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Polish and UK doctors' engagement with hospital management

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Abstract

Purpose – The purpose of this paper is to present the findings of a short research project, conducted in 2010 as part of a larger EU funded action investigating the participation and impact of doctors in management. The authors sought to compare the ways in which hospital doctors in the UK and Poland – countries with distinct histories – participate in management; whether they are converging and whether the type of participation found results from changes in the governance and management of these systems.

Design/methodology/approach – First, a review of existing evidence and an analysis of policy documents and healthcare statistics were conducted. Identifying a lack of empirical data in the Polish context, and a potentially changing situation in the UK, the authors proceeded to collect some exploratory data in Poland, via interviews with expert informants, and to draw on data collected alongside this study in the UK from qualified doctors participating in research on management and leadership development.

Findings – Hospital doctors currently hold similar types of management role in both systems, but there are signs that change is underway. In Poland, different types of medical manager and role are now emerging, whereas in the UK younger doctors appear to be expecting greater management responsibility in the future, and are starting to take up the management training now on offer.

Research limitations/implications – The potential implications of these changes for the profession and policymakers in both Poland and the UK are discussed, with opportunities for further research highlighted.

Originality/value – The paper provides a comparison of how medical engagement within two systems with different histories is occurring, and also of the changes underway. It provides some much needed initial insight via interviews with expert informants within the polish system, which has been under-researched in relation to the involvement of medicine in management.

Keywords Engagement, Doctors, Market reform, Health systems, Medical manager roles

Paper type Research paper

1. Introduction

European health systems have undergone considerable change in recent decades, in terms of the way in which they fund, provide and govern services (Smith *et al.*, 2012). Mechanic and Roquefort (1996) have argued that whilst health systems are converging in their responses to similar technological, economic, demographic and scientific challenges, they are likely to exhibit differences due to their individual historical,

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political and social characteristics. Others support this, finding differences between countries based on their historical arrangements and the way in which professional groups respond to change (Kuhlmann *et al.*, 2009; Leicht *et al.*, 2009). The role that doctors, as a dominant professional group, play in relation to the management of health systems has been a source of great interest across nations (Dent, 2003; Jacobs, 2005; Kirkpatrick *et al.*, 2011; Saario, 2012).

The purpose of this study was to compare the ways in which hospital doctors engage in management within two health systems with very different backgrounds – Poland and the UK – and to identify whether similar reforms to governance and management arrangements have impacted on this and are leading to convergence. Medical engagement with management can be viewed in two ways, as participation in management and as enthusiasm for management (Ham and Dickinson, 2008). While our focus was on comparing the ways in which doctors participate in management and whether this was changing, we found that both the literature and our respondents associated this with doctors' enthusiasm for management. The two countries are interesting to compare, given that the UK was one of the early adopters of new public management reforms and practices (Hood, 1991) and is a "neo-liberal welfare regime" (Dent, 2003; Kirkpatrick *et al.*, 2005), whereas Poland was a later adopter, being an exsocialist/communist regime which now bears traits of both the UK neo-liberal and German corporatist models of health provision (Dent, 2003; Sagan *et al.*, 2011).

The paper is structured as follows. Our methodology is, first, outlined before we describe the funding, ownership and governance mechanisms of the two health systems and how these have changed in light of reforms. Our findings, including possible explanations for them, are then outlined. Finally, we discuss the implications of our work and the further research that is needed.

2. Methodology

Utilising a framework developed by Kirkpatrick *et al.* (2012) we began by reviewing Organisation for Economic Cooperation and Development (OECD) and World Health Organisation documents, to identify factors potentially impacting on the development of medical manager roles. These included: first, the overall structure, funding and expenditure on health by the two countries; and second, the organisation, training and contractual arrangements of doctors. A focused but thorough review of the healthcare management, policy and sociology of the professions literature was then conducted (Charmaz, 2006) using ABI Global, EBSCO Business Source Premier and Medline databases. The title and abstracts of seemingly relevant articles were initially read through for relevance.

Identifying a lack of empirical data on the participation of Polish doctors in management we proceeded to collect some exploratory primary data, in order to gain additional insight into the situation there. Adopting a theoretical sampling strategy (Gomm, 2008), we sought out expert informants involved in medical education and training, management and practice within the Polish health system. Whilst a greater wealth of data exists on the UK system, key reports from the UK context have adopted a similar expert witness approach (see, e.g. the Centre for Innovation in Health Management (CIHM), 2007; Ham, 2008; Hamilton *et al.*, 2008). Following their approach we conducted semi-structured interviews (King and Horrocks, 2010) in the first half of 2010 with experts known to the Polish author, including a manager of a public hospital, a CEO of a private hospital, the President of a Provincial Board of the Polish Chamber of Physicians and Dentists, a former Vice-Rector of a

University Medical College and the President of an Association of Non-Public Hospitals. Having also identified within the literature a potentially changing stance towards management amongst the UK medical profession, we also drew on interviews conducted alongside this study involving 22 qualified doctors (all within two years of becoming a specialist) participating in a study on management and leadership development (Hartley, 2012).

3. The UK and Polish health systems

The UK National Health Service (NHS) came into effect in 1948. It continues to be based on the original Beveridge model of a publically funded (via taxation) service, providing universal coverage, free at the point of use. Doctors were initially co-opted into the system from private practice, with guarantees of clinical autonomy (Kirkpatrick *et al.*, 2005), and were involved in the running of hospitals, as dominant members of decision-making teams, until the late 1970s (Harrison and Pollitt, 1994; Ackroyd, 1996). In Poland, until 1989 the country was under communist rule and the Siemaszko model prevailed, with central government responsible for providing a universal health service, free at the point of use. Doctors held clinical decision-making roles within hospitals, but like other professionals during this period they were poorly paid and their collective power was weakened, by virtue of physician chambers being banned (Dent, 2003).

Political change in the late 1970s in the UK, and a decade later in Poland, has led to change in both systems. In the UK, a neoliberal government came to power with monetarist policies and a desire to improve the productivity and cost effectiveness of the health system through management reforms, including the introduction of a managerial cadre mandated to make change (Kirkpatrick *et al.*, 2005). In Poland, the fall of communism in 1989 paved the way for a new system, based on the German model of funding through social insurance. In conjunction with this, responsibility for provision of services was devolved to regional and local governments (Boulhol *et al.*, 2012).

Despite different political orientations and funding mechanisms the 1990s saw a move to a greater market orientation in both countries, with the separation of purchaser-provider interests (for the UK see Ferlie *et al.*, 1996 and for Poland see Boulhol *et al.*, 2012). In the UK, primary care organisations have become purchasers of care, with hospitals the main providers. The private sector has gradually entered the frame as a provider of certain, mainly routine, services. Management responsibility of NHS hospitals has been devolved to hospital level, through the creation of NHS Trusts and Foundation Trusts, both of which are run by an executive board (Dopson, 2009). This move to Trust status has required the greater involvement of senior doctors in management (Ashburner, 1996; Thorne, 1994).

In Poland, a number of initial insurance funds were combined into one "National Health Fund" (NFZ) with 16 provisional branches in 2003, such that there is now one purchaser of health services. In terms of provision, while the private sector has entered the frame, only 5 per cent of Polish hospitals are currently privately owned (Paris *et al.*, 2010). "Public hospitals", which were once owned by central government, have, however, been passed to local governments and universities (Boulhol *et al.*, 2012). Around 30 per cent of them (at the encouragement of central government) have since been transformed into "non-public" entities, operating under the same legal framework as commercial companies (Sagan *et al.*, 2011). This raises questions as to how doctors might be engaging with management as a result of these new arrangements.

4. Findings

Overall, we found that doctors hold similar medical management roles in both countries. At executive level, while they may be CEOs, the role is not the preserve of doctors. Polish informants suggested that the CEO role there is increasingly held by non-medical personnel, and a recent report in the UK (Ham *et al.*, 2010) suggests that only around 5 per cent of CEOs there are medically qualified. In contrast, the medical director role in both countries is the preserve of a doctor, and also a board-level position. In the UK their influence appears to vary, with some medical directors having input into strategic decision making and others acting in a more advisory capacity (Kirkpatrick *et al.*, 2009), as they do in Poland.

At other levels within the respective hierarchies there are, however, more differences. In the UK, a unit-level role has existed since the 1990s in the form of Clinical Director, responsible for one or more specialities grouped as a clinical directorate. Predominantly held by a senior doctor (consultant) this role is a "hybrid" (Llewellyn, 2001), in being part-time and straddling both the clinical work and managerial worlds. There tends to be a "troika" type arrangement, similar to that seen at hospital level in Denmark (Kirkpatrick *et al.*, 2009; Dent *et al.*, 2012), with the Clinical Director operating alongside a business and staff manager, sometimes a nurse (Ferlie *et al.*, 1996; Dopson, 2009). Clinical Directors are responsible for service delivery as well as staffing, contracting and marketing of the directorate's services, having sizeable annual turnovers ranging from £15 m to £45 m per year (Audit Commission, 2007).

Such a unit-level role does not currently exist in Poland. Rather, "chiefs of ward/clinic" are the important medical management roles (Krajewski-Siuda and Romaniuk, 2008). These are similar to Clinical Director roles but on a smaller scale. The post is held by a senior doctor, reporting to a medical director, who is responsible for all ward operations. Some, but not all, chiefs also have responsibility for the financial standing of the unit. According to a hospital manager interviewed:

> […] where a system of internal budgeting exists there tends to be a greater focus on the financial performance of the ward [but] a lot depends on the personality of the chief, in terms of their approach to financial issues and their relationships with clinical colleagues and managers. There is no prior management training (Hospital Manager, Public Hospital).

Bonuses may be paid to staff and new equipment purchased if the ward budget is not overspent (Baczewski and Haber, 2010), which might explain a greater financial focus amongst those chiefs who have internal budgeting responsibility.

When it comes to enthusiastic involvement with the aforementioned roles, we found historical differences between the two countries. In the UK, the medical profession overall has long resisted managerial involvement (Harrison *et al.*, 1992; Ham and Dickinson, 2008; Hamilton *et al.*, 2008). While a few consultants have enthusiastically taken on the role of Clinical Director (Fitzgerald, 1994; Kitchener, 2000; Forbes *et al.*, 2004), many have been reluctant to do so (Dopson, 1996; Fitzgerald and Ferlie, 2000; Forbes *et al.*, 2004). Reluctance has been attributed, amongst other things, to a lack of management training and preparation for such roles (Forbes *et al.*, 2004; Fitzgerald *et al.*, 2006; Tooke, 2008) and the negative impact they have on both collegial relations (Fitzgerald, 1994; Thorne, 1997; Fitzgerald and Ferlie, 2000) and relations with general managers. For instance, a large survey of clinical and non-clinical managers found that Clinical Directors were the most dissatisfied with the clinical-managerial relationship, perceiving a lack of autonomy and involvement in management decisions (Davies *et al.*, 2003).

In the Polish case, a CEO we interviewed noted similar tensions between clinical and managerial staff, whilst other informants noted a similar lack of prior management training for medical managers and the importance to them of maintaining good collegial relations. However, a hospital manager interviewed also noted that Polish doctors have historically "tended to be attracted to the chief of ward role because of the influence that it gives them" (Polish Hospital Manager). A recent report supports this, suggesting that chiefs of ward have enjoyed a broad range of autonomy, being appointed for six years and often holding the role for longer (Sagan *et al.*, 2011). Other informants suggested that management roles were historically attractive because they offered a way to increase salaries, which were extremely low under communism and for many years afterwards (Whitfield *et al.*, 2002; Dent, 2003). The lack of any financial incentive has certainly been cited as a potential cause of doctors' reluctance to take on management roles in the UK (Ham and Dickinson, 2008; Ham *et al.*, 2010). However, whilst financial incentives may have led to enthusiasm amongst Polish doctors for taking on the chief of ward role, the hospital manager we interviewed suggested that, as with UK Clinical Directors, many have not been as enthusiastic about the responsibilities of management:

> […] they may like the influence and salary, they don't desire the responsibility of the role […] they are more likely to maintain the status quo and make little change (Hospital Manager, Public Hospital).

This reference to the fact that few chiefs of ward make change within the system is interesting, as the need for medical managers, and indeed all doctors, to initiate system change and work productively with managers has recently come to the fore in the UK (Department of Health, 2008, 2010; The King's Fund, 2011). With regards to this, we found signs in the literature of a slight shift in attitudes amongst the UK profession in favour of this. For instance, recent reports suggest that Medical and Clinical Directors now feel fairly well aligned with general managers and management ideas, particularly the need to improve quality of care (Giordano, 2010), and that senior doctors have respect for financial professionals (Audit Commission, 2007). Reports of younger doctors being keen to take up management training and gain experience of working on organisational issues are also emerging (Griffiths *et al.*, 2010; Fellow-Smith, 2004). The latter might be explained by the current professional and policy focus on developing doctors' management and leadership skills, including the incorporation of a competency framework to achieve this into all undergraduate and postgraduate curricula (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2010; Spurgeon *et al.*, 2011). Data collected alongside this study, from qualified doctors participating in research on leadership development (Hartley, 2012), found that they supported the need to engage with management issues, if not necessarily to take on executive roles:

> I think you do have to be management savvy, but I think there's a point at which […] I can't see personally many doctors wanting to become chief execs […] because that's not for us, that's for people who've trained in business. I think advisory stuff, clinical directors, that's great (Surgeon, UK).

In contrast, we found no reports of Polish doctors being encouraged to help reform the system, nor any policy focused on developing their management and leadership skills, although some universities do offer postgraduate courses in management (see, e.g. Institute of Public Health, Jagiellonian University Medical College). Despite this, informants suggested that a change in doctors' engagement with management is

underway in Poland, with younger doctors being increasingly appointed to chief of ward roles, on the basis of their skill sets rather than their political connections:

> Rather than being appointed on the basis of their age and political connections, doctors are now more likely to be appointed on the basis of what they know and can do […] chiefs of wards are getting younger, in their forties and fifties as opposed to their fifties and sixties (President of All Poland Association of Non Public Hospitals and former Vice-Rector of a University Medical College).

The above cited informant suggested that doctors now take chief of ward posts "as a step in their career path, rather than as a position for life as was once the case". Further research is needed to verify the extent to which this is occurring, but existing evidence and our other informants suggest that this might be the case, for a number of structural reasons. First, Polish doctors are better paid than they once were (Kautsch and Czabanowska, 2011), meaning that the financial incentive for taking on a management role has been reduced. Second, recent OECD reports suggests that 50 per cent of Polish hospital doctors are salaried and 50 per cent operate on a self-employed, contractual basis (Paris *et al.*, 2010), forming cooperatives who contract their services to hospitals (Boulhol *et al.*, 2012). Similar fee-for service relationships in the Netherlands exist are argued to be responsible for keeping doctors at "arm's length" from management (Neogy and Kirkpatrick, 2009, p. 6). However, it may be that over time these self-employed doctors find that they need certain management skills, such that management training in Poland becomes increasingly important.

Other structural changes are reported to be having some impact upon Polish doctors' participation in management. One CEO suggested that with the increase in private hospitals, "old style" chief of ward posts are becoming less available as private hospitals are preferring to employ "doctors managing the ward" or "ward managers", who may in fact be nurses. Whilst only 5 per cent of hospitals are currently privately owned (Paris *et al.*, 2010) this is a potentially interesting phenomenon to monitor. Interestingly, this same CEO reported that while opportunities for power and influence may be less in private hospitals, doctors' attitudes there towards management are better than in public hospitals:

> […] they understand that good management is crucial for the survival of the organization, accept change, initiate necessary change, and overall are more cooperative both with managers and among themselves (CEO, Private Hospital).

This was attributed to private hospitals having less of a "them and us" mentality between managers and clinical staff than publically owned hospitals, benefitting from being smaller and having an "open-doors" policy, which enables the CEO and clinical staff to talk to each other frequently, such that issues can be solved more swiftly. Reports in the UK (CIHM, 2007; Hamilton *et al.*, 2008) provide support for such resulting in productive relationships. What then might we conclude from all of this?

5. Conclusions and potential implications

This study found that Polish and UK hospital doctors hold similar types of management roles, albeit with differing levels of responsibility and accountability, particularly with regard to financial affairs. However, there are signs that participation in and enthusiasm for management is undergoing change in both countries.

In the UK, there now appears to be greater acceptance of the need for managerial involvement and competency amongst younger doctors. One implication of this is that doctors there might engage more readily with management roles in the future.

Whether, and how they engage is, however, likely to depend on what is driving this attitudinal change; whether it is the result of the current professional and policy focus on this issue or whether other factors, such as increased competition for jobs, are having an impact. Future engagement is also likely to depend on whether training and development is sufficiently widespread and able to prepare doctors for the management roles they will face, which at present remains unclear (Noordegraaf, 2011) and requires investigation.

In Poland, our informants suggested that enthusiasm for the important and traditionally sought-after management role of chief of ward is on the decline, with younger doctors, who have different motivations, now taking up the role. This was attributed to increases in doctors' salaries and changes in structural arrangements creating new ways for doctors to maximise their income, thereby reducing the impetus for them to move up the management hierarchy. Whilst such structural changes may well underpin change, the extent to which this is occurring, and whether or not younger doctors' motives are particularly different to those of previous incumbents (i.e. more career oriented, less power oriented) is at present unclear, as is the way in which they may engage with management over time.

The fact that around 50 per cent of hospital doctors now work on a self-employed basis (Paris *et al.*, 2010) suggests that the profession in Poland is becoming increasingly stratified, as Freidson (1994) predicted. However, such changes are relatively recent and whether they lead to a significant change in doctors' autonomy and power over time remains to be seen. Likewise, whilst a reshaping of traditional management roles within the private sector might mean that doctors there lose some of their formal authority and influence, to nurses for instance (Abbott, 1988), this new context may also provide opportunities for influence without the need to hold a formal management role, through more open and cooperative relationships with managers. This might then lead to the new, more inclusive and collaborative forms of professional community some have suggested may emerge (Adler *et al.*, 2008). Such ways of working are being actively encouraged by policymakers within the UK, and a national inquiry there has found some examples of collaboration (CIHM, 2007). However, given that the private sector in Poland is currently quite small, any significant effect is likely to depend on the level of growth in private hospital provision and/or the extent to which their culture and practices become more widespread.

6. Limitations and future research opportunities

While our study suggests that medical engagement with management is changing in both systems, further work is needed. In Poland, OECD reports support some of what experts were telling us, but more work is needed to verify all the changes reported. We need to understand the extent to which younger doctors with a more managerial skill set are taking on management roles, and how far this is explained by a decline in interest amongst older doctors and/or by new appointing practices. We also need to understand the motivations of doctors now taking on these roles. For example, whether they are motivated by factors such as the opportunity for broader experience in order to further their clinical career, or by power and the opportunity to increase their income, in the way their predecessors reportedly were, and indeed whether these motivations are mutually exclusive. The extent to which other professionals, such as nurses, are moving into management roles also needs to be explored.

In the UK, while the attitudes of younger doctors towards managerial involvement and training appear to be more positive than those of their predecessors, further

exploration of the extent and drivers of attitudinal change is required. We also need to understand whether the current policy of championing medical involvement in management and system change, and the significant investment currently being made in management education for doctors, is able to increase their engagement in the longer term. The latter potentially has implications for the policies of countries such as Poland, who have yet to focus on such education. Finally, the impact of the changes outlined in both countries on the profession and health system is worthy of further investigation.

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