MANAGEMENT IN HEALTH CARE PRACTICE A Handbook for Teachers, Researchers and Health Professionals	
Title	**HUMAN DEVELOPMENT AND HEALTH PRACTICE**
Module: 4.6	**ECTS (suggested): 0.5**
Author	**Želimir Jakšić, MD, PhD, Professor Emeritus** Andrija Štampar School of Public Health, Medical School, University of Zagreb
Address for Correspondence	**Želimir Jakšić** Andrija Štampar School of Public Health, Medical School, University of Zagreb Rockefellerova 4, 10000 Zagreb, Croatia zelimir.jaksic@zg.t-com.hr
Keywords	Economic and human development, human resources development in health, ethics
Learning objectives	After completing this module students and public health professionals should: • aware of complexity of the development and recognize essential factors influencing the described relations; • increase knowledge on possible different interpretations human goals and ethics in health care practice; • understand importance of careful definition of vision and mission of development; and • improve human resources development and management.
Abstract	Development is not only economic category, but a complex issue.
Teaching methods	Teaching methods include individual preparation, case study, interactive small group discussions, and exercises. After individual reading and group discussion about elements of theoretical background and case study, fulfilling tasks given in exercises and summing up what the group has learned.
Specific recommendations for teachers	Work under teacher supervision / individual students' work: 70/30%. Seminar room, computer and internet connection or dictionaries and basic textbooks on health system development, education and ethics
Assessment of Students	Assessment of written reports on given tasks (seminar paper) and oral examination through defending results of given tasks.

HUMAN DEVELOPMENT AND HEALTH PRACTICE

Želimir Jakšić

THEORETICAL BACKGROUND

The World is changing in traditional way of thinking by redistribution of political power and economic development, scientific advancement and technical possibilities, but recently it is recognized that social relations, culture and ways of communication, human and social capital have a distinct role. Learning and use of existing knowledge should be part of solution.

There is not a simple and safe way to solution, but we have to simplify and first define what one would like to achieve, based on our estimate of needs and available resources.

Development was during 1980s used to describe the process of economic growth and changing in economic structure (e. g. division of labour, industrialization, increase in per capita national income), and that predominant understanding may be traced even now in utilitarian approach to relations of economics and health. However, the adverse results of social inequities after abrupt introduction of neo-liberal economies, human costs of Structural Adjustment Programmes, weakening of social networks ("social capital") and growth of social evils (crime, corruption, insecurity, violence, wars) in spite of apparent economic growth, at the beginning of 1990s resulted in reviving the philosophical, political and socio-economic expectations of the better future for humanity.

Human development concept was introduced (Mahbub ul Haq, Human Development Report 1990) as idea of advancement of the richness of human life. Human Development Index (HDI) was designed as a measure combining life expectancy, education and income. The broader approach to human development was underlined importance of human capabilities and freedoms, "enabling them to: live a longer and health life, have access to knowledge and a decent standard of living, and participate in the life of their communities and decision affecting their lives" (A. Sen. Development as freedom, Oxford University Press, 2001). In this way human development shares common vision with human rights, because in both of them freedom is essential and the basis of self-respect and dignity of all people. The importance on economic inequity, poverty, deprivation, illiteracy and injustice as breaks in the process of development are recognized. Culture and knowledge, innovations and human creativity, became important stimulants of progress besides economic incentives.

Human Resources Management

Human resources are gradually placed in centre of interest, particularly in health care provision. However, major changes emerged during the last decades:

- Human Resources Management developed from previous Personnel Administration and Manpower Planning and Development activities. Even the titles explain the character of change. At present a new slogan indicates further steps: "Working together (in teams and with patients)". Administration (disciplined and clear formal regulations, control and accounting of resources, frequently with bureaucratic tendency) is superseded by management (with priority in better resource utilization, decentralized decisions related to health care implementation), and followed now by

entrepreneurship (creating new opportunities, innovation, orientation toward the future, result orientation and risk taking in resource mobilization and allocation).

- Another direction of change is from "scientific management" to "human relations", to "human capital" and "ethical leadership". In case of motivation for work it is another intended change: from stimulation by money and incentives to encouragement by recognition of achievements and relying on responsibility.

Table 1. Simplified presentation of dominant approaches to management of people at work

"Scientific management" Taylor, 1920-30.	**"Human relations"** Mayo, 1935-60.	**"Human resources"** Olsen et al.1970-90.	**"Leadership based on principles"** Covey et al. 1990 -
People do not like to work, they work only for money	People like to feel important, but under supervision	People like to contribute to common purpose	People are responsible when accepted and free
Simplify tasks and strictly control performance	Discuss plans and listen to complaints	Fully develop participation in plans and decision	Leadership has to be honest, based on ethical principles
Develop standards and regulations	Expected development of self-control	Motivation will grow through participation	Satisfaction at work will enhance quality of work

"Knowledge society"

The XXIst century is meant to have several essential problems to solve: unequal progress in different countries and in depreciated groups and individuals in countries; growing environmental problems, including shortages of water and energy; ageing of population, double burden of health risks as result of epidemiology in transition, social and cultural changes in an global postindustrial and information World with not yet known health and social consequences. For this entire problem, starting with economy, the solution is found out in creative production and use of knowledge. The problem is how the knowledge is understood and how it could be measured. Is it factual knowledge, an objective truth or proper knowledge presenting individual or group ideology? Do we need scientific knowledge or wisdom? Is heart of the problem recognising true or false results or application of what we know, both factual and from experience? Today dominate measures of rigorous but formal criteria, academic or administrative competitive comparisons, more about production then about use and utilization of knowledge. As P Liessman critically observed the concept of knowledge society was transformed into a postulate of informed society ("Information age"), and consequently a necessity of life-long learning.

Ethics

Ethics remain the most important frame of human aspects and quality of health care. The main traditional human ethics ordered doing well, but in the modern times the dominant rule is doing right. This is a deep change. At the beginning of 21st century when most of human values are shaking and uncertain, it is not clear which type of rules will prevail. The increased gap between those who have material goods and power and those who are poor, depreciated and marginalized is producing critical situations in political, social and health matters: in individuals frequent stress, addictions, social isolation, and suicides; in

communities diminished solidarity and increased violence; in states market orientation, uncertainties, crisis of democracy, bigger mortality; damage to environment, domination of more powerful, wars and terrorism.

The problem is aggravated by abrupt introduction and imposing of formal rules and concept of justice strange to local culture. In many developing countries, including those in transition, the major intention is, for instance, formal introduction of bio-ethical codes and request of individual decisions, in societies in which is culturally deeply rooted communitarian (familial, tribal) approach.

Besides described and often discussed "big" ethical problems related to life and death (artificial insemination, abortions, suicide, euthanasia etc.), for health practice are often important daily "small" problems, often hidden by daily routine or covertly present as special care and interest for benefit of offended (like private interests of professionals, imbalance in power of health worker and patients, inequity of arrangements and attitudes toward patients by age, gender, social position, private relations, finding balance between quality and costs etc.). On the relation and trust between professionals and people in need frequent "small" ethical problems may finally have a greater impact then scarce "big" problems.

CASE STUDY: "DOM NARODNOG ZDRAVLJA" (HOME OF PEOPLE'S HEALTH), COMMUNITY HEALTH CENTRE, MEDICAL POLICLINIC - GROWING BIG AND LOOSING SOUL

Community Health Centre (Domovi narodnog zdravlja, DNZ) was an original concept in organization of primary health care. The first root of that concept one can trace more than 90 years back (1921), when the first health centres were organized as an active part of "hygienic services" (A. Štampar) in the former Yugoslavia. They had the following departments: for **hygienic education and propaganda**, for epidemiology and for "social medicine", i.e. preventive services and integrated (dispensary) care for priority risk groups and "social" illnesses (maternal and child health, school hygiene and malaria, tuberculosis, venereal diseases, trachoma et similar). The principle of "dispensary medicine" was integration of prevention, social support and curative medicine. DNZ covered one or more districts, operated health posts in small communities, and were responsible to regional hygienic institutes. In Yugoslavia in 1940 were 10 institutes of hygiene, 51 DNZs and 159 health posts, out of them in Croatia 2 hygienic institutes, 12 DNZs and 53 health posts, a small number for more then 600 local communities. Principal source of financial resources was state budget with only some examples run by health cooperatives. Major change started in 1948 when new health centres ("Domovi zdravlja", DZ) financed through health insurance was organized. They incorporated all out-patient services at the primary care level, including previously private general practitioners and all special dispensaries working for a short time as self standing institutions. The Law on organization of health services 1961 established them as "self-managed organizations", founded by commune and financed through compulsory health insurance. They continue to contribute to health education but started also during sixties to participate in medical education (undergraduate and postgraduate) for nurses and physicians. The DZ were, besides, the cradle of a new specialization of General/Family Practice in 1964 and remained the most important basis for organized postgraduate teaching and research in primary health care. In 1974 health insurance was decentralized to the communal level. At that time health centres were expected to deliver comprehensive primary care based on dispensary type of work. They were either self standing organizations or merged with all other health units in a district,

i.e. also with specialized medical services based in outpatient departments of hospitals. The regular technical meetings of professionals in best of DZ contributed to development of a system of permanent vocational education. During the 30-years period of 1961-91 the numbers show restructuring of organizations and an increase of DZs in comparison with the MCs and particularly with the independent smaller heath posts (Zdravstvene stanice", ZS), Table 2.

Table 2. Number of medical centres (MC), Health centres (DZ) and Health stations (ZS) in Croatia in 1961, 1979 and 1991

Year	MC	DZ	ZS
1961	16	43	154
1979	25	63	57
1991	25	98	10

The average size of individual health centres was also rising so that in 1991 only 47 DZ have been staffed up to 19 physicians, 14 DZ employed 20-39 physicians and 18 more than 40 physicians. Of them 5 had even more then 90 employed physicians and two more then 200. The false philosophy was that big organizations are more efficient. However, the opposite was true. The "soul" of an original "home of health" was lost. Team work was replaced by bureaucratic management and control. The additional contribution by local community diminished, what combined with general economic crisis lead to dissatisfaction of health worker and consequently clients. The analyses showed that integrated approach to health care was successful around general practitioners only in small DZs, but preventive and social aspects were poorly treated in big organizations, where prevailed polyclinic treatment. The participation of people and close relation with community were also disrupted and formally performed only on "higher" administrative and political levels. This was the way how the last days of self-governing socialism demonstrated inefficiency in Yugoslavia. During the severe aggression on Croatia after partition of Yugoslavia 5 MC and 21 DZ were destroyed, but the decentralized system and devotion of health professionals contributed to successful protection of people. After the war, during the time of transition, the main solution for described weak points of DZs, otherwise adequate organizational pattern of primary health care, was found in "privatisation". The preventive services and important public health nursing became part of centralized state public health services, and teams of general practitioners persuaded to start independent ("private") contractual relations with the Croatian state health insurance. Previous DZ in that way remained only an administrative shell caring for premises. The integrated approach to health care remained only a traditional attitude of some of general practitioners and some of MCH and school dispensaries. It happened right in time when in many developing and of the most developed countries ideas of group practices and small health centres became popular.

The case is interesting because demonstrates how socio-political and cultural factors influence not only public health principles, but also organizational patterns. Besides, the health technology based on human relations obviously is suffering from big organizational structures.

EXERCISES

Task 1. A changing world: first think about necessity and available resources

Your task is to write:

a) Mission statement of your organization;
b) Vision statement of your organization.

Mission is declaration of existing general objectives and principles of operations of an organization, and vision outlines what the organization wants to become. Both have to include purpose, accepted values, specificities (what distinguishes them from others), responsibility toward members, clients and society.

Consider external situation and needs:

- Important leads in economics: producing or selling, innovations and role of research and learning in economic development;
- The waves of socio-political changes:
  - Egalitarian and libertarian issues - globalisation/neo-colonialism (look for broader context of social policies);
  - Technicism/humanism, quality/equity ("Panakea" or "Hygiea" in health tradition);
  - Individualism/communitarianism (individual or personal liberty and social justice).
- Suggested middle way solutions:
  Sustained development policy, human rights promotion (supported by humanistic and religious organizations) – are they realistic solutions?

Consider internal situation and needs:

- Collaborators' expectations and interests: genuine or pretended (instrumental). What is needed: diversification or homogenisation, centralization or decentralization?
- Social concern: What is more important? Quality or Equity (practice guidelines based on Evidence Based Medicine or professional autonomy, scientific rigidity or social sensitivity and flexibility?
- Management issues: How to stimulate pro-active attitude and change from stale health administration (order) towards management of services (best use of resources), and further to entrepreneurship (opening new opportunities) in the health system: research, education, practice.

Consider <u>own intentions</u> (be honest and look for own interests):

- Would you really like to become an innovator or would you prefer to remain hidden performer, protected in an administrative system (how much are you afraid of uncertainties);
- In which way you would like to strengthen your leadership? (authoritarian way, democratic, broad-minded participatory way, or laissez faire direction);
- Are you ready to accept risks of innovations? Do you have any political expectations or ethical issues limitations?

Consider type and characteristics of necessary change:

- Essential characteristics
  - **novelty**: transferred or original idea (your imagination is decisive);
  - **intensity**: reforms or radical solutions (masked or open, step by step or great leap);
  - **horizon**: short-term or long-term: results visible at once or later;

- **target:** organizational or functional, described in terms of **4P** (M.Morgan)**:** **P**rocedures/**P**eople/**P**rocess/**P**roducts
- **support** you will need (tolerance, acceptance, commitment) and from whom;
- **expansion method** you are planning (by diffusion, through further problem solving, research and development process).

- Estimated necessary resources and feasibility of change.
- Estimated time for implementation and first results. Be realistic, according to experience of some economists (D. Salamon) the time needed for change in technology is **3-5 years**, in the market behaviour and habits of people **8-10 years**, in management **10-12 years**.

The criteria for assessment of your written statements will be:

1. clear and easy understandable (not ambiguous);
2. realistic and rational (not just idealistic jingle);
3. socially, ethically and culturally acceptable; and
4. memorable and vibrant (not bureaucratic and dull).

What you have learned during this exercise?
Reflect on your experience and discuss it with colleagues.

Task 2. Big issues of "small" ethical problems in routine health practice

One may argue that all ethical problems are "big", because of their gradual but growing influence on identity and moral personality of professionals, the trustfulness of whole profession and behaviour of people. They are usually a slippery slope between normal, traditional and "expected" behaviour and corruption of basic moral conventions. Sometimes people do what is far from their declared principles. The best way to learn about ethics is not to know by heart principles, but to discuss the experiences of daily practice.

Your task is to "discover" the main daily ethical problems in health practice you know, discuss the reason they are present and how one may prevent them to reach the risky level. To list them you may first reflect on the following short (and oversimplified) stories (cases).

Case 1. Confronting interests

"I may trust only in tests done in laboratory where I can supervise the quality of work. You have been already in two other laboratories, but you can see that results, although falling in the same range, slightly differ. This is the reason that I have to ask you to repeat the tests and this time in laboratory I am supervising. New results will not necessarily change your treatment and the diagnosis may remain same, but it is better to test again and be sure and safe. If you do not follow my sincere recommendation, I believe you better find another doctor!" said the doctor who is a famed specialist.

What the patient will do?

Case 2. Restricted choice

An elderly woman with osteoarthritis of her knee is trying to find a new doctor, because two previous doctors she consulted recommended her almost only to observe diet and

reduce weight, and did not listen to her experience of beneficial massage with an ointment she has forgotten name. They also repeatedly insisted on physical therapy in spite of her complaint to the health administrator. They offended her because she is sure they would listen to her more carefully, when she could pay them some money.
The third doctor who was asked to take her on his list refused her telling that his list is full.

Case 3. Hidden external influences

After talks with the representative of a well-known pharmaceutical firm the physician was persuaded that a new drug for diabetics type II would be better for his patients and he decided that all of them should change therapy and use the new recommended drug. Because of his interest the representative of the firm decided to facilitate doctor's attendance to an international congress in Rome, paying him the air ticket.
Has doctor accepted that offer?

Case 4. Ethics of public programs

The public media announced invitation to all women over age 40 to report for a mammography test for early diagnosis of breast cancer. The procedure is safe and life-saving they stated, and all women with positive and suspicious results will be immediately advised to find an expert for further treatment. For those who cannot pay for further treatment there would be a chance to get help by charity organization.
Is it correct that the invitation does not tell anything about possible drawbacks?

Case 5. Priorities

A policy is discussed about the way to arrange the list of priorities for some surgical treatments in short supply. The usual points are discussed: to keep strictly and only the order in which patient came to ask for treatment or would it be necessary to look for some additional facts. Under discussion were: judgment of relevant experts about medical factors (e.g. urgency, expected best results), age and gender, familiar conditions (e.g. number of dependents), other social factors (socially recognized important people, experts, creative artists, national symbols etc.), and sponsors able to materially contribute to the development of similar services by additional equipment or training of health workers.

Although the group was aware that the existing practice will not be in accordance with principles of their choice, they agreed that only the order of coming and age of patient (younger have advantage) may be used as criteria of priority. Was this a correct decision?

Case 6. Informed consent

The informed consent of patient is important and the requirement was introduced that patients should sign a printed statement before a number of important medical procedures. Asked to sign such document, an elderly man asked for 2-3 days time to consult members of his family. It was explained to him that it should be a personal decision and a shorter time can be given to him for thinking it over, but the final decision has to be his own. After explanation the man refused to sign.
Was anything wrong in described procedure?

Case 7. Life is multi-dimensional

A middle aged man, worker, living alone, with chronic respiratory problems was frequently coming to his doctor for new drugs and few friendly words. One day quite unexpectedly he brought a sum of money, not complaining and not asking for anything, but telling to the nurse and doctor who came into the nurse's room, that this money he

prepared for them. Surprised doctor and nurse felt offended, because they never asked money from their patient, and asked "But why are you doing this, have we not been always kind with you?" "Indeed, and this is the reason that I brought to you this small amount of spared money." The doctor and nurse refused money and after a short argument patient took the money back and left. After several days the doctor and nurse heard from neighbours that the man committed suicide.
The life is multi-dimensional and simple rules are not always adequate.

Case 8. How to assure equity

How to decide whether a health unit is contributing to health equity among people? Obvious answer is that (a) no cases of discrimination are recorded. This is, however only the peak of the iceberg. To be confident about the sustainable fight against inequity there must be fulfilled also other conditions (b) like guaranteed universal access, regardless of personal characteristics, physical and geographic restrictions, ability to pay et similar. (c) Adequate knowledge and skills, empathy, and concern of professionals for patient, i.e. style of work are an additional but probably the most important prerequisite. The additional requirement includes (d) personal relations, observing privacy and dignity of people, understanding of cultural and social differences. Even more is required by the further task: (e) full responsibility and participation in the process of health care both by health professionals and patients. The crucial measure (f) would be advocacy of health needs of people in front of higher authorities and fair distribution of resources among the broader scope of other services, representing the disadvantaged and handicapped people. Proactive attitude is the most difficult additional duty requiring political skills and full engagement in the life of community. It is partly out of reach of local powers, but without raising that voice the chances for benefits remain doubtful.

Using the described scale try to estimate how is a certain health unit you know contributing to equitable health of people.

Case 9. Inequity as avoidable inequality

In a school all children are treated equally (school lunch, physical activity, learning conditions), but their health, growth and development, never end as equal and they are disappointed. In another school the children are treated in an equitable way and their health, growth and development have a tendency to be comparable, and they feel satisfied. illustrate what is happening in these schools and how you understand difference between equality and equity.

Case 10. Ethical intervention ladder

There are always many complaints that the general conditions, state policies, role of industries, media and other parties are responsible for poor health care. Should public health programs organized or supported by state persuade people to start participate in health programs and coerce adults to lead healthy lives (by anti-smoking laws, traffic regulations etc.), actively intrude into personal and familial life. Or, opposite, has state be just a careful observer, simply monitoring the current situation, provide information, enable healthy choices, providing incentives for healthy behaviour, and restrict and eliminate free choices of people only in cases when the health risk of others is endangered along what is called the "intervention ladder".

Look for "stewardship model" of public health application of ethical principles (Nuffield Council on Bioethics. Public health: ethical issues. A guide to the report, 2007. Internet: www.nuffieldbioethics.org)

The criteria for assessment of your result: (1) Your awareness of hidden "small" ethical problems in practice, (2) Demarcation of ethical problems: personal and professional, balancing interests of professionals and those in need, formal consent and free decision of choice, quality and costs of medical procedures, equity and equality, (3) Group reflection on origins of unethical behaviour, and ways to prevent it, (4) Group opinion on intervention among colleagues (e.g. in case that one of colleague is alcoholic, corrupt, prone to fraud patients, unacceptably poor in knowledge and skills).

What you have learned during this exercise?

Reflect on your experience and discuss it with colleagues. Learning by reflecting life stories as opposite to learn principles.

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