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A REVIEW OF DETERMINANTS OF HOSPITAL PERFORMANCE

**REPORT OF THE WHO
HOSPITAL ADVISORY
GROUP MEETING**

Geneva, 11-15 April 1994



World Health Organization
District Health Systems
Division of Strengthening of Health Services

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The first part of the paper discusses the importance of maintaining accurate records of all transactions. This is particularly true for businesses that operate in highly regulated industries, where the consequences of non-compliance can be severe. The author emphasizes that a robust record-keeping system is essential for ensuring transparency and accountability.

Furthermore, the text highlights the role of technology in streamlining record-keeping processes. Modern accounting software offers a range of features that can significantly reduce the time and effort required to manage financial data. By leveraging these tools, businesses can ensure that their records are up-to-date and easily accessible.

In addition, the author notes that regular audits are a critical component of any sound financial management strategy. Audits help to identify potential errors or irregularities in the accounting records, allowing businesses to address them promptly. This not only helps to maintain the integrity of the financial statements but also provides valuable insights into the company's overall financial health.

The paper concludes by reiterating the importance of a proactive approach to record-keeping. By implementing best practices and staying up-to-date with regulatory requirements, businesses can minimize the risk of financial misstatements and ensure the long-term success of their operations.

The author also discusses the challenges associated with record-keeping in a digital age. While technology offers many benefits, it also introduces new risks, such as data breaches and system downtime. To mitigate these risks, businesses should invest in robust cybersecurity measures and have a clear disaster recovery plan in place.

Finally, the paper touches upon the importance of training and education for staff involved in record-keeping. Ensuring that employees are well-versed in the latest accounting practices and software is essential for maintaining the accuracy and reliability of the financial records.

INTRODUCTION

Hospitals and Health For All

1.1 Hospitals are an important part of any health system: they provide complex curative care that, depending on their capacity, acts as a first referral, secondary or last referral level curative care facility; they also provide emergency care for the severely injured or the critically ill; they are centres for the transfer of knowledge and skills; they constitute an essential source of information and power; and they generally spend the major part of national health resources. However, hospitals should not be seen as separate and self-contained entities within the health sector, but as part and parcel of a national health system where their role should be to support the primary health care (PHC) strategy as a referral and support mechanism.

1.2 In 1985, a WHO Expert Committee, in its report "Hospitals and Health for All", analyzed and described the role of first referral hospitals in support of PHC. It was stressed that there is a need to reorient the whole health system to meet new challenges through an integrated approach to the promotive, preventive, curative and rehabilitative aspects of health care. National health systems should be founded on local manageable units, district health systems, in which hospitals should be regarded as one of the very important cornerstones.

1.3 In addition, the WHO publication "The Hospital in Rural and Urban Districts" (1990), recommended that the first referral level hospital be integrated within a locally based district health system supervised by a district health council. While buildings and equipment were seen as being important, the main requirement was to effect a change in attitudes and motivation, and bring processes in line with the concept of Health for All. It was stressed that first referral level hospitals should be seen as resource centres for health promotion in districts and for the planning and delivery of PHC.

1.4 In principle, hospitals with a first referral level function could be of any type and size, e.g. even large teaching hospitals might have to accept self-referrals and referrals from first contact level facilities. In practice, however, the concept of first referral hospitals was generally associated with smaller so-called district hospitals in rural or urban settings. Second referral hospitals were seen as serving larger populations and as providing all but the most complex kind of hospital services. Thoughts about tertiary level hospitals evoked views of highly specialized, high technology interventions for less frequent and very complicated conditions and instances of last referral care.

1.5 The largest share of national health expenditure is for hospitals, regardless of the health status and income level of a country. It is not unusual to find shares of 60 to 80 percent of the national health expenditures targeted specifically for hospitals. Within the hospital sector, the large and teaching hospitals generally spend the lion's share of the available financial resources. In addition, the greater part of the other essential health sector resources, e.g. human, physical and technological resources, are usually concentrated in these hospitals.

1.6 Hospitals, and especially large teaching hospitals, act as a reference point for the national health system, and they have a special position of authority that makes them influence medical as well as health thinking for generations

to come. Their potential contribution to the goal of Health for All through a better integration into national health systems has not been fully exploited.

1.7 Large teaching hospitals are usually located in metropolitan areas, where political decision-making takes place. They are often overcrowded and not necessarily doing what they should be doing, i.e. participating in the production of the human resources needed for health, and taking care of patients that cannot be looked after at other levels of the health system. Especially the peri-urban poor and a large share of the rural population have little access to the high level technology and manpower in these institutions, which raises the issue of equity in access to hospitals and health services.

1.8 WHO is conscious that whilst much emphasis has been placed on the need to promote PHC and on the role of the first referral hospital in supporting this process, the role of other hospitals, particularly large teaching hospitals, has unintentionally tended to be neglected. Against this background, a comprehensive view of hospitals as part of a national and district health system is needed. Since first referral level hospitals have already been explored within WHO to some extent, this advisory meeting devoted special attention to the other types of hospitals.

1.9 The purpose of this meeting was to identify and explore some of the major determining factors for the performance of hospitals, such as national, local and institutional policies, financing and cost issues, technology issues, and performance related issues. Further, it was intended to develop ideas and approaches for country specific follow-up action as well as for WHO follow-up action in order to improve the overall performance of hospitals and health systems as a whole.

Objectives

1.10 The objectives of the meeting were:

- a) To identify factors that determine the performance of hospitals, e.g. legislation, regulations, national/local/institutional policies, financing mechanisms, technology, etc.
- b) To create a framework that can be used to review the effect of these factors on the performance of hospitals in general, and teaching hospitals in particular, e.g. their clinical, administrative, and financial performance;
- c) To develop ideas and outline approaches for follow-up action that can be used by countries and WHO in order to improve and readjust the performance of hospitals within the health care system.

Expected Outcome

1.11 The expected outcome of the meeting was to produce a document that would:

- a) outline the factors determining hospital performance;
- b) on the basis of that outline, present a comprehensive view of hospitals as part of a national health system with special emphasis on selected issues;

- c) propose follow-up action on selected hospital and health issues in general;
- d) provide a framework for reviewing the performance of teaching hospitals and a plan for follow-up action on these hospitals that may be used by countries and WHO.

Proceedings

1.12 The WHO Hospital Advisory Group Meeting took place in Geneva from 11 to 15 April 1994. The meeting organized its work by concentrating on a number of themes: the parameters of hospital performance, the impact of hospital and health policies, the significance of financing and cost issues, and the effects in hospitals of rapidly changing technology. Emphasis was placed on optimizing the performance of hospitals both internally as well as within the broader context of national health services. On the one hand it was recognized that hospital policies were being implemented within the constraints of inevitably finite resources, yet on the other that hospitals were operating in a dynamically changing, increasingly sophisticated and costly technological environment.

1.13 The meeting was formally opened by the Assistant Director-General, Dr J.-P. Jardel, who referred to the importance of hospitals within the health system geared to achieving Health For All and to the important contribution the meeting could make to the task of identifying what constituted effective hospital performance within a fully integrated hospital and health care system, paying particular attention to the role of large teaching hospitals. He assured the meeting of the best possible support in the important task ahead and wished all participants well in their endeavours.

1.14 The meeting elected Dr Judith Shamian as Chairperson and Dr Barry Wint as Rapporteur.

Dr Errol Pickering, President of the International Hospital Federation, presented a paper on "National, local and institutional policies for the direction and social control of hospitals as parts of the health system" and Mr Frank Inman gave a presentation on "Issues and problems concerning hospitals in developing countries". This led to a discussion on the performance of hospitals, their mission, quality and quantity of services provided, administrative and managerial processes, human resources and support services. The social control of the growth of appropriate hospital technologies was then discussed following the presentation of a paper by Professor H. David Banta.

Based on a presentation by Mr Andrew Creese, the meeting then discussed resource allocation, methods of financing, and cost containment in and around hospitals. Finally, key teaching hospital issues, including role, constitution, performance and cost, were discussed following a presentation by Professor Dominique Jolly.

1.15 These themes were explored in greater detail and proposals for action for countries and WHO were agreed. The result is summarised in the rest of this report.

HOSPITAL PERFORMANCE: THE MAIN PARAMETERS

2.1 The Hospital Advisory Group found that the one issue which dominates current health care is: how well or badly is the health system performing and how well are hospitals within the health system performing? Are hospitals doing what they should do and what they set out to do? Are they providing effective and efficient quality health care? Are they making best use of the scarce and specialized resources available? Are they integrating with and supporting the rest of the health care system? Are they well run? These were some of the questions which the Group set out to ask and to answer.

2.2 It was recognized that hospital performance could be judged in various ways: How well is it performing clinically in terms of the quality of its clinical services and its clinical support services? Alternatively: How well is it performing administratively as an institution in accomplishing its mission? Are staff trained, employed in the correct proportions and well supervised? Does the hospital stay within its budget?

2.3 Performance was described as: "the execution of activities and the attainment of results through them". Implicit in performance is the attempt to achieve a desired, measurable outcome or target. This can be seen individually as achieving individual professional excellence or competence, or organizationally as the organization, e.g. the hospital, achieving a desired performance level or, indeed, a country achieving predetermined goals in health care. Therefore performance is about setting realistic targets, then trying to achieve them, then measuring how near or far the results were from the target. The process is iterative.

2.4 Countries may set targets which concern the health status of their populations, e.g. to reduce mortality arising from heart disease, malaria or AIDS. These general targets can then be translated into local targets for district populations and local health authorities may be encouraged to achieve specific measurable improvements with the human resources, facilities and financial resources available. In this way local health services would work within a national policy framework to achieve improvements in health care, and hospitals should be requested to make their important contribution.

Integration

2.5 Given the high complexity and cost of hospital care, horizontal and vertical organization of services delivery is crucially important. The services need to be properly integrated and, more particularly, the hospital within it:

- vertically, so that each part of the health system links in to the national policy framework and is accountable at the appropriate level for its performance.
- horizontally, so that each service component works intersectorally. For instance, the hospital should synchronize its efforts effectively with relevant health and other services, such as those responsible for health promotion, immunization, accident prevention, local water authorities, etc.
- internally, so that there is a maximization of available resources at the operational level to produce the desired health outcomes for patients.

2.6 A hospital care system cannot perform well unless there is effective integration in all three dimensions. To do so there must be effective national policy guidelines and appropriate organization for the development and training of sufficient competent health professionals and health administrators to enable services to operate effectively locally; and there must be a rational method of resource allocation and income generation, promoted and supported nationally, to facilitate a consistent and comprehensive provision of adequate health care locally.

The following are all key factors in well performing health care systems and hospitals within them:

Mission, Objectives and Targets

2.7 Each element of the health system, e.g. the hospital, needs a statement of its role and purpose (its mission), a sense of direction and realistic, measurable goals to achieve (objectives and targets). This provides a basis for purposeful hospital care and a springboard to progress that in turn should integrate with national policies and priorities.

Service Quantity and Quality

2.8 Each hospital or health service entity should have a defined range and volume of services which it is to provide to a specific population. These services should meet an agreed level of demand or need according to available resources, and be synchronized with services provided by other health and non-health care agencies. The quantity and quality of services provided should be measurable against common scales for comparison and capable of being costed.

2.9 Robert Maxwell, in "Dimension of quality revisited: from thought to action", defines 6 dimensions of quality in health care, three of which are equity, appropriateness and accessibility. The remaining three are:

- Acceptability: a service oriented towards the consumer in terms of choice, privacy and personal service.
- Efficiency: doing things right; careful use of resources and clear professional standards.
- Effectiveness: doing the right things; the service provided should fit the needs of the people served.

Furthermore it was felt that quality in health care is the outcome of good quality technical care, good interpersonal relationships between the health care practitioner and the patient and the quality of the environment in which care is provided.

2.10 Concepts of quality assurance (QA) like Total Quality Management, Continuous Improvement Programmes and Process Re-engineering offer useful methodologies which can be adapted to health care. There is a growing body of knowledge on quality management in health care in general and hospitals in particular which should be made widely available.

2.11 How accessible and how responsive are hospitals to the health needs of their populations? How effective is the screening and selection process

provided by the referral system? How good is the service provided as illustrated by observation, comparison, patient satisfaction and professional audit?

2.12 It is informative to assess the quality of a service provided by reference to inputs (e.g. money, human resources, skills, materials, drugs and equipment), process (e.g. whether patients are appropriately and promptly treated with courtesy and dignity as inpatients or outpatients by skilled staff), and outcome (e.g. whether the result of the hospital stay was beneficial to the health of the patient). Certainly the first requirement of a hospital should be that it do the patient no harm.

2.13 Further useful concepts are the explicit use of defined professional standards, success criteria (what can we describe as a successful outcome in a specific case?), and consumer surveys (is the patient satisfied?). Also it can be useful to adopt a problem-solving approach to improving quality (what are the obvious and not so obvious problem areas and how can we systematically resolve them?).

2.14 The health professions are taking many new initiatives in professional audit and peer review. The lessons of managing quality in hospitals seem to be that pious quality statements are not enough; that there must be real participation by all professional disciplines in defining and addressing quality issues; that top management must show strong and continuing personal commitment, leading by concrete example and with resources to achieve tangible outcomes; that there must be detailed follow-through on the precise minutiae of measuring performance against quality standards; and, finally, that quality is a continuing process, a journey not a destination, which at the end of the day is defined by the changing needs and expectations of the consumer.

2.15 Practical examples of quality initiatives in countries were:

- Measuring hospital mortality (Chile, Nigeria)
- Measuring hospital infection rates (Chile, Indonesia, Nigeria)
- Measuring the adequacy of prescriptions (Indonesia)
- Improving breastfeeding practices on discharge from hospital (Indonesia)
- Measuring readmission rates to hospital (Canada, UK)
- Better complaints system (UK)

Management Process

2.16 In any health care institution or unit of service there is a need for someone to be responsible for running things, to take the final decisions and accept responsibility for achieving an intended outcome. This necessitates a management process being in place. The responsible person (whatever the title held e.g. director, chief executive or simply "the boss") is the linchpin of the management process, by which the hospital or unit plans, controls and reviews its performance. Performance equates to achieving the agreed goals efficiently and effectively with the resources available. He/she also provides the means for projecting the organization's identity to all external agencies, leads the main management team, which runs the hospital on a day-to-day basis, and is the main communication channel with key players in the organization, e.g. clinicians and other professionals and managers. He/she serves as the organization's intelligence and nerve centre as well as the all important link with the policy making forum, e.g. the Hospital Board, and acts as the official, but not the

only, ambassador for the hospital or unit in respect of the public, the media and external organizations.

2.17 Paradoxically the advent of general management tends to strengthen rather than weaken the team concept, not least because a performance culture will concentrate effort rather than disperse it. It is impossible to overstate the importance of a clearly identified top team which surrounds the Chief Executive and provides corporate solidarity, direction, drive and commitment across the organization: such a team is vital to the success of hospitals and health care. Lack of cohesion and direction are major weaknesses in any organization. Major challenges such as those that exist will only be surmounted by individuals pooling skills more effectively to achieve hitherto unattained heights of team and individual performance reflected in the maxim that a team is more than just the sum of its constituent parts.

2.18 The main task for the team is to build the organization's corporate vision and strategy, translating it into plans and objectives for the organization to implement. Team members will need skills in problem-solving, planning and performance management. The health management team needs to have a consistency of membership which could, for instance, include the chief executive, matron, accountant, medical director, a clinical support services director, plus one or two other key players, e.g. a planner, an information specialist, a human resource (personnel) director or a works director. The important thing is that the top team should include a selective spread of the key functions and the key leaders, influencers and opinion formers in the organization and should not exceed 6 or 7 in number. Team members should be capable of team working, corporate vision, loyalty and of personal competence both as individuals and as part of the team effort.

2.19 Below top team level the hospital or health care unit falls naturally into groupings of services or constellations which have a natural coherence and can be managed by the accountable leader of a functional or departmental team, selected, regardless of background, on managerial ability and potential, e.g. Outpatients, Surgery, Medicine, Clinical Support Services. There should be a multidisciplinary team approach which includes health professionals as part of the management process, and indeed encourages them to carry direct managerial responsibility consistent with their onerous clinical responsibilities.

2.20 What about doctors and nurses in management? Doctors, by virtue of their education, seniority and continuity of service set the tone of the institution and provide leadership. They also determine the use of resources within the hospital. Ideally therefore doctors should play an important role at all levels in the management process. Similar arguments apply in the case of nurses and other health care professionals, many of whom have excellent management skills and potential. If doctors are chosen as chief executives they should, as other managers, have undergone management training and should not have to undertake, in addition, onerous clinical workloads. In industrialized countries, one of the favoured models is the combination of a trained manager as chief executive, working with a practising clinician as medical director, and a nursing director. These three individuals form the senior management team and work with a larger management team that has specific expertise in the areas of finance, human resources, labour relations, and information systems.

2.21 The hallmarks of the new management approach should be open but disciplined communication, team working, strong corporate, including financial,

accountability and loyalty, and an action centred approach to performance. These are some of the tell-tale characteristics of a well run organization. It must also be stressed however that the management process is only a means to an end - better patient care - not an end in itself. But better management will lead to better institutional performance and the rewards which come with it are potentially great: better services with less waste, better value for money, more satisfied patients and a more fulfilled staff.

Human Resources

2.22 In health care the key to everything is the human resource and the constant challenge is to be able to balance the recruitment and retention of appropriately qualified staff with the changing demands for the services required and the resources available. Central to this challenge is the availability of training for the key health professions. Such training requires strategic coordination and an appropriate reward system to ensure recruitment and retention of the requisite numbers, combined with a minimum of wastage.

2.23 In many developing countries, even where there is a satisfactory training output, hospitals struggle to retain the necessary quota of skilled health care professionals and this is usually because they are unable to compete with neighbouring countries in terms of pay and conditions. The truth of the matter is that, however good the strategies and the local management arrangements, if there are insufficient doctors to do the doctoring and insufficient nurses to do the nursing, there will not be good hospitals. It must also be said that recruitment, retention and rewards is a delicate balancing act which requires specialised human resource expertise working dynamically at a strategic and an operational level to ensure that supply is adjusted and attuned to demand within the country and protected from the dreaded brain drain abroad phenomenon. The employment of hospital staff within the national civil service should be reviewed. It can be agreed that civil service conditions should be reserved for specific categories of government employees and that care delivery would benefit from a more entrepreneurial personnel service structure.

2.24 There is a further point here and that is: how well are the skills you are able to recruit and retain being used? Who is responsible at local level for ensuring the best deployment of health care staff at the front line and for administering sanctions where standards of performance are not achieved? This is an absolutely crucial issue: it is possible to get a higher quality and quantity of health care out of a small, committed and disciplined team with limited but balanced skills, than out of a large number of qualified but uncoordinated and uninterested professionals.

2.25 What can the government of a country do to encourage recruitment, training and retention of appropriate numbers of health professionals? It can show that it values their services by paying them adequately and giving them good conditions of service, making it more attractive for them to remain in their native country. It can make it a condition of contract that they stay for a fixed period practising in their country of origin, at least until they repay, as it were, the considerable cost of their training. It can pay them additionally for taking on management responsibility.

2.26 This clearly illustrates some of the key human resource problems in our hospitals. Such problems require a broad and imaginative strategic approach to recruitment, retention and rewards coupled with greater flexibility in the

application of pay, conditions and disciplinary sanctions, and greater financial freedoms to resolve problems in an innovative way locally.

Clinical and Non-clinical Support Services

2.27 It is axiomatic that a hospital is a complex of services which surround the patient in, as it were, a series of concentric circles and that all of these services are interdependent. Good management arrangements do not compensate for an absence of doctors or nurses but can help to rectify the deficit by more imaginative human resource policies. Similarly, superb medical and nursing prowess will not make up for inadequate pharmacy services or a poorly performing X-ray department nor indeed machines that do not work or a cleaning service that is inadequate, although these leading professions will tend to set the standard for others to emulate and indeed they will normally demand, and rightly so, adequate back-up and support.

2.28 The main challenge with support services is their sheer diversity: somehow they have to be effectively tied into the management process and they have to achieve a dynamic interface with the patient services that they are supporting. It is convenient to divide support services into clinical support and non-clinical support or hotel services. Clinical support services like pharmacy, X-ray and pathology require specialist professional skills and equipment, and sometimes suffer through being under-managed or unaccountable. These services need to be very responsive to the needs of patients and frontline services and be clearly accountable for performance. Therefore they should have an appointed manager who will usually be a senior professional and who should have undergone management training.

2.29 In the case of "hotel services" such as catering, portering, maintenance and security there is a potential problem of fragmentation, neglect and hence of ineffectiveness. Again, accountable management and direct supervision of these services is necessary in order to ensure that purposeful and responsive activity is achieved. There is nothing more frustrating than the reaction of "this is nobody's problem" when the oxygen supply runs out or the water shuts off. A correct and comprehensive chain of accountability throughout the hospital organization ensures that all these things are somebody's problem and that adequate training and supervision is achieved and responsibilities properly exercised no matter how great the practical difficulties.

2.30 There is a time to stop grumbling and talking about a problem, which is a support service problem threatening the whole hospital operation, and to concentrate priorities and maximum available effort to remove it, and to see it through to a conclusion. This speed of response and the rapid focusing of maximum effort on the immediate priority problem and cracking it, is often lacking in hospital operations, particularly when it comes to support services.

2.31 There is sometimes the problem of whether the immediate manager is in control of his/her service. All managers need to know where they must go with a problem that they are unable to resolve - having said this, some are adept at dumping their own problems on other people's desks - they must not be allowed to do this; the important questions for all managers, particularly support services managers are: Who are my customers?; Do I have responsibility to internal customers whom I serve within the organization?; Is there a positive, "can do" atmosphere in all sections of the organization?

These questions briefly serve to illustrate some of the problems and issues in the vitally important task of managing support services.

Conclusions

2.32 The Hospital Advisory Group came to the following conclusions prior to deciding on recommendations to countries and to WHO:

- a) There is now clearly a need for countries to focus on the performance of their hospitals and health systems as a whole and to adopt methodologies designed to enhance performance levels.
- b) It is equally clear that performance can be enhanced by proper integration of hospitals internally, vertically and horizontally within the health system.
- c) The importance of quality management in health care is now undeniable and there is a growing body of knowledge available on this subject.
- d) Human resource strategies are crucially important to supporting effective service delivery at hospital level.
- e) The management process is very important in health and hospital settings where complex objectives have to be achieved with a wide range of costly resources and the best way is to develop managers and managerial expertise throughout the health system.
- f) Good performance relies heavily on relevant, accurate and timely information being available and countries therefore need to consider how information systems can be put into place to support the performance management process.

THE IMPACT OF HEALTH AND HOSPITAL POLICY

3.1 The Hospital Advisory Group concluded that hospital performance could be adversely affected by the lack of clear policies from above. If there is confusion about the mission or role of the hospital this can lead to duplicated efforts and waste on the one hand or serious gaps in service delivery on the other. Hospitals are not only crucial to the effective delivery of good inpatient care but often a source of pride and affection to their local populations and hence have a highly symbolic political importance.

3.2 Governments have a clear and unequivocal responsibility to make policy for hospitals and health. The process of policy making is difficult and complex and includes identifying broad aims, clarifying objectives and responsibilities, focusing concerted action and setting a framework against which improvement can be measured. There are a number of guiding principles which underpin the strategic policy-making approach:

Principles

- a) There should first be clarity on what the main health care problems are and which part of these can only be catered for by hospitals.

- b) Policy should be concerned as much with the promotion of good health and the prevention of disease as with treatment, care and rehabilitation, whilst ensuring that neither is achieved at the expense of the other.
- c) Hospital and health policy should recognize that as health is determined by various factors, e.g. heredity, personal behaviour, family and social circumstances, the environment, the opportunities and responsibilities for action to improve health are widely spread from individuals to government.
- d) Hospital policy recognizes the need for concerted action by means of greater cooperation at all levels, from national to local, within the hospital sphere and outside it, and that this is promoted by better information and education in health matters, and by fostering greater participation of health workers in discussion on options and priorities.
- e) Hospital policy recognizes the need to balance central strategic direction with local and individual discretion and freedom to perform, ensuring that where responsibilities are delegated, there is accountability and fair but rigorous review of performance and results.
- f) Hospital policy recognizes that resources are finite and therefore that maximizing resources is an important objective, as is the need to maintain a rational system of resource allocation
- g) A sound policy-making approach is based upon the belief that clear objectives and specific targets are central to the process of achieving an effective strategic hospital policy, within the wider framework of a national or local health policy.
- h) Hospital policy execution stands or falls on the ability to monitor the state of the health of the people, to evaluate the resulting programmes, and to assess their effectiveness in terms of health gain.

Policy Formulation

3.3 Health policies should take into consideration health problems not only in terms of frequency but also in terms of severity and feasibility. All health agencies, particularly hospitals, should combine forces to solve them within available resources. The key is identifying and agreeing which health priorities are most important and then marshalling all available resources in a coordinated manner to address them. In developing and developed countries alike the main priorities will inevitably be the basic health problems of rural or urban communities. All available resources, whether primary, secondary and tertiary health services, or public and private health agencies, illness prevention and health promotion services, or community health and hospital services, can then be mobilised in a concerted fashion. Policies should focus on holistic objectives which force effective intersectoral action and co-operation across the social spectrum.

3.4 The following questions are pertinent. Do we have enough accurate and up-to-date intelligence about health and health-related problems? How recent and accurate is our census data? Does it tell us about the living conditions, water supplies, sanitation standards, and nutrition of the population? Does it help us identify the at-risk groups? Do we know the current life expectancy of our urban and rural populations and the prevailing infant mortality rate?

Do we know the causes of death in our area of responsibility and do we have any measure of the incidence of major diseases? Do we have activity data which tells us about the coverage of our immunization programmes and mother and baby programmes. Do our hospital statistics tell us basic information about attendance, admission and diagnosis? All this information is the foundation for a national strategic health policy within which a robust hospital policy must emerge - to have good policies there must be an adequate knowledge base. Examples of essential areas for health policy development which impact directly on hospital performance are:

- health care targets
- financing systems
- resource allocation
- health services design
- remuneration
- manpower
- technology

Implementation

3.5 There is also a need for an administrative framework or local organizational structure for health care which spans the hospital and community divide and some accountability process between it and national level, i.e. a governable and accountable health care entity. It then becomes possible to assign and develop roles locally and nationally and to bring about a dynamic process which in a more integrated and consistent fashion can drive forward the improvement of health and hospital care.

3.6 How can a national health bureaucracy more effectively assist in better meeting the needs of the patient at home or in hospital, in improving the health of the people, and in facilitating the role of health workers at the front line of health care? Civil servants at the centre, with the politicians, forge the policy and the strategy. Experience teaches that this cannot be accomplished in an ivory tower. It needs to be achieved by means of public and private debate with the involvement of the best thinkers and practitioners at all levels and with the best factual knowledge and information that is available on what is happening, how it is happening and why it is happening at front line level. This means gathering good information, analysing it, discussing it widely and, above all, listening.

3.7 Policy makers can be too prescriptive and even unrealistic in approach, partly out of zeal and a touch of arrogance, but partly because a good policy maker, who is remote from the action, does not necessarily have the skills or understand the needs of a good implementer. Generally policies should be very clear in direction but allow a degree of flexibility in implementation - what managers call, allowing space for them to perform. This process is sometimes called: hanging on while letting go. There is an important intersectoral collaboration role across ministries which lays the groundwork for intersectoral collaboration locally. The wise civil servant at the centre will clearly know when it is time to step back and not interfere with implementation other than to offer support.

3.8 National policy making needs to be balanced by an effective local health care organization spanning the hospital/community divide and taking responsibility for the local provision of health care. This is usually the local health

authority which serves the comprehensive health needs of a defined population. What is its role in the achievement of a national strategic health and hospital policy? How is this role carried out? The local health authority will need to collect, analyze and interpret information about the health of the local population and, within national policy guidelines, determine target areas for actions and interventions to improve the health of the population in key areas. To undertake this task it will need to have the epidemiological skills of the public health doctor.

3.9 The local health authority will need to provide or have provided an efficient and effective, comprehensive range of health services which meets the needs of the local population and addresses the specific targets identified in the local health strategy; to undertake health promotion and disease prevention as well as diagnosis, treatment, care and rehabilitation. To achieve these tasks there will need to be a correct range of health care workers and health care professionals as well as effective support systems, financial resources and a cadre of efficient and effective health care managers. Hospitals provide an important resource base where such expertise can be nurtured. Policies for manpower training and remuneration, health support services, health financing and resource allocation are of vital importance. Such policies need to encourage good health care practice, efficiency, effectiveness and a public accountability ethos.

Monitoring, Control and Accountability

3.10 Finally there is monitoring and holding to account role. This can be bureaucratic, time-consuming, acrimonious and ineffective or streamlined, short and snappy, positive and highly effective. The former is destructive, the latter to be highly recommended. Without a monitoring and control loop between the centre and the periphery, which is sensitively handled, policy implementation does not work.

3.11 A good national strategic health policy uses current knowledge to identify those areas which are of the greatest concern and where there is the greatest opportunity for real improvements in health. Such a strategic policy identifies objectives and targets for improvement in order to stimulate and direct coordinated action. The results are then monitored and assessed through the accountability loop and the process is iterative. The objectives and targets have to be realistic but challenging, agreed by all parties and measurable by indicators. They are most likely to concentrate on problem areas which are shown to result in most deaths, most illness and where the social and economic cost is greatest. Hospitals play a central but highly integrated role in meeting these key policy objectives locally. Thus we recognized the important impact health and hospital policy had on the performance of hospitals.

Conclusions

3.12 The Hospital Advisory Group came to the following conclusions prior to making recommendations to countries and to WHO:

- a) Governments have an important policy-making role in respect of health and hospitals. In particular, in many countries specific policies for government, public, private, charity, and industrial hospitals, have either not been developed or have become out of date.

- b) There is a need to improve methods of policy formulation, implementation and monitoring as this can have very beneficial effects on hospital performance.

THE SIGNIFICANCE OF FINANCING AND COST ISSUES

4.1 The Hospital Advisory Group identified financing and cost issues as major forces in influencing hospital performance. These fell into a number of subject areas, discussed below. In health care, resources are finite and demand is infinite: there will never be enough resources to do all the things needed to solve all medical problems. In some developing countries there are major financing problems: economies in decline are failing to generate the wealth required to maintain the state health care sector, which becomes unaffordable. This is not an enviable situation and poses painful choices for individual nations and the international health community, but it does call for innovative and flexible approaches to financing strategies. It is also recognized that there is a heavy responsibility to ensure that what resources can be raised are rationally allocated and then maximised. Value for money remains the guiding principle whether the budget is large or small, and the less money available the more value that needs to be squeezed out of what little remains.

Financing Strategies

4.2 There is a wide variety of financing strategies being adopted amongst the different health care systems reviewed. Recent trends are summarized in "Evaluation of recent changes in the financing of health services" (TRS 829, WHO, Geneva, 1993). Many systems use public and private funding mechanisms, including general taxation, insurance, and a variety of co-payment systems. It is important to distinguish between sources of financing (e.g. government, private, insurance or external sources) and payment mechanisms (e.g. fee for service, case payment, daily charge, capitation, salary, global budget). It is fully recognized that changing any aspect of financing or payment mechanisms can create incentives and disincentives within the health care system that can have a distorting impact on equity, access, use, efficiency and quality. At this time when so much experimentation is taking place in health systems throughout the world there is an urgent need for evaluative studies to be undertaken which would serve as a useful source of guidance for Member States.

4.3 For hospitals in countries or provinces with weak economies there are stark choices to be faced between collecting fees or ceasing to provide services. Charging patients at least part of the costs of their care is increasingly widespread, given low levels of public funding and poor prospects for real growth. The majority of countries in Sub-Saharan Africa are currently implementing fee payment schemes for health care services at public hospitals. In Vietnam, in 1989, most district hospitals would have been unable to operate had they not been able to collect fees, and in Jamaica, fees were seen to be justified as a mechanism to keep doctors in government hospitals. Retention of fee income at health care facility at district level was recognized to be important by health care providers, though not necessarily by ministries of finance. To reduce the regressive impact of fees on the poor, workable exemption mechanisms need to be implemented, and evidence of improvements in service quality demonstrated.

4.4 The development of health care insurance for health care financing at present covers only part of the total population in many countries. Many

countries have insurance schemes in preparation. More feasibility studies are required of potential insurance schemes. In Colombia, where some 40% of the population have social security or private insurance cover, the government is engaged in the process of defining a mandatory basic insurance package which all insurers must provide. The package will be designed so that it can only be provided economically in service delivery arrangements which involve alliances between hospitals and PHC care providers. The definition and pricing of the package is at present incomplete, but the Government's aim through this mechanism is to ensure universal access to a defined standard of basic care. Experience in Thailand involving the extension of social insurance coverage, including a capitation-based payment system for providers, is having the effect of encouraging investment by providers in PHC facilities thereby offsetting costs.

Financial Resource Allocation Policies

4.5 In many countries, sources of funding are fragmented and financial resource allocation policies are not particularly effective, resulting in unbalanced provision or major problems in providing continuity of services. Experiences of different resource allocation options and policies could shed some useful light in this area. It is recognized in many nations that budget allocation through district or regional offices and relating to defined populations improves equity and efficiency of resource allocation. Many countries lack a rational, population-based resource allocation policy for health care based on the principle of equal access for people with equal need. Incremental budgeting traditions perpetuate highly skewed concentrations of resources to major hospitals in principal urban areas. Some countries are experimenting with the separation of financing from providing services (the so-called purchaser/provider split operating in a without profit internal market) as a means of introducing the pressure of competition and thereby achieving a more rational allocation and better use of resources. In the UK this is forcing major radical change in health provision, particularly in London, where a number of prestigious hospitals are having to close. It is anticipated that advancing surgical techniques will enable 50,000 hospital beds to close in the UK within the next 8 years.

Public and Private Health Care

4.6 A development of widespread concern is the establishment of private practice in public hospitals. The disadvantages of this are most apparent when it is simply a mechanism for queue jumping, and the only beneficiary is the individual patient and the physician who receives fee payment. The advantages of allowing regulated private practice in public facilities are several. In the first place, it allows an improvement in the remuneration of providers (not necessarily restricted to doctors). In Jamaica, this was felt to be a major factor in retaining doctors in government hospitals. A further advantage is that, in a well managed arrangement, the hospital also benefits from the additional income generated. Finally, patients who can afford to pay for a higher level of amenity (e.g. private rooms) remain users of public facilities.

Financial Resource Management

4.7 All health care systems seek to put in place arrangements designed to ensure that the resources allocated are used to best effect. Hospitals need effective financial information systems which usually involve delegated budgetary arrangements using the cost centre approach and a system of accountability for financial performance. Such financial information systems can only be created

and maintained by qualified financial experts who are present at hospital level. Human resource strategy should take account of the need for such a pool of expertise at hospital level and above. Also, the management process should encourage a tight system of accountability upwards. Departmental and organizational managers, including health professionals, have to be knowledgeable about and accountable for their budgets.

4.8 Global budgets are being introduced as an aid to cost control and more effective financial management but this is probably occurring in slightly different ways and with mixed results. Experience from Colombia suggests that, in the absence of appropriate supporting information on expenditure patterns and service quality, such mechanisms do little to enhance performance. The French system of a global envelope, subdivided into regional and institutional budgets, provides a high level of financial security for each health care facility but limited autonomy within the use of funds, as salary levels and hiring and firing practices are subject to general civil service regulations. In countries like the UK there is total decentralisation of budgets and increasing local pay bargaining. Results look promising. Poorer countries, where a high level of budgetary uncertainty remains the norm, would probably regard global budgets as a possible step forward.

Organizational approaches

4.9 There are a number of organizational approaches being used in various countries which are having interesting effects on financing mechanisms and financial behaviour. The more traditional approaches are being replaced. The new spectrum varies from the rigid bureaucratic planning approaches to the competitive, not for profit model using concepts like GP fundholding, contracting out for general services, and the creation of the purchaser/provider split referred to above. These latter approaches can make an impact on service provision, accessibility, effectiveness, efficiency and utilization. Careful and continuous evaluation of these new strategies is essential.

Remuneration and Reward Systems

4.10 Many health care systems operate excessively rigid employment, remuneration and reward systems and function in an over-centralized and bureaucratic manner, which is not necessarily conducive to the effective operation and performance of the service. There are examples of more flexible systems and potential for many improvements in this area. Remuneration and reward systems are crucial to the motivation and, hence, the performance and behaviour of staff. This area also calls for evaluation studies.

Capital Investment

4.11 Another key issue in the management of hospitals is to maximize the return on capital invested in hospitals. In other words, to consider the impact of planned new investments on the health care system and the issues of cost recovery before rather than after the event. It is important to take account of the financial consequences of capital investments in advance. When resource levels are limited, there is always a temptation to starve hospitals of proper levels of funding for maintenance purposes leading to false economies. There is a wealth of advice available on the effective management of the hospital estate designed to ensure the best return on capital invested, adequate budgeting for maintenance purposes, depreciation and

associated issues. Such information would be of great use to many Member countries.

Financial Control, Accountability, Audit and Probity

4.12 In order to secure the limited resources available, there is a concern to promote an environment of sound management control and financial transparency and probity, reinforced by an effective and independent audit mechanism. Systems and procedures are widely available in some countries which might be of interest and assistance to others.

Conclusions

4.13 The Hospital Advisory Group came to the following conclusions prior to making recommendations to countries and to WHO:

- a) There is much experimentation going on in financing health and hospital services, not all with beneficial results on health.
- b) There is widely varying practice in the field of financial resource allocation. Good resource allocation strategies can benefit health and hospital care.
- c) There is widely varying performance in terms of the effective management of resources and a general deficit in accountancy skills.
- d) Remuneration practices are often over-centralised and rigidly bureaucratic which can impair the performance of hospital staff in different ways.
- e) There is general widespread concern to improve accountability, financial control and probity within public services.

TECHNOLOGY: ITS EFFECTS ON HOSPITAL PERFORMANCE

5.1 The Hospital Advisory Group identified the development of health care technologies as an important variable that has an impact on the evolution of hospital care, independent from other social determinants, such as financing mechanisms and institutional policy. The term technology is defined as knowledge applied to valued ends. Therefore, health care technology is not merely machines, but includes the drugs, devices, and medical and surgical procedures used in health care and the organizational and support systems within which such care is provided. Using this definition, it is apparent that without technology the health system has little to offer beyond human care and support. Furthermore, control must be taken in a dual sense. Control means both slowing adoption of technology to ensure that it is cost-effective and also encouraging and even accelerating the acceptance of beneficial and cost-effective technology.

5.2 This is the time of the most rapid technological change in history. Developing countries develop little of their own technology, and the consequence of this fact is that they are behind the developed countries in hospital technology. With accelerating technological change, and the development of many beneficial and cost-effective technologies, there is a strong danger that developing countries will fall even further behind.

Costs and Benefits

5.3 Despite its undoubted value, health care technology is associated with a number of serious problems in all countries. The most visible problem in recent years has been that of financial costs, and relating those costs to benefits by such means as cost-effectiveness analysis. It has been recognized that there is a widespread use of ineffective technologies, for example in such areas as diagnostic and screening technologies and technologies associated with pregnancy and birth. Widespread overuse and inappropriate use of beneficial technologies has recently been documented in a growing number of countries, with inappropriate use rates ranging from 30-70% depending on the specific technology and country. Finally, the problem of lack of access and resulting under-use of some beneficial technologies is gaining increasing attention. These problems have been little studied in developing countries, but it is likely that they are generally worse in such settings than in industrialized countries. In addition, developing countries have special problems in selecting and purchasing medical equipment, servicing and maintaining it after acquisition, and assuring its appropriate use.

5.4 Naturally, the nature and extent of such problems varies greatly with the type of hospital. Smaller hospitals may deploy only basic technology. Large university teaching hospitals are generally the home of high, capital-intensive technology. Sponsorship of hospitals also plays a role in that, for example, public hospitals tend to have more serious financial problems than private hospitals. In order to ensure/promote most efficient use of technologies there is a need for a mechanism to provide clarity on selected utility.

Technology Assessment

5.5 Health care technology assessment (TA) has grown up during the last 20 years to help with technological choices. Health care TA generally examines three implications of technology:

- Health benefits (efficacy, effectiveness) in terms of mortality, morbidity and quality of life
- Financial costs and cost-effectiveness; and
- Ethical and social issues.

5.6 Because the central question in TA is whether value for money is being achieved in health care, the methods of cost-effectiveness analysis have gained particular visibility in this field. Despite its rather short history, health care TA can point to important contributions to rationalizing health care in countries, such as Australia, Canada, France, Netherlands, Spain, Sweden, the United Kingdom and the United States of America. Developing countries, such as China and Mexico, have also become increasingly involved in the field.

Policy for Technology

5.7 Technology assessment produces information, which does not lead to rapid change on its own. The assessment must be associated with certain policies at national, regional, and local levels, including institutional policy of individual hospitals. Every country has some type of health and hospital medical care policy that is implemented through such means as regulation of sites for technology, decisions concerning what services (technologies) to provide or pay for, and methods to assure quality of care.

5.8 A technology policy that has been particularly used by some developing countries is to limit imports. Technology policies are generally quite weak in developing countries, where policy decisions tend to be overwhelmed by other factors, such as national economic policy or foreign aid. An appropriate policy structure would control budgets, guide choice through active assessment, and enlist hospital and clinical professionals in improving the cost-effectiveness and quality of care.

5.9 Hospitals can develop their own policies toward technology, but these policies can obviously not solve national problems. Hospital policies are more effective when supported by an appropriate national policy. In addition clinical professionals and professional societies are becoming increasingly involved in TA and their role is essential for further developments in this field.

5.10 A special subset of policies important for developing countries is the selection, repair and maintenance of medical equipment, maintaining a stockpile of spare parts, and maintaining national and regional inventories. It is difficult to predict technological developments, and technology diffusion often depends on factors unrelated to its benefits and costs, including its association with professional prestige and pay and industry's role in development and promotion. The choice of which technologies to provide to the population seems to be the main possible strategy for developing countries. TA can be a substantial help in guiding such choices.

Drugs

5.11 Strong competition and a high profit margin within the pharmaceutical industry can have unforeseen and unfortunate consequences, e.g. the dumping of prices to improve market shares or different lobbying activities. Within health systems in some developing countries there are often inadequate supplies of drugs although this can be less of a problem in private hospitals than in public hospitals. The main reason is that drug prices are relatively higher in these countries. On the other hand, it is possible to find examples of oversupply and overuse of drugs. Private hospitals financed by public funds might be a relevant factor. Another contributing factor could be that drugs in some countries can be sold without a prescription from a physician.

5.12 Some key questions to be addressed are:

How can appropriate use of drugs be ensured? How can drugs be distributed appropriately and how can the use of new and often very expensive drugs be approached? Experience in different countries shows considerable variations in the supplies of drugs through production, import and export. Joint ventures between transnational pharmaceutical companies and countries are becoming more and more common. There is considerable variation in both relative and nominal hospital spending on drugs. Different purchasing approaches by hospitals or countries might result in considerable price differences (public bidding, negotiated purchase, etc).

Equipment

5.13 What kind of equipment is needed to support the objectives of the hospital and the health care system? The importance of maintenance of existing and potential new equipment (procedures, supplies, etc.) cannot be overemphasized and

therefore training, recruitment and retention of a sufficient number of maintenance staff is crucial. As discussed above, it is widely acknowledged that TA is of great importance. Whilst international comparisons of assessment are useful, different cultures and different health care systems would inevitably approach TA with differing national perspectives. Among countries considerable variations in the use of national guidelines and control mechanisms can be identified. In some countries very comprehensive control mechanisms are present, while in other countries very few control mechanisms can be found.

Standards

5.14 The number and range of national standards for technology can best be determined at the national rather than the global level. New standards need to be developed in order to respond to actual and future needs. These standards could be computer based, audio visual, etc., and could be provided in nationally based information centres. Country experiences reveal large differences in the application of standards. Many countries have few general standards but may have a number of more specific protocols and guidelines. The necessity for locally developed standards and protocols should be emphasized.

Sharing Information

5.15 There is a general need for better information systems contributing to a better and easier accessible assessment of new technology. Such information could be provided through electronic database with access to appropriate and up-to-date TA information for decision makers. Therefore communication technology should be promoted as a vehicle for information on TA and use. Results of TAs could be made available to developing countries through international networks e.g. the Medline system. There is available a growing body of interesting case studies on the assessment and successful introduction and control of new health technologies which is of direct interest to Member States.

Donors

5.16 The supply of high-tech equipment by donors to developing countries is often in the form of aid, grants, or soft loans. It is important to stress that such arrangements should be responsive to the user needs and level of socioeconomic and technical development. Donors need to give explicit consideration to factors such as easy accessibility, availability of spare parts and maintenance in order to avoid the "technology trap", which is very expensive for the recipient.

Conclusions

5.17 The Hospital Advisory Group reached the following conclusions prior to making its recommendations to countries and WHO:

- a) There is a paucity of policy statements regarding how new technology should be handled within the health system.
- b) There tends to be too little regulation of technology and too little dissemination of relevant information on technology within health systems.
- c) WHO has developed useful expertise in the area of health technology which could be further developed to the benefit of Member States.

TEACHING HOSPITALS

6.1 The Hospital Advisory Group recognized that WHO had already been working on first referral or district level hospitals but also acknowledged that it was important to explore large, and teaching, hospitals for a variety of reasons. Teaching hospitals are generally highly complex and costly health care institutions, often of the last referral type, which carry out tertiary care, are involved with teaching and research programmes, forging strong links with academic centres and capable of mobilizing political power to achieve their ends. They demand a high proportion of scarce health resources, value the undoubted prestige of senior academic staff and wield considerable professional power often amplified by the doctors themselves, the media and consumers. They are also often the places where both the elite and the poor people in large cities go to find hospital care.

Health Care Function

6.2 Teaching hospitals perform an important health care function. They operate generally at the highest technical level in a country and are focused on tertiary care with correspondingly high costs. They should be centres of excellence in all areas of their activities, i.e. clinical as well as administrative. Their activities should be related to the health needs of the country and should operate within the limits of the country's resources. This trend should be further enhanced by the full integration of teaching hospitals into national policies and programmes (e.g. home-based care programmes).

6.3 A correct balance is important in the use of these facilities. Frontline facilities should be sufficiently developed and supported by the establishment of proper referral systems interlinking with the teaching hospitals. Their proper use can be further enhanced by the application of appropriate incentives and disincentives. Teaching hospitals should play a leading role in setting quality standards and protocols (in terms of outcome rather than resources/processes). They should be held accountable for a high level of performance against the background of the best use of available resources.

Teaching Function

6.4 Responsibility for teaching of health manpower cannot remain exclusively with a teaching hospital when, in fact, only limited experience is available there for students. Responsible bodies, such as university faculties and government ministries, should plan the teaching of doctors, nurses, paramedicals, health service managers, etc., in appropriately accredited sites across the health care spectrum. Inter-professional teamwork should be emphasized in training as well as patient/consumer sensitivity.

6.5 The use of other facilities will encourage the upgrading of those facilities or centres, thereby enhancing public confidence in them. The content of training should be relevant to the health problems of the country or district and the production of graduates should be in tandem with national or regional manpower plans. Continuing education should be an important element of the training activities.

Research Function

6.6 Better rationality is needed in the organization and planning of the research in order to ensure that the research undertaken is relevant to the needs and specific problems of a country. Research is too often limited to clinical research, but other research related to biomedical and clinical aspects, such as public health prevention, health policy, health services research, QA, risk management and other operational areas, should also be included. Research functions should be coordinated with the national health services and with other research institutes and should tie into the policy level. Research should be properly planned and budgeted and subject to performance appraisal like other activities. The establishment of ethical committees to monitor the ethical concerns was suggested as a possible mechanism. Research needs to be specifically promoted and health workers of various disciplines trained in the skills required to do useful and meaningful research.

Integration

6.7 Like other hospitals, teaching hospitals must establish vertical and horizontal linkages. Where there are no other services for the immediate catchment population, teaching hospitals might be required to make special arrangements to meet primary and secondary care needs of these publics. The outreach activities and contacts must not be limited to the health sector but should include areas such as the pharmaceutical industry, etc.

Governance

6.8 The governance of these extremely complex hospitals is a critical issue, usually involving many players: Ministry of Health, Ministry of Education, universities, private sectors, non-governmental sectors and political influences in the community. Governance mechanisms need to be clear with identification of clear lines of accountability/reporting and bodies should be representative of all the major players. Various organizational and financial mechanisms are being introduced to shift the balance of power in teaching hospitals. Decentralization to regions and districts, with financial authority to purchase hospital services from the teaching hospitals, as well as empowering faculties of health sciences to purchase teaching services, are examples of this. Privatization models are also being tested. The issue of the optimal size of a teaching hospital was raised and identified as an area for further study.

Issues

6.9 There are some issues which need to be identified in respect to teaching hospitals:

- a) What should be the limits of the hospital service provided by teaching hospitals? How do we differentiate the local normative hospital service provided from the specialised and superspecialised services provided as a centre of excellence? How are they to be funded?
- b) What additional complications does the teaching of medical students pose to the patient, the management process and the funding process? How much weight should teaching (the university) be given in the governance of the hospital?

- c) How many doctors should be trained and is their curriculum appropriate to the needs of developing countries, e.g. is it sufficiently oriented to maintaining and improving health status, Health for All, and public health and primary care?
- d) What is the role of the teaching hospital in the training of other professionals?
- e) How much and what kind of research should teaching hospitals be undertaking?
- f) At what rate should teaching hospitals be absorbing and deploying new technology? How should this relate to other hospitals in the country?

6.10 Teaching hospitals must form part of the national strategic health policy and become fully integrated with the rest of the health care system. Teaching hospitals must also submit to the disciplines of the corporate management approach, have in place a strong management process with control and accountability. In countries like the UK the traditional teaching hospitals have now been fully absorbed into the comprehensive health care system and their time-honoured position of privilege with all its best and worst connotations has changed to a difference only of function within a system. The challenge for the developing countries is to ensure that their teaching hospitals subserve the national strategic health policy and not the reverse.

Conclusions

6.11 The Hospital Advisory Group reached the following conclusions prior to making its recommendations to countries and WHO:

- a) There is much work to be done in improving the performance of large teaching hospitals which are difficult institutions to run efficiently and effectively.
- b) The analyses in this report could be useful in providing directions for further study and action.
- c) WHO can perform an enabling role (which needs further definition) in this process.

RECOMMENDATIONS

1. General

The Hospital Advisory Group recommend that:

- 1.1 Countries should seek to develop a strategic policy framework for hospitals with clearly defined roles, functions and targets, within their national health policy and structure.
- 1.2 Countries should seek to put in place an effective administrative framework capable of governing hospitals as part of local health systems implementing agreed health policies.
- 1.3 Hospitals should be an integrated part of the district health care system, not independent from it, although this should allow scope for hospitals to be self-managed in order to improve performance for the communities which they serve.
- 1.4 Hospitals and other units within the health system should implement a management process involving all the health care professions, led by an accountable chief executive and supported by a senior management team which has as its mission improved health care for its patients.
- 1.5 In the present climate of rapid health care reform, it is important that, whilst not discouraging innovation, careful and systematic evaluation of policy, financial and technological innovations should be undertaken before moving to a wider implementation stage by Member States. It is further recommended that reforms be piloted in stages before wholesale implementation. WHO has a crucial role in disseminating information on good practice.
- 1.6 Teaching hospitals have an important role in the health care system and need to embrace rapid change in order to play their correct role in the changing scene of health care. WHO can play a useful role in guiding change by disseminating international intelligence and brokering advice in this field.
- 1.7 WHO should provide strong leadership in promoting closer support, interest and involvement by donors and non-governmental organizations, banks and other agencies in furthering these recommendations.

2. Performance

To countries

Countries should:

- 2.1 develop a performance culture within their hospital services in which there are clear health targets nationally and locally and a performance review process.
- 2.2 aim to achieve a comprehensively integrated health system as soon as possible.

- 2.3 establish a management process within their health systems nationally and locally with chief executives and top teams operating effectively. Management development training should be implemented for all health professionals within professional curricula.
- 2.4 develop quality improvement initiatives using available expertise and designate a specific manager who is responsible for quality within the organization.
- 2.5 establish a national resource centre for the collation and dissemination of comprehensive comparative information on performance (quality, quantity, cost and value for money).

To WHO:

WHO should:

- 2.6 develop guidelines designed to help Member States implement a performance culture within their hospitals. There should also be available simple, convenient and practical assessment tools at various levels of sophistication to facilitate inter-country assessment and comparison of performance.
- 2.7 offer guidelines on the implementation of a management process within health systems nationally and locally and disseminate examples of good practice. Advice and guidance should also be available on management development initiatives.
- 2.8 develop specific technical guidance and sharing of best practices on the subject of specialized QA techniques between Member States.

3. Policy

To countries

- 3.1 Governments should perform a strong strategic policy-making role with respect to hospitals in those specific areas identified; there should be clear health targets and governments should develop an effective administrative framework to ensure sound implementation locally across the whole health spectrum; there should be mechanisms for reviewing progress towards health targets to measure health gain, the effective use of scarce resources and encourage accountability.
- 3.2 In developing and revising hospital policy, governments should be prepared to launch well informed public debate within and outside the health system on important policy and priority issues and seek to ensure that expectations about meeting health needs are informed by a realistic appreciation of the resources available.
- 3.3 Governments should consider establishing mechanisms to provide important objective advice on hospital policy, e.g. one or more national bodies or advisory groups. Such policy advisory groups should be selected as much for knowledge and skills to be contributed as for weight and influence in

communicating the resulting policies.

- 3.4 Countries should aim for a comprehensive and interlocking range of health policies which are compatible, consistent and mutually reinforcing in promoting the better health care of the people of the country. Examples of important policy streams are:

- Health and health care targets
- Financing systems
- Resource allocation system
- Health organization system nationally and locally
- Performance review and accountability
- Remuneration and reward system (including positive incentives)
- Manpower training, recruitment and retention
- Technology assessment and selection

- 3.5 Within a strong, clear and agreed health care strategy, governments should be prepared to delegate decision-making on operational matters to local level (both within districts and within hospitals). There should be strong and effective local decision-making, including the full involvement of the health care professions in the process.

To WHO:

- 3.6 Encourage countries to develop capabilities in effective health policy formulation and communication in the key areas described by disseminating examples of good practice and providing advice and support.
- 3.7 Assist countries to improve national and local health care organization in a manner which encourages more effective implementation of policies, better delegation of decision-making, better resource awareness and better accountability.

4. Finance

To countries

Countries should:

- 4.1 review existing financing strategies for inpatient, ambulatory, and public health care, and introduce change where experience shows that new mechanisms are feasible and are likely to contribute to health objectives.
- 4.2 review resource allocation policies for inpatient, ambulatory and public health care (revenue and capital) with a view to improving equity and effectiveness of funding in relation to population size and health need.
- 4.3 invest in improved capacity for better resource management and accountability, including suitable training for financial, managerial and professional staff groups and improved financial information systems at all levels.
- 4.4 develop more flexible and decentralised remuneration and reward systems and use them to promote beneficial behavioural and organizational changes which

have the potential to improve performance and health outcomes, with careful evaluation of the impact of such change.

To WHO:

Who should:

- 4.5 support countries in the design, implementation and evaluation of innovations in financing strategies, and disseminate information on experiences with change in these areas.
- 4.6 convene a Working Group to explore financial issues for inpatient care in greater depth.
- 4.7 evaluate different methodologies and experiences of resource allocation and develop case studies and options for Member States.
- 4.8 support training initiatives in building financial skills in Member States.
- 4.9 produce a technical document offering guidance to Member States on options for remuneration and reward systems which encourage better behaviour and performance in health care.
- 4.10 disseminate information on different organizational approaches, capital investment appraisal and financial control, accountability and audit approaches.

5. Technology

To countries

- 5.1 National health and hospital policy should include explicit statements regarding:
 - (a) appropriateness of health technology
 - (b) preference for high coverage/low cost technologies
 - (c) adequate maintenance, training and information.
- 5.2 Countries should establish a national regulatory body for technology (equipment, drugs).
- 5.3 Countries should pursue the development of hospital technology related information systems, including technology evaluation programmes.
- 5.4 Countries should use the current WHO guidance and documentation (technical reports etc) as well as other available information in developing TA, policies and programmes.

To WHO:

WHO should:

- 5.5 support countries to undertake hospital technology studies and should

encourage the development of a national body in each country for hospital TA, financing, training, purchase, maintenance. WHO should also assist countries to monitor use, efficiency, profitability and cost of technology.

- 5.6 promote the generation and distribution of an updated recommended pharmaceutical list for hospitals and should encourage the continuous development and dissemination of sufficient and appropriate information on hospital and health care technologies.
- 5.7 support the development of an international hospital technology network using telecommunication options where feasible.
- 5.8 bring to bear WHO's special expertise in technological assessment on other relevant programmes.

6. Teaching Hospitals

To Countries

- 6.1 At national level a mechanism needs to be developed utilizing the resources available to study further the issues, e.g. establishing special institutes, boards, committees on care, research, and manpower planning and developing plans of action to move towards the desired situation. The change process will involve skilful negotiation between many powerful players. One such area is the relationship between the teaching faculty and teaching hospitals.
- 6.2 A major challenge in achieving the change will be getting the players, e.g. providers, politicians, consumers and the media, to change their behaviour and assume fiscal responsibility for demands and promises. Strategies will need to include:
 - public education
 - promotion amongst health professionals utilizing incentives and disincentives (financial and non-financial)
 - organization changes such as policy shifts to an entrepreneurial culture.

To WHO:

WHO should:

- 6.3 provide advice and support to countries engaged in reshaping the roles and relationships within and around their teaching hospitals to achieve better health care performance.
- 6.4 collect data to review and compare country experiences and continue the process of facilitating exchanges between countries.
- 6.5 offer specific assistance in the development of the relevant information systems to facilitate assessment of the situation and to monitor progress. This should include allocating costs between the main functions of teaching hospitals as well as developing productivity and quality indicators.

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ANNEX 1

A REVIEW OF DETERMINANTS OF HOSPITAL PERFORMANCE
WHO Hospital Advisory Group Meeting
Geneva 11 - 15 April 1994

LIST OF PARTICIPANTS

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Dr. I. Tabibzadeh, Chief, District Health Systems, Division of Strengthening of Health Services.

Mr. O. Teglggaard, District Health Systems, Division of Strengthening of Health Services.