Evidence-based management of Caribbean health systems: barriers and opportunities

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Abstract

Purpose – The purpose of this paper is to explore and assess barriers and opportunities for evidence-based management (EBMgt) and decision-making in healthcare systems of the small island developing states (SIDSs) of English-speaking Caribbean.

Design/methodology/approach – The study utilized grounded theory to collect and analyze data on experiences and perceptions of 20 senior managers/leaders from seven Ministries of health in the region. It used semi-structured, in-depth interviews comprising open-ended questions. Data analysis comprised open, focused and theoretical coding.

Findings – EBMgt and decision-making is not a prominent approach taken by top officials of health systems because of internal and external barriers to its use. Indeed the absence of a culture of decision-making based on evidence pervades the public services of Caribbean island states. Notwithstanding, there are opportunities for meaningful application of this management/leadership strategy.

Originality/value – To the author's knowledge, this is the first assessment of the application of EBMgt to health systems of SIDSs of the Caribbean. This paper is concerned with the approach to decision-making in health systems across island states and lends support to the use of evidence in decision-making and policy development. It provides useful direction for policy makers, and senior managers/leaders of these systems.

Keywords Evidence-based policy, Health systems, Evidence-based decision-making, Small island developing states (SIDSs) of the Caribbean

Paper type Research paper

Evidence-based management (EBMgt) and practice is currently well known in many areas of professional practice. It has become the approach of choice in various management and professional fields of endeavor including clinicians, managers, policy makers and researchers in health services (Walshe and Randall, 2001). Given that the need and desirability for evidence-based decision-making has largely been established for a variety of healthcare-related decisions, there is significant and robust confirmation of its use and benefits (Walshe and Randall, 2001; Steinberg and Luce, 2005; Arndt and Bigelow, 2009; Garretson, 2015; Bongers, 2015). Yet, the argument remains that in small island developing states (SIDSs) of the English-speaking Caribbean, EBMgt and evidence-informed policy (EIP) are manifestly wanting.

This paper comes out of a larger study on the management/leadership of health systems of SIDSs of the English-speaking Caribbean conducted in 2013. Its ultimate aim is to assess barriers and opportunities to implementation of EBMgt and EIP.

Small Island States of the Caribbean

The Caribbean comprises 15 independent nations referred to as the Caribbean Community (CARICOM) with a population of over 7.1 million. They are Antigua and Barbuda, The Bahamas, Barbados, Belize (the only CARICOM country that is not an island), Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St Kitts and Nevis, Saint Lucia, St Vincent and the Grenadines, Suriname and Trinidad and Tobago (Caribbean Community, 2011)[1].

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In total, 12 of these 15 member states feature in this study. Montserrat, a non-independent state which forms part of the UK Overseas grouping[2], is not included. Haiti and Suriname, in the main French and Dutch-speaking territories, respectively, are also not included.

EBMgt

Meaning and significance

EBMgt refers to the translation of principles based on research evidence, into organizational practices (Rousseau, 2005). Evidence-based decision-making can be defined as "Making decisions through the conscientious, explicit and judicious use of best available evidence from multiple scientific sources." (Sackette *et al.*, 1996, p. 71). In order to accomplish this task, information from stakeholders of the health system, science and professionals is necessary (De Roo, 2015). Bongers (2015) elucidated this strategy of evidence-based decisions as trans-disciplinary, where integration of disciplines is considered to be central, requiring critical and reflective thinking and the use of the best available evidence. This multidisciplinary approach exposes health systems to a suite of expertise and different forms of evidence that can positively impact decision-making by senior managers within health systems. For Rousseau, such decisions have to be informed by social science and organizational research in order to reduce reliance on personal experiences in preference to systematic knowledge.

EBMgt recommends the use of good scientific practice of systematic research syntheses in management and organizational research (Rousseau *et al.*, 2008; Walshe and Randall, 2001). Efficient and effective management of health service delivery either at an institutional micro level, or larger, organizational/systemic or macro level, requires such an orientation. Several experts have alluded to the importance of systematic research syntheses in evaluating a field's knowledge claims, quality control, threats to integrity, and avoidance of the loss of knowledge (Walshe and Randall, 2001; Rousseau *et al.*, 2008). It can therefore be concluded that the practice of EBMgt essentially represents a combination of critical thinking and use of evidence from several sources to promote the likelihood of favorable outcomes.

Literature on EBMgt is critical of an organizational and administrative approach devoid of evidence-based research in healthcare systems and organizations. Reasons proffered for such an outlook are the imminent danger of the overuse, misuse and underuse of information which can ultimately have implications for well-being of organizations and their efficient management (Arndt and Bigelow, 2009; Chan *et al.*, 2004; Walshe and Randall, 2001).

There is a strong affinity between evidence-based healthcare and management. Arndt and Bigelow (2009) who promoted EBMgt as being a potentially exemplary decision-making process, argued that its practitioners had the benefit of generalizing its results across organizations and systems. Arndt and Bigelow stated that EBMgt mirrored the assumptions of evidence-based medicine in regard to the latter's systematic application of the best available evidence to evaluate managerial strategies. Managers would need to routinely review findings of relevant research studies and research syntheses before making important decisions.

Quality health services and EBMgt – the nexus

A connection potentially exists between EBMgt and quality healthcare delivery. Kurz (2010) confirmed this in his observation that knowing what works requires information on efficacy and effectiveness of various procedures and processes in healthcare systems. In a technical and managerial context, it refers to discrete technical and managerial methods that include systematic examination of processes used in delivery of services, operations research,

teamwork assessment and improvement (Leatherman *et al.*, 2010). Improvement in quality ultimately relates to optimal use of measurement and statistics in daily work, benchmarking, as well as participative management techniques in the system.

The Institute of Medicine (Committee on Quality in Health Care in America) (2001) advanced the view that quality of care is a measurement of the degree to which health services for individuals and populations both increase the likelihood of desired outcomes and are consistent with current professional knowledge. Haughhom (2014) argued that this notion of quality is synonymous with evidence-based care. Indeed, while quality is more than providing care that is supported by science, evidence-based medicine and management decision-making is the foundation on which quality measurement and improvement can be effected.

General impediments to practical implementation

There are serious challenges to practical implementation of principles of EBMgt Some of these challenges include widespread variations in healthcare management practices that present significant barriers to the notion of the EBMgt and time constraints and deadlines that restrain transition from evidence-based theory to praxis (Walshe and Randall, 2001). Other challenges include excessive amounts of research currently in existence and the speed with which new information is churned out (Rousseau, 2005); differing cultural and political assumptions regarding the appropriate approach and emphasis to observing relevant aspects including management, organization and markets, as well as institutions and systems in which they are embedded (Rousseau *et al.*, 2008). The situation is intensified by rivalry among professionals seemingly vying for institutional support, legitimacy and scarce resources.

The issue of standards across health systems is also a concern. Walshe and Randall (2001) lamented that standards being promoted in the clinical world of organizations and systems were not being replicated across the spectrum of decision-making by various health professionals. This implies that there is need for imposition of the same standards on the decision-making process in the area of healthcare management (Hyder *et al.*, 2011). It means that standards and quality that are encouraged for doctors, nurses and other healthcare professionals should be equally adhered to, so that there could be greater uniformity in decision-making.

Need for a culture of research and facilitative organizational culture

The importance of a research culture as a precondition for evidenced-based policy making is highlighted in the literature. Hyder *et al.* (2011) revealed that informants in their study of low- and middle-income countries acknowledged this claim. Given the current organizational and administrative culture of health systems, evidence-based decision-making would require a major shift in the operations of health systems as well, where central capacity weaknesses in the form of integration of services also feature as constraints. This observation has been reinforced by de Savigny and Adam (2009) who noted an absence of a wide range of functional data platforms and monitoring systems that could provide the latest information on health subsystems and continuing health and health-related initiatives. They further observed weaknesses in essential, everyday data collection systems including health information and financial management systems.

Lack of capacity

The capacity of health managers/leaders and those who lead policy decisions has come into question. As highlighted by Hyder *et al.* (2011), there is a seeming lack of sufficient grounding in technical areas. This is compounded by an absence of technical advisors or a technical team to assist in making decisions.

Absence of communication and dissemination infrastructure

Communication and dissemination infrastructure is seen as important so that policy makers can gain access to available research. Hyder *et al.* (2011) stated that a significant barrier to access to research was its ineffective and inadequate communication. Kronenfeld (2014) perceived part of the challenge today as the inability to distinguish reliable from unreliable sources of information.

Opportunities for use of an EBMgt strategy

Notwithstanding the aforementioned impediments to practical implementation of EBMgt, there is growing awareness among researchers and policy makers of the need to undertake research to improve management decisions and performance of national health systems. Abassi (2004) has outlined a number of events that have all converged to produce a positive effect in this direction, thus impelling progress. Developments included the international development community Health Research Summit held in Mexico in 2004 and subsequent calls for further exploration of research into policy formulation. The identification of the need for further exploration and policy formulation was in turn strengthened by recognition of the need for engagement of policy makers in health research and more surveys of decision-makers on the international front. Low- to middle-income countries including Argentina, Egypt, Iran, Malawi, Oman and Singapore have revealed unequivocal support for health research and the high value that policy makers place on such research (Hyder *et al.*, 2011).

The purpose of this paper is to explore and assess existing barriers and opportunities for EBMgt and decision-making in healthcare systems of SIDSs of the English-speaking Caribbean. Barriers include general impediments such as time constraints and deadlines that restrain transition from evidence-based theory to praxis, large amounts of research and the speed with which new information is churned out. Standards across health systems also feature as constraints. Specifically, one has to take into account lack of capacity, and the absence of communication and dissemination infrastructure. In the area of opportunities for use of an evidence-based strategy, there is the emerging development of acceptance of need among researchers and policy makers to which must be attributed, developments in the international and regional community.

Methods

Participants

The chosen method of data gathering and analysis was grounded theory. Processes, actions and interactions were determined from the views of senior officials of MOHs. An understanding of management/leadership techniques of health systems employed by these top officials were generated on the basis of interpretation of that data. In addition, grounded theory assisted the researcher in capturing transitory thoughts and immediate questions from provisional interpretations in coding and memo writing, to actual completion of the study. This helped give concrete form to ideas analyzed from themes and categories generated from the data.

The sampling strategy used was theoretical sampling. Theoretical sampling entails an approach that facilitates the building of theory (Patton, 2002; Charmaz, 2006; Creswell, 2007). A sample of 20 senior officials comprising seven ministers for health, seven permanent secretaries and six chief medical officers across 12 island states in the region participated in the study. Participants were chosen on the basis of their experience and expertise in managing health systems and were thus able to provide the best data available (Glaser and Strauss, 1967).

Data collection methods

All potential participants were informed of the study and invited to participate via telephone and e-mail. In-depth interviews were used to gather information from participants who

expressed willingness to take part in the study. A semi-structured in-depth interview schedule was prepared for this purpose and issued to a panel of national and international experts for review (see Appendix). The instrument was revised and field tested for reliability and validity among ministry of health personnel in the region. Open-ended interviews were conducted with all respondents during regular working hours at the offices of the ministries of health. This open-ended approach elicited interpretations of participants' experiences, tapped into details and sought clarification in an attempt to obtain accurate information. Charmaz (2006) contended that open-ended questions have the benefit of engagement in detailed discussions with participants, potentially yielding unexpected anecdotes and statements. Data collection lasted approximately five months with 20 participants having been interviewed in seven of the SIDS of the English-Speaking Caribbean. By this method of grounded theory, the researcher was able to ground his conclusions in whatever was observed or gleaned from senior managers/leaders, thus drawing from their rich experiences in managing/leading their health systems.

Data analysis

An integrated approach of theoretical sampling, data collection, coding and analysis was used. The simultaneous exercise of data collection, coding and analysis of information has been highly recommended by grounded theory experts Strauss and Corbin (1998), Charmaz (2006) and Glaser and Strauss (1967). Based on this recommended strategy, data were analyzed after the very first interview was completed and transcribed. This process continued with every succeeding interview as a means of identifying emerging themes and categories.

As part of the process of data analysis, new codes, categories and concepts were compared and contrasted. Memo writing was also used to first clarify what was happening in the area of management/leadership in the MOHs, followed by expediting analysis of ideas emanating from the data. Memos were also used to assist with comparison between data and deriving meaning from that data. Credibility of the study was established by member checking, peer review and analysis of discrepant data (Creswell, 2007).

Results

Demographics

In total, 20 participants comprising seven ministers for health, seven permanent secretaries and six chief medical officers from seven countries were interviewed. In total, 15 revealed that they did have former management training. In total, 12 had experience in both the private and public sectors of the health system, with the number of years spent as senior managers/leaders in the health system ranging from eight years to five months.

Perceptions of top officials on evidence-based decision-making

Open-ended, in-depth interviews with top officials revealed that decision-making was not strictly evidenced-based in healthcare systems across the region. Instead, decision-making revealed a pattern that largely took the form of a combination of anecdotal evidence, observations, ability to make judgments and feedback received from colleagues on various issues. These elements characterized an approach that could best be described as intuitive decision-making. On the positive side, this approach also features self-confidence on the part of those who made decisions in the system and their need to be assertive and take calculated risks. Such risks have to be considered against the backdrop of the intricacies of a complex and dynamic health system. Top managers/leaders stated that taking decisions in the system takes into account several dimensions such that:

> […] Sometimes you listen to intuition; something tells you that […] this doesn't feel right, so for me it's a mix of all those things.

Thus, rather than an evidence-based strategy of decision-making and policy formulation, top officials across ministries of health adopt a discretionary style that leans toward informal decision-making which in part comes for the constraints that they face in the system. In this regard, the documentation and formal recording of decisions made or actions taken depend on top officials' judgment of the significance of results and the likely implications to follow.

They, however, conceded that the failure of embedding decisions in the collection, interpretation and use of data was a major constraint. Top officials therefore acknowledged that evidence-based decision-making was critical for effective management and timely decision-making in the system but revealed that there were internal and external barriers to such an approach.

One top manager/leader put it this way:

> We have to be able to gather data, to be able to make informed decisions on a timelier basis.

Another lamented:

> I'm not satisfied at all with the level of evidence-based decision-making. I think we are not making our decisions based on evidence – not because the evidence is not there; but it is not presented in a way that we can […] actually use it because we have a lot of data and a lot of information but it's not being processed and analyzed and used for decision-making.

Timely interpretation of data was also perceived as critical to complex, dynamic health systems with top officials conceding that they constantly face the prospect of obsolete information. This inevitably affects both the quality of decision-making and the delivery of services. Such a connection between evidence-based decision-making and quality management was evident in the reflections of participants, as expressed by one top manager/leader:

> […] I say […] to my epidemiologist you know, with all the surveillance data from the hospital and from the community and this information is somewhere on his desk, and so it is no use to any of us; […] I need to be able to transfer this data […] he would get this information but it needs to be translated so we can make that kind of decision.

Top managers/leaders also demonstrated an awareness of the significance of integrating information and evidence from the public and private sectors, pointing out the shortcomings of the health information infrastructure. They identified such integration as an additional challenge in the use of evidence-based decisions and policy formulation. This is how one top manager/leader analyzed the state of affairs:

> I think we have serious challenges in health – the sector has serious challenges. Recognizing that health for the nation is provided not only by public sector, I think we have a major gap […] in understanding what the health profile is of the country because we have no mechanism that places an obligation on private health providers to subscribe to the data bases we have […]. I believe that our health information infrastructure needs immediate attention.

In addition to the imperative of using the available technology to facilitate the assembling and interpretation of information and evidence for decision-making, another prominent theme advanced by top officials was the notion that health systems ought to take into account all related considerations in making decisions pertinent to their operation and administration. They suggested that in addition to epidemiological concerns, the social, political, cultural and economic factors that impact health ought to be featured. Lamenting the limited time available to engage in such research efforts and the paucity of data-driven policy, the following excerpt adequately represents the sentiments of participants:

> When I look at the research part, people who occupy positions like mine in the system don't really have time for research as such; it would have been nice to have a little research unit. There is a lot

> going on, but […] we don't have the time to sit down and write up so that it can be shared and presented in that way. So I think the research part or the research skills, I haven't really been utilizing them […] like we have an epidemiology unit and the data that we get from there etc., it certainly assists; but to me at this level, its not to me data driven […] I mean there is a bigger picture; this is what the public wants; sometimes you have the political pressures; so its all marrying the picture.

Finally, top managers/leaders revealed that ad hoc relations with partners and stakeholders, a weak financial and human resource base, the vagaries of the political culture, absence of political will and an obsolete public service and administrative structure all conspired to further constrain an evidence-based decision-making approach to management and policy formulation.

In regard to opportunities for the use of the strategy of EBMgt, participants referred to emerging elements of teamwork, collaboration, consultation and networking within their ministries as opportunities for engaging the technique of evidence-based decision-making. They also placed much emphasis on recent developments in regard to the emergence of regional organizations and policy actions such as Universal Health Care and National Health Insurance that spurred national debate and concern over evidence-based decision-making and policy formulation before full implementation. Such developments they deemed critical to the use of this approach to managing and leading health systems.

Discussion

This paper sought to explore and assess structural as well as informal barriers and opportunities for EBMgt and decision-making in healthcare systems of SIDS of the English-Speaking Caribbean.

Barriers to EBMgt

The general literature on EBMgt records serious impediments to practical implementation of principles of EBMgt that can in large measure be applied to health systems of the SIDS. Senior officials in this study did identify time constraints and deadlines that restrain transition from evidence-based theory to praxis, excessive amounts of research currently in existence and the speed at which new information is churned out. They, however, placed more emphasis on those forces peculiar to health systems of the SIDS including the absence of a culture of evidence-based decision-making, timely interpretation of available data and shortcomings of the existing health information infrastructure. In addition, while past studies have emphasized the challenge posed by intense rivalry among professionals seemingly vying for institutional support, legitimacy and scarce resources, senior officials of health systems of SIDS perceived that such rivalry was superficial in the case of the SIDS. Instead, they highlighted the recurring and deepening problem of private/public sector trust deficit and the ever present value of suspicion that hinders private sector integration in decision-making. With all of the constraints featured above, senior managers/leaders of health systems of the SIDS would do well to heed the advice of Arndt and Bigelow (2009) who cautioned that given the complexity of decision-making, the healthcare environment, and intricacy of replicating results across systems and organizations, senior managers/leaders need to ensure that their decisions match expected outcomes.

Top managers/leaders also factored in the need for political will on the part of the leadership of health systems and the political directorate of these island states. This observation has been echoed by Dr Carl Theodore in a national health accounts stakeholder consultation and training workshop held in Grenada in 2015. He pointed out the lack of political will to carry out monitoring and evaluation so critical for providing information on realization of projected targets in the health systems. Writing in the context of the management practices of the public service of Grenada, an island state of the

Caribbean, Roberts (2010) lamented that one of the perceived realities of the public services is that decisions and policies based on evidence do not form part of the culture of decision-making. Indeed the requisite investment needed for health research and development (R&D) is not a feature of either the health governance or health finance landscape of SIDS. Moreover, there is little evidence of convergence between health R&D pursuits in the region and healthcare systems (Theodore, 2015).

This situation is mirrored in other parts of the world. Walshe and Davies (2013) suggested that in the wider context of the UK, there was diminished collectivity and reduced collective capacity for and interest in R&D. In the SIDS, not only is there a need for building an evidenced-based culture to form the foundation of decision-making and policy formation (Caribbean Commission on Health and Development Report, 2005; Greene, 2010), there is also a need to increase collaboration and sharing of information. Key agencies and institutions would therefore have to play significant roles in moving toward a more evidence-based managerial practice. These include: government agencies, the private sector, various professional associations at both local and regional levels as well as major educational institutions like the University of the West Indies and St George's University located in St George's, Grenada. This would in turn demand a new outlook by ministries of health, led by a change of attitude on the part of senior personnel toward research evidence and the research process.

Scope for evidence-based decision-making practice in health policy and management by SIDS is limited because of the apparent research-practice gap in health policy and management that warrants the use of EBMgt. Ministers, permanent secretaries and chief medical officers admitted that failure to embed decisions in the collection, interpretation and use of data served as a major impediment to effective and efficient decision-making.

The current study also found the absence of timely and appropriate interpretation of data and adequate analysis of existing information. Top officials attributed this to a lack of expertise and systems in place to facilitate such activity. Dr Theodore (2015) bewailed the weak statistical capacity of island states and the inferior nature of health statistics citing such areas as mortality, infant mortality and morbidity rates, as well as the lack of national health spending surveys.

Until recently, demonstration of the lack of interest on the part of governments, policy makers and managers themselves has been an even bigger challenge. The Caribbean Public Health Agency (CARPHA) – a new single public health agency of the Caribbean which was established in 2011, and began operations in 2013 – corroborated these claims by senior management revealing that a former regional health institution found that governments across the region generally lacked the capacity to interpret, assess and use research for health policy decision-making. More importantly, the type of research needed for this type of decision-making was not being conducted (CARPHA, 2015). This state of affairs is not, however, peculiar to SIDS of the region as other parts of world including developed countries point to such features (Chan *et al.*, 2004; Rousseau *et al.*, 2008; Walshe and Randall, 2001). As recognized by Walshe and Randall (2001), EBMgt would require a more deliberate policy on the part of governments in the region, as well as increased investment in research and dissemination infrastructure.

Central capacity constraints in the form of integration partnerships and the absence of communication and dissemination infrastructure featured as constraints in past studies. Senior officials in this study alluded to inadequate data collection tools, disconnected systems of data collection, late submission of data, incomplete data, errors in compilation of data, duplication, and loss of records due to poor storage and reluctance of the private sector to provide health systems with information. These elements contribute to poor quality and availability of data.

This study also recorded weaknesses in essential, everyday data collection systems which included health information and financial management systems. It would therefore

appear that good quality health system data for basic health service reporting across island states in the region is lacking. This serves as a hindrance to not only high-quality evaluations, but also monitoring and evaluation of health systems' basic functions. There is an urgent need for systems to invest in procurement of quality data critical for more efficient and coordinated efforts in improving health and health systems.

As suggested in the extant literature, senior officials admitted a lack of sufficient grounding in technical areas. This calls into question their own capacity to lead policy decisions. They further disclosed the absence of technical teams and advisors to assist in making decisions.

Opportunities for EBMgt for SIDS of the Caribbean

Studies have clearly demonstrated the significance of international/regional developments and events in spurring consideration of EBMgt (Abassi, 2004). Participants in this current study did replicate such considerations highlighting the critical role of international and regional entities such as the World Health Organization and the Pan American Health Organization. Demonstrations of this development are evident in strategic plans for health of several island states across the region (Grenada National Strategic Plan for Health, 2015) where national health information systems are being promoted as one of the six building blocks of health systems under the WHO "Framework for Action." During the launching of Grenada's National Strategic Plan for Health: 2016-2025, national health planner Clement Gabriel of the ministry of health and social security of Grenada stated that the intention is that health systems can "ensure the production, analysis, dissemination and use of reliable and timely information on health determinants, system performance and health status" (Gabriel, 2015). Participants also welcomed agendas of Universal Health Care and National Health Insurance – now under active consideration by several island states across the region. In their estimation, these two developments have also played a key role in leading debates that have focused on the dearth of information for informed decisions in these strategic directions (Grenada Universal Health Care Plan, 2015).

Top officials also alluded to the establishment of The Evidence Informed Decision Making Network of the Caribbean (EvIDeNCe), launched on June 24 2015 by CARPHA, as a further opportunity to develop this ethos of decision-making. With the objective of "provision of accurate, reliable, timely and relevant public health information" in keeping with CARPHA's own mandate (CARPHA, 2015), senior officials including policy makers and researchers have all joined voices in relishing the possibility of accessing information to inform their decision-making needs through evidence briefs and organized dialogues with relevant stakeholders.

Conclusion

This study lends strong support to the fact that evidence-based decision-making is desirable but requires a major shift in the operations of health systems and entire governmental operations today. Given the historical, political/cultural decision-making realities that govern current public services practice in the region, health systems would be hard-pressed to apply its seemingly cumbersome demands. The process of transition would require the following approach outlined by Haughhom (2014) at both the national and regional levels:

- a systematic approach to data acquisition across health systems;
- standardization of measurements, calculations and definitions;
- implementation of well-designed analytic infrastructure, automation of information distribution and ability to discern trends in data; and
- integration of evidence into policy and decision-making within health systems.

Notes

1. In April 1973, the then heads of government of Barbados, Guyana, Jamaica and Trinidad and Tobago agreed to sign an accord called the Georgetown Accord in Guyana establishing CARICOM – the Caribbean Community. By May 1, 1974, other island states signed up, with Antigua and Barbuda and St Kitts and Nevis signing up by July 1974.
2. Montserrat is part of the United Kingdom Overseas Territories (UKOTS).

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Appendix. Sample questions

Grounded theory interview questions about management/leadership of SIDS' healthcare delivery systems

Questions about top managers'/leaders' general perceptions and experiences related to the management/leadership of the healthcare delivery systems of the SIDS.

The job

(1) Tell me about your previous experience in the public/private sector:

- How have the experiences prepared you for your current role as Minister/PS/CMO?

(2) Tell me about how your educational background/training has contributed to your current role in the MOH?

- What aspects of the training do you use?
- How easy is it to use this training?
- How difficult is it to use this training?

(3) Tell me about what you do as Minister/PS/CMO?

- For how long have you been in this particular role?
- What are some of the most important lessons you have learned during this period?
- Take me through a typical day in your role as Minister/PS/CMO.
- What are some of the support systems that facilitate your role as Minister/PS/CMO?
- What are some of the functions you perform as Minister/PS?CMO?

(4) Which of these functions do you consider the most critical in your current position?

- Tell me what you would consider to be your most difficult functions.
- Tell me what you would consider to be your most unproblematic functions.
- Tell me about some of the hard decisions that you have had to make as Minister/PS/CMO.

(5) Tell me about the challenges you face as Minister/PS/CMO in this MOH.

- Which of these aspects are the most challenging for you in the MOH?
- What strategies do you use to overcome them?

(6) What are some of the issues outside of the MOH of this country that affect decision-making within this MOH?

- Which of these issues appear to be the most significant?
- How have you been able to deal with these issues?
- Who are the other stakeholders involved in the delivery of healthcare in this country?
- Describe the relationship that exists between the MOH and these stakeholders.
- Describe the aspects of this relationship that can be improved.

(7) What are some of the issues/events outside of the country that affect decision-making within the MOH?

- Which of these issues/events appear to be the most significant?
- How have you been able to deal with these issues?
- Who are the stakeholders outside of the country that impact the delivery of healthcare?
- Describe the relationship that exists between the MOH and these stakeholders?
- Describe the aspects of the relationship that can be improved.

(8) Who are the other top management/leadership persons in this MOH with whom you work?

- Describe your relationship with each of them in turn.
- How do you communicate with each of them in turn?
- What do you enjoy most about working with fellow managers/leaders in the MOH?
- What do you enjoy least?

(9) Tell me about how you go about making a work-related decision.

- How many persons work in your department?
- How many persons do you supervise directly?
- How do you incorporate staff in decision-making?
- How would you describe your relationship with your staff?
- How do you communicate with them?
- How do you resolve conflict in the department?

(10) How satisfied are you with your performance?

- What do you enjoy most about your role?
- What do you enjoy least?
- Tell me about the aspects of the job that you like.
- Tell me about the aspects of the job that you do not like

Reflections

(1) Tell me what you have learnt in your capacity of Minister/PS/CMO in this MOH.

- Looking back on your initial period on the job, is there anything you would have done differently?
- Is there anything you would not change?

(2) Tell me the competencies/capacities that you need to make you a more effective Minister/PS/CMO.

- Is there anything specific that you think would enhance your capacity as Minister/PS/CMO?

(3) What recommendations can you give to improve the management/leadership capacity of the entire MOH?

- What resources and support do you think would enhance the management/leadership capacity of the MOH?
- What advice would you give to someone who has just been appointed to your position?

(4) Is there anything relevant and new that occurred to you during this interview?

- What else would you like to add that we have not discussed?

Thank You!

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