cities of India with a population of 18 million. A major part of the population lives in slums, hutments and even on pavements while a minority live in crowded apartments. Being a commercial center the privileged prefer going to a private health setting while most of the marginalized and poor population have no choice but to use the health facilities provided by public health system fully or partially subsidized by government.

Modern management skills need to be incorporated for its benefit-profit based approach so that it creates a win-win situation for everyone, i.e. all the stakeholders, shareholders, lawmakers, policy makers, health providers, general public and managers (WHO 1974). It should ensure full transparency and accountability as it involves the welfare of human beings as the sole motivating factor. A greater emphasis should also be laid on

Table 1: Management of Hospitals (n = 5) [Questionnaire for management of the Hospital]

S.No	Statements	Yes Frequency	Yes %	No Frequency	No %
1	Health /treatment, protocols are in place, well defined and shared with the staff	5	100	0	0
2	Hospital services and availability units are well managed	5	100	0	0
3	Periodic evaluation of administration, finance, quality of care, man power, management are in place mostly with proper guidelines	5	100	0	0
4	Programme includes financial outcomes, volumes and cost of treatment and care, quality of treatment and care waiting	4	80	1	20
5	Written guide issued to all staff members?	3	60	2	40
6	Whether the manage-ment protocol included with periodic evaluation of work.	3	60	2	40
7	Is there a system for comparing the achieved goals of the units with the hospital set goals?	4	80	1	20
8	Evaluation for upgrading the health care and patient care directly related to modern technology and protocol in place?	3	60	2	40
9	Is there an ongoing programme regarding development in patient care management?	3	60	2	40
10	Is financial profit sharing with employees present?	5	100	0	0
11	Stakeholders participation, i.e patient, public, staff lacking in hospital management is more self centric and not much keen on staff welfare	3	75	1	25
12	Does the hospital management have functional and established routines for direct contact with patients, public and the media?	4	80	1	20
13	Is there a hospital program and guidelines for dealing with situations where personnel need special support?	4	80	1	20
14	Does the hospital have a prospective process in its management?	3	60	2	40
15	Does the hospital management have functional and established routines for direct contact with patients, public and the media?	3	60	2	40
16	Does the hospital have a management process and a control system?	3	60	2	40
17	Does the hospital use an analysis process to secure described needs	3	60	2	40
18	Does the net hospital income after tax be shared granting additional bonus to the staff members?	3	60	2	40
19	Should the management of the hospital explore the possibility to become specialty hospital for different diseases?	3	75	1	25
20	Either free of government or fully subsidized for affordable and quality care for all except for private hospital for the wealthy	4	80	1	20

Source: Patients, General Public, Staff members of the hospital (Doctors, Nurses, Technicians, Auxiliary etc) and Hospital Managers.

CME's Continuing Medical Education (CME) manpower development so as to be in synergy with changing trends and keep pace with the rapid expansion of science and technology. We hypothesized that every hospital should function effectively in the interest of society. The objectives of this study are: (1) to assess methods for maximizing the usage of manpower and manpower resources in hospitals, and (2) to study infrastructure and utilization of the resources of the hospital.

Research methodology

There are many hospitals in Mumbai but they are different in nature, status and level and so it is difficult to compare them and make valid conclusions. Therefore, the following hospitals have been selected for study as they belong to the same cohort group providing tertiary level health care to urban metropolitan populations but functions under different management system such as public funded, private or trust management, etc., (1)

Table 2: Working staff – satisfaction

Sr. No	Variable	Subvariable	Frequency	%
Participation	Day to day activities	No	17	61
	Policy making	No	14	54
Working facility	Adequate		19	70
	Inadequate		8	30
Facility for staff from the hospital		Free treatment	11	41
		Multiple	12	44
Proposal to club your monthly health care expenditure after retirement		No	12	57

Source: Patients, General Public, Staff members of the hospital (Doctors, Nurses, Technicians, Auxiliary etc) and Hospital Managers.

Advanced Centre for Treatment, Research & Education in Cancer of Tata Memorial Centre, Mumbai (trust under public sector). (2) Sir JJ Hospital, Mumbai (public sector), (3) KEM Hospital of BMC Parel, Mumbai (local Municipal Corporation), (4) Hinduja Hospital and Research Centre, Mumbai (private trust), (5) Mahatma Gandhi Mission Hospital, Mumbai (trust in private sector). We experienced a lack of complete transparency on sharing / revealing information by hospitals. In this study, both primary and secondary sources of information have been used (Ibekwe Perpetus 2010).

We have considered the WHO guidelines during preparation of the questionnaire. The practice of "adhoc" theorizing has been avoided. The actual data was verified before analyzing a factor; no generalization was made without actual data to support them. The following survey methods were used. Observations and informal interviews of patients and the general public; also the staff members of the hospitals (Doctors, Nurses, Technicians, Auxiliary etc) and management of the hospitals (Tables 1 and 2) formed the basis of data collection. The patients residing in hostels of the hospital were eager to share their personal feelings with the researcher. A detailed questionnaire was prepared and used to include questions on various aspects, i.e. HRD activities, training, projects, IT application, professional's appraisal and the functions of various divisions.

Results

Data analysis and interpretation (sample study through observation, questionnaire and interview schedule).

The response of the patients attending various public and private funded hospitals is almost the same as far as the type of care received from doctors and other hospital staff.

In general, the health providers were found not to be paying proper attention to the patients in the Out-Patient Department (OPD) as well as in the wards (Sundararaman 2009). Inadequate infrastructure in public hospitals lead to an irresponsible attitude hence a change in the attitude of the staff members engaged in the service facility at the state / local run governments. hospitals is warranted. The allied services being provided in the tertiary care hospitals of trusts and the private sector were better than that of government sector hospitals, whereas the allied services being provided in the center of excellence (ACTREC) has been found to be a good model as it is fully equipped with training ideas for workers engaged in housekeeping, laundry, attendants in wards, pest control etc. The center is availing the services of the workers engaged by outsourced agencies in a developing model where the individual development of the worker is looked after to keep the workers motivated. Management always prefers to discuss issues with the floor workers to maintain the cordial relations.

Discussion and recommendation

Widespread poverty and depressingly low living standards in the developing countries pose a very serious threat to development, peace as well as human creativeness. It is a fact that poverty breeds poverty and poverty of opportunity perpetuates it. However, in the last few years economic growth has been ahead of population growth in the developing countries including India. But the problem of the population growth continues to be a grave challenge on the health care administration in urban areas in general and rural areas in particular. The solution to these problems needs an integrated effort and co-operation by the government, administrators and rural people (Basavanthappa 1963).

Hospitals are unique and complex in nature and in terms of the legal framework under which they operate. Therefore, hospitals have come under the ambit of service industry and industrial laws in all respects are applicable to them apart from the prime responsibility of service to humanity. Thus, in order to increase the supply of tertiary health care to the masses at the economic expenditure levels, it has become necessary to involve the public sector in share holding and voluntary participation to improve the health care system not only in the city but also in the rural areas too. The effectiveness of the center of excellence and corporate culture for medical care may be expanded to benefit large sections of population including poor societies (low income groups) and others also. The utilization of resources by the hospitals may be improved to enhance the capacity of existing health care facilities by enlarging the system of preventive care, treatment, post-treatment and service benefits to the patients, special groups like the geriatric population, public and staff members working in the hospital while maintaining the growth of the establishment / organization. Health planning has become necessary for proper use of material manpower and financial resources for the purpose of improving the health services. The need for medical care, safe water supply, adequate nutrition, immunization, family planning are all community health needs (WHO-1971).

Human resources development (HRD)

The shortage of qualified doctors, nurses and technicians /

technologists may affect the process of recruitment. Therefore it has also become unavoidable to introduce an impressive scheme for attracting and retaining the talents of concerned category of human sources, i.e. medical, scientific, technical and administrative staff also. The recruitment policy of the government is very much different and subject to many obligations towards the society, but it differs from the recruitment policies in practice in autonomous body hospitals under government. Whereas the HRD policy of corporate trusts hospitals and private trust hospitals are much closer to each other.

This process of compliance of public regulation is a time consuming process and does not attract talent and is also subject to the local pressures of different kinds in one or the other. There is no additional scheme to attract and retain the talent in medical education and hospitals which a large number of people attend for tertiary care. In the case of corporate trust hospitals, the HRD policy is much different from the state policy. The trust management has bestowed the full authority on the Director / authorized trustee to choose the best. They also have a scheme for attracting the talent and retain them. The scheme is in addition to the pay package and usual allowances applicable to the medical fraternity and other service staff. The turnover of the consultants in the medical field is less, but middle level and lower levels (Senior Residents and Residents) are higher for want of scheme which is applicable to them. The turnover of service staff category workers is negligible and there are only some cases of disciplinary separation. The rules, regulations and obligations are complied with faithfully and motivational schemes are implemented through training and other modalities adopted in the corporate sector. While some other private trust specialty hospitals, has adopted a unique policy of HRD limited to the need based decisions which are taken by the trustees responsible for the functioning of the medical college and hospital and abide by the local rules and regulations made applicable by the state government i.e. providing treatment to the indigent patients (whose income is less than $500 per annum or Rs.25,000/- per year) out of the funds created i.e. corpus of 2 per cent of the total billing of the hospital is kept in a separate account for providing free treatment to indigent patients. In view of the findings observed during this study it is recommended: That the HRD activity of each of the hospitals should be given the bigger say in hiring of the best people in the field and there should be an attractive model of scheme for retaining them.

Infrastructure development

During the interaction with the higher management of the selected hospitals in this study it was revealed that the provision of funds for infrastructure development provided by the public funded body was always inadequate whereas the corporate Hospital and Research Centre is making annual provision in the budget for infrastructure as per the policy decision taken by the Trustee considering the environmental conditions and demand and supply of the tertiary care services. The shortage of space has also become the hindrance for improving the infrastructure development facility. In view of the above discussions and findings, it is recommended that space should be earmarked by the local development authorities for development of the hospital in the area to cater to the needs of the people based on the population.

Management system

Only some of the workers of each discipline in the hospital system accept health care delivery as a service to the humanity and most of the workers are there in the system to earn their livelihood. There is no mechanism to ascertain the medical negligence or mistakes in reports issued by the hospitals. The quality check system needs upgrading to ascertain the order of standards maintained in the multidisciplinary hospitals. There is no guarantee or assurance system for alternatives of outsourced agencies if such agencies fail to keep up their services and supplies to the hospitals. Even though, the health care and treatment protocol in most of the super specialty privately run hospitals are in place and well defined and shared with the concerned staff members. The hospital services and ancillary units providing services to the hospital are well managed in most of the super specialty hospital. The system for the periodic evaluation of administration, finance and accounts, target achieved, quality of care, manpower management is in place mostly with proper guidelines. The system for evaluating the need for upgrading the health care or the patient care with respect to modern technology and protocol is in place in all the super specialty hospitals. The financial profit sharing with all the employees is not in the super specialty hospitals even though they are charging the patient at very high except those patients who are under the indigent category in the poor sector of the society because of judicial binding imposed legally. The stake holders participation i.e. patients, public, staff is lacking in hospital management or hospital management is more self centric and not much keen on staff welfare. This is not a win-win situation for both management and staff. Most of the hospitals think of diversifying the facilities for providing specialty health care and services to the patients in different specialties as per planned protocol subject to infrastructure facilities made available in such hospitals. Most of the management of the super specialty hospitals is of the opinion that the quality care at the affordable charges be provided either free by government or highly subsidized by the government/health insurance companies to all except, for those super rich hospitals for rich people.

Conclusion and specific recommendations

This study has been concluded with the following recommendations with a view to strengthening the hospital management system for health delivery in India or other developing countries. Health care is the primary need of every human being and it cannot be taken care of without centrally located hospital services for easy access including the geriatric population. Refresher training programs should be designed and conducted in such a way that every category of staff members and other service provider agencies are encouraged from time to time to attain the service mission. Developing a specific protocol to solve specific problems in the hospital, working to include the problem of manpower, logistics, transport, communication, failure of equipments (on time / off time), transfer mechanism of the staff for optimal utilization of manpower and infrastructure, operational arrangement of manpower, providing residential accommodation near the hospital and recruitment of each category of the staff (professional, medical/non-medical, technical, auxiliary and administrative categories) should be made transparent in the human resources development policy of the hospital of specialty and super specialty and medical center for excellence. Needless to mention that as of now doctors are treating patients based mostly on the tests results that lack humane approach such as

consideration given to ethics, cost involved or social aspect of patients and this leads to the health being unaffordable for majority. Thus the health seeking behavior of the population is low. In order to improve the health seeking behavior of the population as well as making the health staff sensitive to the need of the community and the people, the medical education need radical change at every stage of the training where greater emphasis should be laid to improve the knowledge on psychological behavior of the community, economic background, ethics aspect of all medical management (Sengupta and Srinivasan 2010). It has been found feasible and more appropriate to add that the desired health delivery system may be achieved in India by establishing the corporate hospitals under the public/private participation by adopting the health insurance scheme to be taken care of by the government of India as a social health guarantee to the people of India as a matter of constitutional fundamental right. ❑

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Credentialing for health care leaders: An overview of ACHE's FACHE credential and its contributions to the health care management field

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ABSTRACT: The American College of Healthcare Executives' (ACHE's) credentialing program for health care executives has evolved to match the changing role of the health care leader, the health care environment and other external factors. The FACHE credential signifies board certification in health care management. Those who obtain the credential are referred to as ACHE Fellows. There are rigorous requirements for achieving the credential – including passing an exam based on the competencies necessary to perform the role of hospital administrator – as well as recertification requirements. ACHE's voluntary credentialing program contributes to the professionalism of the health care management field and supports lifelong learning and leaders' commitment to excellence in health care management.

The American College of Healthcare Executives (ACHE) is an international professional society of more than 40,000 health care executives who lead hospitals, health care systems and other health care organizations. In addition to being a foremost continuing educator for the field of health care management and a publisher of books, journals and a magazine, ACHE also offers its FACHE credential, which signifies board certification in health care management. ACHE members who attain the credential are known as Fellows of ACHE. More than 9,000 of ACHE's members hold the FACHE credential.

The vision of ACHE is to be the premier professional society for health care executives dedicated to improving health care delivery. Its mission is to advance its members and health care management excellence. ACHE's voluntary credentialing program plays a vital role in this vision and mission, as it contributes to the professionalism of the field and supports lifelong learning and health care leaders' commitment to excellence in health care management.

History of the credential

When ACHE was founded in 1933, its goal was to raise the standards of the health care management profession. Before that time, the profession of hospital administration had not yet been established. There were individuals supervising hospitals and performing hospital administrator duties, but the titles "hospital administrator" and "health care executive" were not yet used.

Beginning in the 1930s, the United States saw the development of the first graduate programs in hospital administration. This signaled an era of professionalization of the field. ACHE was founded around this time to establish the profession of hospital administration and provide a means for the professional development of hospital administrators.

In the United States, the role of the health care executive has evolved throughout the years as the role of hospitals and the face of care delivery have changed and become more complex. Likewise, ACHE's credentialing program for health care executives has evolved to match the changing role of the health care leader, the health care environment and other external factors.

About the FACHE credential

The premise of board certification in health care management was founded on the belief that as health delivery was evolving as a system with many components and varied forms of leadership, that leadership should be incorporated under one umbrella of professionalism to help health care leaders achieve common goals. While the requirements for becoming a Fellow have changed throughout the years as the field evolves, this premise holds true today.

There are multiple requirements to become board certified in health care management, including academic preparation, tenure, experience, continuing education and professional and community involvement. The credentialing program and its multifaceted requirements are designed to be both rigorous and inclusive.

Currently, the requirements for becoming a Fellow are:

- A master's or other post baccalaureate degree (prior to 2007, the requirement was only a baccalaureate degree; a post baccalaureate degree is now required, making the credential even more rigorous).
- A current health care management position and five years of health care management experience.
- Three years' tenure as an ACHE Member (candidates who apply to become a Fellow must be an ACHE Member).
- Three references from current Fellows (one of which must be a structured interview).
- 40 hours of continuing education units – at least 12 of which must be ACHE Face-to-Face Education credits – earned during the five years preceding becoming a Fellow.
- Participation in two health care related and two community/civic activities, requirements that emphasize the health care leader's integral role in the communities in which they serve.
- Passing the Board of Governors Examination in Healthcare Management.

The Board of Governors Examination

Sitting and passing the Board of Governors Examination in Healthcare Management is a key component in the process of becoming board certified in health care management as an ACHE Fellow. To ensure the exam's rigorousness and relevance to the field, a psychometrician manages the exam's development. Psychometrics is an area of study concerned with how to effectively measure an individual's skills, knowledge and abilities that may be needed for employment in a particular profession.

As part of the exam's creation, a job analysis survey was conducted. A job analysis is a systematic examination of a particular job, occupation or profession. The job analysis process uses several methods to ensure a thorough description of the health care executive's job, including: review of available training materials, interviews with health care executives, attendance at/review of subject matter expert workshops, and a survey of health care executives to describe their job requirements.

As the next phase of exam development, a list of tasks required for the job of health care management and the knowledge areas, skills and abilities (KSAs) required to perform those tasks was developed. The task list and KSA list were expanded upon by subject matter experts. Those lists were then developed into a survey administered to health care executive job incumbents. The survey is conducted every five years and was most recently given to 8,000 health care executives in 2012. The survey respondents are asked to indicate how important the task or KSA is to their job and how frequently it is performed in their role. Results from the survey are translated into a test blueprint that describes the content and weight or proportion of each knowledge area. These results help shape the exam's knowledge areas (Box 1).

To further ensure the exam reflects the current health care field, ACHE created an Exam Committee made up of ACHE Fellows. The committee oversees development of the exam and reviews any revisions that are made to the exam. Changes to the exam are also reviewed by ACHE's Board of Governors.

Changes to the exam may include revisions to the questions and exam content areas. For example, as the challenges of implementing health reform in the United States continue to unfold, exam questions in the future may center more around quality of care, patient-centered care and performance excellence, as these are areas all health care leaders will need to be even more familiar with.

ACHE provides a number of resources to help members who are interested in taking the Board of Governors Examination prepare for it. Resources include an in-person review course and

Box 1: 10 Knowledge Areas on the ACHE Board of Governors Examination

The American College of Healthcare Executives (ACHE) Board of Governors Examination in Healthcare Management is made up of 10 knowledge areas. The knowledge areas are based on the competencies necessary to perform the role of hospital administrator. Below are the 10 areas and the percentage of the exam each knowledge area makes up. To view a sample exam outline, visit www.ache.org/mbership/credentialing/EXAM/exam_outline.cfm.

Governance and Organizational Structure	5%
Human Resources	11%
Finance	10%
Health care Technology and Information Management	5%
Quality and Performance Improvement	10%
Laws and Regulations	8%
Professionalism and Ethics	8%
Health care	18%
Management	15%
Business	10%

Source: American College of Healthcare Executives.

Box 2: Board of Governors Examination Resources

The American College of Healthcare Executives (ACHE) offers a number of resources to help prepare members to take the Board of Governors Examination in Healthcare Management, a key component of the process to earn the FACHE credential and become board certified in health care management. Resources include:

- An Online Tutorial, which uses an online self-study format to help refine the individual's knowledge and improve study skills. The program provides a detailed look at the different topics covered on the exam and resources to help focus exam preparation.
- The Board of Governors Examination Review Course, an in-person, two-day course that gives participants an in-depth review of the exam's 10 core knowledge areas, helps individuals gain a better understanding of the exam's structure and reviews test-taking strategies.
- The Exam Study Set, a collection of books from ACHE's publishing division, Health Administration Press, which helps individuals prepare for the exam. The books feature topics covered throughout the exam's knowledge areas.
- The Exam Online Community provides users with links to resources, online study groups and discussion areas to help with their exam preparation.

Source: American College of Healthcare Executives.

an online community (see Box 2 for a full list of exam-related resources).

ACHE also provides several resources on its website, ache.org, in the "Credentialing" area of the site, such as sample questions and study tips.

The recertification process

Once candidates attain Fellow status in ACHE, they must recertify their credential every three years. Recertification maintains the integrity of the ACHE credentialing program and helps ensure ongoing commitment to professional development and lifelong learning.

There are several requirements for recertification, including: participation in at least two health care and two community or civic activities and completion of 24 hours of health care management continuing education credit since the Fellow's last recertification (of those education credits, at least 12 must be ACHE Face-to-Face Education credits). As an alternative to the continuing education credits, individuals may choose to retake and pass the Board of Governors Examination.

In addition, all ACHE members must annually attest that they have abided by the ACHE Code of Ethics as a standard of conduct for members. Since the earliest days of ACHE, the organization has maintained a concern for upholding professional ethics in the field of health care management. While other professions such as medicine, law and nursing had to abide by codes of ethics before practicing in their professions, no such code of conduct existed for managers before ACHE established one in 1941.

The Code of Ethics contains standards of ethical behavior for health care executives in their professional relationships, including with colleagues, patients or others served; members of the health care executive's organization and other organizations; the community; and society as a whole. Just as ACHE's credentialing program evolves to match the changing needs of the field, the Code of Ethics has also undergone several revisions and is reviewed and updated regularly.

The credential's meaning

For those who achieve it, being board certified in health care management as an ACHE Fellow provides the personal satisfaction of achieving a goal and professional recognition. It also demonstrates those health care leaders' professionalism, competence, leadership skills, ethical decision making and commitment to lifelong learning and service to the field and community.

Those who become ACHE Fellows not only demonstrate a dedicated commitment to the field, but they also demonstrate increased loyalty to ACHE. ACHE has recorded higher rates of involvement by Fellows – compared to other ACHE members – in ACHE activities that give back to the profession. This includes involvement in those initiatives aimed at helping to prepare the field's future leaders such as ACHE's formal volunteer mentoring programs.

Candidates who attain the FACHE credential demonstrate that they have the broad knowledge that provides the foundation for succeeding as a health care executive in today's rapidly changing health care field. To learn more about the FACHE credential and recertification process, visit the "Credentialing" area of ache.org. ❑

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Is leadership compatible with hospitals? Lessons from 10 years of teaching leadership to hospital managers

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ABSTRACT: Leadership methods can be understood and applied by hospital managers in the same way teachers and the seminar's participants respect certain conventions. Each method should be discussed and adapted, recognizing its limitations for use within hospitals. This article first presents what is taught in a traditional leadership course and then, discusses ways the course can be adapted for use by hospital managers.

Innovation in hospitals is an essential but arduous and tortuous task. Raising service quality and productivity in ways that improve patient satisfaction and public finances are recent concerns for hospital managers. Management, leadership, and change in management style have become focal points for hospital managers, not only to be in charge of their own future, but also to enable their organizations to survive in an ever-fiercer competition with other health organizations.

Obsolete management methods are still practiced, and leadership is still a weird concept in some hospitals. Many hospital managers just cope instead of managing. Service quality for patients takes a back seat to science and technology. Out-of-date hospital management practices are no longer acceptable considering the complex nature of the business, the extent of hospital involvement in the health sector (inpatient care accounts for 29 percent of current health expenditure on average across OECD countries), the changing health care landscape, or patients' growing expectations about prompt service, high-quality services, and reasonable costs.

Hospital managers will be forced to innovate and to master leadership methods if they want to survive in the face of rising costs, new public financing systems, a fast-growing patient consumerism, and shortage of health professionals.

Hospitals are thinking short term and quick fixes. This mindset is often wrongly applied to the management of the hospital itself. Lack of strategic and marketing planning and weak leadership are the results. This article offers a brief insight into some of the leadership methods used by more and more public services and adaptable for use in hospitals.

Personal leadership

Which behavior patterns should managers adopt to increase their influence over others? The factors conducive to obedient behavior in most people, according to sociological studies, are: not showing signs of stress, never complaining or explaining, increasing visibility and decreasing accessibility, increasing similarity and decreasing familiarity, carrying signs of authority, speaking slowly and in a low voice, wearing a good watch and quality shoes, working on a clear desk, standing and sitting tall, etc.

Adaptation to hospital managers' audience

Managing hospitals is not easy. Leadership is particularly challenging in hospitals because they are two-headed systems. The administration is responsible for the "support" processes and the employees; the medical chief of staff is in charge of the doctors and the clinical processes. For the administrators and the clinicians, a key management challenge is to design and promulgate a shared vision for the organization, formulate a single long-term strategy, promote a common commitment, and in order to speak and act in unison every day.

Managing doctors is more challenging than managing "regular" employees. As highly-qualified stakeholders, doctors behave as if the organization were "theirs." They have their say on attempts to improve efficiency. Effective change management therefore requires strong efforts and leadership. Enabling change entails a great deal of discussion with every member of the patient-care team regarding the content of a reform (targets, goals, processes), the way in which it is presented, the timing of the proposal, and the means of implementation. When change must be made, it is appropriate that clinicians be fully engaged in designing, supporting, and implementing it.

Doctors can take the lead in supporting measures that improve the quality and efficiency of care. They can share the belief that doing more with less or doing things differently is possible. But it requires motivation and conviction. Here, motivation must be distinguished from manipulation. The techniques are the same, but the use made of the results is different. When the benefits are shared it is motivation. When one party keeps all the benefits of

change it is manipulation.

Organizational leadership

Leadership begins with individuals in prominent positions—but it does not end there. A leader who displays vision, writes a persuasive mission statement, and gives meaning to his staff's work day to day and for the future, has an excellent chance of winning willing collaborators.

If the leader selects some performance indicators to be improved and posts them everywhere, they are reminders that the plane has a pilot. A simple and public instrument panel is a leadership tool. What is measured is often done. It is difficult to improve what is not assessed. The effectiveness of an organization's chain of command should supported by performance indicators.

Adaptation to hospital managers' audience

In hospitals, the collaborators are professionals who know what they must do. Leadership culture in hospital necessitates working across boundaries, accepting responsibility for outcomes, solving problems collaboratively, fostering management dialogue based on transparency and performance.

Hospitals could be divided into service lines, focused on medical conditions and managed as distinct "business units," led by doctors. This organization, based on clinical leadership, enables devolution of decision making to the front-line level. Clinical involvement is thus fostered. The role of the director is to provide support to the staff in order to improve performance for patients.

Assessing the performance is no longer taboo. Nevertheless, this is where such a management method shows its limitations. Performance measurement can be useful in hospitals, but close involvement of physicians in setting targets is imperative for success. Then, posting of the performance results must be discreet. Last but not least, performance must be based on a comprehensive approach, with a mix of indicators on financial efficiency, patient service quality, and staff working conditions.

Leadership by benchmarking

To progress and improve, comparison can be useful. Certain key factors can often be compared with the results obtained by the best organizations – the competitors.

Such comparative data are easier to obtain than one generally thinks, especially in the groups and networks in which comparable activities are carried out by different people, in different units, in different areas. Standards and good practices in each sector can often be found in each sector, either in professional literature or with information vendors.

However effective this method may be, its limitation is not the difficulty of applying it but the fear of comparing oneself to other organizations.

Adaptation to a hospital managers' audience

Studies reveal substantial differences in the dispersion of hospital performance. Learning by comparing is a method practiced more and more frequently in hospitals. Doctors commonly use the medical state-of-the-art and best practices. There is ample room for comparing occupancy rate of beds or operating theatres, variation in length of stay, frequency of tests and diagnoses, etc. Service processes are a promising new field of comparison within hospitals. Groupings of hospitals, federations, unions, and so on are recognized as helpful to their members.

But comparisons can be misleading. Perfect comparability is not attainable. Comparative data that make sense are not always easy to find. Hospitals need to compare similar groups of hospitals (local hospitals, emergency wards, specialized clinics, teaching hospitals). For transparency, comparison with non competitors is often preferable.

Leadership by strategy

To survive, choices must be made. Darwin was right. These choices must be more advantageous for hospitals than the changes of the customers, the competitors, and the economy. The first choice to be made is between becoming the leader by pursuing a higher standard of excellence in operations, or in customer-orientation, or in innovation. It is an exclusive choice: one cannot be the leader in all fields. The choice must be based on a hospital's strongest point and its activities directed toward its particular market. It is a multiple choice question with only three possible answers. Without proper leadership, not even the best and boldest strategy can get off the ground.

Adaptation to a hospital managers' audience

Hospitals often make the same strategic choice: the choice of operational excellence with constant improvements in the application of sciences and regulations. Thus, since that choice rarely suffices to set one hospital apart from the others, more and more of them are changing their strategy. Having made a operational excellence a routine, they put their energy into either adaptation to their customers' preferences or innovation.

Patients are demanding greater varieties of services and shorter waiting times. Adaptation to consumer demand means that hospitals should become patient focused, rather than doctor driven. Hospitals are a consumer service center and should be managed as such. Most patients' complaints concern not the core-business, medical services, but "support" services: appointments, telephone services, admission, housekeeping and food services, discharge, billing, and other ancillary services.

Cost leadership

Cost leadership means the same things done by other hospitals, with the same quality, but faster and at a lower cost. Managers must be constantly focused on reducing costs and waiting times without sacrificing quality. Constant cost cutting means paring down all the costs, complexities, and functions that are not essential to customer satisfaction.

Cost leadership entails transforming "activities" into "processes," guaranteeing lowest costs and fastest delivery possible within a quality target. This is a key management task. These processes will then be simplified, automated, subcontracted, and delocalized to free resources for new projects.

Adaptation to a hospital managers' audience

Cost cutting is not usually a concern for a hospital: a price tag cannot be put on health. The course lexicon therefore has to be adapted to hospital managers. Discussion should center on eliminating "useless" costs, "waste," and "redundancy" while maintaining high quality.

"Lean principles" and tools can be adapted to manage service

organizations and hospitals alike. The point is to strip away, layer by layer, waste: overproduction by reducing the average length of stay, poor quality by reducing medical errors or hospital infections, excessive waits by providing resources "just-in-time," not too soon, not too late. The same strategy could be implemented to reduce excess inventory, excess motion, underutilization of staff, and processing without adding value.

Productivity gains from such cost-cutting activities should not be presented as profits but as a source of resources for new projects. Reductions in operating costs will allow hospitals to invest in new equipment, building extensions or hire additional nurses and doctors.

Market share leadership

A market leader has undeniable advantages. The number one position inspires confidence. A leader's size allows it to buy at less cost. It can select its staff from a bigger pool of candidates. A hospital can become number one by becoming larger by amalgamation or smaller by specialization. It is better to be number one in a small market than to be at the bottom in a large market.

Adaptation to a hospital managers' audience

How can a competitive advantage be established? A minimum of activity build a reputation for high-quality work quality and a minimum of operating hours to ensure smooth running are needed. Some hospitals stop operating when they lack the scope to focus on one or two activities for which they are the local reference points in medical and marketing terms. Hospital market shares by pathology, technique, and treatment are increasingly easy to gather. "Magnet hospitals" achieve high-quality patient outcomes and offer better working conditions for doctors and employees.

Conclusion

To become a leader, more and more hospitals put overall patient satisfaction at the top of their strategic goals. This strategy has been paying off because it is the best way of breaking even in health care. We expect more hospitals to apply modern management tools and methods as they begin work in this new exciting patient-first model. Other management methods contribute to leadership: employee satisfaction, sound marketing plan, innovation management, shared knowledge management, clear communications, business ethics, conflict management skills. Hospitals have no choice but to change and use these tools. The world is moving and shifting fast. Managers know that. And you know that. Are you ready for the new, challenging but exciting task of managing a modern hospital? ❑

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Résumés en Français

1) Face aux mythes des soins de santé

Résumé : Toutes sortes de mythes compromettent l'efficacité de la gestion des soins de santé. Par exemple, le mythe selon lequel le système ne fonctionne pas (et en fait, qu'il s'agit bien d'un système), et qu'on peut y remédier par une ingénierie sociale détachée et un leadership héroïque, ou en le traitant comme entreprise commerciale. Il faut reconsidérer la gestion de ce secteur au-delà des cadres supérieurs, sa stratégie par « corporate venturing » (apport de capital-investissement) et non planification, son organisation comme collaboration dépassant le contrôle, et notamment le système lui-même comme un système qui dépasse la somme de ses parties.

2) Compétences de leadership et de gestion en matière de santé: une démarche systémique

Résumé: Atteindre les objectifs nationaux et internationaux de santé exige des systèmes de santé plus efficaces. Il faut donc impérativement améliorer le leadership et la gestion des systèmes de santé, ce qui en améliorera l'efficacité et la réactivité, et au bout du compte les résultats thérapeutiques.

Pour construire un cadre global de compétences fondamentales de gestion et de leadership, il faut partir d'une réflexion et d'une méthodologie systémiques comparables aux sciences de la complexité qui prend en compte tous les éléments et niveaux du système de santé avec leurs interactions possibles sur les effets. Les résultats de ce travail auront d'importantes incidences stratégiques pour les autorités nationales de santé désireuses de renforcer les capacités de gestion et de conquérir un leadership transformationnel pour les systèmes de santé.

3) Leadership & mondialisation : Recherche sur la formation à la gestion sanitaire

Résumé: Les répercussions de la mondialisation sur la formation universitaire en matière de gestion des soins de santé sont évidentes, mais difficiles à chiffrer. La Commission sur la formation à la gestion sanitaire (Commission on Healthcare Management Education, CAHME) a récemment autorisé deux études de recherche visant à réunir des données spécifiques et à répondre à des questions importantes sur les programmes universitaires accrédités aux Etats-Unis et au Canada. Deux sondages ont fourni les données les plus complètes qui influent les activités internationales de formation par 70 programmes. 22 pays ont été inventoriés; les informations étaient compilées par 21 organisations d'accréditation ou d'amélioration de la qualité. Les observations sur le leadership et la demande en professionnels de santé qualifiés sont discutées en termes d'accréditation, de certification, de modèles de compétence, d'évaluation des résultats, d'amélioration de la qualité et d'impact de la mondialisation sur l'éducation supérieure.

4) Leadership et qualité de la gestion : facteurs-clef pour l'efficacité des systèmes de santé

Résumé: Dans les pays en développement, l'efficacité des systèmes de santé tient à la qualité de la direction et de la gestion, mais c'est un facteur négligé par les universitaires et les bailleurs de fonds. Cet article, basé sur des modèles existants reproductibles, propose une démarche pour renforcer les institutions locales de formation à la gestion.

5) Réformes des soins de santé et des hôpitaux en Australie – La perspective d'un district de santé local

Résumé: La scène internationale ne manque pas de réformes des soins de santé et des hôpitaux. L'accroissement de la demande en services médicaux qui découle du vieillissement des populations et du fardeau croissant de pathologies chroniques, les progrès continuels des technologies médicales (et notamment l'expansion rapide des systèmes informatiques), et les exigences sans cesse croissantes de la communauté signifient que des dépenses des soins médicaux de la plupart des systèmes de santé augmentent plus vite que le PNB (OCDE 2008). La plupart des pays sont aux prises avec les difficultés de créer pour l'avenir un système de santé durable. Cet article fournit un aperçu des réformes en cours dans les systèmes de santé publique d'Australie et de la Nouvelle Galles du Sud, qui comprennent le transfert des responsabilités aux districts locaux de santé, un ministère de la santé plus modeste et mieux ciblé, une plus grande transparence et une réforme du financement. Cet article examine les défis que cette réforme présente pour les districts locaux de santé et les moyens possibles pour y faire face localement. Cette réforme a également mis en lumière les compétences requises des directeurs et autres cadres supérieurs de la santé pour gérer et diriger des organisations de santé aussi complexes.

6) Scénario actuel des soins de santé en Inde et privatisation dans les économies émergentes – Comment avancer?

Résumé: Dans cette étude, nous examinons les problèmes de gestion et les difficultés opérationnelles affrontés par différentes

catégories de plateformes de prestations de soins de santé tels que les hôpitaux-entreprise, les hôpitaux privés de niveau moyen et les hôpitaux publics de Mumbai. Des suggestions sont proposées et nous pensons qu'il est possible de remédier à bien des carences ou limitations rencontrées dans le système actuel, et qu'il est possible d'avancer pour soulager les souffrances de la vaste majorité d'êtres humains qui vivent dans nos mégapoles. Trois grands problèmes émergent dans le secteur de la santé publique : - le transfert des ressources humaines qualifiées du secteur public au secteur privé ou aux hôpitaux-entreprise, les infrastructures des systèmes de santé publique et des services auxiliaires mis à rude épreuve, facteurs aggravés par le manque de responsabilisation au niveau des directeurs et gestionnaires.

7) Accréditation, obtention, évaluation des titres de compétence, agrément hospitalier

Aperçu des titres de compétence ACHE's FACHE et leur contribution à la gestion des soins de santé

Résumé: Le programme d'évaluation des titres de compétence qui a été élaboré par le Collège américain de cadres de santé (American College of Healthcare Executives', ACHE) pour les directions des soins de santé a évolué pour s'adapter au rôle changeant des directeurs de santé, à l'environnement médical et à d'autres facteurs extérieurs. Le titre de compétence FACHE signifie un certificat du comité en gestion de santé. Ceux qui obtiennent le certificat reçoivent le titre de membres associés ACHE ("ACHE Fellows"). L'obtention du titre est soumis à un strict processus — entre autres, passer un examen pour prouver qu'on a les compétences requises pour jouer le rôle d'administrateur d'hôpital—ainsi qu'aux exigences d'une réaccréditation. Le programme d'accréditation volontaire ACHE contribue au professionnalisme des gestionnaires de soins de santé, et favorise la formation continue sur toute la vie et l'engagement des dirigeants à une recherche permanente de l'excellence en matière de gestion de des soins de santé.

8) Le leadership est-il compatible avec les hôpitaux ?

L'expérience de dix ans d'enseignement du leadership aux gestionnaires hospitaliers

Résumé: Les méthodes de leadership peuvent être comprises et appliquées par les gestionnaires hospitaliers de la même façon que les professeurs et participants à des séminaires respectant certaines conventions. Il convient de discuter et d'adapter chaque méthode en tenant compte de ses limitations en milieu hospitalier. Cet article commence par montrer quelle est la teneur d'un cours classique de leadership, puis discute des manières d'adapter le cours pour qu'il soit applicable au gestionnaire hospitalier.

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Resumen en Espanol

1. Gestión de los mitos de la salud

Resumen: La gestión de la salud sufre de toda una serie de mitos, por ejemplo que el sistema está fallando (de hecho, que es un sistema) y que se puede arreglar con una ingeniería social objetiva y un liderazgo heroico, y tratándolo más como un negocio. Este campo necesita un replanteamiento significativo para que su gestión vaya más allá de lo que dicen "los jefes"; su estrategia debe ser arriesgando, no planificando; su organización como una colaboración fuera de todo control y especialmente en sí, como un sistema más allá de sus partes.

2. Liderazgo de salud y competencias de gestión: un enfoque sistémico

Resumen: Para lograr los objetivos de salud nacionales e internacionales se requiere de sistemas de salud más eficaces. Fortalecer el liderazgo y la gestión de los sistemas de salud se vuelve entonces algo esencial para lograr una mayor eficiencia y capacidad de respuesta, en últimas mejorar los resultados de salud. La construcción de un marco global de las competencias básicas de liderazgo y gestión debe abordarse aplicando el pensamiento sistémico y las metodologías afines a la ciencia de la complejidad que toman en cuenta todos los componentes y niveles del sistema de salud y las posibles interacciones entre ellos que influyen en los resultados. Los resultados tienen importantes implicaciones políticas para las autoridades nacionales de salud que buscan fortalecer la capacidad de gestión y la construcción de liderazgo transformacional en los sistemas de salud.

3. Liderazgo y Globalización: La investigación en educación de la administración de salud

Resumen: El impacto de la globalización en la educación de graduados en administración de atención de salud es evidente, aunque es difícil de cuantificar. La Comisión de educación de gestión en salud (CAHME) autorizó recientemente dos estudios de

investigación para recopilar información específica y responder preguntas importantes sobre los programas de postgrado acreditados en los Estados Unidos y Canadá. Dos encuestas proporcionaron los datos más completos que afectan los esfuerzos de educación de gestión internacional de la salud en 70 programas. Se realizó un inventario de 22 países; se compiló la información de 21 organizaciones acreditadas o de mejoramiento de calidad. Se discuten observaciones sobre el liderazgo y la demanda de profesionales de la salud calificados en términos de acreditación, certificación, modelos de competencias, evaluación de resultados, mejora de la calidad y sobre el impacto de la globalización en la educación superior.

4. Liderazgo y gestión de calidad: principales factores en los sistemas de salud eficaces

Resumen: La eficacia de los sistemas de atención de salud en los países en vías de desarrollo está relacionada con la calidad de su liderazgo y de su gestión, sin embargo, ese factor ha sido descuidado por los académicos y los financiadores. Basado en modelos existentes que se pueden reproducir, este artículo propone un acercamiento al fortalecimiento de las instituciones locales de capacitación en gestión.

5. Salud y reforma hospitalaria en Australia - La perspectiva de un distrito de salud local

Resumen: La reforma hospitalaria y de la salud no es nueva en la escena internacional. La creciente demanda de servicios de atención de salud debido al envejecimiento de la población y el aumento de la carga de enfermedades crónicas, los continuos avances en la tecnología médica (incluyendo la rápida expansión de los sistemas de información) y las crecientes expectativas de la comunidad significan que el gasto en atención de salud de la mayoría de los sistemas de salud está creciendo a un ritmo mayor que el PIB (OCDE, 2008). La mayoría de los países parecen estar tratando de ver cómo se puede crear un sistema de salud sostenible para el futuro. Este artículo proporciona una visión general de la reforma al nivel de los sistemas públicos de salud de Australia y Nueva Gales del Sur (NSW), que incluye la transferencia de competencias a los Distritos Locales de Salud, un ministerio de salud más pequeño y focalizado, el aumento de la transparencia y la reforma de la financiación. El artículo examina los desafíos que presenta esta reforma para los Distritos Locales de Salud y cómo estos problemas se están abordando a nivel local. Esta reforma también pone de relieve las competencias que se exigen a los directores generales y a otros altos ejecutivos de la salud en la gestión y dirección de estas complejas organizaciones de salud.

6. Escenario actual de la atención de la salud en la India y la corporatización en las economías emergentes - ¿Cuál es el camino a seguir?

Resumen: En este estudio, examinamos los problemas de gestión y operativos que enfrentan las diferentes categorías de plataformas de atención de salud, como los hospitales corporativos, los hospitales de nivel medio privados y los hospitales públicos en Mumbai. Se hacen algunas sugerencias y creemos que muchos de las carencias o limitaciones que existen en la configuración actual se pueden despejar y se puede crear un camino a seguir para aliviar el sufrimiento de la gran mayoría de los seres que viven en nuestras mega ciudades. Tres temas principales surgieron en cuanto a sistema de salud pública se refiere: se está transfiriendo personal de salud capacitado del sistema público al de hospitales privados o corporativos, una fuerte presión sobre la infraestructura del sistema de salud pública y los servicios de apoyo agravada por la falta de rendición de cuentas de parte de gerentes y administradores.

7. Acreditación para líderes en atención de salud: Una descripción de la Credencial FACHE ACHE y sus contribuciones al sector de la gestión en atención de la salud

Resumen: El programa de acreditación para los ejecutivos de atención de salud del American College of Healthcare Executives (ACHE) ha evolucionado para ajustarse con el cambio de funciones del líder en atención de la salud, del medio ambiente de la salud y otros factores externos. La credencial FACHE representa la certificación del consejo en la gestión sanitaria. Los que obtengan la credencial se conocen como Miembros ACHE. Hay requisitos rigurosos para lograr la credencial -incluyendo la aprobación de un examen basado en las competencias necesarias para desempeñar el rol de administrador de hospitales, así como los requisitos de re certificación. El programa de acreditación voluntaria ACHE contribuye a la profesionalización del sector de la gestión en atención de la salud y apoya la formación permanente y el compromiso de los líderes para la excelencia en la gestión sanitaria.

8. ¿Es el liderazgo compatible con los hospitales?

Lecciones de 10 años de enseñanza de liderazgo para administradores de hospitales.

Resumen: Los métodos de liderazgo se pueden entender y aplicar por los directores de hospitales de la misma manera que los profesores y los participantes a un seminario respetan ciertas convenciones. Cada método debe ser discutido y adaptado, reconociendo sus limitaciones para su uso en hospitales. En este artículo se presenta en primer lugar lo que se enseña en un curso de liderazgo tradicional y luego se analizan las formas en que el curso se puede adaptar para su uso por el director del hospital.

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- In official relations with the World Health Organization (WHO) and the Economic and Social Council of the **United Nations** (ECOSOC), it is strategically positioned as a bridge between IHF members, the United Nations.
- Acts as a **global facilitator for health care delivery** among and between key governmental and non-governmental stakeholder organisations.

What Is the Corporate Partnership Programme?

The IHF Corporate Partnership Programme, launched in 2009, is an **opportunity** presented to major corporations seeking to join IHF members in working to improve hospital and **healthcare performance** around the world.

Partnership is open to a limited number of companies who are fully engaged in the **global health sector** and have a **good reputation** as providers. Affiliation with this Partnership Programme gives a strong signal to the global community that the Corporate Partner is a major world player in the hospital and healthcare sector.

The Partnership package provides **access to hospital and healthcare decision makers** from around the world. The Progamme provides an exclusive opportunity for relationship building and sharing of ideas and experiences between corporate leaders and executives in the hospital and healthcare sector. **Dialogue** through this platform will ultimately introduce new ideas and expand knowledge in the healthcare market.

The benefits of the Programme are designed to maximise interaction between actual and potential clients through a **"one-stop shop" approach**.

Opportunity to ultimately create a **corporate leadership body**, to act as a neutral platform for wide-ranging intra-industry discussions on issues of mutual concern beyond and outside of traditional parameters of marketing in order to **foster collaboration** and **enhance confidence** in commercial relations in the health sector as well as **performance** and quality of services and **life** to the **community** at large.

Becoming a Corporate Partner

Contract Terms

- ***Payment*** covers a calendar year period of:
  1January – 31 December

(For the 2-year option, payment can be made on annual basis)

- ***Letter of Agreement***
  The Corporate Partnership is established upon signature of a letter of agreement by representatives of both the International Hospital Federation and an authorised signatory of the Corporate Partner organisation.

Application

For additional information, please contact:

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Meet IHF corporate partners

Aramark is a leader in professional services, providing award-winning food services, facilities management, and uniform and career apparel to health care institutions, universities and school districts, stadiums and arenas, and businesses around the world. The company is recognized as one of the "World's Most Ethical Companies" by the Ethisphere Institute, one of the "World's Most Admired Companies," by FORTUNE magazine and one of America's Largest Private Companies by both FORTUNE and Forbes magazines. ARAMARK seeks to responsibly address issues that matter to its clients, customers, employees and communities by focusing on employee advocacy, environmental stewardship, health and wellness, and community involvement. Headquartered in Philadelphia, ARAMARK has approximately 250,000 employees serving clients in 22 countries.

Learn more at www.twitter.com/aramarknews

Bionexo is the center of a community comprised of over 15,000 players of the hospital business. Through our web platform, we integrate hospitals throughout the supply chain sector, focusing on business development and relationships. Established in 2000, in just 10 years, Bionexo was structured in Brazil, becoming the largest marketplace reference to the hospital industry and contributing significantly to the professionalization of the purchasing sector and growth of the healthcare market.
The success of this innovative business model has led to Bionexo for Latin America and Europe, where also attained leadership in addition to export technology and implement a new concept in commercial transactions of organizations.
Everything happened in a short time, just like businesses are made between the companies that integrate our platforms.
This makes Bionexo the largest core of the hospital sector in Brazil.
Pioneering and innovation, helping thousands of companies and hospitals.

www.bionexo.com.br

Esri is the world leader in GIS technology. Esri software promotes exploring, analyzing and visualizing massive amounts of information according to spatial relationships. Health surveillance systems are used to gather, integrate and analyze health data; interpret disease transmission and spread; and monitor the capabilities of health systems. GIS is a powerful tool for identifying health service needs. Esri software is extensively used by health organizations throughout the world, including the US Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), 127 national health ministries, and over 400 hospitals.

For more information, contact Christina Bivona-Tellez, CBivona-Tellez@esri.com. www.esri.com/health

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IHF events calendar

2012

MEMBERS

PORTUGAL

4th International Hospital Congress
November 8-9, 2012, Lisbon, Portugal
Website: http://www.apdh.pt

USA

University Health Care System Consortium (UHC) Annual Conference 2012
September 13-14, 2012, Orlando, Florida, USA
For more information: https://uhc.edu/UHC2012.htm

American Nurses Credentialing Center: ANCC National Magnet Conference
October 10-12, 2012, Los Angeles Convention Center, CA
Website: http://www.anccmagnetconference.org/

Healthcare Supply Chain Association: 2012 International Expo
October 22-24, 2012, JW Marriott Grande Lakes, FL
Website: www.supplychainassociation.org/?page=Events

COLLABORATIVE

Hospital Management Asia 2012
September 13-14, 2012 – Hanoi, Vietnam
For more information: http://hospitalmanagementasia.com

3rd International Symposium (ASSIAPS)
October 18-19, 2012, Brussels, Belgium
For more information: http://assiaps.com/php/index.php?lang=en&page=44

2013

IHF

38th World Hospital Congress*
June 18-20, 2013 – Oslo, Norway
Theme: Future health care: The Opportunities of new technology
Email: Sheila@ihf-fih.org / kine.martinez@nsh.no
Website: http://oslo2013.no

MEMBERS

USA

American College of Healthcare Executives: Congress on Healthcare Leadership
March 11-14, 2013, Hilton Chicago, Chicago, IL
Website: http://ache.org/Congress

American Hospital Association's Annual Meeting
April 28 - May 1, 2013, Hilton Washington, Washington, DC
For more information: www.aha.org

*Events marked * will be in English/host country language only. IHF members will automatically receive brochures and registration forms on all the above events and will be entitled to a discount on IHF Congresses, and Leadership Summits.*
For further details contact the: IHF Partnerships and Project, International Hospital Federation,c/o Hôpital de Loëx, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: sheila.anazonwu@ihf-fih.org Or visit the IHF website: http://www.ihf-fih.org

Medtronic

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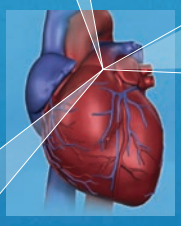

The story continues at medtronic.com/innovation.

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18–20th JUNE 2013

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PROUD ORGANISER NSH

International Hospital Federation