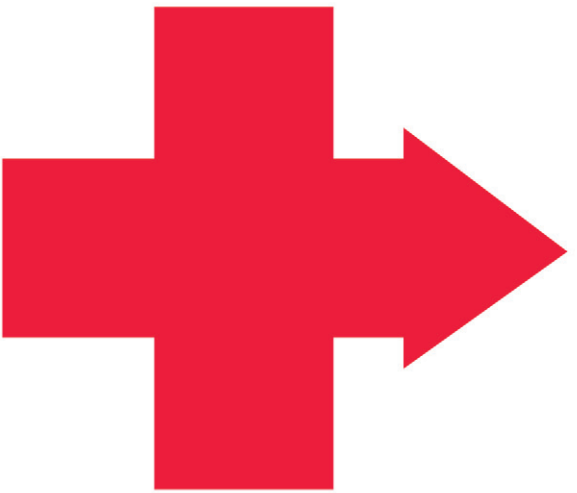
European Health Management in Transition



Health Management 2.0

Transformational Leadership for Challenging Times

Usman Khan and Federico Lega

HEALTH MANAGEMENT 2.0

European Health Management in Transition

Series Editors:

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Healthcare is currently undergoing an unprecedented period of change, which is presenting a challenge to the fundamental tenants of health management and policy established over the last decades. The differentiated nature of the change agenda and the pace of change has been such that there has been limited space or time to provide a structured or comprehensive response, or to consider at a strategic level how health management teaching and practice should evolve and develop. This then is the focus for the *European Health Management in Transition* series, published in association with the European Health Management Association (EHMA).

Books in the series investigate how changes to the health and social care environment are leading to innovative and different practices in health management, health services delivery and design, roles and professions, architecture and governance of health systems, patients' engagement and all other paradigmatic shifts taking place in the health context.

The books provide a roadmap for managers, educators researchers and policy-makers to better understand this rapidly developing environment.

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Usman Khan and Federico Lega: *Health Management 2.0: Meeting the Challenge of 21st Century Health*

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HEALTH MANAGEMENT 2.0

Transformational Leadership for Challenging Times

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INVESTOR IN PEOPLE

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PREFACE

The best stories are always the ones that bear retelling. So it is with the frog in the pan of water. We are told that the frog who is dropped into a pan of boiling water will immediately jump for his life. However, the frog put into a pan of cold water, which is then slowly heated, will not respond to his predicament until it is too late! Likening the twenty-first century health manager to a frog may not be the most auspicious of book introductions, but it does help to set the scene on this occasion.

Modern European health systems have developed significantly over the 75 years since their inception at the end of the Second World War and have in no small part been responsible for the resultant increase in life expectancy and reductions in morbidity. So too have the cadre of healthcare managers made their contribution to improving the economy and efficiency of health systems. Yet the analogy with the frog in the pan holds, because much of the change that has been witnessed appears to have been piecemeal and reactive. Slow to react to emergent challenges such as the rapid growth in non-communicable disease and apparently unable to deliver integrated care or to reorientate care towards prevention and early diagnosis and away from reactive treatment and potentially burdensome care, European health systems and the managers running them have often appeared to be in a game of catch up.

Then came the COVID-19 crisis of 2020. Even at this point in the pandemic's progress it is apparent that it represents the most significant system disrupter that global health systems have had to deal with in more than a century. Whether such disruption is enough to persuade the frog to jump out of the pot is uncertain. Early learning suggests that evolutionary steps such as telemedicine have been fast tracked in response to the disruption to health and care services witnessed during the early waves of the crisis, whilst some long-standing barriers to organisational cooperation have been set aside in response to the call to rally around a common point of need.

The saying goes that one swallow does not make a summer, so it is uncertain as to whether the individual changes that are becoming evident will in combination come to represent the paradigm change which this book contends will be necessary for the long-term sustainability of European health systems. As a consequence, this volume remains part critique and part call to arms, with our hope being that it helps to inform, provoke, motivate and drive health managers to take meaningful steps towards the leadership role required in times of Health Management 2.0.

Usman Khan and Federico Lega
April 2021

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This is the second volume in the Emerald Points Series European Health Management in Transition. The book has been in gestation for more than two years, and during its development, we have been able to draw upon the support of a significant number of colleagues and friends, who we would like the opportunity to thank.

First and foremost, our thanks go to the European Health Management Association, its Membership, Board and Executive. Without the support of EHMA this Book Series would not have got off the ground, and without the advice, comment and support of EHMA Members, this volume would not be as complete as we hope it now is.

We would also like to thank our own academic homes of KU Leuven and Milan University as well as Mark Exworthy, Siegfried Walsh, Alexandre Lourenço and Andrew Corbitt-Nolan for advice on particular chapters as well as the volume itself. Our respective partners provided much additional critical input and support for which we are grateful.

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1

INTRODUCTION

Usman Khan

The provision of universal healthcare funded through taxation was a common aim for the majority of European countries after 1945. The reconstruction of the nation state had at its core the establishment of an efficient and effective health system which would take away the day-to-day insecurity and risk faced by many and replace it with cradle to grave protection from preventable illness alongside treatment and care for communicable and non-communicable disease (NCD). The results have been nothing short of spectacular. Increase in life expectancy has grown significantly, driven as it has been by a seismic drop in infant mortality levels (European Commission, 2006). European data regarding premature mortality paint a similarly positive picture indicating that

> *Europe has been making clear progress over recent decades in reducing premature mortality from non-communicable diseases (NCDs).*
>
> (World Health Organisation, 2018)

Yet the school report for European Health Systems remains far from perfect. Setting aside economy and efficiency and focussing simply on effectiveness, 75 years of universal healthcare have failed to fully address health inequalities as it has failed to contend with the emergent challenges of the post-war period. Nor can prevention and early diagnosis be said to have been driven on from the ambition of post-war health system thinkers such as the United Kingdom's Nye Bevan, to be a fully integrated part of everyday life.

The concomitant notion that European health systems are underperforming or even failing is longstanding, with health policy and management literature returning to this same common theme at regular intervals. Well-respected texts from the end of the last century were already referencing concerns about health system sustainability identified some two decades previously:

> *By the beginning of the 1970s, confidence in the post-World War II health policies and options evaporated.*
>
> (Blanpain, 1994, p. 2)

Such concerns now appear prescient and enduring, not simply a matter of the post-war consensus slowly unravelling but also a long-standing challenge to the ability of health management to deliver effective and sustainable health systems.

Even at this early juncture, it is important to provide clarity with regard to a number of the terms used throughout this book, by first defining what we mean by sustainable and perhaps then going one step further and describing how we would know if we had achieved sustainability. Those well versed in discussion about healthcare quality will know that it is a well-trodden path, so we will content ourselves by referencing Braithwaite et al. (2019) with the notion of

> *…a durable, resilient and sustainable healthcare system to withstand impending and ongoing challenges while providing effective and efficient healthcare that is safe and of high quality.*
>
> (Braithwaite et al., 2019, p. 6)

Whilst the 'where are we going?' part of the question may appear relatively straightforward to answer the 'when do you know you are there?' part is more problematic.

Whatever the case is regarding the definition of sustainability, facing up to cumulate health policy and management challenges over half a century must today be set alongside having to additionally contend with a world now tentatively taking its first steps on from the first wave of the most impactful global pandemic since the Spanish flu more than a century ago.

Finding a basis for ringfencing the remit of this volume presents its own challenges. In line with the Emerald Points Series, our focus will be on European health systems in the period subsequent to the end of the Second World War. What this provides for are common parameters, such as healthcare being provided on the basis of a socialised model, albeit with important variations with regard to funding models and investment levels. It also provides for a common needs framework, characterised prior to the outbreak of the coronavirus pandemic of 2020 by a reducing focus on infectious disease tied to the success of common public health measures including national immunisation programmes, improvements in maternal health and general improvements in living standards and increasing challenges around NCD and ageing. Such generalisation should not however seek to underplay significant variations with regard to health system development and health outcomes, across Europe.

Setting the issue of variation to one side, it is somewhat ironic given the apparent scale of the challenges facing health systems that many commentators have viewed health systems to generally have responded to the challenges they have faced in a cautious and piecemeal manner (c.f. Peiró & Maynard, 2015). The hypothesis underpinning this volume is that the incrementalism that has underpinned post-war health system development was always problematic but is now an endemic inhibitor of necessary change to rapidly growing health need and expectation. No longer fit for purpose, we propose that European health systems currently sit at a precipice that will require a paradigm change in health policy and management to bring healthcare back from a potential abyss. The hackneyed phrase of the current situation facing European health systems representing a perfect storm has never rung truer, as we see the failings of the current system limiting its ability to respond appropriately to the rapidly evolving health needs landscape, being unable to successfully coral evident advances in health and social care practice to make necessary change. As a consequence, healthcare management will be driven to respond to this paradigm shift by means of a more fundamental reassessment of what constitutes health management, who does it, when, where and how.

HEALTH SYSTEMS, POLICY AND MANAGEMENT

But let us first take a step back to ensure that we share a common understanding of the environment that we are assessing. Healthcare itself as a word or phrase does not provide an easy starting point. Although commonly referred to in academic, policy and care settings, there remains concern as to whether healthcare is a word. Michele Issel, for instance, states that as a noun one should only refer to Health Care as

care provided by an organised health service (Issel, 2014, p. 269). However, for the purposes of this book, healthcare is defined encompassing the organised infrastructure, services and related personnel who provide healthcare to the population living within a particular health system. Healthcare would also include related social care provision.

The term Health System has historically had more resonance in relation to global health, following the WHO definition to include all the activities whose primary purpose is to promote, restore and/or maintain health (Buchbinder, 2012). On this basis the book will refer both to national health systems and to the European health system in as much as each shares a common framework built around state or social insurance funding, with services provided free at the point of use.

The notion of healthcare is further complicated by the many stakeholders that are involved in its planning, resourcing and delivery. Within this, the historic role of the healthcare professional and more precisely the physician is of marked importance. Traced back to the barber surgeons practising from medieval times onwards, their role in all aspects of healthcare is well accounted for. This may then provide for more limited space within which to consider the role of the healthcare administrator or manager. Formally healthcare management is the profession that provides leadership and direction to organisations that deliver personal health services and to divisions, departments, units or services within those organisations (Buchbinder, 2012, p. 17). However, the intersection between health policy and management is a challenging one to set out and a more challenging one to assess. It is also apparent that the challenges in understanding the roles played by the many stakeholders involved in health policy and management only adds to the complexity of the challenge.

PARADIGM CHANGE

Setting the title of this book at Health Management 2.0 is a deliberate attempt to provoke and challenge current thinking and whilst being principally focussed on the practice of health management, we naturally expand our remit to consider Health Systems 2.0. Such framing borrows from the world of information technology, where fundamental change such as that from Web 1.0 to Web 2.0 can bring with it not just a major change in the manner in which a technology works but also may lead to major organisational change as happened when having seen the change to Web 2.0, when Google took over the number one web browser status from Netscape. This shift not only impacted on the provider landscape, but also it significantly and meaningfully transformed the fundamental understanding of what the Internet was and what it could do. This notion of software version or update, with the first number designating the major change, e.g., 1.0 and 2.0, and the following subsequent minor changes, e.g., 1.1, 1.2, etc., is well established and the degree to which a major software change can lead to fundamental change is necessarily case-dependent, with the impact on search engines of Web 2.0 being of far greater significance than say a change to a word processor or graphics package.

An additional means to reinforce the notion of major system change which we employ in our book is to link the notion of version change to paradigm theory as forwarded by Thomas Kuhn (Kuhn, 1962). Kuhn's work was focussed on the world of science, with his core examples being Newtonian physics, caloric theory and the theory of electromagnetism. Kuhn argued that paradigm shifts arise when the dominant paradigm under which normal science operates is rendered incompatible with new phenomena, facilitating the

adoption of a new theory or paradigm (Kuhn, 1962, p. 52). Unsurprisingly, Kuhn's thinking has been applied outside of the immediate realm of science, to both describe and explain fundamental changes in societal, economic and political territories.

The analytical framework utilised in our book draws then from the thinking of IT and science to help us to locate current developments in health and social care, with the particular focus being to assess whether recent developments in health system development or health management practice can be viewed to constitute incremental change or whether they should be viewed to constitute more fundamental change. Such a discussion is more than prosaic, as the potential concomitant of healthcare going through a period of fundamental change, which could constitute a paradigm or major system change, is that systems and processes surrounding such change such as management practice will need to respond accordingly by changing their methods and practices in a similarly significant manner. Whether such changes in health management practice should in of themselves be viewed through the prism of fundamental systems or paradigm change will be the subject of further discussion in Chapter 4. But let us first return to scene setting by considering the constituent elements of the modern European health system, which will enable us to set a framework within which levels, types and forms of change can be assessed.

ASSESSING HEALTH SYSTEM CHANGE

We propose that health system change can be assessed from a four distinct but related perspectives: needs focus, policy focus, innovation focus and a management focus. Firstly, the needs focus refers to manner in which population health need

is assessed. Healthcare systems need to respond to evolving and changing patterns of health need, such as the ageing population, growth in NCD and so on and the breadth and depth of such an assessment has manifestingly changed in the period since modern European health systems were established in the post-war period. Alongside health need we additionally posit that consideration should be given to notion of health expectation, that being a public or patient centric assessment of what constitutes health and well-being. In the next two chapters, we give space for an assessment of the nature of such change and consideration as to whether it should be viewed to be fundamental in form.

Secondly, from a policy perspective, healthcare is impacted by changes in relation to finance, regulation and governance. Given the high level of political investment made in healthcare by governments across Europe, it is unsurprising to see that healthcare has always been an important plank of public policy. This is grounded in finance, where GDP levels and percentage levels given over to health spending have always been the subject of debate, where regulatory and governance matters have preoccupied politicians and administrators as they seek to maintain sufficient levels of control over national health systems and spending on national health systems.

Thirdly, the innovation focus on life sciences and more broadly on technology (including digitalisation which has always been central to health policy and practice), has in recent decades begun to evolve at a rate and scale as to fundamentally alter the landscape within which healthcare is provided. For established domains of activity such as pharmaceuticals, the most notable developments include those in precision medicine, whilst across life sciences the scope of remote diagnostics is just one of a series of developments which are again changing the landscape of the care continuum. The fourth and final dimensions relate to public health

services where policy and practice come together to shape, develop and sustain the resultant health system. This then is the realm of health management.

What is presented in this book is the argument that European health systems have in the last decades undergone periods of change, yet such change has often appeared piecemeal and reactive. Whilst strategy developments within areas such as digital transformation or service integration have appeared to provide a degree of shape, little appears transformative in form or nature. Top-down policy direction, which provided broad parameters for the development and maintenance of the post-war care system, appeared less able to adapt in the face of transformative pressure for change.

The burden on health management is then a significant one. Charged not only dealing with day-to-day challenges relating to service quality and efficiency, health management has also been given responsibility for mediating between a population whose expectations regarding their own makers caught in the headlights of indecision. Health needs have undergone radical change and policy. The challenge to ensure that basic treatment and care systems are fit for purpose and then that systems are able to adapt to a rapidly changing environment appears to have been a difficult one for all involved. The question can be asked, if it has not been possible to successfully eliminate variation as a variable within healthcare in the manner that the airline industry has in flight safety, nor has it been able to integrate care in the way that the leisure industry constructed the package holiday, then how can it be expected to realise the potential from digital health or big data?

Whilst variation in access, quality and outcome remained something of an Achilles heel, incremental change has been sufficient in maintaining a level of consensus regarding the efficacy and value of publicly funded health systems. As need has evolved and expectations grown, health systems have

sought to adapt and develop with varying levels of success, but there is increasing evidence of systems under strain unable to adapt to the current pace of change. Taking this as our starting point, our book reflects further on the drivers for change in European health systems before considering how health management can best frame its response and in doing so it will make its own paradigm shift from Health Management 1.0 to Health Management 2.0.

OVERVIEW

The book will help the reader to understand the notion of Health System 2.0, setting out as it does why it should be viewed to represent a paradigm shift rather than an evolution and how Health Management 2.0 will be needed to deliver on it. Put simply a paradigm change with regard to a system necessitates a paradigm change with regard to managing the new system.

The second chapter focusses on the notion of European Health System. It focusses on how health management has evolved in the post-war period and in particular how the emphasis across Europe has moved from a traditional bureaucratic focus on system and process, to one more versed in the public management reform agenda where changes in pace, complexity, structure and combined to produce a landscape fundamentally different from that of HealthSystem 1.0.

Chapter 3 addresses the process of corporatisation that has taken place in many health systems and its implications on leadership and management practices. Challenges posed by new policy paradigms and organisational reconfigurations are highlighted. The chapter tracks the manner in which health policy and health organisations have changed in the last 20 years to cope better with the 'new normality' of the health

sector before setting out how these dynamics are calling for a significant development towards clinical leadership and greater engagement of both managers and clinicians in new managerial practices.

Chapter 4 on Health Management 2.0 sets out how alongside the 'normal' challenges of health management there is an increasing need to utilise a new range of skills and competencies to deal with emerging challenges and opportunities within the framing of European Health System 2.0. The chapter will present an overview of the most recent developments in health management practice and will then set these against the backdrop of HealthSystem 2.0 with a view to establishing what role health management could and potentially should play in facilitating a change to a new architecture and landscape for health systems. Chapter 5 moves the reader onto a consideration of leadership within HealthSystem 2.0. Building on from the assessment of Health Management 2.0, this chapter will consider current needs for 'good' leadership in healthcare, with a view to assessing approaches which may be best placed to support healthcare in the twenty-first century.

The concluding chapter then serves as a starting point for the rest of the series, considering the challenges that lie ahead in being able to realise the opportunity provided by Health System 2.0. The chapter will take a thematic approach to review how health and health management are undergoing rapid change, which requires a major revision of thinking and practice. This chapter will also consider how health management teaching and practice should respond to the challenges of HealthSystem 2.0.

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HEALTH SYSTEMS IN TRANSITION

Usman Khan

INTRODUCTION

Received wisdom is that health policy-makers, healthcare professionals and health managers collaborate to develop sustainable health systems which respond to evolving health need. This characterisation of Health System 1.0, which was outlined in the last chapter, will now be tested, with consideration given to the notion that the sustainability of this model of healthcare is no longer assured. The chapter takes as its starting point an assessment of the current drivers impacting upon European health systems.

Turning then to health management, the chapter will focus on the shift from Health Administration to Health Management, tracking the manner in which health system management has changed since the end of the Second World War and in particular how the emphasis across Europe has moved from a traditional bureaucratic focus on system and process to one more versed in the public management reform agenda of the

1990s onwards. This will set the scene for later chapters, where developments in clinical leadership and greater engagement of both managers and clinicians in new managerial practice will be assessed.

Taking the discussion further, we seek to establish whether we are currently operating within a modified iteration of Health System 1.0, where one can posit there having been a number of 'updates' from 1.1 to 1.2 and so on, yet the system fundamentals have remained the same, or whether we are migrating towards a paradigm shift which will be recognisable as Health System 2.0.

Picking up on the initial discussion in the previous chapter we can site many examples of the notion of paradigm change. Examples as diverse as Industrial Revolution 4.0 (Liao, Deschamps, Loures, & Ramos, 2017) and Public Music 3.0 (Charron, 2017) often focus on a single point of development whereby the notion of system or version change is then by itself the recognition of a new starting point or baseline from which a broader change movement then emanates. What is important to note here is that within such a construct, whilst minor modification can enable small improvements in system performance, it is paradigm change and paradigm change alone which leads to system transformation. Take the change from Web 1.0 to Web 2.0 and now to Web 3.0. In each case the fundamental basis of the Web being as its originator, Tim Berners-Lee envisaged as a hyperlinked information system, a library of on-screen data (Naughton, 2016). From the simplicity of Web 1.0 with its read-only static content to Web 2.0 as the Internet of convivence and communication and onto Web 3.0 with its machine learning and multifarious presentation, at each stage in the evolutionary journey, there have been points of step change, each of which has brought about a rapid and significant change in the understanding of what the

Web is and what it is capable of. What then for the evolution of health systems? It could be considered no more than a prosaic presentation to set out whether it is more appropriate to talk about our health systems to be at version 1.4 or even 1.10 rather than 2.0 or 3.0 but we would argue that it is more than this.

What precipitates system change is in part dependant on the system dynamics within a particular domain, be that health, music or industrial development. Equally what may hinder system change will vary from domain to domain or sector to sector, and as we shall see in this chapter, the strength of change resistors within European health systems can be considerable. We have gone onto question whether Health System 1.0 remains fit for purpose and if not whether it will be able to manage legacy issues relating principally to economy and efficiency, alongside having to deal with emerging challenges such as the current obesity crisis or the growing challenge of dementia and if not whether the balance of change drivers and resistors will enable a necessary step change to Health System 2.0.

THE POST-WAR EUROPEAN HEALTH SYSTEM

The post-war European landscape for health and social care was disparate and complicated. Europe had come out of a global conflict economically devastated, politically disorientated and socially diverse. Health was seen to be a touchstone issue, an integral part of the post-war reconstruction project with relatively clear goals and priorities. Those goals focussed on issues such as infant mortality and perinatal death, infectious disease and the need for widening and deepening health protection. There was also an increased focus on public health issues, which

ranged from public and workplace health and safety to the setting of minimum standards for air and water quality. Non-communicable disease (NCD) also became an increasing focus, with treatments for conditions ranging from common cancers to diabetes and heart disease developing and evolving.

There were then a number of core elements to Health System 1.0, many of which were driven by a need to address weaknesses in the piecemeal health systems that existed prior to the outbreak of the Second World War. The building blocks of European Health System 1.0 were to see health services provided on a universal and comprehensive basis through state funding and free at the point of need. There were manifest benefits to such an approach, replacing as it did the prior system of ad hoc and piecemeal treatment and care which left large proportions of the population lacking even basic health protection. A population focus on universal coverage, where access and affordability were the principal value metrics led to significant investment in the physical healthcare infrastructure and the health and social care workforce. Public health was also made a priority within European Health System 1.0, with clean air and water and workplace safety particular areas of focus. Immunisation programmes also featured heavily in many European Health System programmes, the impact of which on twentieth century health is well established:

> *…if you asked a public health professional to draw up a top-ten list of the achievements of the past century, he or she would be hard pressed not to rank immunization first.*
>
> (Stern & Markel, 2005, p. 611)

Health System 1.0 retained and in many cases expanded a commitment to public health and the role of primary care.

However, Health System 1.0 was principally defined by its commitment to an extended base of secondary care, with the hospital central to every modern European health system plan. The post-war period saw the expansion of a building programme, with a move to larger centres for secondary care and the establishment of tertiary care. The health workforce also rapidly expanded during this period as it also diversified. In his assessment of post-war European health system evolution, Jan Blanpain comments that

> *In retrospect, it is remarkable how consensus existed among health authorities, politicians, organized medicine, the World Health Organization, the media, and the public in viewing the hospital as ultimately becoming the sole and central provider of total health care for the community.*
>
> (Blanpain, 1994, p. 7)

European Health System 1.0 was then structured and institutionally focussed. The population was viewed to prioritise standardised and comprehensive healthcare over any notion of engagement or empowerment. At the risk of overgeneralising, it is possible to contend that European Health System 1.0 was fundamentally paternalistic in form and nature.

Yet excessive talk of a uniform European health system would be wrong. Not only was Europe divided between Soviet satellite states and the West, but also the differences in funding levels for health systems in Southern Europe to those in the North lessened the relevance of the common position of health being almost exclusively a publicly funded good. For instance, Claus Wendt and colleagues suggest there to be three following basic models for European healthcare: a health service provision-oriented type that is characterized by a high number of service providers and free access for

patients to medical doctors; a universal coverage – controlled access type, where healthcare provision has the status of a social citizenship right and equal access to healthcare is of higher importance than free access and freedom of choice and a low budget – restricted access type where financial resources for healthcare are limited and patients' access to healthcare is restricted by high private out-of-pocket payments and the regulation that patients have to sign up on a general practitioner's list for a longer period of time (Wendt, Frisina, & Rothgang, 2009, p. 433).

Yet even here, funding and ethos remain common differentiators to pre-war European health systems and to post-war private insurance models such as in the United States. Equally there are few domains of public service which can be said to have been dominate in the mind of the European citizen as healthcare and it is no great surprise that even the strongest European federalists have sort to challenge the consensus that health should remain a national competence, with only limited scope for collective action (Greer et al., 2019).

European Health System 1.0 also saw the emergence of what we have in parallel termed Health Management 1.0. Whilst in the immediate post-war period it would be more appropriate to talk about health administration rather than health management, it was still evident that the scale of post-war socialised health systems necessitated the establishment of a cadre of administrators who were able to provide an operational interface between health policy-makers and healthcare professionals (Blank, Burau, & Kuhlmann, 2017). This having been said, the role of the clinical leader remained and remains prevalent in many post-war European health systems, a throwback to pre-war times which health policy-makers seemed unwilling or unable to challenge medical leadership (Kirkpatrick, Kuhlmann, Hartley, Dent, & Lega, 2016).

HEALTH SYSTEM EVOLUTION

It is easy to undervalue or understate the very significant benefits which have accrued for Europe's citizens from the provision of a managed and resourced system of healthcare. Writing in 1971, Omram had been able to describe the post-war period as having been the Age of Receding Pandemics, during which there was a progressive decrease in mortality and an increase in life expectancy (Rechel & McKee, 2014). It is important to stress the successes that Health System 1.0 was able to deliver in the post-war period. Life expectancy increased, whilst infant and perinatal mortality fell. Widespread immunisation programmes enabled the pre-war scourge of infectious disease to be addressed with renewed vigour.

Three pillars of the post-war European Health System 1.0 can be highlighted, these being comprehensive, state-funded and free at the point of need. However, it would be wrong to paint a picture of the post-war health landscape as being homogenous or not facing significant challenge. The presentation of Health System 1.0 as being a clearly delineated or even coordinated development programme would be an overstatement, with one commentator stating that

> *The history of healthcare quality prior to 1960 is a fragmented collection of unrelated events rather than a streamlined organized effort.*
>
> (Sheingold & Hahn, 2014, p. 2)

Beyond the contention that post-war health systems in Europe were fragmented and disjointed, a body of thinking soon began to develop which viewed there to be a more fundamental problem, one which was shared with health systems in a broad range of more developed economies. Although his work was focussed on the US health system, with its primary

private sector focus, the work of William Kissick highlighted challenges for modern healthcare systems with global applicability. With his conceptualisation of the Iron Triangle, Kissick outlined a fault line running through modern health systems where cost, quality and access were seen to be in a permanent state of flux, and balance and equilibrium were unachievable ideals (Kissick, 1994). Representing Kissick's thinking within a modern return on investment (ROI) framework, Van der Goes et al contended that programmes and policies aimed at improving access can be costly, as can quality improvement initiatives. Conversely, they state that cost reduction efforts may come at the expense of quality or access, concluding that such zero-sum game outcomes are seldom acknowledged by policy-makers (Van der Goes, Edwardson, Rayamajhee, Hollis, & Hunter, 2019). The long-term impact of this existential fault line is difficult to overstate, representing as it does a reoccurring theme for health policy-makers and managers to address.

But this alone has not been the only challenge faced by health system planners and managers. Two further structural fault lines of Health System 1.0 can be identified as having had an increasing impact on system sustainability. The first was that despite often referencing preventative public health rhetoric, Health System 1.0 was fundamentally reactive in form rather than proactive, being most suited to managing episodic demand. Whilst able to meet demand such a system is likely to be inefficient because it does not manage such demand effectively. This is not to say that health systems did not from the outset prioritise public health, primary prevention and self-care, but that despite this, the gravitational pull of the health system was towards a centralised and institutional treatment and care. The second structural fault line relates to the imbedded core of Health System 1.0, which was to focus at a population level, a focus that helped deliver

general benefit, but which did not lend itself towards a focus on individual personal health.

Nor is this where the challenges facing Health System 1.0 end. Despite being established with a structure designed to respond to efficiently and effectively meet patient need, it also became evident that European health systems found themselves contending with challenges relating not just to quality standards or access but also to issues lying at the heart of a system designed to deliver universal coverage, the most challenging of which has been variation. Common place across multiple industries including the automotive and building sectors, what proved evident was not only the scale of such variation but also the evident problems faced by health managers in successfully addressing the challenge. The attempted response in Health System 1.0 has failed. In a 2015 editorial piece in the European Journal of Public Health, Salvador Peiró and Alan Maynard contended that

> *…researchers have consistently demonstrated remarkable unwarranted variations in clinical practice. Such waste deprives potential patients of care from which they could benefit. It is unethical.*
> (Peiró & Maynard, 2015, p. 2)

As the chapter develops, we will consider the manner in which Health System 1.0 can be seen to have evolved through what in IT terms would be called system revisions, which leave the fundamental architecture in place whilst providing fixes or adaptions to improve overall functioning. But before doing so, we provide a broader comparison of Health System 1.0 with an outline of the pillars which would underpin a hypothetical idealised notion of Health System 2.0.

Table 2.1 sets out five defining characteristics of Health System 1.0 which have been extrapolated from the detail set out in this chapter. In the case of Health System 1.0, these can

Table 2.1. Health System 1.0 vs Health System 2.0.

	Health System 1.0	Health System 2.0
Style	Paternalistic	Enabling
Form	Standardized	Personalised
Focus	Reactive	Proactive
Enabler	Treatment focussed	Prevention focussed
Dynamic	Universal	Differentiated

be seen to reflect the nature of the immediate post-war challenge facing European states, with the most likely drivers to underpin the provision of universal access at scale. By contrast and referencing an idealised notion of Health System 2.0, one can see the defining characteristics standing in stark and often dichotomous contrast to those of Health System 1.0. This having been said, the process to develop the comparative table itself can be legitimately challenged as being too simplistic or over generalising; however, we feel it worthwhile exercise not least to provide a reference point as we further unpack both Health System 1.0 and Health Management 1.0.

Up to this point we have referred only to Health System 1.0, but as with technology, it is generally the case that a system will undergo revision so as to address weaknesses in prior versions as well as to add minor system enhancements. In assessing the evidence of health system evolution in the post-war period adapting and modifying the work of Jan Blanpain (1994), it is possible to identify four such points of update for European Health System 1.0.

By the 1970s and early 1980s, a wave of reform swept across Western European health systems (Blanpain, 1994). The

driver for such reform was the assessment that Health 1.0 had stalled in relation to meeting key policy targets:

> *By the beginning of the 1970s, confidence in the post-World War II health policies and options evaporated. A new wave of reforms gathered momentum. Expenditures on health care had risen beyond affordable levels, and despite this, the impact of health care on survival seemed negligible or even perverse, with an alarming decrease in the life expectancies of middle-aged males.*
>
> (Blanpain, 1994, p. 7)

Health System 1.1 can be described as a system update focussed on addressing core service inefficiencies, including resource allocation and utilisation. For Blanpain, the changes paid only 'lip service' to health promotion and disease prevention, focussing instead on managerial and organisational reform. Health System 1.1 was then primarily organisational in focus, rationalising healthcare infrastructure and in the case of mental health marrying this to a new service focus on care in the community.

A further system update can then be assessed to have occurred when health management became aligned to the new public management movement of the late 1980s and early 1990s. The impetus behind what we can term update 1.2 was that whilst Health System 1.1 had proved itself able to develop and scale healthcare, it was not dynamic or flexible enough to meet the increasing breadth or depth of challenge it faced. New Public Management drawing on learning and effective practice from the private sector witnessed a growing professionalism of healthcare management, with learning drawn upon from the United States in particular and much of the focus of Health System 1.2 was on improving quality, efficiency and effectiveness.

European Health System 1.3 is distinguishable in the transfer of attention towards the use of regulatory instruments as a tool to help improve health system operation. From the 1990s onwards, regulatory bodies for quality and safety in medicines and clinical care were established at both a national health system level, such as with the widely lauded UK National Institute for Clinical Excellence in 1999, and at a European level with bodies such as the establishment in 1995 of the European Medicines Agency. The impact of these regulatory bodies should not be underestimated, and their spread and growing influence continues today. However, limits were also evident in the limited scope this version update had on addressing continuing challenges regarding healthcare quality and safety as well as health system affordability and sustainability.

The final system update to European Health System 1.4 began at the turn of the twenty-first century with Western national health systems such as the United Kingdom, the Netherlands and Germany rapidly expanding the role of the private sector. Private tendering of public services had started in Europe as early as the 1980s, but the scale, depth and breadth of this really took hold on European health systems some two decades later. Much of this change focussed at a service level first with ancillary services such as catering and cleaning and later with some clinical services including diagnostics and elective surgery. In countries such as Germany and the Netherlands, the privatisation movement extended to organisational structure, where commenting on the German example Nils Böhlke and Thorsten Schulten asserted in 2008 that

> *There is no other country in Europe that has seen such an enormous wave of hospital privatisations over the last years than Germany.*
>
> (Greer, Schulten, & Böhlke, 2011, p. 2)

The privatisation movement extended to healthcare capital financing, with the UK's Private Finance Initiative a means to 'hit two birds with one stone' in enabling the expansion of hospital infrastructure without immediate or discernible impact on public finances (Gaffney, Pollock, Price, & Shaoul, 1999).

Drawing together common themes from any assessment of health system form must be heavily caveated, not least because the extent, scope and pace of change has varied significantly between and across countries. Yet there is evident purpose in making such an attempt, if it is only to provoke a process of reflection amongst readers. In Table 2.2, we have set out an idealised schematic to help set out the nature of each stage of the evolutionary process of Health System 1.0, highlighting the versions which may have had most impact on shaping health service delivery and which if any are likely to remain within Health System 2.0.

In Table 2.2, we propose being able to build at scale with volume of activity the key metric of Health System 1.0. This single driver had a high impact or success level but having got the scale established, was less important going forward. By comparison the structural adjustments that characterise Health System 1.1 did provide for economies of scale, as efficiencies were sort through organisational consolidation, a process which continues on to this day albeit on a modified scale. The transition from health administration to new public management that characterised Health System 1.2, brought the value of health management to the frontline of healthcare development. The focus of Health System 1.3 by contrast was centrally about the checks and balances brought in through regulation with such bodies having a notable and long-term impact and being likely to feature as part of any emergent version of Healthcare 2.0. It is then interesting that Healthcare 1.4, where

Table 2.2. Evolution of Health System 1.0.

	Health System 1.0	Health System 1.1	Health System 1.2	Health System 1.3	Health System 1.4
Defining feature	Scale	Efficiency	Management	Systems	Economy
Key metric	Volume	Structure	Competencies	Impact	Cost
Impact	High	Medium	Low	Medium	Low
Longevity	Low	Medium	Medium	High	Medium
Health System 2.0 relevance	Low	Low	Medium	Medium	Low

the market was introduced within the framework of both social insurance and single payer models, appears less likely to be a driver of equivalent importance in Health System 2.0.

Setting out four identifiable updates to Health System version 1.0 is not to imply that such updates were applied universally or consistently across or between particular national health systems. For example, not only is it the case that the experience of Eastern European countries has been distinct both with regard to investment and resourcing, but also many have been able to successfully draw upon stronger public health traditions. Equally, whilst GDP levels are not the only determinant of health system sustainability, differences in GDP and differences in percentage GDP spend would often have as much if not more of an impact on health system performance than any of the system updates we have set out. That having been said, it remains important to be able to set out the process of health system change, most particularly in terms of it giving content for an assessment of the situation today.

In summary, European health systems were established on the foundations of public funding to provide comprehensive healthcare available to the totality of the population free at the point of use. Many European countries can reflect on having been broadly successful in meeting this ambition, albeit with the caveat that there has been significant variation across and within particular national health systems. Beyond this variation, however, lay additional challenges which in combination have combined to not only dilute evident achievements but also to act as an ongoing hindrance to delivering on an ever-lengthening change agenda. The concomitant conclusion then is that Health System 1.0 has had structural weaknesses, which versions 1.1 onwards have failed to fully address, which in turn has made them poorly prepared to then take on a series

of additional challenges which have come to the fore during the first quarter of this new millennium.

HEALTH SYSTEMS UNDER PRESSURE

There were features of European Health System 1.0 that were being viewed to be problematic, limiting its ability to deliver efficiency and effectiveness. These in of themselves may not be sufficient to challenge fundamental system sustainability and create sufficient momentum for system change, but when set alongside a plethora of additional drivers to emerge in the first decades of the current century, one can see a crisis in the making.

In the following section we consider, first, how health need has developed and evolved over the last two decades in a manner which has come to challenge system effectiveness and affordability. We then go on to outline how these pressures have been compounded by the emergence of a less paternalistic and more empowered patient and public community. This then will be set against the backdrop of a health innovation landscape, which is creating opportunities to change health and social care in a manner which could not have been envisaged a few decades previously, opportunities which Health System 1.0 appears unable to make full benefit of.

EVOLVING HEALTH NEED

Assessing the evolving nature of population health need is a well-trodden path and as such our presentation of this landscape is limited to setting out central dynamics of change, alongside an assessment as to whether these may or may not in combination lead to paradigm or system change. To help

facilitate our discussion we focus on two related health domains, each of which is undergoing significant change. Firstly, we look at how NCDs have grown, diversified and become increasingly impactful. Secondly, we turn to mental health and more broadly health and well-being.

The rapid growth in NCDs can in one way be viewed to be a success measure of Health System 1.0, in that life expectancy has grown significantly over the last 50 years and with it the likelihood of individuals who have avoided accidents and infectious disease, succumbing in later years to NCDs such as diabetes, coronary heart disease and dementia have grown significantly (McNamara, 2017). We are faced with an ageing population in Europe where over 91% of deaths and almost 87% of Disability Adjusted Life Years (DALYs) in the EU (European Union) in 2017 are the result of NCDs (European Commission, 2019). Current health systems in Europe and beyond are struggling to deal with this burden of health need and traditional healthcare has not been able to develop sustainable, affordable and effective means to treat the most challenging of NCDs (Stuckler & Basu, 2013). The success of the post-war health system has in many ways helped create the space where NCDs have been able to develop. Where the disjuncture appears is in a health system built principally as a reactive resource to address critical and urgent need, having to expand its time horizons and fundamentally readjust its methods and approaches. When faced with patients presenting with increasing need and increasing complexity of need, European health systems have been able to respond by seeking to treat more, rather than taking a step back and working more intensively at the diagnosis and prevention stage (Williams, Rechel, McDaid, Wismar, & McKee, 2018).

Take the single issue of obesity as a major NCD. WHO figures from 2020 present a stark picture, where the

worldwide prevalence of obesity nearly doubled between 1980 and 2008 (World Health Organisation, 2020). According to country estimates for 2008, over 50% of both men and women in the WHO European region were overweight, and approximately 23% of women and 20% of men were obese. The instruments at the disposal of healthcare professionals, policy-makers and managers to address this challenge focus on prevention, treatment and care (Branca, Nikogosian, & Lobstein, 2007). Prevention is concerned with public health and most particularly health promotion, where regulatory instruments such as price and access remain outside of the control of health stakeholders. Treatment and care is evolving, but the costs for treatments such as bariatric surgery are significant and the overall effectiveness of any attempt to reduce obesity is very limited (Panca, 2017). Health System 1.0 seems poorly suited to respond to such complex and multidimensional issues, which require a focus on the three areas of prevention, personalisation and empowerment, factors which were not accounted for in developing its original architecture. This has left such health systems playing catch up with one hand tied behind their backs, a recipe for disappointment if not abject failure.

A further evolving domain of need relates to mental health. Today the discussion in the most advanced national health systems relates to building parity between mental and physical health, but the staging posts on this as yet unfulfilled journey trace back to a point where mental health conditions were often given scant regard by health policy-makers, whilst those working in mental health services found themselves to be poorly resourced when compared to their physical health counterparts (Muijen, 2008). Consequently, as the discussion has expanded to include notions of well-being, national

health systems have found it difficult not just to resource increased and widening demand but also to know how best to incorporate such care within existing systems. As a result, there is increasing evidence of care transferring from the state sector to private, voluntary and workplace sectors, with the former becoming primarily focussed on secondary care over primary and preventative services (Moreno, 2020). This again calls into question the suitability of Health System 1.0 to appropriately deal with the growing and highly differentiated nature of mental health service need.

Following on from the assessment of mental health need is the broader agenda of well-being, which has found an increasing presence in health policy thinking over recent decades. For a large proportion of the European population, the notion of well-being is a distanced one when set against day-to-day struggles with more immediate health and social care needs, beginning with securing access to maternity and post-natal care, transitioning through challenges associated with NCDs and ending with long-term and palliative care. Yet for other sections of the community, the notion of well-being has come to define a new ambition and expectation. Whilst the WHO set out as early as 1946 the ambition of its intention as wanting for the world's population '…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Health Organisation, 2018), it has taken three quarters of a century for this ambition to find its way more concretely into European health policy and practice. Well-being has been incorporated into European health systems in areas such as pharmaceuticals, where first QALYS and then latterly DALYS and health related quality of life (HRQoL) have been incorporated to enable a wider range of health outcomes into assessments of effectiveness (Sassi, 2006). The challenge for Health System 1.0 is to holistically

incorporate the notion of well-being not simply into reactive treatment and care but also into a broader proactive and supportive approach which empowers individuals to take ownership in a spirit of cocreation. This in turn brings us to the next challenge facing Health System 1.0, that being the challenge of paternalism.

THE PATIENT WILL SEE YOU NOW

The focus of this book is on the health systems that have been established and developed across Europe since the end of the Second World War; systems welcomed as a benefit of a benevolent welfare state, where the patient is the grateful passive recipient of treatment and care provided in the main on a reactive basis. Such a paternalistic approach retained elements of personal responsibility, such as to exercise, eat well and utilise preventative measures such as vaccination. However, traditional European health systems were not designed so as to enable patients or citizens to take control of their health and well-being (Gallagher, 1998).

This is not to say that many European health systems are not looking to develop the manner in which they engage with their patients. Whether at the level of the patient-health professional consultation or with collective forms of engagement, there are numerous examples of tools, techniques and programmes which seek to make care and treatment less paternalistic and more engaging (Mathur, 2018). However, the challenge faced by most health systems is that they are not constructed in a manner which makes fundamental empowerment intuitive, nor is the culture of health systems set in a way to help facilitate a fundamentally different form of engagement to the paternalism on which the system was first established.

The voice of the patient was first manifest within the advocacy movement, with one of the most notable campaigns being that around AIDS/HIV (De Cock, Jaffe, & Curran, 2011). The growing strength of patient activism became manifest most particularly in medicines development and regulation as well as access and reimbursement issues. More recently, patients themselves have been seeking to develop their own roles, in realms which would not have been considered or countenanced in previous times. Patient educators are being integrated into health professional curriculum design and teaching, and patient innovators are developing solutions to long-standing challenges where traditional development and innovation have failed. Within the realm of service improvement patients are now being more fully involved in clinical pathway redesign, while patient governors are increasingly finding space in organisational management and governance. The challenge for health policy-makers and managers is to ensure that developments in patient engagement are meaningful rather than tokenistic. This not only brings the issue of culture and the role of healthcare professionals to the fore but also shines a light on the fundamentally paternalistic infrastructure of healthcare.

A further connecting domain regarding patient empowerment is that of personalisation. Personalisation in healthcare is an approach being driven from a range of stakeholder groups. With rapid developments in genomics and work on the human biome, the future is increasingly being viewed in terms of individual treatment plans and personalised medicine. This is being met by an increasing demand from citizens and patients for a more tailored approach to healthcare, moving away from the spirit of collective goals and coverage. In the following

section we examine this issue further as we ask the question as to whether existing European health systems are well placed to make most benefit of current levels of healthcare innovation.

HEALTHCARE INNOVATION

Healthcare innovation has always been central to health system development, but in recent decades, the scale, pace and breadth of change has reached a point where national health systems are finding it increasingly challenging to effectively connect with it. This is necessarily linked to the dynamics of state-funded national health systems, where the relationship between demand and supply-driven innovation can become problematic. As with the section on health need, a summary account of health services innovation is provided in relation to three related areas. Primary amongst these is the digital health agenda, which in itself is providing a massive push to health systems innovation. Secondly are developments within the field of genetics and genomics, often connecting to the digital agenda and in doing so precipitating significant changes in all aspects of healthcare. These connect to the personalisation agenda raised in the previous section. Much of this innovation pushes beyond the boundaries of the traditional focus on treatment and care.

The digital agenda is the most important single change dynamic impacting on modern health systems. The dimensions of the digital health landscape have been effectively set out in the draft WHO Draft Global Strategy on Digital Health 2020–2025 (World Health Organisation, 2020). The document asserts that digital transformation of healthcare can be disruptive, listing in particular the Internet of Things, virtual care, remote monitoring, artificial intelligence (AI), big data

analytics, blockchain, smart wearables, platforms, tools enabling data exchange and storage and tools enabling remote data capture and the exchange of data and sharing of relevant information across the health ecosystem which is

> *…creating a continuum of care have the potential to enhance health outcomes by improving medical diagnosis, databased treatment decisions, digital therapeutics, clinical trials and self-management of care as well as supporting health workforce.*
> (WHO, 2020, p. 4)

The importance of health management in realising the potential of digital innovation has been subject to significant assessment. Commenting on challenges within a unified single payer system such as the National Health Service, a Kings Fund report homing in on a change management study on the role of the health manager stated:

> *Flexibility when managing digital change was a key theme, with sites changing culture where necessary, and keeping the board involved in how the project was progressing at all stages. It was also accepted that digital change requires an adaptive approach that suits the project and the staff who are going to be involved in the change. Crucially, though, users only positively engage with change when they see it as a clinical change, not an IT project.*
> (Maguire, Evans, Honeyman, & Omojomolo, 2018, p. 3)

These are just some of the challenges faced in supporting digital transformation, but they help to highlight how Health Management 1.0 could be considered to be a potential resistor for change as much or rather than a driver.

The reasons presented for the relative lack of progress are structural, cultural and procedural, but the reality is of a platform with the potential to transform health systems only having been successfully rolled out in a limited number of European countries such as in Scandinavia and the Nordic region (Bonom, 2016). This picture of limited and piecemeal progress was disrupted however the impact of the COVID-19 pandemic. Driven by the crisis, the principal means to engage with healthcare professionals moved from face to face to virtual consultations, with a report in the Lancet written at the height of the pandemic stating:

> *In the face of a surge in cases of coronavirus disease 2019 (COVID-19), physicians and health systems worldwide are racing to adopt virtualised treatment approaches that obviate the need for physical meetings between patients and health providers.*
> (Webster, 2020, p. 1180)

Estimating that for the United States the majority of consultations had gone online within a matter of weeks, it became evident that a pandemic had achieved what health systems and health managers previously had not. This is not to say that the situation will not have reverted to a greater balance between virtual and face to face, nor does it suggest that virtual consultations are without challenges or are suitable in all cases. What the example does suggest, however, is that there is a fundamental inertia in existing health systems, which has not always worked in the best interests of wider population or personal health needs or interests.

Personalisation has proven to be a central connecting stream of innovative thinking in healthcare. To an extent innovation around personalisation has been driven by the

need to respond to patients and citizens demanding more bespoke healthcare, but it also reflects technological drivers in fields such as pharmaceuticals where the ability to develop medicines designed around the genetic profile of individuals is leading to a potentially revolutionary change in treatment and care.

Finally, one may turn to genetics and genomics which began to make an impact on health innovation with the accurate and complete human genome sequence completed in 2003. The potential scope of genomics is difficult to assess, tied in as it is to precision medicine and the personalisation agenda but would appear to offer the potential to push health systems towards a transformative stage. Evidence presented of systemic inertia within current models of healthcare which may hinder the timely adoption of new and innovative models of care (Cornel & van El, 2017).

The health system landscape increases in complexity as the pace of change increases, so the question posed is whether the fundamental architecture upon which European Health System 1.0 has been built has the capacity and flexibility to adapt to this. In the next section we turn to health policy itself to assess how it has sought to impact on this change landscape.

HEALTH POLICY IN TRANSITION

Taking as our starting point the WHO definition of health policy, we see it set out in the following manner:

> *Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the*

> *future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.*
> (World Health Organisation, 2020, p. 1)

Health policy will as a consequence be developed with reference to an assessment of demand and supply factors, with the decisions, plans and actions associated with health policy building from a vision to the mission to be delivered by a health system. In this section we give consideration as to how the vision for European health systems has changed over time and how this process may have been impacted by the financial parameters within which health systems are required to operate. Further consideration is given to additional elements of health system architecture including setting the regulatory environment. Building beyond the fundamentals of health system architecture, the section goes on to assess how at a national health system level, health policy-makers have sought to connect the pieces of an increasingly complex and differentiated health environment.

Given the enormity of the challenge facing European health systems, it is notable that references to clear visions for change have often been absent. A paper going back to 1992 focussing on the United Kingdom considered the development of national health strategies, with the authors stating:

> *Consistency in central government policies and communication of the strategy were criticised.*
> (Fulop, Elston, Hensher, Mckee, & Walters, 2000, p. 1)

Strategies are often focussed on particular aspects of health and well-being such as health inequalities, with one study commissioned under the auspices of the then United

Kingdom's Presidency of the EU in 2005 spoke about significant variation of approach (Judge, Platt, Costongs, & Jurczak, 2006). That having been said, there is also evidence that suggests that as a combined thematic approach, health policies can have a significant impact on health practice. An article in the British Medical Journal in 2013 setting out research on health policy in 10 domains including child health, infectious disease and alcohol stated:

> *Differences in health policy performance are not only due to financial resources but also reflect difference in will. Universal adoption of effective health policies throughout Europe would lead to enormous health gains.*
> (Mackenbach, Karanikolos, & McKee, 2013, p. 16)

What this appears to suggest is that European health policies can and do make a difference to the health outcomes of national populations, but there remains a significant inconsistency with regard to the development and implementation of such policies across different European national health systems. Such policies also operate at a thematic rather than a global level and as such are less able to address some of the cross-cutting themes such as patient empowerment or personalisation.

Beneath health policy lies the fundamental architecture around which health systems are built. Comprising parameters for funding including systems for reimbursement, the regulatory framework and commissioning protocols, they have a major impact on guiding how the dynamics considered in this chapter come to play out. Consensus in relation to the principle of state-funded healthcare has been a constant and consistent feature of European health systems. European health systems fall into social insurance and direct state-funded models and there has been very little movement

between systems and even less with regard to drawing in private financing models, be that private insurance or direct payment. A central concern of European health systems has been on government health funding at a percentage of national gross domestic product (GDP). GDP levels vary significantly between European countries as has the percentage take of GDP spent on health. This is also evident in the percentage of overall health spending that is directed towards public health and related preventative measures (Jusot & Sirven, 2012). In broad terms, weighting remains firmly structured towards treatment and care, rather than prevention and self-care (Quaglio, 2013). It is also noted that health systems have been subject to significant regulation at both national and European levels (Legido-Quigley, 2008). The value of this is well established, but when it comes to innovation and improvement the question can be posed as to whether such regulation may have in actuality hindered health systems from taking a more radical path and in doing so acted as a resistor to paradigm change.

HEALTH MANAGEMENT EVOLUTION

Earlier in this chapter we set out how Health System version 1.2 represented the change from health administration to health management. Aligned to the New Public Management Reforms of the 1980s and 1990s health management went through a process of professionalisation, development and expansion, which gave management a broader remit within which to work and a more developed toolkit from which to draw. The question considered in this section is whether this toolkit and these permissions have been sufficient to enable health managers to successfully engage with the change agenda that it has encountered during the last decades. Given that health

management has often found itself caught mediating between a multiplicity of pressures and stakeholder views, having to interpret health policy direction and then to support its implementation, we can focus on the relationship of health management to health system innovation.

Taking first patient empowerment, one might assume that health management would respond to it positively, patients representing as their do the ultimate health service customer and bringing as it does an additional perspective to that provided by health professionals. However, the reality of patient engagement has been more nuanced. Whilst there is undoubtedly evidence of health management successfully incorporating the patient voice into multiple aspects of health system operation, there is a balancing narrative which has found health management acting as an inhibitor of meaningful engagement by patients and citizens and overall progress being limited and tokenistic (Ocloo & Matthews, 2016).

Innovation is an even more challenging domain to assess with regard to the role played by healthcare management. Once again there is amble evidence of health management practice actively and successfully supporting innovation across health systems, including digital innovation and service improvement. But health management has also found reason to challenge innovative practice by means of supporting healthcare professionals against the impact of digital technologies, with the United Kingdom identified as a particularly problematic example (Asthana, Jones, & Sheaff, 2019). In this example the authors list macro, meso and micro factors which in combination are holding back digital innovation in the UK's National Health Service and contend that a greater degree of central direction will be required to '…address the deeply embedded barriers to innovation in the NHS' (Asthana et al., 2019, p. 5).

Assessing the challenges faced by health managers will be the focus of the next chapter, where consideration will be given as to the balance between the skills and competencies of today's health manager as set against the permissions framework within which they operate and the wider health system culture with political, industry and health professional interests to assess and manage. Before moving onto the next part of this chapter, it would be remiss not to consider the managerial and system impact of the COVID-19 pandemic. This is not simply because of the magnitude of the impact that the pandemic has had on global health systems or the concomitant social and economic challenges that have come in its wake. What it has also done is to bring into sharp relief the challenges faced by health systems which were already going through a process of transformation, but which have been brought back to the basics of Health System 1.0, that being countering the challenge of infectious disease through the mechanisms of state managed healthcare. What became evident in many health systems was that with an increasing focus on NCD, many health systems initially struggled to deal with the challenge of managing a large-scale outbreak of an infectious disease. Of particular relevance to the focus of this book is the pressure that the COVID-19 crisis brought on national health systems to return or strengthen a top-down and paternalistic mode of operation. Whether the same can be said for the wider population is less certain, but the impact on the traditional 'doctor knows best' view may have an impact beyond the immediacy of the crisis itself. As one contemporaneous medical blog posted during the first weeks of the pandemic in 2020 stated:

> *The COVID-19 pandemic is causing the world to radically transform its attitude towards public health and national protection in a time of crisis, however*

> *the almost universal establishment of state-enforced health policies is leading some to rethink the more general perception of the 'autonomy vs paternalism' question in medical ethics.*
>
> (Zemmel, 2020, p. 1)

The impact of the COVID-19 crisis may also stretch beyond culture, with the potential to influence aspects of health policy and most particularly the fundamentals of Health System 1.0 architecture. One of the most rememberable quotes regarding politics and the nature of the electoral process came from James Carville as a strategic in Bill Clinton's successful 1992 presidential campaign reminding his team that 'It's the economy, stupid' (Soronka & McAdams, 2015). As we reflect on the global impact of the 2020 COVID-19 pandemic on our collective mindset, this phrase can be usefully reset as 'It's the Hospital Stupid!' The focus and reassurance provided by the bricks and mortar that can be classified as constituting a hospital at a time when dealing with a then untreatable pandemic is fully understandable (Cavallo, Donoho, & Forman, 2020). However, an unintended consequence may be to hinder the current debate as to the most appropriate infrastructure for the twenty-first century health system.

TALKING ABOUT A REVOLUTION?

There is likely to be a high level of agreement that European health systems are in the midst of a significant period of change, albeit with the caveat that this is being experienced within the full breadth of European national health systems to different degrees and at a differing pace. What is more challenging is to establish the scale of this change and to assess the

potential impact on health system sustainability. The basic architecture of European health systems has remained unchanged since they were established in the post-war period. Minor system changes have followed as outlined earlier, not that such developments flowed in a linear form, with developments often following the form of waves rather than steps. Nonetheless, what one can reasonably refer to European Health System 1.4 is the point that we have arrived to at the first quarter of the twenty-first century. The fundamentals of European Health System 1.1 or 1.4 is undoubtedly different from 1.0. Patients find themselves a more meaningful actor in aspects of healthcare ranging from treatment pathways to medicines approval, whilst prevention and self-care now feature prominently in settings from the home to the workplace. There is also evidence of an improvement movement with a focus on realising meaningful change. But Health System 1.4 is not Health System 2.0, and drawing again the analogy between a health system and the World Wide Web, it has not been the case that there has been a fundamental system change in European healthcare, which could be viewed in any way to be an equivalent to the change from Web 1.0 to Web 2.0.

When you draw together the essence of each of the change dynamics set out within this chapter, one is left with a health system with an orientation towards innovation and empowerment with individuals proactively managing their health and well-being within a society which provides the resources and infrastructure to support such an approach. This, though, is less of a modification of current health systems and more of a vision for an aspirational health system which is just as significant as that which forged universal healthcare, free at the point of use in the post-war European landscape. This then returns us to the question as to whether European Health System 1.0 can be moulded into the shape of what appears to

be a significant system update or whether there is a need for European health systems to undergo a process of more fundamental change in the manner than it did when it was first established in the post-war period. There is evidence to support both arguments.

In the concluding chapter, we will return to consider a series of scenarios for European health systems which may play out over the next period. One of these will undoubtedly be continuing iterative change or system updates as we have termed them. But a further scenario will be Health System 2.0, where pressures build to what Malcolm Gladwell has termed a tipping point (Gladwell, 2000). Whilst Gladwell talked about a tipping point being 'that magic moment when an idea, trend or social behaviour crosses a threshold, tips, and spreads like wildfire', there is an evident read across to Kuhn and paradigm theory in that it sets out a path or pressure which builds to the point that the status quo proves to be sustainable no longer. What happens next is less certain. If history has taught us anything then, it is that system inertia is capable of absorbing major shocks, allowing a return to a status quo that had previously been viewed to be unsustainable. The breadth of stakeholder representation with vested interest in the status quo will make a Web 2.0 moment challenging to achieve. But there is evidence that a parallel Health System 2.0 may in fact start to develop outside of the strictures of national health systems. This suggests an idealised future for healthcare where health need is systematically addressed, the orientation of healthcare moves from paternalism to empowerment and the full benefit of health innovation can be realised. This would also include a full accommodation of the changing needs framework, with an orientation to ensure that prevention and self-care are integral to the new vision.

Paradigm change, system update or tipping point are not processes which can be centrally shaped or directed, which leads to the question as to how would we know if we had

reached Health System 2.0. The short answer is that we might not be able to make such an assessment. However, it could also be that criteria could be developed to help us. Thinking these, though, we could begin to look at the question from a number of angles. Various attempts have been made to develop criteria to assess health system preparedness in relation to digital health or personalisation (Odone, 2019; Digital Health Index, 2019; Future Proofing Healthcare, 2020). Ranking issues on the basis of a scale is one way to begin looking at this issue. Further examples of this could be to have at one end of the scale paternalism and at the other empowerment. One can then assess on the basis of policy, structure, incentives, culture and outcomes the extent to which a particular health system is closer to one end of the spectrum than the other. A second potential measure could be proactive versus reactive, with the former being characterised by a health system built around health literacy, prevention and empowerment and the latter treatment and care. A final dimension could be posseted to be based around the original WHO definition of health with absence of illness at one end of the spectrum and health and well-being at the other. This would be a complex and potentially arbitrary process which does not allow for that more nebulous idea that 'you will know it when you see it!' Such is the case with system change in that whilst you can account for the pressures which may create change, it is far more difficult to make an assessment as to whether European Health System 1.0 has in fact passed its tipping point.

CONCLUSIONS

In this chapter we have considered the establishment and development of what we have termed European Health System 1.0 and its subsequent evolution. Publicly funded and broadly

free at the point of use, European Health System 1.0 has progressed through system change in the half-century since the 1970s. Seeking to improve its efficiency and effectiveness, it has attempted structural change in primary, secondary and tertiary care as well as in mental health as institutional care gave way to a more community-based approach. The market has been introduced in various ways, with the majority being provider-focussed and little appetite to countenance anything more than limited private sector involvement. Health policy reform has seen the tide coming in and then going back out again with respect to the level and form of central government control. Decentralisation has become a means to help address some of the inherent weaknesses in a predict-and-provide model of care. So too the health management reforms which began alongside New Public Management in the 1980s and which continued to develop and expand into the 1990s and beyond. Not only has health management become more firmly embedded in all aspects of the modern health system, but also principles of health management have found themselves incorporated into health professional education, training and practice.

It has been set out that in addition to the structural challenges faced by all health systems which have centred on the difficulty of balancing access, affordability and quality, there have been emergent themes relating to evolving and growing health need set against a landscape of increased personalisation and patient empowered. Health systems have gone through periods of change, which have sought to address organisational, political and cultural challenges albeit with limited success. The version of the European health system today not only appears to have had only partial success in addressing the challenges it has faced but also has found it difficult to realise the benefits being offered within the health innovation and improvement space.

The central conclusion of this chapter is that the fundamental dynamics informing European health system development are changing in a manner and at a pace that must be considered to be significant. Whether this will see a shift from Health System 1.0 to 2.0 remains a moot point, but it is one which requires our further attention. In the next chapter we turn to look in more detail at how health management practice has sought to adapt to these changing times and consider the extent to which the health manager can act as a facilitator or agent of change and in so doing can help usher in Healthcare 2.0.

3

HEALTH ORGANISATIONS IN TRANSITION: FROM IATROCRACY TO CORPORATISATION

Federico Lega

INTRODUCTION

Health systems and organisations are trying to cope with the new normality through actions both at policy and organisational levels. We will briefly recall here what is taking place at policy level. Then we will discuss in depth the trajectories of change at organisational level, where new designs, new roles and leadership responsibilities are emerging and redefining the need for what we named 'management 2.0'. Fig. 3.1 illustrates the *fil rouge* of this chapter.

THE RISE OF PROTO-MANAGERIALISM

The issue of securing health system and health organisation sustainability has become very popular, dominating public debate over the last 30 years (1). The 'new public management'

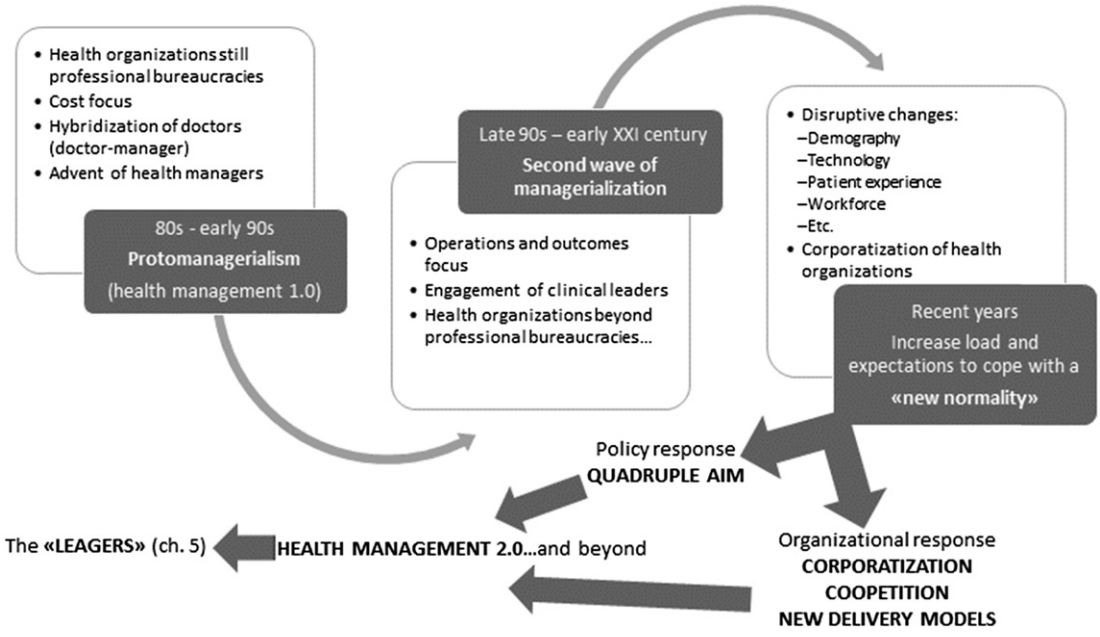

Fig. 3.1. Health Organisations and Managers in Transition. *Source*: Lega (2020).

approach implemented in the '90s by many European countries contributed to the great emphasis put on the financial management of health organisations. The introduction of austerity measures was the most common strategy used by European countries during the recession which began in 2008 (Green, 2018).

This is of no surprise, since according to the Romans 'primum vivere, deinde philosophari'. However, the cultural dominance of the economic field caused a cultural shift, an inversion of ends and means, whereby cost management became 'the one and only issue'. Consequently, health systems and health organisations were often reconfigured, transformed, downsized, merged, redesigned, streamlined, etc., for the purpose of improving their cost management capacity: to reduce costs.

It was in this environment that what can be labelled 'proto-managerialism' emerged in the 1990s in many health systems and health organisations.

Before that period, the model of 'professional bureaucracy' described health organisations well, as they were characterised by a functional specialities-based internal design. Such design was fit to accommodate specific needs driven mostly by the interests of the medical class, such as

- The need to develop a specific expertise and skill set, from the allocation and ownership of resources and logistics (beds, operating theatres, outpatient clinics, nurses, health staff, etc.) to clinicians.
- The need to clearly separate (and position) the 'turf' governed by different physicians in the same hospitals or across different hospitals, a common path in professional contexts.
- Staff self-interest, whereby the distribution of doctors and medical work was more influenced by professional interest,

financial inducements, rivalries and career aspirations than by patients' needs. In general, the influence of power and politics on organisational design choices is well-documented (Perrow, 1986; Pfeffer, 1981, 1992).

The common root and progress of medical knowledge and specialities led to striking similarities in the organisation of hospitals located in different countries, such as the United States and Latin American market-oriented countries as opposed to NHS and public system-based countries. Additionally, healthcare management tended to be characterised as passive and custodial in deference to professional groups – especially physicians – who exerted considerable control over healthcare demand in all contexts (Ackroyd, Hughes, & Soothill, 1989; Hanlon, 2001; Perrow, 1965).

In the 1990s, this model was revisited with two major paths of change:

1. The introduction of a layer of top management (CEO, COO, CMO, etc.), apt to guarantee better unitary management and strategic development of the health organisation.
2. The development of a stronger 'technostructure' to serve the needs of management. Planning, budgeting, management control, quality and strategic human resource management are some examples of the functions that quickly emerged within health organisations and were responsible for developing and running operational mechanisms that supported clinicians' decision-making and accountability.

This marked what can be considered 'proto-managerialism'. Health organisations started to practice more structured decision-making processes concerning planning, investments,

budgeting and performance appraisal. Yet the results were not very satisfying. Research has shown that clinicians often did not play the game. Three major responses emerged. (1) Circumvention: that is involvement in management in order to legitimise existing behaviour and power, in accordance with the idea of purely self-serving leadership. (2) Custodial orientation: involvement limited to the minimum necessary reporting and budgeting. When senior professionals reluctantly took on administrative roles, their approach was often predominantly 'custodial', wedded to the concepts of practice held by the service providers themselves (Kirkpatrick, Bullinger, Lega, & Dent, 2013). The focus was not on the organisation, but on serving the interests of the professional base. (3) Partial hybridisation: that is when clinicians transformed into 'finance doctors' and (unfortunately) financial viability explicitly or implicitly determined clinical choices. A fourth category is the one of the 'fugitives'. They simply did not play the game at all (Lega & Sartirana, 2016).

This is why this phase was called proto-managerialism. Health managers, the top managers, did try to introduce management practices within hospitals and health organisations, facilitated by the emergence of accounting systems and output measures (i.e., DRGs), but often this resulted in cost management and financial micromanagement. It was necessary, but not sufficient to support the leap towards the type of management required by an increasingly turbulent and dynamic environment. After all, healthcare is the prototype of a volatile, uncertain, complex and ambiguous (VUCA) context.

Unfortunately, during the years of austerity, this approach was further reinforced by external pressures. There was a lack of strategic planning or thinking. Management was mostly reactive. Innovation was often still adopted randomly, according to professional or political interests. Discipline on operations was weak. The same symptoms were spread among all European countries.

Acknowledgement of this situation spurred renewed attention to the process of health service delivery managerialisation. According to recent studies and debate, management seems able to enhance value produced by health systems, organisations and professionals (Ham, 2012; Lega, Spurgeon, & Prenestini, 2013; Porter & Kaplan, 2011). Therefore, most health systems started to wonder how to improve the managerialisation of their health organisations (Kirkpatrick, Bullinger, Dent, & Lega, 2012; Lega, 2008; Lega & DePietro, 2005; Lega et al., 2013). But which kind of management should be employed? Which managers? How could professionals become engaged in the game? How could management be reconciled with ethics in the face of sensitive decisions?

FROM ROWING TO STEERING

The second wave of managerialisation started when health systems, under the huge pressure of sustainability, started to recognise that they had to shift their focus from the predominant attention to cost management if they were to survive and retain legitimacy. We can position this phase as starting around last years of the first decade of this century.

Two major goals came into the picture: Operations and Outcomes. Until the '80s the control of health systems was mainly based on allocation of input, in the '90s output measures were introduced and by the late 1990s and at the turn of the century, outcome measures emerged. Only very recently was focus on PROMS and PREMS introduced. Although clinical/critical pathway tools, process re-engineering approaches, lean management techniques, etc., emerged in the '90s, their implementation was patchy and limited. Clinical governance tools and audit methods have also only started to flourish and spread over the last 10 years (Buja et al., 2018).

During the recession years, decision-makers tried to gain even more control over health system costs through renewed focus on input. Limits were imposed on health organisations from recruitment and personnel replacement, to purchasing and borrowing policies, to experimental new technology implementation. Payments and tariffs of care treatments were re-negotiated and reduced. Whatever strategy was used to keep health expenditure under control, in the short term, all health systems focussed on input control.

Clearly, this scenario prefigured the risk of rationing and a lack of focus on quality and outcomes. Thus, operations and outcomes slowly but steadily became more evident (Lega & Calciolari, 2012; Lega, Villa, & Barbieri, 2009).

'Appropriate' sustainability required a new focus for managers and for the professional system. Operations and clinical choices became the target. There was a need for a new management approach that would help to address prioritisation issues arising in decision-making at both the strategic and shop floor levels. Something to support the improvement of delivery processes through better understanding and action on the 'black box' of clinical processes. Inappropriate use of diagnostics, drugs and therapies, defensive medicine, artificial variability, turf wars among specialists and waste of resources could no longer be sustained. Some sensitive decisions, such as when to use expensive bio-drugs, prostheses or medical devices in patients with a low probability of positive outcome or which prosthesis or drug to adopt for patients with limited life expectancy, were emerging on the agenda of public and social insurance-based systems. Outcome became the North Star for decisions with ethical implications.

Therefore, managers and professionals had a new focus at the top of the agenda. Meanwhile, the 'value-based healthcare' paradigm was substituting and incorporating previous mantras, such as TQM, process re-engineering, lean, patient-centred organisations, etc.

From recent studies and debate, it was apparent that good management could enhance the value produced by health systems, organisations and professionals (Bloom, Propper, Seiler, & Van Reenen, 2009; Goodall, 2011; Spurgeon, Clark, & Ham, 2011). The value of management as a mean of better management of value was being addressed.

Evidence was increasingly demonstrating that management does matter. Not just the proto-managerialism of the first phase, which indeed supported health organisations to improve their rowing, the aim of 'doing things right'. It had also become time for more effective steering. Managers were acting as leaders and helping their health organisations to 'do the right things'. Doctors were turning into clinical leaders, fully engaged in sustaining the effort of their organisation to improve operations, clinical choices and strategic development. This was effective hybridisation, where managerial values were assumed and integrated with professional values: the mix generating better strategic orientation (Goodall, 2011; Prenestini & Lega, 2013).

As a consequence, two new functions grew significantly within the health organisations' technostructure: clinical governance and operation management to serve the new focus. The same path, albeit at a different pace and different 'translation', was observed throughout Europe (Kirkpatrick et al., 2012; Lega & DePietro, 2005).

Yet while management was evolving in this direction, recession hit Europe, and new challenges and aspirations emerged. Good perspiration was not enough for health managers. There was an increasing need for inspiration. A 'new normality' was redefining the health sector.

Understanding the type of leadership needed and developing its skills and practices went to the top of the agenda for the next level of management: 'management 2.0'.

A NEW NORMALITY

To answer the question of the leadership needed and how to develop it within health organisations, it is necessary to have a good understanding of the contents and needs generated by 'new normality'. There are two clusters of changes taking place in the health sector that are reshaping the context for management (Lega & Calciolari, 2012).

The first cluster concerns 'evolutions' currently in progress. Health organisations face several challenges due to

1. Varying patient epidemiology determined by
    - the ageing of the population leading to a need for a new type of care
    - an increasing number of 'frail' patients (chronic, frequent-user, not self-sufficient) who need an integrated continuum of care
    - more high dependency or critical patients, but not so unstable as to require intensive care
    - post-acute surgical patients needing a medical tutor (i.e., 'ortogeriatic' patients)
    - a higher number of elderly patients with cognitive problems, complex social backgrounds, etc.
2. Technical and technological innovation in service delivery
    - new treatment opportunities due to new skills
    - operations with quick recovery (day surgery, one-day surgery, week surgery, etc.)
    - freestanding surgery, mininvasive, robotics, etc.

- increasing risks of 'turf wars', due to the overlapping of 'catchment' areas between medical, surgical and interventional diagnostics (i.e., cardiovascular, neuroscience, oncology, etc.)

3. Expectations of improved flow and quality of care

- building patient-centred hospitals, with the care setting designed around the needs of the patient
- increased efficiency and productivity
- specific pathways designing for urgent vs elective care
- multidisciplinary 'production platform' (wards, operating theatres, intensive care, outpatient rooms, etc.) designing, with flexible allocations (i.e., pool beds, OT jolly, etc.)

4. Accountability on outcomes

- showing a track of attention paid to evidence-based medicine and clinical governance
- taking into account prems and proms

As if all the above challenges were not enough – and they are certainly only a subset of what professional managers are really facing – there is the second cluster of issues to remind us why healthcare is the most complex environment and health organisations the most challenging to manage: the prototype of the VUCA environment.

Health systems are facing a new normality not merely of evolutions, but of 'revolutions'.

Disruptive innovation is fast and furious: artificial intelligence, robots, precision medicine and regenerative medicine. Technology and algorithms are set to run healthcare. Financial

struggles are common to all countries, even the richest. In many places, healthcare professionals are experiencing a loss in status and role and there is a widespread shortage of doctors in many developed and developing countries.

New business models are emerging and spreading: low cost or low-price healthcare, focussed hospitals, medical tourism. In this context, it seems new paradigms are needed for this new normality. As a matter of fact, a paradigmatic revolution is what the cohort of managers has to face.

Henceforth, there is enormous space to develop new strategic directions.

Some hints: the health sector rather than just the system needs to be looked at. Relationships between public and private players are evolving in different directions. Coopetition is pairing competition. Furthermore, industry and health authorities/providers relationships are undergoing profound transformation. What is the sense of partnership here? Where is the ground to cooperate?

Patients are as central as ever. How can the shift from compliance to concordance be made? How can co-creation and co-production of services be developed? Empowerment is not only what is required but also engagement and co-responsibility.

Chronic care models are evolving in population health management. But what is happening exactly? The focus is shifting towards risk factors and prevention. How can this be organised? How is this going to change orthopaedics, neurology, cardiac care, etc.?

Task shifting and skill mixing have been on the agenda for the last 20 years, yet there is little research on the matter.

Hospitals claim they are patient-centred: is it just propaganda or is real transformation happening? Are managers significantly improving patient flow logistics? After all, no patient likes to stay in hospital, everyone has the right to be treated as fast as possible. Patients' time is precious too, so

services should be designed to match patients' needs. If these simple concepts are adopted as 'ambitions', then health managers and clinical leaders could really be able to transform hospitals into patient-centred organisations, even to some extent client-centred ones.

Therefore, in view of these disruptive revolutions, there are still two pressing questions: what type of leadership is vital for these changing times and how are organisations management practices evolving?

RESPONSES AND THEIR TRANSLATION ACROSS EUROPE

Health systems and organisations are reconfiguring under the pressure of the new normality they face. Significant changes are taking place at policy and organisational level – redefining the need for what we named 'management 2.0'.

The Policy Level

Here the major effort is to implement logics of the population health management. That is, managing health and wellness, proactively, with a focus on prevention, risk factors and disease management for chronic conditions, supporting co-creation and co-production of health services. In this light, increasing 'health literacy' is a challenge both for patients and health organisations (hence, for 'management 2.0'). If we really want to change the dominant paradigm in the care provision from compliance to concordance and from empowerment to self-management and co-production, we need to raise the level of health literacy in all 'players' of the health chain. Investments in health literacy seem particularly worthy, as quality, efficacy and sustainability have a positive

correlation with co-production and concordance. Further, if better informed and educated patients are more difficult to manage by clinicians, they will also be keener to spot and assess the deficiencies in care provisions. In the end, this 'pressure' could lead health systems and professionals to make that leap towards a more patient-centred organisation that is expected and desired.

Population health management is often connected with the notion of 'Triple Aim', which is an approach developed by the Institute for Healthcare Improvement (IHI) in order to optimise health system performance (Berwick, Nolan, & Whittington, 2008). According to IHI, the goal of the Triple Aim is to 'improve the patient care experience, improve the health of a population and reduce per capita healthcare costs'. It's a single strategy with three key goals.

Recently, an additional fourth goal has been introduced – improved clinical experience – leading to the creation of the Quadruple Aim (Bodenheimer & Sinsky, 2014). The idea is that without an improved clinical experience on the provider side, the three other patient-centric aspects will not reach their full potential.

The four components of this framework, around which all European Countries are developing their current strategic directions of health policy, are:

1. Improved patient experience: Improving the patient experience aims to enhance the quality of care that patients receive, having a greater focus on individuals and families. Focus is on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. This means adopting logics of business modelling in healthcare to design service delivery. And specific attention is given to health literacy, as more educated patients can manage their health more effectively.

2. Better outcomes: With the Triple Aim also naturally comes the goal of improving the health of the overall population. Measuring outcomes, more transparency and pay for performance are the pillars.

3. Lower costs: The Triple Aim intends to reduce the per capita cost of healthcare. Keeping this aspect linked with improved patient experience and improving the health of populations ensures that while costs are driven down, the quality of care is not compromised.

4. Improved clinical experience: The aim is to create conditions and motivations for the most effective delivering of health services. It's a responsibility of managers. The pressure that is put on caregivers is immense, leading to unwanted outcomes that can negatively affect the quality of care provided. Research highlighted the correlation between decreased staff engagement or burnout and lower patient satisfaction, reduced health outcomes and higher costs – which goes directly against the Triple Aim. In order to combat this, an improved clinical experience should be included in the Triple Aim, updating it to the Quadruple Aim. The Quadruple Aim is the framework that guides the direction that health systems – including both patients and providers – should pursue. As Rome was not built in a day, the change will not happen overnight, nor will improving the health system performance. It's a long-term horizon that will be reached through short-term goals (and ambitions) set by single providers and authorities.

The Organisational Level

Here the change seems to converge around two major patterns: coopetition and corporatisation. Both are not new concepts. They have been around for decades. Yet, only in the last 10

years we saw their extensive diffusion and adoption. However, before going into describing the contents of both paths, some caveats are required. While there are strong indications that these developments have become 'international fashions', they have been subject to translation, as existing comparative research points to 'distinctive national or regional variants' (Dent, 2006) in the way reforms have been introduced.

The existing literature on health management reforms offers a number of clues for to how one might account for variation between national systems. Some authors have emphasised the importance of path dependency in health regimes and how this can mediate both the timing and direction of reforms (Burau & Vrangbæk, 2008; Dent, 2003). Others focus more on the role of the clinical professions and how differences in the power and resources (for example, in terms of cultural and political capital) might influence their response to changes in job roles and expectations (Degeling et al., 2006; Kuhlmann & Allsop, 2008; Kurunmäki, 2004). However, the translation done at country level did not change the substance of the two paths of innovation, which remains true at all latitudes and longitudes.

COOPETITION

Coopetition is a neologism coined to describe cooperative competition. Coopetition occurs at inter-organisational level when companies interact with partial congruence of interests. They cooperate with each other to reach a higher value creation if compared to the value created without interaction and struggle to achieve competitive advantage.

Often coopetition takes place when companies that are in the same market work together in the exploration of knowledge and research of new products, while at the same time they compete for market share of their products and in the exploitation of the

knowledge created. In this case, the interactions occur simultaneously and in different levels in the value chain.

While there are well-known difficulties in this process, as distribution of control, equity in risk, complementary needs and trust, several advantages can be foreseen, as cost reductions, resources complementarity and technological transfer.

In healthcare, coopetition is developing through the creation of vertical and horizontal networks promoted by the member institutions. Vertical networks refer to the strategic alliances between levels of care: hospitals with rehabilitation centres, primary care centres, family physicians, etc. Horizontal networks refer to integration at the same level – hospital with hospital. The development of multi-hospital networks is a widespread trend in the healthcare systems of main industrialised countries. It started in the late '80s in the United States.

Horizontal networking implies an overall reorganisation in services' delivery, with a differentiation of complexity and concentration of volumes of cases treated at different sites or hospitals in the network. Coopetition through horizontal networks generates opportunities for consolidations, repositioning and further specialisation of clinical services. These relate to changes in the clinical services mix, whose reasons can be traced in different expectations (Lega, 2008):

- Economic gains resulting from rationalising of services by reducing excess capacity to treat patients, such as operational savings emerging from consolidation of specialities and services and closure of units.
- Volume-based quality improvements, given by the concentration of services in fewer units (duplicated and redundant clinical units are merged).
- Identification of areas of excellence, on which the services portfolio should be concentrated to generate and to sustain competitive advantages.

- Quality improvement due to more effective staff recruitment and staff retention, as the network brand becomes attractive.

Specifically, changes that could be facilitated by 'coopetitive' horizontal networks among hospitals are

1. Consolidation and repositioning of clinical units, such as line units (surgery, medicine, gastroenterology, urology, etc.) and ancillary services (radiology, laboratory, pharmacy, etc.). Two possible sub-strategies are

    - Designing a hub and spokes organisational model, in which, with respect to the same clinical speciality, some units that represent centres of excellence are identified as network's hubs, while the others operate as antennas or peripheral centres (Lega, 2005). This design supports the implementation of a policy of separation of simple and routine procedures from those that are complex. The simple interventions (usually carried out in ambulatory or day hospital and day surgery settings) are executed in peripheral centres, while the complex cases are always managed by the centre of excellence (hub). In this way, peripheral centres work under maximum efficiency conditions, while the hubs concentrate complex activities developing know-how economies (expertise) and better volume-based quality.
    - Re-designing hospitals' vocations, from general (community hospital) to specialised (speciality hospital). This enhancement of the specialisation of the different hospitals allow for re-directing both simple and complex cases belonging to a specific discipline towards the facility where the required competencies are located. In this

manner, a focussed factory is created (Skinner, 1974), a hospital which is specialised in one or few areas of interventions, but which runs all the services and specialities needed for treatment of eventual complications and to carry out necessary diagnostics procedures. Some examples are focussed clinics for the treatment of hernias or cataracts and also cardiology, paediatric, oncology, orthopaedic, ophthalmologic and psychiatric hospitals. The process of specialisation facilitates the concentration of knowledge and expertise: productivity, efficiency and volume-based quality are underlying the goals.

2. Hospital closures or restructuring. Unproductive or redundant hospitals might be closed or converted into different structures, such as nursing homes, outpatients centres, community mental health centres, rehabilitation centres, etc. This choice is consistent with the goals of hospital-based contexts where healthcare delivery needs to be shifted to primary and community-based care settings. They represent very delicate strategic choices because they normally generate internal as well as external resistances from employees, citizens, institutions and other stakeholders. The fact that the hospital closed or re-converted belongs to a network, which guarantee the delivering of services previously managed by the hospital and the repositioning of its employees, might facilitate the process.

Developing 'coopetition' is a main challenge for health managers.

Clearly, the network objectives and strategies must be in tune with the powers attributed to the governing body, whichever they may be. In fact, on one side, there can be objectives and strategies for which a 'weak' (loose) governance (based on alliances, inter-institutional collaborative contracts,

informal agreements, etc. – types of integration that have been labelled as 'virtual integration' (Lega, 2005)) of the multi-hospital system might be well suited, as for projects of cooperation on matters of public interest (the construction of an hospice, the coordination of emergency services, etc.) or for investments otherwise not socially justifiable or financially sustainable by a single facility (the purchase of high technology, the opening of new specialised service requiring to be professionally and economically viable for a market embodying the population served by more than one facility). On the other side, there can also be goals and strategies for which a 'strong' (tight) governance body (based on a unitary governing body resulting from mergers or creation of holding structures) is desirable if not indispensable. For example, this seems to be the case of networks aiming at the rationalisation or downsizing managers, professionals and other personnel, at closure or repositioning of some services, at other 'radical' actions.

Also, among the main obstacles, there is the difference in cultures between 'coopeting' organisations – a very important barrier to bringing organisations together (Prenestini, Calciolari, Lega, & Grilli, 2015). This is particularly true when referred to the clinical practice, where the evidence-based medicine has not yet reduced significantly the 'grey areas' of mixed evidence which allow clinicians to retain profoundly different opinions and procedures on same problems. From a general point of view, other barriers and drawbacks to successful performances of networks might be

1. The false myth that bigger is better, whereby it is believed that the larger the network grows (in terms of number of joining hospitals/sites), the larger are the cost saving opportunities and the better is the competitive position. This is not always true:

- As already discussed, there are emerging transaction costs. They skyrocket as the number of hospitals increases and geographical distance among the hospitals becomes relevant. Many players, or few dispersed players, are in situations that are extremely hard to manage and put cost savings strategies linked to consolidation processes at risk. Some studies show that optimal size for the network is around six to eight hospitals (Lega, 2005). On very large dimension, it could be advisable to subdivide the network into partially or completely autonomous sub-networks, in order to avoid excessive transaction costs.
- Attractiveness of services and reputation do not depend much on the size of the network, but more on its internal composition. Large network formed by hospitals with a weak reputation will not experience a proportional competitive success, even in a dominant monopolistic-type position (whenever possible, people and third-party payers will anyway look for other providers).

2. The reduced accessibility for external stakeholders, which used to have direct access to top management and after the consolidation might have to deal mainly with 'peripheral' middle managers (Fulop et al., 2002). In case of tight integration, local stakeholders on one side could feel the senior management as remote, and on the other side they might become very concerned about the ability of top management to oversee quality and efficiency of outcomes delivered in the network's peripheries. Limited travelling times between sites and a fast and trustworthy communication system are crucial to ensure a good tight central governance. Otherwise, it might be better to opt for a looser governance based on strategic coordination of independent but cooperative hospitals.

3. The temptation of 'cashing' in a very short time all the possible savings, which could threaten the system's ability to develop itself in the medium to long term due to the eventual negative impact on personnel morale and commitment (Lega, 2005).

4. The temptation, on the contrary, of making the 'easy' choice of postponing critical consolidation actions (clinical services consolidations, hospitals' closure, structural redesigns, etc.), which are key to the concretisation of the network's expected benefits. Network's executives could be wary in implementing radical cost savings strategies for two reasons: on one side because these strategies inflame resistance from physicians and other employees adversely affected, and on the other side because such strategies might discourage possible opportunities for future mergers or network's enlargement. Hospitals who were thinking of joining might be worried about their future, and barriers to integration are immediately reinforced by the ones that forecast to be adversely affected. Nonetheless, action is necessary as to secure the benefits projected and to avoid morale downfall due to negative impressions regarding the network's commitment to deliver on its premises (Weil, 2000).

5. Given the above challenges (and opportunities) it is clear how much we need a 'Health Management 2.0', leading coopetition development through strategic visions and managing through strong practices.

CORPORATISATION

By corporatisation we mean reforms of governance of public and private health organisations that have included the following: (1) increasing the management autonomy of the organisation (autonomisation); (2) exposing health organisations to market-

like pressures and (3) divestiture of the organisations from the pure public sector regulations (semi-privatisation). The whole process started with the advent of 'New Public Management'. Changes (1) and (3) referred mainly to the public domain, while (2) affected all kind of health organisations that increasingly are facing market-like contexts, greater expectations in terms of outcomes, transparency and accountability to the system and challenging financial pressures. In response, a new 'entrepreneurial' and business-like mindset seemed to be necessary to survive the evolving environment, both at top level and middle level and from CEOs to clinical leaders, from board to bed side. In this light, corporatisation of health organisations drew more attention towards benefits of coopetition. But even more interesting is the shift that corporatisation determined in the internal design and dynamics of health organisations, especially in hospitals.

Clinical directorates have been created, and benchmarking of departmental performance has been introduced. Many of these efforts are part of the growing trend towards applying 'best-practice' management techniques from private companies to reform governance of the hospitals. Frequently, attempts are made to introduce business process reengineering, patient-focussed care or quality improvement techniques.

Clinical directorates (CDs), in the sense of 'intermediate organisational arrangements through which defined parts of larger hospitals health services are managed' (Lega, 2008), were introduced in many health systems since the mid '90s. By means of such reform, accountability chains within hospitals were streamlined. Changes – starting with the introduction of a stronger role for Chief Executive Officer (CEO) of the hospital – looked at strengthening the role of management in hospitals as a strategy to improve efficiency in the provision of services. From this stream of managerialism emerged the attempts to reorganise hospital activities along the lines of

CDs. CDs were also labelled divisions, departments, business units, etc., representing a divisional design in organisational terms which, as Braithwaite and Westbrook (2004) note,

> *…are distinguishable from traditional ways of structuring and managing acute health services which emphasized discipline-based (urology, cardiology, thoracic surgery, etc.) and functional groupings such as medicine, nursing, and administration and finance.*

While it spread worldwide only from the late '90s, the model of CDs originated at the Johns Hopkins Baltimore teaching hospital in 1972 (Chantler, 1989; Heyssel, 1989). As it was described 'the essence of what became known as the "Johns Hopkins Model" consisted of grouping resources, with specialties and doctors aggregated in multispecialty units, each managed by a team (or triumvirate) headed by a medical chief, supported by a lead nurse and administrator. Each group (or, later, Directorate) was given responsibility for a budget and made accountable for direct costs with discretion to allocate resources and purchase services such as cleaning, catering and maintenance. Lead clinicians were also made responsible for the operational performance of their units ("translated" as divisions, departments, clinical directorates, clinical service lines), delivery against targets and the human resource management of staff. In organizational terms, the model involves a break from the traditional functional structure (say with single specialties and specialists running hospital resources, while health care management tended to be characterized as passive and custodial in deference to physicians who exerted considerable control over health care demand without management control) with the hospital representing a kind of "holding company" of semi-autonomous divisions (based around product/service lines or clusters of activities) (Lega & DePietro, 2005)'.

Expectations on benefits from CDs were the following:

- Re-integration of hyper-specialised competences, so as to improve their clinical governance through a better integration of clinical pathways and the mutual respect of areas of expertise (to minimise potential 'turf wars'). Corporatisation through CDs also include intra-organisational coopetition that occurs between individuals (inside CD) or units (among CDs) within the same organisation.
- Exploitation of scale and scope economies, by sharing the CD logistic resources (beds, OR, ambulatories, etc.), technologies and ancillary staff.
- Improving corporate governance and reducing the 'span of control' for CEOs.
- The assumption was that by treating clinical departments as business units, hospitals can transform their approach to management and achieve considerable clinical, operational and financial results.

As noted by Bury, Carter, Feigelman, and Grant (2008)

> *Departments (divisions, CDs, clinical service lines) can be regarded as equivalent to the business units, or service lines, in a commercial organization. Each department functions as a service line responsible for the quality of the product delivered, the customer's satisfaction with that product, the productivity of the people who work in the department, and the department's economic performance. For hospitals, the product is patient care, and economic performance is the degree to which a department provides that care within the limits set by a country's reimbursement system. Clinical departments can*

> *function as service lines only if they have the power to make decisions. Thus, Service Line Management (SLM) allocates autonomy to the front line: the clinicians in each department, particularly the clinical directors, have greater control over its activities and greater input into its long-term goals. Of course, this autonomy must be earned. Clinicians must accept greater accountability for the functioning of their departments, and all departments must be monitored regularly to ensure that performance problems are corrected. […] We strongly believe that each service line should have a single point of accountability, so we recommend each one to be headed by one clinical leader. If a hospital wants a clinical leader and a general manager to share service line leadership, it must make sure that both parties understand who is responsible for making final decisions. […] These clinicians will need to understand the broader challenges their hospitals face, to accept ownership of their service lines, and to be capable of making decisions that take into account many financial, operational, clinical, and human factors.*

Implementing SLM is challenging because it requires a number of important changes to the way a hospital works; the key elements include its organisational model, culture and capabilities and its approach to strategic planning. Implementation also requires robust systems for managing performance and information. However, hospitals that have implemented SLM have found the effort worthwhile. Clinicians can indeed drive operational effectiveness, so their hospitals can deliver higher-quality healthcare, provide patients with a better experience and perform more efficiently (Bury et al., 2008).

Even if the introduction of CDs and SLM suggests a convergence of hospital management around the world, it is clear that there has also been much scope for variation and translation of the CD concept both within and between health systems.

The overall characteristics of health systems could also impact on the speed of change. In 'command and control' NHS, like Italy and France, the CD model was prescribed centrally through legislation, and adopted quickly and in a relatively standardised fashion, partly as a result of coercive isomorphism (Lega, 2008). In decentralised systems, such as Germany or the Netherlands, adoption occurred more by mimetic isomorphism, with replica of 'best practice' imported from high-profile institutions from abroad, like the United States (Kirkpatrick et al., 2013).

Notwithstanding these differences in timing, it is well recognised that the establishing of CDs gave to hospitals the ground to pursue their own corporatisation process. The intention of the clinical directorate model was to create a single line of command, with all clinical staff reporting through to directors and ultimately the CEO.

HYBRIDISATION

The introduction of the CD model generated a shift in focus: the source of legitimacy for the hospital increasingly became its performance, and the board of directors became the source of authority (Thornton, Jones, & Kury, 2005). This corporatisation also led to 'managerial-market orientation' (Scott, Ruef, Mendel, & Caronna, 2000) or 'efficiency logic' (Arndt & Bigelow, 2006).

CDs are expected to facilitate the development of 'business modelling' within health organisations. Modern healthcare needs a new approach in designing and reconfiguring care

provision. Business modelling can be a driver and a solution for this challenge. If the necessary mindset in healthcare to identify a business model in providing care is adopted, there might be a better chance of designing a care delivery process that answers the right questions: who needs to be served, how, with which portfolio of services and core and peripheral components, what resources are needed.

In other words, health organisations and their professionals need to be pushed into asking the big question: 'what makes us valuable?'

If hospitals and health organisations are able to answer such a question, they would most likely develop much more 'customized', efficient and effective care provision through business modelling. Chronic care, precision medicine, personalised therapy and many other disruptive changes in modern healthcare will increasingly call for this new mindset.

As the pace of change is increasing, as systems, organisations and professionals are introducing new models to cope with sustainability and quality challenges, health managers have the responsibility to react quickly to investigate and assess these changes.

CDs, and similar development within health organisations, such as SLM, required doctors 'engaged' as clinical leaders. Not only the CEO and other top managers were requested to speak the language of private sector management, but also the leadership role of doctors was emphasised in the new organisational architecture of hospitals and health organisations (Lega, 2008). Chantler (1989) noted that 'In return for the freedom to manage their own affairs they [clinicians] had to accept responsibility for the financial consequences'. Lega (2008) also noted that some CDs in the Italian context acted as if they adhered to management principles as a pragmatic strategy to safeguard their identities and achieve their professional objectives.

As a matter of fact, the engagement of doctors – often referred to as a process of hybridisation – was neither a given nor an easy task. How much and how far did doctors want, or understand, the roles required to lead CDs? Conversely, did they adopt forms of 'custodial orientation' instead (Ackroyd, Hughes, & Soothill, 1989) going into leading positions with the aim of maintaining the status quo and protecting the interests of the professional community?

The evidence seems to point to different outcomes for a number of reasons (Kirkpatrick et al., 2013). Sometimes clinical leaders of CDs were bypassed by their own doctors, as the latter – through their own (specialist) hierarchy – could refer to a staff committee or similar organism, often with veto power on decisions take by CDs (as in the Netherlands or France). CEOs and Medical directors interfered with CD leaders as they wanted to keep direct contact with doctors and 'nurture' consensus within the organisation. CD leaders lacked management levers (incentives, penalties, planning powers, career management, etc.) to be really influential over their ranks. Compensation and benefits were not attractive or stimulating enough to generate the necessary dedication to CD leadership roles. As a result, the management authority of clinical directors was often blurred (Spurgeon et al., 2011). However, due to context, with different institutional and legal frameworks, interpretation of the corporatisation process was different; thus, achieving diverse outcomes was inevitable.

Except for one thing – the original 'sin', that is, the lack or insufficient attention paid to the 'contextualisation' of the roles of clinical leaders. A role is 'the function assumed or part played by a person or thing in a particular situation', 'a socially expected behaviour pattern usually determined by an individual's status in a particular society (organization)', 'a function or part performed especially in a particular operation or process' (Merriam-Webster dictionary). In management science, a role is

a constellation of tasks and the expected behaviour to perform them. So, the question is: how good have hospitals and health organisation been at supporting the development of clinical leadership roles? How fit was the notion and understanding of management 'translated' by clinical leaders?

IN SEARCH OF 'LEAGERS'

Health systems, health organisations and hospitals reorganised to face the increasingly turbulent 'hostile' context. Coopetition and corporatisation developed through the late '90s and following years. Yet all these reconfigurations were merely a necessary condition they were not enough by themselves. As Mintzberg (1997) underlines: 'hospitals are constantly reorganizing, which means shuffling boxes around on pieces of paper. It was believed that by somehow rearranging authority relationships, problems would be solved. But all this may have reflected nothing more than the frustration of managers in trying to effect real change in clinical operations'.

What needs to be done better is what we defined 'contextualisation', which refers to two main dimensions, culture and competence, for two main protagonists: health managers and clinical leaders. How can health managers and clinical leaders be supported to 'fit' within their roles, and how can they be helped to develop the competences required to be effective in their practices?

Reshaping Culture

One major need is still more effective integration between professionals and the managerial culture. Traditionally, hospital decision-making has been dominated by physicians

who have often pursued goals which were critical to their status as professionals, but incongruent with organisational goals critical to maintain the resource base of the hospital. In this framework, hospitals face the difficult task of enhancing the role of bureaucratised professionals. The term bureaucratised must be interpreted in its pure nature, hybridisation, as it underlines the need to engage physicians (and other professionals) in managerial issues, aligning their interests as much as possible with organisational goals. The more complex the health organisation or the hospital, the more it requires physicians to fit with its programmes (Lega et al., 2013; Lega & Sartirana, 2016). This is not only necessary but also a valid investment. Studies that addressed the relationship between characteristics of managers and performance of health organisations seem to converge towards an increasingly vital role of medical managers and leaders. Bloom et al. (2009) found that hospitals with clinically qualified managers are associated with better management practices. Goodall (2011) found that chief executives of the best US hospitals (as ranked by US news and world report league tables) were predominantly with clinical backgrounds. About 16 out of the 21 hospitals which ranked top were led by doctors. There are also studies that show how 'doctors in the lead' are better able to influence their colleagues' clinical activities than non-medical managers, even if they struggle to win over their own professional culture in terms of recognising the importance of management on performance (Shortell & Kalunzny, 2000). An investigation conducted in the United Kingdom reveals a number of significant relationships between the engagement of doctors in management and several performance measures. Mortality, waiting times and a number of dimensions of organisational wellness are correlated with engagement of doctors in management (Lega et al., 2013).

At the same time, while engaging doctors in management remains a priority, it seems as important to support the development of the cohort of health managers with non-medical backgrounds. Understanding the complexity of professional organisations and health sectors, coping with multi-stakeholder environments, facing ambiguity in goals and appraisal and running decision-making on the edge between ethics and sustainability are just some of challenges that health managers have on their agenda. Many are wicked issues, which require strong values and visions rather than just technical skills. As professional and managerial cultures need to merge, the managerial one requires enrichment with professional (and medical) values. The bottom line for health managers is the following thought: 'any health organisation is more than its professionals, but it will never be better than they want it to be'. Understanding the way professionals think, their values, their beliefs and incorporating all these in decision-making and practice is the 'cultural shift' expected by health managers who aim at being truly effective (and leaving a good legacy behind them). This does not mean bending decision-making to professional dynamics but finding the right ground to take different perspectives into account and to make shared sense.

Competences

Two last reflections are needed here to conclude our excursus on the changes that took place in most European countries under the corporatisation process of health organisations. They are two reflections that help to better clarify why health systems and organisations are desperately seeking to develop managerial capabilities at all levels, from the upper echelons to the shop floor.

First, as one would expect, research demonstrated that trial-and-error experimentation marked the early generation of marketising hospital organisational reforms. Institutional reforms are always experiments which require adaptation, re-modelling and fine-tuning which forces health organisations to revise, rethink, reshape their mission, values, cultures and strategic positioning.

That is why, in the 'new normality', contextualisation of leadership and managerial roles requires health organisations and their professionals to ask the big question: 'What makes us valuable?' but not in an abstract sense. What makes us valuable for the system, professionals, patients, associations, etc., for the many stakeholders? – now, in the current situation, given the expectations set by organisational or institutional environment.

What we need is making sense of reforms and changes, generating new visions, 'boarding' people on the new adventure. After all, as the poet Chesterton noted, 'An adventure is only an inconvenience rightly considered. An inconvenience is only an adventure wrongly considered' – envisioning and aligning the 'human side' of the organisation. Contextualisation requires health managers and doctors with clinical leadership roles to understand their primary responsibility in this area. Human resources management is key. Motivation is crucial as the shortage of doctors, the burden of malpractice litigation and the societal devaluation of role and status are taking a toll on health professionals. Attraction and retention of qualified professionals, skill mix and ageing workforce are often key points on the strategic agenda of health organisations. Many of them still struggle to make the leap towards better HR policies. That is where leaders need to step in. Studies on leadership report significant positive correlation with health organisation performance. Leadership is not equivalent to management practice, but leaders can engage in

a range of managerial behaviours that affect individual and team performance (Lega, Prenestini, & Rosso, 2017). There is much to focus on.

Secondly, several studies investigated the impact of management in the health context. A recent study conducted on more than 1100 hospitals in seven countries, where management practices in orthopaedics and cardiology departments were investigated and correlated to clinical performances (Lega et al., 2013) and found that improved management practices in hospitals are associated with significantly lower mortality rates (for emergency heart attack admission – AMI) and better financial performance (increase in income per bed). Studies on operations management applied to health organisation are located in the same research stream. A realist review conducted on lean management practices in health organisations from 1998 until 2008 identified 33 articles that describe cases of lean change and report positive results on efficiency, productivity and quality (Lega, D'Andreamatteo, Ianni, & Sargiacomo, 2015).

It is now clear that addressing the value question encompasses tackling issues such as artificial variability (unmotivated differences in therapies, diagnostics consumption, timing, pathways, utilisation rate of resources, second opinions, etc.), defensive medicine and cost-benefit decision-making. It is not just a question of health system architecture, or governance of health organisations, but it takes an in depth look at the quality of micromanagement on the shop floor, where care and cure are delivered. As already highlighted, over the last two decades, most health systems have continuously rearranged their structure and governance. This shuffling around of boxes might help but is not sufficient if efforts are not redirected towards clear long-term nurturing and development of management capabilities.

Management seems to be key, at least at this stage of modern medicine to improve access quality and sustainability of health services and systems, to better performance, improved delivery processes through a better understanding of and more appropriate action on the 'black box' of clinical process (Lega et al., 2013). The inappropriate use of diagnostics, drugs and therapies, defensive medicine, artificial variability, turf wars among specialists and resource waste can no longer be tolerated in the face of this 'new normality'. That is why specific, stronger competences on operations management, performance management and business planning and modelling in the next cohort of health managers and clinical leaders are needed, along with envisioning, priority setting and stakeholder management. Leadership and management. Not just leaders, not just managers: Leagers.

4

HEALTH MANAGEMENT IN TRANSITION

Usman Khan and Federico Lega

INTRODUCTION

Having set out in the previous chapter a picture of increasingly complex and rapidly evolving health need, driven by increasingly articulate and empowered citizens and patients and a set of European health systems which are in turn becoming increasingly complex and diverse, it is a little wonder that the practice of health management itself becomes subject to a process of critical review. In simple terms one is asked the question as to whether health management as a discipline and health managers as a collective body are able to meet and successfully navigate the challenges presented in today's health and social care environment.

This chapter will set out how, alongside the 'normal' challenges of health management, there is an increasing need to utilise a new range of skills and competencies to deal with fundamental challenges and realise opportunities facing today's health systems. This chapter will present an overview of the most recent developments in health management practice and

will then set these against the backdrop of the system pressures described in Chapter 3, with a view to establishing what role health management could and potentially should play in facilitating a change to a new architecture and landscape for health systems. Having done this, the chapter will go on to envisage how health management skills and competencies can be best taught and imbedded into everyday practice. Finally, the chapter will look the reach of health management today, making the case that modern management skills and competencies should be extended beyond healthcare managers and healthcare professionals to patients and citizens – the notion that 'we are all managers of our own health' – which requires everything from increased health literacy to personal leadership and empowerment. Whether such changes can be said to constitute a paradigm change in health management practice will then be a matter for reconsideration in the final chapter.

FROM HEALTH ADMINISTRATION TO HEALTH MANAGEMENT

As discussed in Chapter 3, New Public Management (NPM) became a notable area of study in public policy from the 1980s and into the 1990s. Fundamental to this movement was the assessment that public administration had run its course with respect to having brought into operation the fundamental tenants of managing bureaucracies at scale. NPM borrowed much from business thinking, introducing a whole new lexicon for health management policy and practice. The history of the last two decades of the last century and the first two decades of the twenty-first century has then been centred on the refinement of these tools of NPM and their application to a whole new range of health and social care-related challenges.

In the same manner in which health administration can demonstrate its value in underpinning the establishment of significant health bureaucracies capable of providing basic healthcare to its citizens on a near universal basis, so too health management born out of NPM can point to notable gains in relation to the economy and efficiency of health and social care provision. Yet problems have remained. Healthcare has not realised the level or scale of benefits from improved management practice as many other areas of the economy. Wicked problems continue to beset European health systems in a form and manner which brings into question the overall effectiveness of health management.

There are then a number of Health System 1.0 issues which health administration was not able to deal with but which health management has also struggled. The reason we label them as being 1.0 issues is that they relate to providing the basics of healthcare at scale, this being the underlying driver for the establishment of post-war European health systems. Many of these issues are focussed on system variation, most notably in relation to care outcomes. They also extend to system weakness and the failure of leadership, as shown by issues such as the control of healthcare acquired infection. The combined impact of system failure and unwarranted variation is of a form and level which industries such as nuclear energy, or airline travel, would not find to be sustainable. That having been said it needs to be recognised that, as a brain and technology intensive industry, the complexity of healthcare remains greater than in these industries. On this basis one may even posit that the crisis is one which brings the policy and management interface to a point of existential crisis. As was seen in the initial stages of the global response to the COVID-19 pandemic, the trust between policy-makers and healthcare managers was often stretched to breaking point, as the locus of responsibility

moved between the two with neither party having the required levels of confidence in the other.

According to American social and organisational psychologist Robert Katz, the three basic types of management skills are technical, conceptual and interpersonal (Katz, R. 2009). Linking to the challenges outlined in Chapter 3, one could include technical skills such as those related to digital health technology, conceptual skills relating to problem definition and analysis and the interpersonal skills to change management. Discussion regarding core health management competencies is ongoing as is the assessment of the skills (technical expertise), knowledge (facts and principles) and abilities (physical, mental or legal power) required to support these competencies (Counte, 2019). Competency itself is the application and demonstration of appropriate knowledge, skills and behaviours. Core competencies have been cited to include leadership, stakeholder engagement, resource management, innovation and improvement (Healey & Marchese, 2012). The relative focus or weighting given to particular competencies has also evolved over time, the highest profile of which is health leadership, which has increasingly been seen as the determining competence in health management.

It would be too strong a contention to say that current systems of health management are not fit for purpose, but it is not unreasonable to assert that whilst recording significant gains regarding access, quality and efficiency, they have failed to successfully address a number of the basic fault lines running through European health systems. This refers to the existing health management challenges, but it also relates to new challenges set out in Chapter 3.

LOCATING HEALTH MANAGEMENT 2.0

It is evident that health management as a discipline is in a continual cycle of evolution. Practice develops and the average

health manager today is likely to undergo education and training which is significantly different from that of their forbears. What we argue in this book is that however progressive this incremental enhancement and development is, it will not be sufficient to fully meet current or future health system needs. As such we forward the argument that health management as a discipline needs to undergo a paradigm change which reaches from the disciplines with which it is involved, the space within which it is conducted and the stakeholders who are subject to its practice.

Our starting point is that health systems today have a complexity to them which few would have imaged in the light of their establishment in the post-war period. Perhaps the first level of complexity came with the need to interface with an increasing number of stakeholders, moving from the traditional system where the manager would work with clinical colleagues, often through a prescribed management structure with clinical directors and a medical director. With interdisciplinary working becoming ever more complex, today's healthcare manager is required to both understand and interface with a far broader constituency. As a consequence, the importance of interorganisational and interinstitutional networks and collaboration cannot be overstated. To this we can add the breadth of stakeholders that today's healthcare manager needs to be engaged. This has expanded significantly over the last decades, representing a major shift which health managers are only slowly becoming accustomed to. The breadth of vertical and horizontal growth can be witnessed across organisational form. While traditionally the healthcare manager mediated the space between health policy and practice and, in doing so, engaged primarily with organisational boards, civil servants and health professionals, the healthcare manager today is required to

navigate a far more complex arena. Of particular importance is the interface between the healthcare system and the service user. Whilst the term patient may in many ways be viewed as outdated, the notion of the healthcare manager needing to create space and provide the systems and processes for engagement has become an increasing preoccupation. Thirdly, the involvement of the private sector, not least within the interorganisational networks alluded to earlier, is an additional area which has witnessed significant change over the last decades. Whilst the fundamental underpinning of socialised healthcare being funded through state insurance or central taxation has not to date faced principled challenge, the role of the private sector has grown substantially and with it the complexities of managing a new interface at a health system level. Finally, Health Management has traditionally been associated with care provided within traditional healthcare settings, namely the hospital, primary care and community services including mental health but not normally extending to social care. Healthcare settings are continuing to evolve and develop and healthcare managers today need to respond accordingly.

In Table 4.1 we have attempted to draw together a simplified comparison of Health Management 1.0 with Health Management 2.0, by setting out the binary opposites which set them apart.

Health Management 2.0 is focussed on transformation and, to be successful, it will need to actively shape the health system change agenda as much as it is shaped by it. Identifying five transformational domains for healthcare management, it is possible to set out a programme which represents an agenda for paradigm change. The first development in health management is the move from transactional to transformational leadership, where the healthcare manager increasingly becomes a facilitator whose role is to lead the

Table 4.1. Health Management 1.0 vs 2.0

	Health Management 1.0	Health Management 2.0
Style	Instructional	Empowered
Form	Hierarchy	Partnership
Focus	Procedure	Outcome
Enabler	Paternalism	Cocreation
Dynamic	Evolutionary	Transformational

change process. Leadership is such a crucial aspect of modern-day health management that we have set aside Chapter 5 to consider the matter in full. A second management driver sees health systems moving from a focus on improvement to one on innovation and change management, which recognises that piecemeal improvement may not be sufficient for the pace of change facing modern health systems. Thirdly, today's health managers are having to recognise a change in focus from implementation to cocreation and stakeholder empowerment signalling as it does the multi-stakeholder environment in which modern European health systems now operate. At a system level, we are also witnessing health managers increasingly moving from systems focussed on traditional risk management to one which undertake risk stratification and risk appetite assessment. Fourthly and finally, we refer back to the earlier point on the complexity of the modern European health system, and we contend that we are witnessing a managerial transition from health organisational management to health systems management. Built as it is on a new framework for partnership working, this network approach to health

system engagement increasingly requires organisational development skills and competencies.

In the following sections we seek to tease out a fuller sense of the challenges facing the modern European health system by highlighting 9 domains where a paradigm shift in approach will be required if health managers are to simultaneously meet existing challenges and to be prepared for future ones. In each case we adopt a common framework which involves us setting out the domains within each area, an assessment of how these are evolving and the opportunities and risks they present with regard to supporting health system sustainability. We then go onto assess the management challenges associated with each domain, identifying those which may be assessed to be normal, enhanced or unique.

MANAGING DIGITAL

Digital health refers to the use of information and communication technologies within and across health systems. Digital health has a broad scope and includes the use of wearable devices, mobile health, telehealth, health information technology, health data and telemedicine. Digital health solutions have the potential to transform European health systems and European healthcare by helping to improve access to health services, reduce inefficiencies at organisational and system level, improve the quality of care, lower the cost of healthcare and facilitate more personalised healthcare. These are unsurprisingly similar to the broader objectives of European health policy reform, the difference being how digital innovation can help to develop, expand and potentially accelerate the process of change.

Alongside these opportunities however come associated risks and challenges which health management is centrally

charged with having to address. The management challenges with respect to digital innovation all fall broadly within the remit of commonly accepted competencies frameworks. The central challenge for health management with regard to the digital landscape is less about the nature of the challenge and more about the scale of need and the capacity and capability of health managers to absorb and respond to it.

Given the diversity, complexity and significant resource requirements of the digital space in health, the first health management challenge relates to technical competence within the relevant domains. Management systems necessarily allow for technical expertise to be brought into a general management setting, but where the governance systems lack the level of expertise needed to manage or scrutinise digital health developments, then problems may emerge. The conceptual skills required to deal with complex and often multi-organisational challenges are also of a magnitude and form which is likely to challenge many health managers. Facing an issue such as developing health data interoperability, the ability of health managers to frame and respond to development and implementation challenges may be challenged. Yet of the three managerial areas it is interpersonal skills which are most important reflecting the importance of bringing different stakeholders together to work on often highly complex matters. Additional barriers to successful digital change include the constraints organisations face in their workforce, constrained budgets, organisational attitudes towards risk and the relationships that exist between key stakeholders and organisations.

One index on European health readiness suggests Estonia to be the leading nation with regard to the successful utilisation of digital platforms in healthcare, whilst Germany and France are deemed poorly positioned to make

best benefit of current opportunities (Digital Health Index, 2019). Standing away from the relative and turning to the absolute, the picture does not look promising, with one commentator believing:

> *…the needed transformation in the structure of healthcare and medicine fails to catch up with the rapid progress of the medical technology industry.*
> (Meskó, 2017, p. 1)

The learning from studies of digital innovation in Europe paints a clear picture (Stroetmann, Artmann, & Stroetmann, 2011). Firstly, leadership and the establishment of trust are highlighted as being of importance. A reliable infrastructure supported by good training is also identified and then interestingly a regional over national focus.

A recent Kings Fund report suggests that most of the barriers facing digital innovation can be mitigated through time and effort and by treating digital projects as change projects rather than IT projects (Maguire, Evans, Honeyman, & Omojomolo, 2018). The report also stresses how effective and consistent staff engagement and resource allocation to the project are key success factors. What can be suggested is that the current competencies framework for health management is being severely strained by the needs and opportunities presented within the digital health sphere, but that countries such as Estonia provide insight into how health managers can work alongside health policy-makers to deliver sustainable change. Yet such examples should not detract from the contention that it is the responsibility of managers to 'invest' in digital competencies within their organisation to support the building of a vision and a strategy for digitalisation.

MANAGING IMPROVEMENT

Health system improvement has been an increasingly important area of focus for health policy-makers and managers alike. As we have seen in prior chapters, the challenges of achieving health system sustainability have been repeatedly revisited, and frustrations relating to the inability of health systems to deliver on access, efficiency and quality remain evident. Within this framing, health managers find themselves focused on delivering incremental change to achieve goals that actually require paradigm change.

Pressure for improvement emerges from a number of sources. It can and often does come from the ground up via teams of healthcare professionals identifying the potential scope for improvement. It may also come from patients through formal or informal routes. External sources will also be important with audit and review an increasing route through which the need for improvement is identified. Finally, there will be top-down pressures, not necessarily connected to any particular performance issue which could be a trigger point.

Health management has become well versed with the tools and techniques of improvement, with organisational change management in particular finding itself at the heart of many health management teaching programmes (Perletha, 2001). Through the establishment of designated service improvement hubs, there has been the possibility of using techniques such as Plan, Do, Study, Act (PDSA) to help develop a culture of continuous improvement. It is also important to stress the importance of other techniques developed within the industry such as lean and Six Sigma (de Koning, 2006). Such techniques have been shown to have had transformational impact in areas such as motor

manufacture but have yet to be comprehensively adopted in the European healthcare environment.

The role of the health manager in improvement is multifarious, with three elements identifiable as being of particular importance. Firstly, the health manager plays an important part in translating national intent on improvement from policy to practice. A second interrelated element of this will be in facilitating the connectiveness from national support programmes to local health systems. Thirdly, there is the need to provide the time and ensure that relevant stakeholders have the skills and competencies to engage with improvement programmes effectively.

An increasing preoccupation for health managers and policy-makers is the challenge not simply of being able to achieve service improvement in the experimental conditions of standalone initiatives, which are often provided with focussed support and high levels of resourcing, but also to disseminate these effectively and achieve the all too challenging goal of spreading effective practice. This has been recognised at a European policy level and supported with multibillion Euro research programmes such as Horizon Europe, and the establishment of industry associated research and development partnerships such as EIT Health.

At a national level there are a multiplicity of state agencies which have been established to support health improvement within national health systems (Arundel, Casali, & Hollanders, 2015; Beyer et al., 2003; Groene, 2014; Busse, Klazinga, Panteli, & Quentin, 2019). The challenge however is to assess remains how the impact of such agencies can be maximised, with research suggesting that a significant gap continues to exist between the theory of improvement and the ability to realise consistent change on the ground.

For the health manager, the key is often to create the time and space to engage with improvement. Often it is the simplest response to continue to do what has always been done and in the absence of meaningful consequence to underperformance this can be a default. Taking the next step requires time, resource and the ability to develop or access improvement skills and competences.

MANAGING THE WORKFORCE

Health workforce is a core issue for European healthcare. The complexity of the matter and the increasing diversity of the workforce have brought the role of the health manager and health management to the fore. For the health manager prioritising the workforce requires a focus on needs assessment and planning, the outputs of which will not only transfer into recruitment and retention but also involve them in considering issues relating to skills mix and task shifting (European Commission, 2019).

Whether referring to the global health shortage of seven million nurses by 2030 (Drennan & Ross, 2019) or wider issues relating to key health domains such as older people's care (Michel & Ecarnot, 2020). A focus on increasing flexibility in relation to health workforce has become a well-established trend in European health system thinking (Nancarrow et al., 2017).

This is often an involved process presenting pieces in a jigsaw presenting a challenge for the health manager to deal with within what often presents as a such a conflicted environment.

One means to respond to this is to ensure that health workforce data are as complete and fulsome as possible, so as to

enable the health policy community to consider what means it may have to address particular issues. At a national and European level, the overall quality and quantity of health data has been transformed over recent decades, providing a far stronger underpinning for change (Kuhlmann, Batenburg, & Dussault, 2019).

Many of the macro issues regarding health workforce will be dealt with at a national or regional level, whilst others are most impactful at a European or global level. This often leaves the health manager seeking to make micro adjustments at an organisational or team level. Task shifting and skills mix can operate at an organisational level and can be impactful through say the redesign of care pathways. Likewise, working on the idea of being an employer of choice and so reducing the impact of staff turnover or reduced motivation levels can have also be impactful. However, studies do highlight the limits to local action as they do to the importance of central resource and support (Kroezena, 2019).

The health manager is commonly at the wrong end of health workforce issues, impacted by them on a day-to-day basis, but without access to the levers which could provide for longer term sustainability. Engaging in the research and data collection processes, now wide ranging at a national and European level is one way in which to be engaged in the agenda as is a focus on the micro responses around organisational culture and role and task shifting, which has been shown to make a difference.

MANAGING TEAMS

Healthcare organisations worldwide seem to have started converging patterns of change towards a common paradigm: the care-focussed organisation. To cope with the several

pressures recalled in the previous paragraphs, the emerging trends seem to drive the reshaping of health services delivering processes around the needs of care processes (and patients) and away from the traditional physicians-centred view.

For a care-focussed reorganisation the main trajectories are the following ones:

- clinical integration.
- multidisciplinary and multiprofessional teams.
- focus on patient groups and needs.
- engagement of clinicians.

Clinical integration is pursued through:

- *Units grouping*: Units (specialities) are often aggregated in divisions in accordance with care requirements. This type of redesign applies best in large hospitals either with a significant number of specialities or looking at rationalisation of duplicated units.
- *Clinical service lines redesign*: Physicians are integrated along the same care process, through their grouping according to 'products', such as body organs/parts (heart, head-neck, liver, etc. – grouping specialists co-operating at different stages of the same care/cure processes), to homogeneous medical areas (oncology, digestive apparatus, muscle-skeleton – grouping specialists co-operating either at the same time or at different stages on the same care/cure processes) or to age of patients (elderly, maternal, paediatric departments). This type of redesign fits well large multi-speciality hospitals, especially the teaching ones, since it generates more focus on innovation and research along specialisation paths.

In organisational terms, this redesign generates a shift from a functional structure towards a divisional or matrix one. Departments and divisions, grouping the specialities, are often crossed by clinical services lines.

Hospitals are simultaneously organised along the two dimensions of traditional departments (services) and service lines (Lega & Calciolari, 2012; Lega & DePietro, 2005). Key staff and managers have two lines of accountability – one to the department and one to the service line.

In this perspective, clinical service lines may be defined as a family of organisational arrangements based on a hospital's outputs, rather than on its inputs. Clinical outputs of healthcare can be defined in three ways:

1. procedures or interventions, such as surgery, radiation therapy or organ transplantation.
2. management of diseases, such as comprehensive care for cancer or for heart disease.
3. management of care for and/or maintaining health of identifiable segments of the population, such as older adults or children.

All of these bases for service lines can be readily found in practice, and they are not mutually exclusive. Key defining characteristics of clinical service lines are that they are multidisciplinary, have a clinical care mission and provide a mechanism for integrating personnel and services across disciplines (Charns & Tewksbury, 1993).

Multidisciplinary and multiprofessional care teams: Care-focussed approach to patients requires integrated cure and care delivered by multidisciplinary and multiprofessional teams. These teams are in charge of studying and implementing clinical

or care pathways. Consequently, the team should be formed by physicians and other professionals (nurses, technicians, etc.) belonging to the specialities-based units where the pathologies object of study were usually treated. This means blurring the traditional boundaries between specialities and professionals. Teamwork is at the basis of the approach defined as 'patient-focussed care', where small teams of cross-trained care givers are empowered to deliver clinical and administrative services. Individuals from different disciplines are assigned to permanent teams. Staff retains formal reporting relationships to discipline-based services or departments. The service line manager serves as the team leader and provides input to members' performance evaluations. Generally, the teams have a clinical mission. Some teams are not managed by single managers but by management teams – for example, a triad representing medical, nursing and administrative leadership or a dyad of a physician and a nurse leader.

Health organisations are re-configuring around teams. And teams are very difficult to manage, as they have cultural issues due to different background and professional status and belongingness of members and as they are based on non-hierarchical relationships. Wiersema and Bantel (1992) noted that team size and heterogeneity of members are negatively correlated to social integration and communication. Socialisation processes can reduce role and identity conflicts and ambiguity, building a shared framework of understanding (Currie & Procter, 2005). It is also worth underlining that teamwork must not result in lack of responsibility: Chantler (1989) observes that too often, when everybody is supposed to be responsible, the reality is that nobody actually takes responsibility. On the contrary, several authors note that at all times patients need to know who is directly responsible for their care. Each patient needs to know his or her case/disease

manager, the one taking responsibility to coordinate the teamwork.

This mixed evidence highlights the challenge and the role of health managers. They are the ones expected to turn health organisations towards a 'teams-based' organisation, the ones that should empower those clinical teams and the ones that should engage their own management team in marrying these new organisational paradigms and generate the necessary transformational change. Quite a challenge!

MANAGING PARTNERSHIPS

European health systems are undergoing a period of significant change with regard to the manner in which constituent parts of the health system are being required to collaborate in ways and to an extent not seen before. But more than this, there is also increasing evidence of health systems being encouraged or even instructed to engage beyond their immediate environs, most particularly with regard to social care (Glasby & Dickinson, 2009). This process was evident before the enormity of the COVID-19 pandemic took effect on our health systems, but we are also now witnessing an acceleration of these processes as the pragmatic urgency of closer cooperation between institutions and agencies intensifies.

Partnership is a central theme at a pan-European level as Hans Kluge – Director of the WHO European Region – has made clear (Kluge, 2020). However, the aspiration for greater collaboration across and between organisations is likely to require collective efforts across platforms, alongside consistent ongoing resourcing and support. This was demonstrated to have been the case in initiatives such as the WHO Healthy Cities initiative (Green, Price, Lipp, & Priestley, 2009).

There is the additional challenge of how formal health systems can and should engage with broader aspects of health and social care. Take for instance self-care where despite having started as a relatively modest endeavour, it has grown to a multibillion-dollar industry, with a growing connection with healthcare systems and policy (Narasimhan, Allotey, & Hardon, 2019).

The drive for more effective organisational engagement has been witnessed to come from four main sources. Firstly, at a national policy level, it has long been established that politicians and health policy-makers have viewed intra-organisational barriers as being a significant impediment to the achievement of health system sustainability. This has manifested itself in different ways in different health systems. For those centralised national health services such as the United Kingdom, Italy and Spain, there has been scope to set out parameters for partnership engagement, such as the recent establishment of the Integrated Care Systems in the United Kingdom (Briggs, Göpfert, Thorlby, Allwood, & Alderwick, 2020).

It will be interesting to assess how the COVID-19 pandemic impacts on partnership working in the medium to long term. It is certainly the case that in the short term there has been an increase in organisational cooperation, particularly across local health systems (Sendall & Lang, 2020). In many cases this took place as more formal platforms for engagement were suspended or downgraded, potentially providing the space for such engagement to take place. That all having been said, one of the challenges of partnership working across health systems is that much of this may be largely transactional in nature rather than being driven by a strategic narrative. Building effective partnerships is never a straightforward process (Wildridge, Childs, Cawthra, & Madge, 2008).

Effective partnership working is not a given and nor is it straightforward as Glasby and Dickinson made clear in the context of their study of collaboration in the UK health system (Glasby & Dickinson, 2010). Studies dating back more than a decade were already highlighting the challenges of many forms of partnership working and the need to set modest goals which focussed on building trust and confidence between organisations and noting the investment required was often significant (Hunter, 2012).

All of this suggests that health management has an important role to play in helping to shape and initiate credible partnership working across as well as between local health systems.

MANAGING PATIENT INVOLVEMENT

Patient engagement can be considered to be the defining theme of recent health system development (Barello, Graffigna, & Vegni, 2012). Patient engagement has led to improved health outcomes and can also potentially improve efficiency (James, 2013). Historically, the driving force behind the movement to more fully involve patients in the design, delivery and review of health services came from the emergence of the patient advocacy movement and a wider pull from health policy-makers and healthcare professionals, who collectively considered healthcare to be too paternalistic (Wong-Rieger, 2017). There has also been a number of high-profile cases of poor clinical practice and care where a lack of meaningful engagement with patients was subsequently found to have been a major contributory factor (Wachter, 2010). Alongside this has been the need for the pharmaceutical industry to be able to access patients to be involved in drug trials, which has over time evolved into a more extended role for patients in

medicines development (Patrick-Lake, 2018). However, in recent years it has been developments in clinical practice which has increasingly brought the focus on the importance of the patient as change agent. From the evolving science around the human genome and more latterly human biome to the connected evolving of precision medicine, there has been an increasing call to both view and respond to patients as individuals. It is also the case that patient engagement has been demonstrated to improve outcomes, although findings related to efficiencies have been more difficult to establish (Hibbard & Greene, 2013). With developments in patient engagement moving into the arena of cocreation (Batalden, Batalden, & Margolis, 2015).

Patients are now regularly involved in a broad range of activities. From the traditional forms around patient advocacy, medicines development and service and care assessment, we are now seeing an extension of the role of the patient into regulation, research, education, improvement and innovation (Coulter, 2012). Health management has a pivotal role in this process, as it is required to interpret and implement policy direction with regard to patient engagement, requiring the integration of the patient into existing interdisciplinary working systems and structures. The challenges here may be significant as the traditions of paternalism can be difficult to shift, most particularly where these are well established.

A useful notion that the health manager can seek to reference is that of the patient voice and the patient perspective. In the former, the focus is on bringing in the authentic lived experience into health policy and practice, whilst the patient perspective relates to the manner in which all stakeholders can seek to view an issue from the perspective of the patient. There are skills and competencies which health managers will need to develop and to ensure are developed

within the organisations and systems in which they operate. But it cannot be underestimated how challenging it is to transform a paternalistic culture into a patient-centred one. Establishing shared goals and objectives will be one aspect of this, which will be all the stronger where supported by a system-wide mission and vision.

Evaluation of patient engagement is a mature and developed field of study. Limitations of engagement have been well studied with weaknesses regarding engagement at the implementation stage and a lack of wider stakeholder engagement identified as common challenges (Concannon et al., 2014). Health managers have a responsibility to ensure that patient engagement is integrated into health system working in a meaningful and credible way. There is an established literature on the risk of such engagement becoming partial, tokenistic and lacking in impact, with poor patient engagement generally being viewed to be worse than no patient engagement.

It is highly improbable that the patient engagement genie could be put back in the bottle even if that were to be an objective. Its development is almost certainly going to take different trajectories and work over different timescales across the European health system landscape, but the tools and techniques for engagement are at an improved point of maturity so it will to an extent be for health management to assess what to do next. How far patient engagement can help facilitate that paradigm change from the institutionally paternalistic Health System 1.0 to a meaningfully public and patient-focussed Health System 2.0 is difficult to assess. Realistically, even the most expansive platform of systematic and comprehensive patient engagement will have its limits. Although this is no reason for health managers to take a step back.

MANAGING PLURALISM

The degree of pluralism in health organisations is dramatically and progressively increasing today (Camillus, 2008). All organisations are pluralistic, but at different degrees (Denis, Lamothe, & Langley, 2001). The professional public-owned organisations – such as hospitals, universities – are examples of highly pluralistic contexts (Jarzabkowski & Fenton, 2006). It is not complicated to imagine, afterwards, that public health organisations (PHOs), especially academic medical centre (AMC) like large public university hospitals, are on the top of pluralistic contexts.

Pluralism has its origin in external and internal pressures for organisations (Pettigrew, 1987). Many external stakeholders and competitors apply severe pressures that affect the organisation's strategy. For instance, in the case of AMC, national and local governments make an intense pressure to impose higher levels of efficiency to the hospitals. Otherwise, University's main goal is the improvement of research and teaching. Citizens, through their associations, require, conversely, a higher quality of service. External pluralistic pressures impose contradictory objectives generating strategic ambiguity. This exacerbates an already difficult situation for the natural trade-off among care, research and teaching that are the pillars of strategic mission of each AMC (Schreyögg & von Reitzenstein, 2008).

Consequently, the powerful and conflicting interests of external stakeholders slow down or prevent health managers from finding a shared strategic consensus. In other words, they avoid the strategy-making to be an explicit, coherent and unified direction for the organisation, as emphasised by the traditional theory. The resulting strategic ambiguity could produce a strategic paralysis or a dilution in strategic change initiatives (Denis, Langley, & Rouleau, 2007).

Therefore, health managers need to develop specific strategising practices in pluralistic contexts to support an effective decision-making. *Inter alia*, some of the most important seem to be the following:

- Enhance relationships through strategic group workshops. First, a positive context must be created, a forum where it is possible to socialise the strategy in a coordinated way that reduces internal conflicts. Second, it is necessary to strengthen relationships through a mutual understanding among individuals and constituencies. Generally, a positive interaction among decision-makers is driven by reciprocal interaction (Balogun & Johnson, 2005; Mantere, 2008), adaptive control systems (Floyd & Lane, 2000) and formal or informal meetings.
- Base discussion on 'brutal facts'. In pluralistic contexts, strategy socialisation may not be enough to produce a common strategic consensus (Iaquinto & Fredrickson, 1997; Knight et al., 1999). The protection of individual and group interests could remain a priority and strategy become the field of political games, where power and compromise drive the decision-making. Otherwise, a coalition of actors may seek to control the strategic course or disturb or distort it. The alignment of strategic premises could be built through the share of quantitative data. Denis, Langley, and Rouleau (2006) have shown that the use of rigorous quantitative analysis promotes rationality and neutralises the political games. The brutal facts are powerful tools to produce a sense of urgency and to facilitate convergence on strategic consensus in the pluralistic context.
- Develop shared mental models. Different stakeholders differ in their cognitive styles and ideology. An essential

prerequisite for strategy consensus is the existence of mental structures to organise knowledge (Mintzberg, Ahlstrand, & Lampel, 1998, pp. 157–159). Denis et al. (2006) also affirm that numbers contribute to ambiguity reduction if an explicit shared system of meanings – that fosters convergence in representations – is adopted.

MANAGING STRATEGIC POSITIONING

During the past decade, there has been increasing interest in the strategic planning processes used by health organisations, especially in public context. There is some consensus that better tools are required to achieve higher levels of performance (Collins, 2001). As discussed in previous chapters, this view has been strongly influenced and supported by the rationalism of the reforms of NPM, which stress that public sector organisations must adopt strategic planning practices if they are to improve their management in the long term, to guide public institutions and to improve their performance in an increasingly turbulent context.

The formulation of strategy in the public sector requires a disciplined effort to take the fundamental decisions and actions that shape and guide what an organisation is, what it does and why it does it, all within a legal framework. Strategic planning is necessary in order to confront and create a sustainable future, and there is widespread consensus that such planning demonstrably influences the organisational context (Mintzberg et al., 1998).

It has been well-documented by previous scholar that the formulation of public healthcare strategy is hampered by a number of internal and external constraints in public organisations, namely their multiple stakeholders, the

ambiguity of their goals, the distinct nature of their goals of equity and accountability and the bureaucracy involved. PHOs are embedded in a rich and tight network of relationships with different stakeholders, including local, regional and national governments, unions, professional networks, scientific associations, citizen and patient advocacy groups, the media, pharmaceutical companies and equipment providers.

Because of this complex context, the speed of its change, the never-ending innovation and the challenge of sustainability, health managers have the responsibility to help their organisation to find the best strategic positioning within the competitive, institutional and social environment.

Health organisations cannot wait and see. They need to search intentionally their positioning and shape their future.

What a challenge for Health Managers 2.0.

MANAGING BUSINESS MODELLING

As already discussed, there is one simple sentence that sums up the distinctiveness of health organisations:

> *…they are certainly more than just the sum of their professionals, as they require resources, technology, logistics, etc., but they'll never be better than what their professionals want them to become.*

This remark underlines a huge difference. In businesses, the human side is important, but not as much as in health organisations (Lega, 2020). Businesses need leaders, but then the job of the leaders is to make the people (employees) to fit the system. The employees are selected, trained and 'indoctrinated' to support the system (organisation). The system is the independent variable. In healthcare organisations, it's rather

the opposite: the system is mainly engineered to support the practices of healthcare professionals. The practices are the independent variable. They are introduced and changed by professionals, not by the system. Obviously, we do not have to build health organisations around all professionals' wants or needs, otherwise we will go back to the old days when they were iatrocracies or professional bureaucracies (Lega & DePietro, 2005), but a degree of customisation is required. This characteristic brings consequences and managerial implications. Such as the fundamental role that plays the processes of alignment of interests, the so-called 'sharing of minds' among the professionals and the management (Lega, 2012), which is even more vital when professionals play the hybrid role of doctor-manager (Lega, Spurgeon, & Prenestini, 2013).

We do have evidence that management matters in healthcare. We do have evidence that the introduction of managerial practices makes the difference in performance of healthcare organisations (Lega et al., 2013). But we also know that this introduction and development does not mean we can treat healthcare organisations as mere business.

Yet, some business-like approach can be positive, specifically the management side of business. Health systems and health organisations face tremendous challenges, and they struggle to answer the fundamental question: what makes them valuable? Prioritisation, decision-making, resource allocation and reconfiguration of services are difficult and complex tasks, but at the same time essential as ever. Though it requires specific customisation, the introduction of business-like techniques and practices seems to be the way to go (Lega, 2020). To support health systems and health organisations in selecting the right things to do, and then do them right.

In the end, in these turbulent times – the 'new normality' – health systems and health organisations require a greater 'discipline' to manage their specific organisational dynamics. Business modelling would allow health organisations – public as well as private – to manage more effectively and efficiently the 'black box' of healthcare delivery (Lega et al., 2013). Where is clearly understood that if it is true that (no margin, no mission), it is also even more important to remember that margin is not the mission.

This is the business suit that can help them – a customised business suit dressed in a context dense of healthcare values.

This is what we ask to health management 2.0.

CONCLUSIONS

Health management in modern times is more challenging than ever. Nine topics were identified as significant challenges and functions defining Health Management 2.0.

Yet, what was highlighted with the previous points is only part of the key issues in the agenda of twenty-first century health managers. The whole discussion developed in this chapter and chapters 1–3 identifies the many changes taking place in the health sector and in health systems and how this is reflecting in the request for new competences and skills for the current and next cohort of health managers.

In this light, most of the debate in the academic environment has outlined the shift from management to leadership as the dominant trajectory to be pursued by health administrators, to cope with the new reality, the so-called 'new normal'.

In the next chapter we will discuss in depth this point – how leadership could and should be developed among health managers? Which leadership? Why we are asking health managers to develop the most effective combination of hybrid roles as leaders and managers? The 'leagers'. To be continued….

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5

HEALTH LEADERSHIP IN TRANSITION

Federico Lega

Literature on strategic management in health organisations often borrows from theory developed in business-oriented contexts (Lega & Cristofoli, 2009; Lega, Vendramini, Festa, & Coscioni, 2018; Meier, O'Toole, Boyne, & Walker, 2006). The recent influence of new public management is evident, and rhetoric about the usefulness and goodness of strategic planning tools developed for the private sector is at its peak. The work of health managers, however, is not adequately reflected in the proposed frameworks of this body of literature research. There is a need for a conceptual framework that better captures the essence of strategic management of health organisations (especially when public) and provides a better foundation for training and executive education. In 2007, Professors Thomas A. D'Aunno and Mattia J. Gilmartin undertook a systematic review of leadership in healthcare highlighting how researchers were missing the opportunity to develop general leadership theory in healthcare sector mainly because they were not stressing

enough the role of professionals as leaders, the need of understanding the role of gender in leadership and because of the barriers to collaborative, multi-disciplinary studies. The aim of this chapter is to contribute to the building of this framework, specifically, leadership in times of health management 2.0.

FOUNDATIONS OF LEADERSHIP IN HEALTH ORGANISATION: WHAT WE KNOW, WHAT WE SHOULD KNOW

In turbulent times, such as the ones being experienced by health systems and organisations worldwide, it is crucial to investigate what we know, what we don't know and what we should know, to understand how to shape leaders and what makes them successful: from theory to practice, from foundations of leadership to needs generated by health management 2.0.

Prior to a discussion on leadership, there should be clarification on what distinguishes it from management. The Merriam Webster dictionary defines 'to lead' as 'to guide on a way especially by going in advance; to direct on a course or in a direction' and 'to manage' as 'to handle or direct with a degree of skill; to make and keep compliant'. The core difference lies in the fact that leading is the process of influencing goals and motivation, and managing is the process of delivering results. Doing the right things vs. doing things right.

One is a leader because subordinates follow, not vice versa. Bucqueroux has re-conceptualised the two concepts quite helpfully (Spurgeon, Clark, & Ham, 2011). The following table identifies the differentiating factors:

Leader	vs	Manager
Vision		Implementation
'Big picture'		Detail
Long term		Short term
Inspire		Direct
Strategic planning		Action planning
Outline framework		Assess progress
Proactive		Reactive
Motivate		Facilitate
Change agent		Steady hand

In this light, leadership is about the 'big picture', and management is about details. Leaders do sense-making, and have vision, ambition and synthesis. Managers problem-solve through analysis. Their focus is performance and execution. Leadership has long-term horizons and strategic focus. Management has short-term goals and responsibility for operations.

It is clear that both 'functions' are essential for organisations, as they complement each other and should be balanced. It is possible to have too much or too little of either. Strong management with no leadership tends to entrench an organisation in deadly bureaucracy. Strong leadership with no management risks chaos, and the organisation itself may be imperilled as a result.

The two 'hats' are two overlapping sets: 'most scholars seem to agree that success as a manager or an administrator in modern organizations necessarily involves leading' and vice versa (Lega, Prenestini, & Rosso, 2017).

Therefore, health managers coping with current challenges need to undertake both functions: leadership and management. Unfortunately, during the corporatisation process of health organisations, the management function dominated. Many health systems are now investing in developing leadership capacity in their top managers and clinical heads (CHs). Yet, as introduced earlier, a comprehensive and clear framework on leadership in health organisations is still far off.

DOMINANT THEORIES

Since the 1960s, leadership has endured as a 'trendy' topic in academic, professional and recreational discussions. However, neither a univocal definition nor a 'recipe' for becoming a good leader exists. Leadership is a vast area of study, as research has highlighted how it is so much more than leaders themselves: its notion includes and is shaped by followers, peers, supervisors, work settings, context and culture and by the nature of the organisation (public, private or non-profit organisation). Because of culture, and path dependency, it is also affected geographically and historically, by different mindsets, beliefs and values.

In this respect, the most accredited theories and frameworks on leadership seem to be 'contingent leadership', 'situational leadership' and 'transformational leadership' approaches.

The contingency theory of leadership emphasises that the effectiveness of leadership is dependent on matching a leader's style to the situation. This theory was originally developed by Fiedler after studying various leaders in different contexts but predominantly in the military. The theory assumes that leaders have their own style, and they will be effective if placed in a command position with a good match with their followers' (co-workers') expectations and attitudes (Lorsch, 2010).

The 'situation' within which the leader will perform their role, and thus be more or less effective, is shaped according to contingency theory by three factors:

1. Leader–follower relationship: Leadership acceptance within the organisational hierarchies. Here, we can refer to the issues of motivation and psychological capital and safety. Subordinates must trust, have confidence in and feel adequately motivated by their superiors. Goal setting, recognition and organisational environment are fundamental to building a positive relationship.
2. Task structure: Management by objectives (MBO) and clarity of tasks are key for sound leadership. Superiors must provide maximum clarity on their expectations in terms of the goals, methods and behaviour expected from subordinates. There should be clear guidelines to follow, and progress should be easily tracked. Feedback is of paramount importance, and designing jobs is also fundamental. In structuring tasks, leaders should consider factors of motivation which contribute to determining a true enrichment of a job, such as:

    - Skill variety: It refers to the variety of different skills and talent required to perform the work;
    - Task identity: An identifiable piece of work that an individual can perform from beginning to end and that has a visible outcome;
    - Task significance: It refers to the impact and value a job has to the organisation, to society and in general to the lives of other people;
    - Autonomy: It refers to freedom and discretion in scheduling work and in making independent decisions while performing a task;

- Feedback: It is the information regarding work performance. Feedback sources can be direct – derived from the job itself, or indirect – derived informally from supervisors, peers, clients or other people involved and formally from the organisation's performance evaluation system.

3. Positional power: This is the amount of authority that a leader has to influence the productivity of their followers, in terms of rewarding or punishment. Positional power may be weak if subordinates do not report directly to the leader, like in a matrix organisation, or because of poor or limited tools. In any case, leaders need to exercise their roles, clearly distinguishing 'formative' from 'summative' evaluations: the former could be linked to incentives/penalties, while the latter should support personal and professional development.

Contingency theory assumes that a leader's style cannot be significantly influenced or modified, and, therefore, it advises searching for the right match between leader qualities and the context where he/she is designated to work. On the contrary, 'situational leadership' stresses the need (and capacity) for leaders to adapt to the situation (Graeff, 1997; Lega et al., 2017; Spurgeon et al., 2011). In this case, the 'situation' is defined by the development/readiness level of the organisation, that is, followers' managerial/psychological maturity. Leaders are expected to evaluate their organisation through the assessment of the competence, skills, motivation and general confidence of their subordinates. Then, leaders must adapt their style according to the situation and change it as necessary, rather than having a natural dominant style. The leader does not impose their style, and the organisation is not forced to accommodate the leader's style. Situational leadership is also different from opportunistic leadership, where a leader switches styles in order to gain control

and for their own selfish goals. Situational leaders adapt styles to support the development of collaborators and make the best out of the team. They consider ability (skills and competences) and willingness (confidence, commitment and motivation) demonstrated by subordinates. Ability and willingness can be nurtured by the leader, while the excitement of doing something new might heighten the motivation of collaborators which is why leaders should promote 'collective ambition' to their collaborators and then support them to achieve it.

Based on the two components above, there are four possible situational leadership styles, defined as task vs. people focused. Task-oriented behaviour is considered as 'directive', which implies giving directions, setting goals, defining targets, imposing methods, etc. People-oriented behaviour is more 'supportive'; it implies two-way communication and emotional support. Therefore, situational leadership proposes four distinct styles, based on the cross between ability/willingness and task/people orientation (Hersey & Blanchard, 1982).

1. Directing (high direction – low support): The leader gives instructions about what and how task goals are to be achieved by subordinates and supervises them constantly.
2. Coaching (high direction – high support): Coaching is an extension of the directive style. The leader still provides detailed directions and takes decisions. However, they also focus on giving encouragement and solicit input from subordinates while explaining the reasons for the decisions taken.
3. Participating (low direction – high support): In this style, the leader tries to make their followers more independent in task achievement, and they allow them to take routine decisions while facilitating high-level problem-solving. The operational autonomy of their collaborators increases.

4. Delegating (low direction – low support): The leader and collaborators agree upon details of goals and tasks. Then, workers have the complete freedom to perform them.

The contingency and situational theories of leadership explain the background for the development of transformational leadership. Finding the best leader–follower match is an antecedent for transformational leadership. If the leader has a style which is coherent with the expectations and capacity of their subordinates, they will have more chance of transforming the organisational behaviour, the culture and the individuals (as they become followers). Transformational leaders set visions and ambitions, motivate the organisation and generate ethics and values that change behaviour. They are able to align individual aspirations and motivations to the organisation's vision, producing what is called a 'meeting of minds'.

Transformational leadership is often associated with charismatic leaders, those who have disruptive views, lateral thinking, exemplary behaviour and servant leaders, and those who serve their organisation facilitating the empowerment and ownership of change by subordinates. In both cases, transformational leaders aim at leaving the organisation – once they terminate their duty – different and better, as well as wanting to assist in their followers' development to the next level of leadership and management qualities.

BRAIN-INTENSIVE AND PUBLIC ORGANISATIONS: LEADERSHIP RE-LOADED

Contingency, situational and transformational leadership provide a good framing for understanding what we expect from leaders and how to match leaders and followers.

However, leading people is not equivalent to leading the organisation. Here, we need to explore better the issue. What frameworks we have to describe what we expect from leaders when they 'drive' the whole organisation and not just their direct team? That is where health organisations could really differ, as they are so complex, brain-intensive and dynamic compared to all other modern organisations that inevitably require some specific effort from leaders.

In a recent meta-analysis of trait and behavioural theories of leadership in healthcare, Derue, Nahrgang, Wellman, and Humprey (2011) concluded that much of the research evidence fails to provide an integrated framework for understanding what constitutes leadership. A definition for healthcare leadership, which espouse a systemic view and is not too far from general theory statements, has been identified:

> *Leadership is a dynamic process of pursuing a vision for change in which the leader is supported by two main groups: follower within the leader's own organization, and influential players and other organizations in the leader's wider, external environment.*

Many countries define today the doctors' leadership qualities through a series of competency-based frameworks. Styles and behaviour approaches were also applied to leadership in healthcare, with a specific focus on transformational and transactional leadership. In general, it has been noticed that in healthcare systems, organisational asymmetries are greater than in the private sectors; therefore, classical approaches used to frame organisational challenges for leaders have to be adjusted (Lega et al., 2017). The 'culture of professionalism' was celebrated by medical professionals, who were always upholding their autonomy apart from managers and administration. In this respect, the

concepts of collective and distributed leadership came into practice in the healthcare sector.

However, we still don't have a framework able to capture all the elements that are central to a comprehensive approach to leading health organisations, one that considers the system, culture and context, and one that is fully aware of the clear effects of publicness, such as (Boyne, 2002):

- Increase in complexity: Public organisations face a variety of stakeholders, each placing demands and constraints on their managers, sometimes in conflict with each other.
- Permeability: Public organisations are 'open systems' that are easily influenced by external events.
- Instability: Political constraints result in frequent policy changes and the imposition of short-time horizons on public managers. It is extremely difficult to pursue medium-term projects with the necessary continuity.
- Distinctive goals, such as equity and external accountability, that do not exist or are limited in the private sector.
- Ambiguity, as the political process is often responsible for imposing or influencing continuous shifts in priorities, whereas private organisations select and control better their own goals.
- Greater bureaucracy and red tape: Public sector health organisations fight with an unnecessary and counterproductive obsession with rules and processes rather than results and outcomes.
- Decreased managerial autonomy: For instance, public managers have particularly low discretionary powers with regard to personnel issues because they are subject to inflexible regulations regarding hiring, firing and promotion.

- Lower level of organisational commitment, largely because of inflexibility in personnel procedures and weak links between performance and rewards.

FRAMING LEADERSHIP IN TIME OF HEALTH MANAGEMENT 2.0

That is extremely challenging to lead healthcare organisations is hardly surprising given their complexity, and there exists plenty of evidence to support this fact. Healthcare organisations are often large pluralistic contexts, and in pluralistic frameworks, the powerful and conflicting interests of internal and external stakeholders make it difficult to communicate and enforce explicit, coherent and unified strategic directions. There is evidence that pluralism, enhanced by professionalism, or by publicness, results in extremely devious and power-based decision-making. Decision-making is often described as 'political', 'informal' or 'ad hoc' (Lega & Cuccurullo, 2011).

In this respect, theory on strategic management and leadership has not yet developed specific frameworks on the exercise of roles of top managers and CHs within the delicate relationships of politics, management and society. The majority of public management literature tends to adopt the concept of strategic management developed for the business environment. Research on the nature of strategic public management is scarce, punctiform and lacks a comprehensive picture (Bovaird & Loffler, 2009; Joyce, 1999; Lane & Wallis, 2009).

This oversimplification and failure to broaden the scope of the research has not helped to prepare managers of public health organisations (PHOs) for their tasks.

Many PHO managers feel they are 'in a different league' and, therefore, subject to illogical, politically driven decisions.

Politicians often act according to sub-interests and consensus-building objectives, as in the case of the closure of small-scale hospitals.

In the following paragraph, we'll try to fill this gap by proposing an interpretative framework that clarifies the contents, contexts and peculiarities of a strategic public management approach in healthcare organisations. The framework is grounded on empirical analysis and aims at identifying the principal functions managed by leaders governing PHOs.

The speculative framework is composed of the following five dimensions: playmaking, enabling (and engaging), aligning, compromising and equivocality.

Playmaking

Firstly, strategic public management in healthcare (SPMHc) involves a significant degree of playmaking by leaders. Quite often, they face 'wicked' (ultra-complex) issues. These are problems that cannot be treated successfully with traditional linear, analytical approaches. They are difficult to clearly define as the nature and the extent of the problem depends on who is involved; different stakeholders have different versions of what the problem is. Often, each version of the policy problem has an element of truth; no one version is completely or verifiably right or wrong. The debates concerning the causes, the extent of the issues and the solutions to the issues such as out-of-pocket expenditures, health coverage, population medicine and emergency network design are good examples. Many of these issues should be defined by politicians. Unfortunately, politics is often unable to find a strategy; therefore, leaders must step in and take coordinating action; tackling an extremely complex or

wicked issue usually requires the contribution of many public institutions (i.e., health promotion) and a great deal of consensus-building among all stakeholders. Furthermore, even when a decision is made by politicians, interaction and coordination is generally required for the implementation of the decision. Therefore, playmaking means initiative and network management (multilevel governance) by leaders. They are expected to not only 'steer' but also 'connect' and be capable of building consensus around decisions and coordinating efforts to address complex issues. SPMHc includes network building and management.

Enabling

Secondly, SPMHc necessarily involves enabling creating conditions, so that middle managers, leading clinicians and health professionals have direction and can pursue their objectives with continuity.

Because many PHOs, at all levels, are constantly subject to external and internal pressure and attempts to influence decision-making processes (i.e. purchases, recruitment, inspections, licences and so on), a major task for top level management is to counter these pressures and to insulate middle managers from attempts to re-direct their decisions. Enabling is also necessary to avoid administrative middle-line managers of PHOs from shielding themselves with bureaucracy by actively using formalism to stop or slow down processes in which they feel pressured. From this perspective, enabling is the closest task to the traditional idea of strategic planning, as it encompasses the definition of strategic priorities and the allocation of responsibilities and resources to pursue the fundamental objectives – those 'things that cannot go wrong'. If middle managers share a

strategic vision, have clear direction and can work with continuity, they are better able to achieve the expected results. Top management has the job of minimising external, internal, lateral and diagonal interferences together with a meeting of minds with their leading clinicians and health professionals so as to clarify the expected conduct in the face of such interference. As Exupery wrote, 'if you have to ask your men to build a ship to sail, you should first have them longing for the sea'.

Aligning

Thirdly, SPMHc is founded on alignment processes. Enabling requires aligning. The meeting of minds introduced in the previous point is a process of alignment of goals, expectations and priorities among the top- and middle-tier public managers and the politicians. As Senge (1990) wrote, 'if any one idea about leadership has inspired organisations for thousands of years, it's the capacity to hold a shared picture of the future we seek to create'.

When resources are not enough to satisfy all legitimate expectations, when negative or irrelevant issues are on the agenda, and when political directions are ambiguous (either because they are not explicit or because they are explicit but contain internal inconsistency), public managers first need to identify their acceptable and expected behaviours. This said, PHOs need to clarify the strategic 'to-do list' through confrontation with politicians and main stakeholders, and they must then share this list with their middle managers. Paradoxically, sometimes strategy-making in public contexts looks more like the art of knowing what not to do. Once the boundaries of the organisation's 'strategic space' are clear, the public manager can set directions and share them with the rest

of the organisation. In many cases, the identification of the room for strategy requires the involvement of leading clinicians as they have a better knowledge of what the citizens, patients and local community need and want. Furthermore, they probably have better relationships with powerful external stakeholders, which could be influential and should be taken into consideration.

In this respect, one specific category of the alignment process is engaging. Traditionally, the decision-making of PHOs has been dominated by clinicians who have often pursued goals critical to their status as professionals but not congruent with organisational goals critical to maintain the resource base of the institution. Though it may look to be a past condition, recent studies confirm its permanence and its existence (Spurgeon et al., 2011). Engaging clinicians (and other professionals) in managerial issues and aligning their interests as much as possible with organisational goals is a key task. The more complex the PHO, the more it requires physicians to fit into and accept its programs.

In general, during the alignment process, managers of PHOs confront consensus-driven, mission-driven or market-driven strategic alternatives. As public managers perceive them as worthwhile and salient in their strategic agenda, some 'wants' (i.e., citizens and patients' expectations on waiting times or services' locations) may become institutionally recognised needs even without clear political direction.

Compromising

Fourthly, SPMHc is clearly embedded in frequent compromises. PHO managers are expected to balance and reconcile conflicting objectives. Decisions are often the results of the interplay of various actors. Each actor can bring a different

claim, as each actor aims primarily to satisfy his/her own interests. Within the decision-making arena, actors can interact, bargain, negotiate and struggle. Compromise is natural in political environments because consensus is built through the fine-tuning of decisions and agreements. It is also natural for PHO managers; they are often faced with decisions that raise a variety of external and internal interests.

However, compromising assumes a deeper meaning for public organisations; many of the chief executive officers (CEOs) and medical directors (MDs) interviewed highlighted in different interviews that they cope with two specific issues (Lega, 2012):

- Triangulation processes: Compromising is expected to occur along the vertical and lateral lines of PHO managers, namely, with politicians, managers of other institutions, community representatives, unions and – to a large extent – with their own middle managers and leading clinicians/professionals. The latter compromise is at risk of triangulation because of the spoil system of appointment in place for many CEOs and MDs of PHOs and because of the personal network of political/media/community relationships that clinicians often have. Thus, a clinician may activate a personal relationship with the external environment if he/she considers a decision made by the CEO to be threatening or intended to produce a counter-effect. In this way, he/she is 'triangulating' outside the organisation to interfere with the CEO's decision. PHO managers need to 'insulate' their work from such interference based on strategic choices, strong alliances and consensus with politicians and other stakeholders.
- Extensive democratic dissent: In many countries, clinicians employed by PHOs enjoy a special career-based system based on automatic promotion (seniority), no true

evaluation of performance, a closed culture and very complex and difficult dismissal procedures. More often than not, they have a 'job for life'. In this context, it is not unusual for leading clinicians to feel free to openly criticise the conduct of their CEO and MD in the media. The golden rule of 'don't wash your dirty linen in public' that applies in the private sector apparently often does not apply in PHOs. In the PHOs of several developed countries (such as Italy, France, United Kingdom, Spain and the United States), this behaviour is strongly influenced by culture. Public dissent is often amplified by the media and welcomed by public opinion as a brave attempt to report one of the infinite mismanagements of public institutions, and this can be used against PHO managers like moral blackmail.

Equivocality

Lastly, SPMHc lives with equivocality. Politicians are eternally optimistic, even though their programs are usually overloaded with policies and actions designed for consensus-building and whose feasibility is dubious. CEOs are expected to have strategic plans with the same overloaded goals. This is partly the result of an unwritten agreement in which PHO managers are expected to have a high degree of institutional (political) isomorphism. If there are keywords in the political agenda, or key policies, they must find a place in the strategic planning of public organisations, regardless of their degree of feasibility. It is like a game played by two actors who know perfectly well that the actual expected result is something completely different. The classic example is the budget. All PHOs are expected to close their provisional budget with a forecasted balance; however, in many cases, public managers and politicians know that a deficit is unavoidable, and, thus,

the key issue for the public managers is defining the range of acceptable deficit. Politicians will not usually define the acceptable deficit ex-ante because they want to keep the public manager under stress and remain free to evaluate his/her conduct ex-post; they may later need a scapegoat even if the deficit is actually contained. In general terms, politicians will not define many exact objectives, as evaluations are conducted not only on results but also on affiliation and trust. Healthcare CEOs have to live with this ambiguity. They have no clear directions as to how far they can push for change and revolution within their organisations in striving to make them more efficient and effective while also creating resistance, protests and triangulations. They have no clear idea about the degree to which politicians will support their drive for modernisation, as consensus always remains a key issue for politicians. Thus, what is the trade-off between innovation, change, modernisation and consensus? This is the core of the idea of equivocality. We know that there is evidence that managers of PHOs have a stronger desire to serve the public than private managers (Allison, 1993), but how much do they foster this desire by promoting change in the midst of protests by unions, political parties, lobbyists and so on if their job is at stake? One CEO interviewed said, 'I have to serve all the stakeholders, but when I'm on the firing line, I'm my principal stakeholder'. Experienced public managers know that SPM requires a risk-taking attitude to manage equivocal decisions.

PEACE BUILDING

Playmaking, Enabling, Aligning, Compromising, Equivocality. That is PEACE. The words and acronym were not chosen at random. These words ultimately reflect what CEOs

and MDs told us when we tested the framework: keeping the peace is what they feel all stakeholders expect from them. Radical, strategic change is rarely, if ever, endorsed by politicians or by internal and external stakeholders. While such change might be advocated by one of them, they will not take the lead. At the end of the day, PHO manages are alone. There is an ineffable solitude that their statements betray; when they are under fire, they are often, if not always, alone. That is why playmaking is so very important; the engagement of politicians, the external scrutiny, alliances and social control are key levers to drive change and back up complex decisions on wicked issues.

Thus, SPMHc organisations are also about peacebuilding while steering the organisation toward the future. Innovation and change are their tasks, but when they occur and disrupt the previous state of equilibrium, PHO managers must re-establish a new, tough, different and 'social' peace. PHO managers are expected to promote consensus-building through alignment, compromise and playmaking while pursuing the mission through their enabling work and the understanding of trade-offs and risks related to the dimension of equivocality.

The PEACE model provides a refined ground to explain strategic management in the public healthcare sector. It responds to the popular concept of thinking strategically while acting democratically that sums up the essence of strategic public management. It could also be a potential metric for measuring, in the future, how much strategic management is actually practiced by healthcare leaders, beyond the strong rhetoric on the 'one best way' often used to define desirable strategic management in public sector organisations.

Next, Fig. 5.1 illustrates trajectories and implications of leading and strategic management in the new normality of health systems and organisations, and provides the *fil rouge* of this chapter.

OPERATIONALISING LEADERSHIP PRACTICE FOR CLINICAL HEADS: FROM LEADERS TO LEAGERS

In times of management 2.0, health leaders can look at different leadership theories and models and at the peace framework to reflect on their styles and practices.

Much of the activities described by the peace framework applies also to CHs, those running divisions, departments, service lines, units, etc.

To be effective at the 'next level', they are expected to combine qualities of the leader with skills of the manager, that is, generating directions and making things happen. That is why, we defined them 'leagers'.

The Leadership Cycle

Their work is expected to develop through a 'strategic cycle' built around three phases: envisioning, enabling and implementing. Practices required by the three phases include the

functions of peace frameworks and provide CHs with a 'method' to play their role.

Envisioning

Envisioning implies defining the strategic direction of their unit, aligning the visions of their co-workers and collaborators. Through this activity, CHs do sense-making of the context and engage their team in defining how to fill in the 'strategic space' within which they can make choices. The perimeter of the strategic space is bound by mission, capacity of the team, expectations of stakeholders (top management and other internal/external actors, i.e. patient associations, politicians, scientific networks) and competition. What to do and how to do it is the big question for CHs. They can (must) ask themselves and their team THE question: what makes us valuable? Then develop strategic planning and a specific strategic plan for the next years.

This envisioning also encompasses two other very important activities undertaken by CHs.

The first is the role of 'filter' they play with regard to the ambiguity and uncertainty (or equivocality as stated in the peace framework) that often affects health organisations, specifically when public. They absorb uncertainty and provide their team with clear direction (and consequent risk-taking).

The second is developing a strategic plan for their unit. This is also a way of defining the 'contract' with their own organisation to 'bind' expectations to their performance as leader.

Good envisioning is what makes CHs leaders.

Enabling

Enabling, similar to what was stated in the peace model, refers to creating conditions, so that the team has clear direction and

can pursue goals and targets with continuity. Therefore, in this respect, it also includes functions such as playmaking and compromising. CHs are expected to set smart goals for their team, make choices about the most effective division of labour, provide constructive feedback, and coach and support each individual collaborator.

CHs must then work to generate a context (through their playmaking) of relationships that facilitates the work of the team and when necessary builds effective compromise.

There are three further points of attention. First, CHs need to adopt the right motivational factors to increase the commitment of their team. Each team member could be better motivated by specific drivers: financial incentives, recognition, group work, status, etc. Second, CHs must provide psychological safety. Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or about mistakes. The team culture should be characterised by the 'obligation to dissent' if anyone has a different view. What CHs should be asking and building is loyalty, not fidelity. Third, enabling is about defining a 'pact' with the team. This is about setting the right 'rules of the game', about ensuring that vision does not become a hallucination, strengthening sense of purpose and generating a context permeated by the feeling of organisational justice. Enabling is what accredits CHs as leaders.

Implementing

Implementing is 'making things happen'. It involves designing and managing controlling systems and developing the dashboard to measure and assess expected performances. They are milestones and checkpoints that help a CH keep the team and individual collaborators on track. Here, the CH plays the role of manager.

Implementing is never straightforward. Professionals are well-known to be resistant and resilient to changes that affect their interests. They adopt many strategies to protect the status quo, as described by Ackroyd et al. (Ackroyd, Hughes, & Soothill, 1989) with the term 'custodial orientation'. This suggests a form of management practice that is essentially encapsulated by professional interests and which is primarily focused on maintaining the status quo (as defined by the professional community).

In this light, envisioning and enabling might not be sufficient to generate the desired change. CHs might have to cope with change management processes and go through the three fundamental steps (Schein, 1965):

1. Unfreezing, which is the process of disrupting the habitual behaviour of employees. It may happen through the provision and sharing of information, or through more enforcing tools (norms, financial incentives, rewards and punishments, etc.). This action involves communication and sharing of the need for change. People must perceive the sense of urgency for change. In other words, since people are not in the market for solutions until they recognise that there is a problem, the need for change should be made obvious for everybody, not just the top management of the organisation.

2. Substituting, which is the replacement of old behaviour with new one. Involvement of team members in defining new behaviour enhances support to change. From another perspective, it is impossible for a few people in senior positions to work out all answers themselves.

3. Refreezing, which is the process of institutionalisation of the new behaviour. This implies bringing positive outcomes to the attention of the members and reinforcing new

behaviour patterns. The goal is to re-establish the level of comfort employees experienced prior to the change.

Implementing is where CHs combine the qualities of the leader with the capacity of the manager. Managing change also means avoiding falling into simplicity traps; avoiding implementers making sense of their task by concentrating on a narrow set of factors; and removing the 'complications' that involve full change (Weick, 1979). This 'selective attention' might lead to an overemphasis on some aspects of change and to an underestimation of other aspects that in the end causes the failure of the overall change. CHs must control the 'whole picture', while digging into the 'black box' of health service delivery processes.

In this light, every time CHs lead organisational development processes, they are managing a complex change involving envisioning and implementation.

As a matter of fact, through the strategic cycle, CHs are defining and executing an organisational development process as they are re-setting the organisation's goals (strategic planning) and design (division of labour) to meet strategic ambitions and organisational challenges. They are expected to execute the changes necessary for the gradual achievement of the new state of their unit over a desired time span (usually 3 years is the length of a strategic cycle). A three-year span might be necessary to achieve consolidation of organisational changes and to assume their new roles and responsibilities. Further, CHs are expected to think and react fast, recognising the fact that opportunities (and challenges) can emerge from within the organisation without any previous formal plan or analysis. Clinical leagers need then to recognise the process of emergence and to intervene when appropriate, killing off bad emergent strategies but nurturing potentially

good ones. The objective is to assess whether the emergent strategy fits their unit and organisation's needs and capabilities. This is a function of strategic management. Leagers must be able to combine top-down rational planning with bottom-up emerging strategies, revising the deliberated strategy in course of action and consequently modifying organisational design and development patterns to fit the new strategy.

Posture for Leading

Further, CHs in acting as leagers could be required to have a specific posture, that is, a set of 'meta-expectations' connected to the exercise of their role. They are expected to deliver performance and results, but how should they behave to contribute to the 'search for excellence' of their organisation? There is a huge body of literature on styles, behaviour and best practices of leaders, but hereafter, we will highlight those approaches that distinguish great clinical leagers from good ones. Leagers are not just leaders and not just managers. They combine visionary capacity with pragmatic focus. They help their organisations to become better places in many ways, but what really makes a difference seems to be their capacity to sustain the effort to develop an organisational culture of excellence. A culture based on the continuous effort to face and cope with three major 'pathologic dynamics' that affect all types of organisation:

1. The focus on 'problemistic-search' decision-making;
2. The attractive trap of 'satisficing';
3. The strong path dependency or 'retention of solution'.

By problemistic search, we mean the cases where search for alternatives is triggered when the organisation encounters a problem (Cyert & March, 1963; March & Simon, 1958).

It describes a behaviourally plausible process by which organisations learn from performance feedback. When organisations recognise their performance is below aspiration, this awareness could lead to search for a solution to the problem, resulting in change intended to restore performance to the aspired level.

Problemistic search highlights reactive behaviour. If and only if the problem is perceived as such – that is awareness and urgency are recognised – the action will be taken. Conversely, we expect leagers to have a proactive posture. Issues need to be addressed before they become problems. That is what sets apart great CHs. Satisficing is a decision-making strategy that aims for a satisfactory or adequate result, rather than the optimal solution. Instead of putting maximum effort toward attaining the best outcome, satisficing leads to adopting a minimalist approach with regard to achieving the first attainable resolution that meets basic acceptable outcomes and leads to quick solutions, shortcuts and low performance level. This is because aiming for the optimal solution may necessitate a significant expenditure of time, energy and resources, which the organisation (its leaders and managers) is not willing to spend. Satisficing often results in 'garbage-can' decision-making.

Implication for CHs as leagers, and for health organisation leaders, is the expectation that they be a driving force in raising performance thresholds – even beyond what is expected by the MBO system. Leagers are expected to be ambitious. For themselves, the team they manage, their organisation: servant leaders continuously pushing the organization to challenge its performance.

The satisficing strategy can include adopting a minimalist approach with regard to achieving the first attainable resolution that meets basic acceptable outcomes. Satisficing narrows the scope of options that are considered to achieve those outcomes, setting aside options that would call for more intensive, complex or unfeasible efforts to attempt to attain optimal results.

Last, by 'retention of solutions', we mean the natural tendency to search for solutions to problems from past experience. Organisations, like people, are mostly driven by the past rather than pulled by the future. However, we expect leagers to be naturally inclined to explore innovations, to benchmark against competitors and to infuse their organisations with the latest trends. That includes studying others and adopting positive and lateral thinking. CHs usually attend scientific society meetings where they get the latest news on innovative technology and practices, yet they don't have meetings with specific focus on organisational issues. This is where more is expected of them; curiosity about what is changing in the way services are delivered, about the latest organisational transformation and about opportunities to rethink the way things are organised and managed.

BEYOND 'OLD SCHOOL' TRAINING

How do we prepare top management and CHs to perform their expected role?

By now, it is clear that traditional training courses are not as effective as they were supposed to be. They can provide an introduction to the role and some useful techniques (i.e. project management, business planning, lean approaches, etc.), but no more than this.

Competence frameworks developed over recent years, such as the ones drafted by the NHS Leadership Institute and the

International Hospital Federation, are helpful to outline the complexity and variety of skills that need to be focused on. Yet, settling leagers in their roles is not just a matter of content and notion; it is more about their training method.

Class experience is certainly useful, as well as the use of the most recent evolution in training technology such as digital platforms, blended learning and virtual action learning.

But what seems to be of paramount importance for the future is investment in strengthening two specific paths for training the next generation of leagers:

1. Reflection opportunities,
2. Communities of practice.

Reflective Practitioners

Leaders and managers, leagers, need to find a contemplative space in which to do sense-making of their own practices, a place and a time where they can develop self-learning. The role of the trainers is to provide conceptual frameworks and leave the leagers to do their own interiorisation, so they become reflective practitioners. They could be supported in reflecting by following key principles (Winter, 1987).

- Reflexive critique: An account of a situation, whether notes, transcripts or official documents, will make implicit claims to be authoritative, i.e., it implies that it is factual and true. Truth in a social setting, however, is relative to the teller. The principle of the reflective critique ensures people reflect on issues and processes and make the interpretations, biases, assumptions and concerns upon which judgements are made explicit. In this way, practical accounts can give rise to theoretical considerations.

- Dialectical critique: Reality, particularly social reality, is consensually validated, which is to say it is shared through language. Phenomena are conceptualised in dialogue; therefore a dialectical critique is required to understand the set of relationships both between the phenomenon and its context, and between the elements constituting the phenomenon.
- Plural structure: Leading organisations embody a multiplicity of views, commentaries and critiques. Multiple possible actions and interpretations are often possible. This plural structure of sense-making requires a plural text for understanding. Reflection within a contemplative space, therefore, could act as a support for ongoing discussion among leagers and collaborators, rather than a final conclusion of fact.
- Theory, practice, transformation: Theory informs practice, and practice refines theory, in a continuous transformation. It is up to the leager to make explicit the theoretical justifications for the actions and to question the bases of those justifications.

Communities of Practice

Communities of practice are made of peers in the execution of real work. People who develop a shared repertoire and resources such as tools, documents, routines, vocabulary, symbols, artefacts, etc., embody the accumulated knowledge of the community. This shared repertoire serves as a foundation for future learning.

> *Over time, this collective learning results in practices that reflect both the pursuit of our enterprises and the attendant social relations. These practices are thus*

> *the property of a kind of community created over time by the sustained pursuit of a shared enterprise. It makes sense, therefore to call these kinds of communities of practice.*

A community of practice involves much more than the technical knowledge or skill associated with undertaking some task. Members are involved in a set of relationships over time (Lave & Wenger, 1991), and communities develop around things that matter to people. The fact that they are organising around some particular area of knowledge and activity gives members a sense of joint enterprise and identity. In other words, it involves practice (see praxis): ways of doing and approaching things that are shared to some significant extent among members. In this view, communities of practice represent perfect contexts where professionals and managers of an organisation subject to change might discuss their problems and search for solutions. Communities of practice work as knowledge building and sharing context, where problems can be discussed with peers having to cope with the same issues.

Therefore, leagers can benefit immensely from being involved in a community of practice, where they can freely explore their practices and learn through the comparison of experiences. In this light, community of practices could also provide contemplative spaces, pushing to the next level the whole learning process.

Focus on the Neglected Issues

Whatever will be the methodological choice made to develop the future training of leagers, one thing is clear beyond any doubts.

It must be an opportunity to cope both with the self-learning process on personal practices and with the need to address the neglected issues. Anyone that spends his or her time sharing it between academic halls and organisational shop floors knows there are questions in healthcare managers' mind that are constantly ignored by researchers and can't find easy answer through 'instructions' that can be taught. There are good excuses for this. These are complex questions that require sophisticated research designs and many control variables. These are questions that can be investigated only when embedded in a specific context. These are questions that often do not get you to publish on top journals and, therefore, conflict with the 'publish or perish' dominant logic. Therefore, most trainers know less than leaders and managers about them.

Still, these are 'the questions' whose discussion training should facilitate: What are the most effective organisational models for hospital to pursue patient-centred reconfiguration and to pursue any other specific strategic goals and operational objectives connected with the challenges of multi-disciplinary, skill mix, process management? How should we organise nursing staff in relation to medical staff? How could we manage frail patients or rolling-door/frequent flyer patients such to avoid re-test, artificial variability in clinical practices, redundancy etc.? Is there a clinical governance system that really works and makes the difference at the organisational level? Why? Who runs it? How could we give 'structure' to multi-disciplinary teams beyond announcement effect that we need to integrate etc…? How clinicians can effectively work in matrix systems? Which are the alternatives to build motivating career paths for physicians? What implications derive from these alternatives? Which incentives produce which effects? How we build the 'navigator' for patients? How patient centricity can be achieved? Which is the professional role most fit? And many other questions…

Executive education for health managers has the responsibility to help them to name and frame those issues. In the 'new normality' of modern healthcare, trainers have the responsibility to bring education to the next level of meaningfulness.

6

REFLECTIONS

Usman Khan and Federico Lega

There was an evident level of challenge or provocation in titling our volume 'Health Management 2.0'. The reason we did it was in no small part so as to be able to contribute to the current debate as to where European health systems are going and how best they can be managed. We have aimed to address both an academic audience alongside health policymakers, healthcare professionals and health managers.

The book started by setting out the path to the establishment of post-war European health systems with its unifying strands centred on the public financing of health and the general availability of treatment and care free at the point of need. Borrowing from the discourse of technology, we entitled this 'Health System 1.0', a baseline to enable the reader to assess changes to health policy and practice over the subsequent seven decades. The thread of the discussion in following chapters then did not focus on the detail of health system change but on establishing whether such change should be best viewed to be transformational – Health System 2.0 – or whether it should be more appropriately viewed as being transactional – Health System 1.1, 1.2 and so on. The central chapters of the book

then focussed on the constituent elements of the change agenda, taking us from service improvement to strategic positioning and business. A chapter was then dedicated to looking at the importance of leadership in this new model of health management practice.

In this final chapter, we will return to this motif, as we draw together the debate and set out our final reflections. Having started with a summary of the main themes of the book, we move onto a discussion as to the meaning of paradigm change and its relevance to health management theory and practice. We conclude the chapter and the book with a short section about the potential learning arising from the current discussion for the policy, academic and health services communities.

REFRAMING AMBITION

The first point of discussion returns us to the volume title and the notion of change. Having set out our contention that European health systems are at a point of paradigm change, we must ask ourselves once again why this matters and what its consequences may be for the practice of health management. In particular, we wish to consider how health systems and health management interact and the likely impact of change in one domain on the other. Further to this, we want to ask if health management can or should seek to play a role in facilitating or enabling paradigm change and whether conversely it could act as a brake or barrier to systemic change.

The reason the questions outlined above matter, is because concerns regarding long-term health system sustainability, which emerged less than two decades after post-war health systems were established, have failed to entirely dissipate and in the case of many countries have in fact grown and proliferated. Such challenge has in itself been subject to the charge of

not being clear with regard to health system sustainability as to 'what does good look like?'. Here, it can be easiest to go back to basics by considering once again the United Nations' articulation in the 1946 Constitution of the World Health Organization (WHO), where the definition of health was given as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (United Nations, 1946). Current limits to human life see life expectancy growing, but the maximum life span remaining remarkably constant at something over 100 years (Dong, Milholland, & Vijg, 2016). Health systems and health management become then vehicles for benefits realisation within this framework. If our ambition in the post-war period was to ensure that individuals were able to live to retirement age and supported as they faced the more significant challenges of old age, then 'six good decades and one fair one' would have been a reasonable aim. This could be achieved with health systems that safely take you through birth and adolescence and into adulthood, with a strong early primary prevention coupled to an effective reactive system of treatment and care. However, changes within and outside healthcare are now taking us to the point where more people will be able to live close to the maximum life expectancy and within this they can expect not just good decades of health but great decades and not just the six to take us to retirement but eight or more to take us well into older age. 'Eight great decades and two good ones' provide for a new vision, but one where the mission must be more focussed on a foundation of high levels of personal health literacy, self-care and empowerment coupled to a health system which is anchored in prevention, screening and early diagnosis. Health System 1.0 has been designed for six good decades and one good one, but it will take Health System 2.0 to enable us to deliver eight great decades and two good fact ones.

ENVISAGING HEALTH SYSTEM 2.0

There is a question as to what Health System 2.0 would look like? This can be considered with respect to inputs, outputs and outcomes. We have already said that Health System 1.0 is at its core a reactive system, and whatever the elements of proactive engagement incorporated, the leopard cannot fundamentally change its spots! The first way in which we would be able to recognise that we were living within a Health System 2.0 would be that it is driven by a proactive intent at all levels. One would be likely to see significant investment in preventive medicine and a focus on reducing health inequalities. One would also see a much greater focus on health literacy and health empowerment for all population cohorts and across every societal domain. Homes, workplaces, schools and the wider environment in which they were situated would all be focussed on enabling the highest levels of health and well-being. Screening and prevention would be given the highest priority, and treatment would be viewed to be the exception rather than the norm.

In terms of finance, one would expect to see a fundamental reapportionment of resources from treatment to prevention and to a lesser extent care, as the focus of the state moved from the hospital to the home. The impact of personalisation is then likely to have a significant impact on health financing, with treatment becoming increasingly bespoke in form and nature. This in turn is likely to require increasingly sophisticated social insurance models, to avoid a situation where the public appetite for pooled risk is brought into question. Hospitals would increasingly become centres for treatment and care of an increasingly small cohort of very sick patients, with the majority of care for larger cohorts of high need such as Alzheimer's disease being delivered in the community. As models of finance are established to reward effective prevention over reactive treatment, the service model

will evolve to support personal empowerment which can maximise levels of resilience and support a new model of self-care which is able to draw on the best of health technology innovation and health data use. Health System 2.0 will then incorporate aspects of Health System 1.0, but it will also be fundamentally different in form and function.

HEALTH MANAGEMENT 2.0

What then can health management do to respond to this rapidly evolving landscape? At a simplistic level, it will need to continue to develop and evolve its practice so as to best respond to the situation it is facing. The balance of health management competencies will continue to evolve with the human and social aspects such as leadership, facilitation and communication growing in importance, as those traditional ones such as resource planning and allocation may relatively recede. Within health management and policy teaching, there is evidently the scope to expand the curriculum to more fully account for contextual discussion on the sustainability of health systems and for evolving trends such as co-creation to be more fully incorporated. That, in turn, would suggest that the health management curriculum would need to evolve so as to be able to teach the skills around subjects such as interdisciplinary working and patient and public engagement. Beyond this, there would also be merit in assessing other aspects of teaching and learning, not least of which would be how to best involve the patient voice and patient perspective in a spirit of co-creation.

The broader question is whether more or better health management will be able to deal with the challenges it faces or whether it will risk becoming overwhelmed and as such to be seen by important constituents as being part of the problem rather than part of the solution. As said, it is unlikely that health

management or health managers will alone be in a position to change the shape of European health systems. That responsibility will in part lie within health policymakers and the pressures to which they are subject from non-governmental, academic and industry voices. Health policymakers have seen the problems and have sought to use the instruments they have to improve the situation. They have changed the structure, increased emphasis on primary care, they have regulated, they have increased spending, they have brought in the private sector and marketised, they have supported service improvement and innovation, they have introduced more and more highly trained managers and they have sought to empower health professionals and patients.

How does this impact the health manager on the hospital ward, in the diagnostic and treatment centre, at the primary care centre? How does it impact at an organisational level as well as at a health system level? The answer is that within the confines of day-to-day working it will only have an impact if the wider health system enables it. There needs to be a greater level of fluidity at both an organisational and individual level and an enhanced skill set to mediate effectively between platforms and within an increasingly diverse landscape.

The skill set of facilitating effective interdisciplinary working will undoubtedly feature heavily in the portfolio of Health Management 2.0 as it did within the latter stages of Health Management 1.0. It may also be that the methods and approaches associated with co-creation will feature more. Co-creation is a recent addition to the health management lexicon, with its roots lying across the domains of innovation, technology, management, marketing and consumer research (Galvagno & Dalli, 2014). This paternalistic backdrop was well captured by Sonya Makhni in an editorial of the *AMA Journal of Ethics*:

> *Historically, patients have been considered passive recipients of services provided to them by those in the health care industry. The ecosystem of health care evolved relatively independently of their voices, which is contrary to the customer-provider interaction in many other industries outside of health care.*
>
> (Makhni, 2017, p. 1070)

Touchpoints between health systems and individuals, as patients and citizens, continue to expand and develop. Individuals are now routinely involved in governance, management, design and improvement in a manner which could not have been envisaged 25 years ago, let alone 75 when post-war health systems were established in their current form. Yet, the challenge remains that such initiatives remain piecemeal additions to what remains a fundamentally paternalistic system.

What then does Health Management 2.0 look like? The health manager of the future will need to draw upon a broader range of skills and competencies than it is currently the case. While spreadsheets and process maps will continue to feature, there will be a move towards a more flexible and outward focussing toolbox from which to draw what is framed around enabling the principal stakeholders involved in health and well-being to come together on an equal standing to cocreate solutions. Focussed on individuals and communities, such efforts would be targeted at maximising the potential for whole populations to realise the goal of being able to live eight great decades and two good ones. That is why in Chapter 5, we introduced the notion of 'leagers', as we expect and ask to heads of health organisations to become proficient both as leaders and managers, the best performing hybrids. It was not a case that not many years ago Mintzberg, after a few years of work within healthcare and a long career previously spent in researching private business and sector, came to say: Running

even a complicated corporation must seem like child's play compared with managing a general hospital: the strident doctors, the beleaguered nurses, the sick patients, the worried families, the demanding funders, the posturing politicians, the escalating costs, the accelerating technologies – all embedded in cases of life and death (Mintzberg, 2016).

Health managers can play an important role in both shaping and facilitating a new basis of engagement between the individual and the healthcare they receive. They can help provide the opportunities for meaningful engagement, and they can develop and share the skill set which will enable the maximum value to be realised from them. This in itself is, however, unlikely to be sufficient as it is the space outside of the immediate treatment and care environment in which energies need to be focussed. A more fundamental bridge is required between the personal, private and public spaces in which health is mediated. Health management can be an enabler, but it can also act in an inadvertent or deliberate manner to be a resistor to change. Which of these it becomes, it will in part be dependent on how health policy evolves, but health management education and training also have their part to play.

TIPPING POINTS

It is increasingly recognised that healthcare is becoming a matter for individuals as consumers and citizens. Whether this can be deemed to be part of what we ordinarily view to be a health system or whether it sits alongside it, that is a matter for debate. But that more prevention, screening, diagnosis and care will move from an institutional to a personal setting is a natural consequence of citizens becoming more health literate and patients empowering themselves. Industry has already begun to respond to this personalisation of healthcare. It now offers products and services which bypass traditional health

systems to offer healthcare directly to the individual. There are manifest limits to this with regard to affordability, access and the ability to navigate an environment surrounded by the risk of unmanaged and often unregulated care. It also needs to be recognised that this is still a relatively small proportion of healthcare, which is largely focussed in more affluent countries with higher resourced health systems. There is also a limited interface between private healthcare and public healthcare. That all having been said, it would be reasonable to say that this sector is acting as a potentially disruptive force upon traditional health systems. At a policy level, this could challenge the consensus which has allowed for the collective pooling of resources to support state funded healthcare, while at a health system level, it could disrupt operation and efficiency.

European health systems are additionally likely to find themselves facing continuous pressure with regard to cost, access and efficiency. An intrinsically reactive system will continue to struggle as it seeks to change orientation towards prevention and early diagnosis and to bring along a population which is imbued with a sense of self-entitlement married to a confidence that the reactive health safety net will be there to catch them as and when they may fall. The treatment juggernaut will continue on its path gaining further momentum as technology facilitates the development of an ever greater range of treatment and care options. This further loading of health systems will provide opportunities, but it will also increase pressure on system sustainability which in turn will bring increasing challenge to health managers and health management practice.

Attempts to instigate transformational health system change are well established, yet resistors still appear more powerful than drivers and inertia remains an elemental challenge. If this is the case, then it may be in the way that Uber was established as an additional system to the transportation system acting then

as a transformational agent, so Health System 2.0 could emerge as an additional strand operating in parallel to publicly funded and managed healthcare. Given that much of the preventative and preparatory orientation of Health System 2.0 does not require healthcare infrastructures or resourcing of Health System 1.0, we could postulate a situation where the two systems run in parallel until Health System 2.0 grows and develops to the point at which it begins to colonise Health System 1.0. Health System 2.0 may then take in those aspects of the old order which could fit into a new person powered system for health and well-being, directed and controlled by empowered and health literate citizens. However, heavy caveats must be placed on such thinking. Firstly, self-care remains a small growing sector of healthcare and one which is most often seen in more affluent segments of more developed economies. Secondly, while this sector is facing some elements of prevention, screening and care being repatriated from the hospital to the home and from state to personal funding, its impact remains marginal at best. Finally, the market has not been slow to respond to this growing trend, and with the global self-care market now estimated to exceed $11bn a year, it can be seen how an initially empowering community-based movement could easily become simply a new aspect of the private healthcare industry.

What might then precipitate or hinder Health Management 2.0 emerging and what can help facilitate successful adaptation to Health System 2.0? It would seem inevitable that paradigm change will either lead to or will require a fundamental reshaping of current health system structures. In the former case, it could be that a number of factors may come to bear on current health systems so as to make them fundamentally unsustainable. Affordability is one variable, which in the context of the likely long-term impact on having to manage the Covid-19 pandemic could lead health policymakers to be

required to find fundamentally lower cost healthcare. This could link to demand overload, most particularly within domains where care is either high cost such as oncology or where service responses are seen to be ineffective in the face of growing needs such as in the area of obesity.

FINAL THOUGHTS

What is the purpose of management and what in particular is the purpose of health management? If we accept that health management is concerned with functions which include planning, organising, resourcing, leading or directing an organisation, then health management can be said to refer to that within commonly accepted health system domains. Management as such must respond and react to a dynamic environment where the market, policymakers and the wider population, made up of citizens and patients, interplay. To what extent can it be argued that health management is maintaining a system which is in crisis or at least which is not delivering against the mission of maximising health and well-being? Writing at this time of crisis, it is evident that European health systems are proving themselves to be largely resilient, all be it to a challenge more redolent of a former age with only limited crossover to the more prescient challenges considered in earlier chapters.

The fact that we are still talking about later releases of a first-generation version of health systems and health management is in itself surprising, given how many other areas of our life, from energy to transportation, are into second, third or later generations of change, and the very fact that so many elements of supply and demand have changed significantly during the same period. This is not to say that health managers were not set clear and ambitious health policy goals ranging from patient empowerment to digital transformation. However, these self-same policymakers can also be charged

with providing little more than levers in the sky for health managers to achieve meaningful change. This is not to say that European Health System 1.4 is not a significant advance on 1.0; it is just that the modifications that have with the support of health managers taken place are increasingly showing themselves to be insufficient to meet evolving needs.

But health systems are, if nothing, resilient entities, well able to resist pressure and opportunity alike. Consulting a crystal ball to assess what a book on health systems written in 2045 will be reflecting upon is difficult to assess. The authors will be considering a century since the establishment of the modern-day health system within a social and economic environment which we cannot currently be expected to predict. What can reasonably be asserted at this point looking forward is that Health System 1.0 will have been superseded by a future health system which will bear only limited resemblance to today's health system, let alone that of the post-war period. Whether it is able to deliver or exceed on the current potential to make eight great decades of life and two good ones a reality for Europe's citizens remains to be seen. Whatever the case may be, Health Manager 2.0 is most likely to operate within a broader societal framing than it is the case at present, out of the hospital and into the home as perhaps one day – not too far away – we will all become our own health managers.

LINK TO SERIES

In developing the European Health Management in Transition Series, we aimed to give space to consider a broad range of issues which impact on or are impacted by health management. The theme of paradigm change will continue to feature in future volumes as we consider how European health systems will change over the next decades.

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