



**The power of management in medical services.  
Can we manage better for higher quality  
and more productive medical services?**

*Puterea managementului în serviciile medicale.  
Putem administra servicii medicale  
de o mai bună calitate și eficiență?*

*Magdalena BARBU*

The Bucharest Academy of Economic Studies, Romania  
e-mail: maggy\_ro@yahoo.com

*Marian NĂSTASE*

The Bucharest Academy of Economic Studies, Romania  
e-mail: nastasemarian@yahoo.com

**Abstract**

*Medical services are the most important services of all since we all depend on them. Their quality and productivity can assure a wealthy nation and therefore good economical results. The offer of medical services depends on medical personnel and more than this, on the management in the medical field since any resource not managed well or not managed at all is only a lost one, regardless its value. Management is therefore the key, the "how to" method of obtaining the desired result. The same approach can be applied into our study in order to reach more productive medical services which to prove high quality to all patients. We need to use and to squeeze the entire force of management tools in order to reach our goal: accessible medical services full of quality. The current worldwide crisis situation makes us think that after job and food, even medical services (also a basic thing after all) can become a "luxury" although this should never happen. Therefore we must do whatever needed to improve the way medical organizations are driven so that the quality of their medical services will be better and better and the productivity will be at a higher level. Medical management should have as a goal making it possible for patients to be able to solve their health problems as soon as possible and as good as possible.*

**Keywords:** *quality, productivity, medical services, human resources, management of health care organizations*

**Rezumat**

*Serviciile medicale sunt cele mai importante deoarece toți depindem de ele. Calitatea și productivitatea lor pot asigura sănătatea unei națiuni și, astfel, să se obțină și performanțe economice. Oferta serviciilor medicale depinde de personalul medic și, mai mult decât atât, de managementul sanitar, deoarece orice resursă care nu este gestionată corespunzător este o resursă pierdută. Astfel, managementul este cheia, adică modalitatea cea mai sigură de a ajunge la rezultatul dorit. Aceeași abordare poate fi aplicată și acestui studiu pentru a obține servicii medicale mai productive care să ofere o calitate ridicată tuturor pacienților. Trebuie să utilizăm și să direcționăm forța managementului pentru a ne*

*atinge obiectivul: servicii medicale de calitate și accesibile. Criza existentă la nivel mondial ne determină să percepem importanța deosebită a serviciilor medicale, după nevoile de hrană și de locuri de muncă, dar uneori acestea apar ca un lux ce nu este accesibil oricui. De aceea este important să adoptăm acele măsuri necesare pentru perfecționarea managementului organizațiilor sanitare, astfel încât calitatea și productivitatea serviciilor medicale să fie la un nivel tot mai ridicat. Managementul sanitar trebuie să asigure condițiile ca pacienții să-și rezolve problemele de sănătate, cât mai repede și cât mai bine posibil.*

**Cuvinte-cheie:** *calitate, productivitate, servicii medicale, resurse umane, managementul organizațiilor sanitare*

**JEL Classification:** M10, I11

### **The need for professional management**

**E**nsuring safety for patients and medical personnel and improving quality are national objectives for health systems in developed countries as well as into the countries that are developing. This is kind of a response to increasing patient expectations, media coverage and the belief that there are effective methods to improve quality, safety and productivity in order to please most of citizens at the highest level possible (Bunker & Frazier & Mosteller, 1994).

Health care organizations are increasingly expected by governments and founders to introduce quality systems and strategies. Some health care managers and practitioners also believe that action can and should be taken, irrespective of external pressures or context – be it even the present worldwide economic crisis.

The approaches that can be followed to ensure safety, improving quality and productivity are more. One is to invest more money into personnel; other is to increase the targets without investing more money etc. The key question that arises is: which strategies are most appropriate and cost-effective for a particular medical unit in a specific situation? Should we manage thinking locally or globally? Which approach should a government promote?

The approach should be “Think global act locally” since we need to have a systemic view for the whole medical system but to apply in each medical organization the tools it needs the customized measures in order to improve and keep this trend also for the future (Stahl et al., 2006).

First of all, every organization and therefore also a medical one needs a strategy. Moreover, this has to have a quality part. A regional or national hospital quality strategy is a long-term one, namely a program to increase patient and personnel safety and improve hospital quality. There can be specific strategies in each hospital and strategies to improve quality in many hospitals. It’s important

that the leaders of such organizations to be able to build up a vision (Năstase, 2007) able to attract the energy and dedication of all the personnel.

A quality strategy differs from a quality tool in being an overall approach an organization takes over a period of time, rather than a specific method for a particular purpose. But the strategy has to meet all the requirements for meeting the environmental challenges and all the components have to work together (Nicolescu & Verboncu, 2008) Thus, a program for external inspection of hospitals is a strategy. A particular method for carrying out inspections is referred to by quality specialists as a tool. It is possible to pilot-test a tool, but not a strategy (Institute of Medicine, 1990). Benchmarking is both a tool and a strategy. WHO (World Health Organization) will even develop a separate policy synthesis of research into quality tools.

### **Setting a direction**

Hospital strategies can be considered “good” or “bad” taking into account several things. In evaluating strategies, it is necessary to identify alternatives and judge their effects, using evidence and clear criteria. There is a strong correlation among strategy – organizational culture – performances (Verboncu and Nicolescu, Popa, Nastase, 2008). In fact, the organizational culture represents a powerful force that can be used by leaders for sending their message and having a cultural framework that could support the employees’ initiatives (Nastase, 2004). Evidence in relation to the following criteria were sought to assess quality strategies: ease and cost of implementation, impact on health personnel, patient outcomes and cost savings (Roybal & Baxendale & Gupta, 1999).

The power of medical management resides in setting a direction for the entire medical organization by having a consistent strategy, ensuring adhesion from personnel side and permanently improving the way their functions are executed.

Generally speaking, the types of strategies encountered during analyzing specialized literature are as following:

- Quality management system: defines responsibilities for quality and puts into place the structures and systems to ensure it. The International Organization for Standardization (ISO) issues guidelines used by some European hospitals to design quality management systems. The composition of such a system is interpreted differently from country to country in the absence of overarching standards.
- Quality assessment and accreditation, internal or external: There are many assessment systems; the best known in Europe is the European Foundation for Quality Management system, based on the American Baldrige Award system. A related strategy is voluntary or compulsory external quality assessment by a third-party peer review organization, or governmental body. This may or may not involve issuing formal accreditation. Accreditation systems differ in which aspects of hospital operations are assessed and whether quality outcomes are considered in the assessment. Some experts argue that hospital accreditation programs are not a good use of resources in low-income developing countries.

- Total quality management and continuous quality improvement: Total quality management is a set of principles and methods applied in many different ways, originating from organization-wide industrial quality programs (Scutchfield & Keck & Mays, 2009). This strategy focuses on attention of personnel and on providing the best patient experience and outcomes. Quality tools are used by multidisciplinary teams of workers to make changes, and the approach is generally thought to require strong management leadership. It is based on a view that quality problems are more often due to poor organization than to individual faults. Continuous quality improvement is the same as Total quality management in most literature, although it sometimes refers to a concentration on multidisciplinary project teams analyzing work processes and using repeated cycles of testing small changes.
- Quality collaboratives: it is already a national and regional strategy in Australia, Norway, Sweden and the United States, promoted by United Kingdom's National Health Service, and being tested in middle-income developing countries. The strategy consists in bringing together project teams from many different hospitals. The teams typically meet every 3 to 9 months to learn and apply quality methods and to report their progress. It was meant to provide an economical way to learn models of effective practice and quality methods, to stimulate enthusiasm and get faster results than are usually obtained with Total Quality Management strategies (Riddle, 1995).
- Re-engineering: uses some of the Total Quality Management methods, but includes a more radical redesign of "production processes" which normally involves small-scale and incrementally tested changes.
- Quality indicator comparison: seeks to motivate patients, clinicians and others to use information about quality to make improvements, but is not prescriptive. It can be used by one hospital taking part in a comparative data gathering program, or as a voluntary or compulsory strategy for hospitals in an area to collect and report the same data. Some comparison systems are public and promoted to encourage both patients and providers to take action to improve quality.
- Increasing resources: increasing the financing, personnel, facilities or equipment used in a medical organization with the aim of treating more patients or treating the same number faster, better and at lower cost-per-person;
- Large-scale reorganization or financial reform: changing the structure of a hospital or health system so as to facilitate better decision-making or use of resources. Changes in financing methods are made as a way of improving quality;
- Strengthening management: improving quality by increasing management responsibilities, authority or competencies. It is sometimes used as part of other types of strategy. It is useful and can be applied only for medical units managed by professional managers in order to be possible to put more charge and work on them. In cases when manager of the medical organization is a physician as well things are more difficult since the persons is overloaded from the very beginning;

- Standards and guidelines: formulating standards of what is expected from health providers, communicating, providing training in, and enforcing the standards. Examples are the United Kingdom's national standards frameworks, the Zambian national technical standards, and clinical practice guidelines for various health conditions. Most medical and clinical audits fall within this category, as well as some approaches called "quality assurance" and "clinical pathways".

- Patient empowerment and rights: giving patients a voice, for example through complaints systems or patient satisfaction questionnaires. There may also be methods to strengthen patient power through legal entitlement, advocacy or other institutions, such as a right to treatment within 30 minutes of arriving at an emergency room. A number of Nordic countries have patient guarantees as well as patient rights in law (Leebov & Scott, 2007).

- Benchmarking: uses comparative information about quality with additional methods to help providers decide how to improve quality. There are specific methods for identifying, documenting and applying the best practices.

- Risk management and safety: identifies high risk procedures or situations that put the hospital at financial risk from patient claims. It includes methods for diagnosing causes of adverse events.

As we can see, more strategies have quality as focus. This is normal and is also a general tendency since competitiveness is higher and higher in medical field also, private medical services having an ascendant trend (Cengiz & Barry & Murdick, 2003).

Regarding which strategy is best among the upper described ones, given the lack of evidence it is still considerable discussion about which strategies are or could be effective. One debate concerns "generic" versus "specific" strategies: would more resources carefully allocated do more to raise quality than a specific quality strategy? Many professionals think that increasing personnel, equipment and training is the best strategy. Quality adepts believe that "doing more of the same" can sometimes harm clients which in our case mean patients. They also think that applying quality methods systematically within a strategy is more cost-effective on the long run. This is the most fundamental debate in the field. The debate is especially acute in developing countries, where there is similarly poor and conflicting evidence of the results of different approaches. It is increasingly recognized that quality strategies in these countries supported by donors have not been sustained, exactly the way it happened some time ago into the high-income countries. There is debate about program costs and possible savings or benefits, but no research into the economics of different strategies.

### **Some incentives and some barriers for strategic planning**

Another much discussed problem is individual versus organizational approach. Some strategies concentrate on individual practitioner change, such as training or guideline implementation, and others on organizational changes. Adherents of the latter dispute the opinion according to which in order to obtain

significant quality improvements a lot of changes in work organization and procedures are needed. They say that traditional profession-specific approaches do not change the system.

However, professional training is quicker, easier to implement and can be made more effective by supervision. This discussion reflects competition between management and professional “ownership and control of quality” and that quality strategies involve significant political issues. In practice, individual-oriented strategies depend on and effect change in the organization, and organizational-change approaches apply training and guidelines on the individual level.

As the conditions that affect business and healthcare organizations worldwide have become more turbulent and uncertain in the nowadays crisis, strategic planning has decreased in popularity. Into the United States, strategic planning is criticized for decreasing creative responses to the new marketplace, for encouraging compartmentalized organizations, adherence to old-fashioned strategies, tunnel vision in strategy formulation and overemphasis on planning to the disadvantage of implementation.

Still, effective strategic planning can be a force for mobilizing all constituents of an organization, creating discipline in pursuit of a goal, broadening an organization's perspective, improving communication among disciplines, and motivating the organization's workforce. It is worthwhile for healthcare organizations to preserve these benefits of strategic planning, while recognizing the many sources of turbulence and uncertainty in the healthcare environment.

Very discussed is also the problem of incentives and a “climate” for quality. One view is that quality is best improved by an open and honest discussion of gaps between current and acceptable quality, by making public the best results and how they were achieved, and rewarding hospitals for improving their performance over time.

Another view is that this is time consuming, that poor quality providers are the least likely to participate in voluntary programs, and that national governments have a duty to ensure minimum standards and to protect people from poor or unsafe care. This view supports compulsory inspection or accreditation, with sanctions for poor quality and rewards for improved quality. The alternative view is that this damages the open and positive climate thought to be most effective for quality improvement.

There are more arguments for and against “police, punish and reward” approaches, and “inspire and develop” approaches. Many governments use both, causing problems for the agencies facing both ways: to apply sanctions and at the same time to encourage open sharing of quality performance information. Related to this is the issue of publicizing quality performance data. Critics argue that the data are misleading, easily misinterpreted and subject to falsification by providers and that internal, anonymous distribution are more likely to be effective with professionals. Others argue that public release of data will improve the quality, and

that researchers and the state have no right to withhold data about poor quality that the public needs to protect itself and make informed choices (Enăchescu, 1995).

But is it appropriate to apply “industrial” quality strategies to health care? It is well known that medical services represent a special “field”, a sensitive and not very flexible one. Once the acceptance of the methods in healthcare grew, the problem now became how the industrial methods are best translated or adapted for this particular environment (Green & Kreuter, 1991). Quality experts think that a strategy has to be tailored to specific circumstances, and debate about the point where adaptation loses the “active ingredient” and results in reduced effectiveness.

Regarding the use of specific quality strategies in non-Western countries with comparable income levels it can be said that it is possible for them to be applied but only after adapting them to the cultural environment. Many quality methods are based on Western assumptions about rational management, authority and employee participation that do not apply in some countries.

The cultural preconditions for a quality strategy to be effective within a country or an organization are very clear. Also, it is generally agreed that a strategy has to change the culture of an organization to be effective. It should also be clarified what a quality-culture or safety-culture is, how can it be measured and how can it be changed. There is widespread recognition that conditions surrounding a quality initiative are important for its success. Comparative research into implementation of complex change has found that success depends on a range of local factors. The only generalizations that can be made from these comparisons are which factors appear to be important and which decision-makers need to pay attention to in implementing changes: there is no general model or series of steps which will guarantee success in all situations.

A hospital quality strategy creates conditions to encourage initiatives and projects within the organization: there is some evidence that continuous quality improvement projects require physician and management involvement, managers to allow personnel time, and good data support to be effective. The question that arises is: what are the financial incentives and priorities which conflict with both short term and long-term quality improvement? For sure that different conditions are important for different types of strategy, but a medical unit manager should not set a strategy only because of some unique conditions. A very important thing is which types of evidence are possible or desirable and about appropriate methods for evaluating quality strategies? Some opt for quasi-experimental controlled studies and others for comparative studies. Currently there is very much used a combination of data on strategy outcomes with data on implementation processes. The way of selecting and following a certain route depends on the context (economic, social, infrastructure – traffic jams can make physicians punctuality be a problem and therefore patients’ consultations/interventions be a problem), personnel, capacity of the organization, financial resources, and many other factors that should be very seriously considered (Wallace, 2007).

In any case, all medical organizations managers should choose the best fitting strategy and obey to it. This means having plans, programs and actions driven into the strategy's direction. Everything should be done according to it in order to achieve the proposed goal.

### References

- Bunker, J. P., Frazier, H. S. & Mosteller, F. (1994) Improving Health: Measuring Effects of Medical Care. *Milbank Quarterly* 72(2)
- Cengiz H., Barry R., Russell R. & Murdick, R. (2003) *Service Management and Operations* (2nd Edition), Prentice Hall
- Enăchescu, D. (1995) *Sănătate publică și management sanitar*, București, Editura All
- Green, L. W. & Kreuter, M. W. (1991) *Health Promotion Planning: An Educational and Environmental Approach*. 2nd edition, Mayfield editor; California, Mountain View
- Institute of Medicine (1990) *Medicare: A Strategy for Quality Assurance*. Vol. I. K. N. Lohr, ed. Washington D.C.: National Academy Press
- Leebov W. and Scott, G. (2007) *Service Quality Improvement: The Customer Satisfaction Strategy for Health Care*, Nebraska, iUniverse books
- Năstase, M., (2007) *Lideri, leadership și organizația bazată pe cunoștințe*, București, Editura ASE
- Năstase, M. (2004) *Cultura organizațională și cultura managerială*, București, Editura ASE.
- Nicolescu, O. & Verboncu, I. (2008) *Managementul Organizației*, București, Editura Economică
- Riddle, D. I. (1995) *The Role of the Service Sector in Economic Development: Similarities and Differences by Development Category*, New York, Praeger Publishers
- Roybal, H., Baxendale, S. J. & Gupta, M. (1999). "Using Activity-Based Costing and Theory of Constraints to Guide Continuous Improvement in Managed Care." *Managed Care Quarterly* 7 1-10/1999
- Scutchfield, F. D., Keck, C. W. & Mays, G. P. (2009). *Principles of Public Health Practice*. 2nd edition, Albany, NY, Delmar Publishers, pp. 140-141
- Stahl, T. et al. (2006). *Health in all policies. Prospects and potentials*, Ministry of Social Affairs and Health, Oslo
- Verboncu, I., Nicolescu, O., Popa, I. & Năstase, M., (2008). *Strategy-Culture-Performances*, București, Editura PRINTECH
- Wallace, R. B. (2007). *Public Health and Preventive Medicine*. 15th ed., Stamford, Appleton & Lange