# Polish and UK doctors' engagement with hospital management

Hartley, K and Kautsch, M

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# "Polish and UK doctors' engagement with hospital management"

***Keywords: health systems, market reform, doctors, medical manager roles, engagement***

**Abstract**

**Purpose:** This paper compares the way in which two health systems with distinct histories, the UK and Poland, have altered in recent years. It focuses on the way in which these changes may be impacting on hospital doctors' engagement with management in each country, and whether there are any signs of convergence.

**Methodology:** A framework for the comparison of medical management roles, developed by Kirkpatrick et al (2012) was adopted, with a thorough but focused review of the medical management literature, together with analysis of policy documents and healthcare statistics conducted (Charmaz, 2006). The study collected some much needed primary data from expert informants within Poland and also drew on other interviews conducted with postgraduate level doctors in the UK over the same time frame, the first half of 2010. A theoretical sampling strategy was used in each case (Gomm, 2008).

**Findings:** The research suggests that doctors' engagement with management in both countries is changing, but for different reasons. In the UK, it appears that the duration of public management reforms and recent support for management involvement at academy level may be increasing engagement, whereas in Poland new structural arrangements appear to be decreasing doctors' engagement.

**Research implications:** The paper highlights recent changes in doctors' engagement with management in both systems, and considers possible explanations for this along with implications for the profession in each country. It also offers avenues for future research.

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## Introduction

European health systems have undergone considerable change in recent decades, in terms of the way in which they fund, provide and govern services (Smith et al, 2012). Mechanic and Roquefort (1996) argued that whilst health systems are converging in their responses to similar technological, economic, demographic and scientific challenges, this does not mean that they will not exhibit differences due to their individual historical political and social characteristics. Others support this, finding differences between countries, based on their historical arrangements and the way in which professional groups respond to change (Sehested, 2002; Kuhlmann et al, 2009; Leicht et al, 2009). The role that doctors, as a dominant professional group, play in relation to the management of health systems has been a source of great interest across nations (Dent, 2003; Jacobs, 2005; Kirkpatrick et al, 2011; Saario, 2012).

This study sought to compare the way in which doctors engage with management in two countries with very different backgrounds, Poland and the UK. While the UK has attracted previous academic interest, Poland has received surprisingly little attention within the public management literature. The two countries are interesting to compare, given that the UK is a 'neo-liberal welfare regime' (Dent, 2003; Kirkpatrick et al, 2005), and one of the early adopters of new public management reforms and practices that emerged in the late 1970s (Hood, 1991), whereas Poland is an ex-socialist/communist regime which bears traits of both the neo-liberal UK and corporatist-German models of health provision (Dent, 2003; Sagan et al, 2011).

The paper is structured as follows. Firstly, our methodology is outlined. The paper then provides an overview of the two health systems, in terms of the ways in which they were funded and governed in the immediate post war period, the reforms that have taken place and how they currently compare. Our findings on the way in which doctors engage with management within each health system and how this is changing are then

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discussed. Possible explanations for, and implications of, the changes are discussed, along with opportunities for future research.

## 1. Methodology

A framework developed by Kirkpatrick et al (2012) was utilised to help structure our work. This suggests that a number of potential factors might have impact on the development of medical manager roles: (i) the structure, funding and expenditure on health (ii) the organisation, training and contractual arrangements of doctors and (iii) the management roles taken by doctors in each country. The research drew on both primary and secondary data sources from the healthcare management, policy and sociology of the professions literature. Firstly, a thorough but focused review of the literature on medical manager roles was conducted (Charmaz, 2006), via a search for relevant articles and initially reading through abstracts on the following databases: ABI Global, EBSCO Business Source Premier and Medline. Secondly, Organisation for Economic Cooperation and Development (OECD) health statistics were reviewed and policy documents analysed. Thirdly, we collected exploratory data during the first part of 2010 from expert informants within the Polish system. These included a manager of a public hospital, a CEO of a private hospital, the President of a provincial board of the Polish Chamber of Physicians and Dentists, a former Vice-Rector of a University Medical College and the President of a Polish Association of non-public hospitals. We also drew on interviews being conducted in the UK alongside this study with 22 postgraduate level doctors, to highlight signs of attitudinal change towards engagement with management in the UK context. A theoretical sampling strategy (Gomm, 2008) was used in each case, with semi-structured interviews (King and Horrocks, 2010) conducted throughout.

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## 2. The UK and Polish Health Systems

The UK National Health Service (NHS) came into effect in 1948. It continues to be based on the original Beveridge model of a publically funded (via taxation) service, providing universal coverage, free at the point of use. Doctors were initially co-opted into the

system from private practice, with guarantees of clinical autonomy (Kirkpatrick et al, 2005), and were involved in the running of hospitals, as dominant members of decision making teams, until the late 1970s (Harrison and Pollitt, 1994; Ackroyd, 1996). In Poland, until 1989 the country was under communist rule and the Siemaszko model prevailed, with central government responsible for providing a universal health service, free at the point of use. Doctors held clinical decision making roles within hospitals, but like other professionals during this period they were poorly paid and their collective power was weakened, by virtue of Physician Chambers being banned (Dent, 2003).

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

Despite different political orientations and funding mechanisms the 1990s saw a move to a greater market orientation in both countries, with the separation of purchaser-provider interests (for the UK see Ferlie et al, 1996 and for Poland see Boulhol et al, 2012). In the UK, primary care organisations have become purchasers of care, with hospitals the main providers. The private sector has gradually entered the frame as providers of certain, mainly routine, services. Management responsibility of NHS hospitals has been devolved to hospital level, through the creation of NHS Trusts and Foundation Trusts which are run by an executive board (Dopson, 2009). This move to Trust status required greater involvement of senior doctors in management (Ashburner, 1996, Thorne, 1994). In Poland, a number of initial insurance funds were combined into one 'National Health Fund' (NFZ) with 16 provisional branches in 2003, such that there is now one purchaser of health services. 'Public hospitals' (previously owned by central government) have been passed to local governments and universities

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(Boulhol et al, 2012) and are now legally independent institutions, run by a CEO who has full financial responsibility. Encouraged by central government, a number of local governments have transformed public hospitals into 'non public' hospitals, operating under the same legal framework as commercial companies (Sagan et al, 2011). As in other new EU member states (particularly post-communist countries), private hospitals are increasingly entering as providers (Ryc and Skrzypczak 2009). While the total number of hospitals has remained much the same over the last decade, the share of private hospitals has risen steadily to around 30% in 2009 (Boulhol et al, 2012). All of this raises the question of how doctors might be engaging with these new governance and management arrangements. The next section outlines our findings.

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## 3. Findings

Medical engagement with management can be viewed in two ways, as participation *in* management or as enthusiastic involvement *with* management (Ham and Dickinson, 2008). The paper firstly outlines the management roles that hospital doctors hold within the UK and Poland, before moving on to consider the ways in which the empirical data suggests their enthusiasm for involvement may be changing.

Doctors hold similar medical management roles within hospitals in each country. At senior level they may be CEOs or Medical Directors. However, our interviews suggest that the CEO role in Poland is increasingly held by non-medical personnel, and a recent report in the UK (Ham et al, 2010) suggests that only around 5% of UK CEOs are medically qualified. In contrast, the Medical Director role in both countries is the preserve of a doctor and a board level position. However, doctors' influence in the role appears to vary, with some Medical directors in the UK having input into strategic decision making, while others act in a more advisory capacity (Kirkpatrick et al, 2009), as they do in Poland.

When it comes to involvement at other levels within the respective hierarchies, there are more differences between the two systems. In the UK, a unit level role has existed

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since the 1990s in the form of the Clinical Director, who is responsible for one or more specialities grouped as a directorate. This role is predominantly held by a senior doctor (consultant) and is a 'hybrid' (Llewellyn, 2001), in being part-time and straddling both the clinical work and managerial worlds. There tends to be a 'troika' type arrangement at this level, similar to that seen at hospital level in Denmark (Kirkpatrick et al, 2009; Dent et al, 2012) with the Clinical Director operating alongside a business and staff manager, sometimes a nurse (Ferlie et al, 1996; Dopson, 2009). They are responsible for service delivery as well as staffing, contracting and marketing of the directorate's services. Clinical directorates now have sizeable annual turnovers, ranging from £15m to £45m per year (Audit Commission, 2007).

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Such a unit level role does not currently exist in Poland. Rather, 'chiefs of ward/clinic' are the important management roles (Krajewski-Siuda and Romaniuk, 2008). These are similar to Clinical Director roles but on a smaller scale, with the post held by a senior doctor who reports to a Medical Director and is responsible for all ward operations. Chiefs' level of responsibility varies, however, with some but not all chiefs having responsibility for the financial standing of the unit. According to a hospital manager interviewed:

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

The fact that where such a system of internal budgeting exists bonuses may be paid to staff and new equipment purchased if the ward budget is not overspent (Baczewski and Haber, 2010) might explain the greater focus the above hospital manager spoke of. However, relationships with clinical colleagues are important to doctors in both countries. In the UK, while the CEO may appoint a Medical Director, candidates need to have the credibility of their peers (Fitzgerald and Ferlie, 2000; Thorne, 2002) and Clinical Directors have historically been nominated and appointed through peer selection. Since 1998, doctors in Poland have also had considerable influence over who

holds medical management roles, as well as into health policy (Ministry of Health, 1998).

When it comes to enthusiastic involvement with roles such as Clinical Director and Chief of Ward the research found historical differences between the two countries. In the UK the medical profession overall has historically resisted involvement (Ham and Dickinson, 2008; Harrison et al, 1992; Kings Fund, 2011). While a few consultants have enthusiastically taken on the role of Clinical Director (Fitzgerald, 1994; Kitchener, 2000; Forbes et al, 2004), many have been reluctant to do so (Dopson, 1996; Fitzgerald and Ferlie, 2000; Forbes et al, 2004). Reluctance has been attributed, amongst other things, to the negative impact on collegial relations, with tensions between Clinical Directors and other consultants being an issue (Fitzgerald, 1994; Thorne, 1997; Fitzgerald and Ferlie, 2000), as well as tensions with general managers. For instance, a survey of UK clinical and non-clinical managers, which included responses from 445 Clinical Directors, found that Clinical Directors were the most dissatisfied with the clinical-managerial relationship, owing to a perceived lack of autonomy and involvement in management decisions (Davies et al, 2003). A Polish CEO interviewed noted similar tensions between clinical and managerial staff in Polish public hospitals. In the UK, a lack of training and preparation for doctors to take on management roles has also been cited as a potential reason for doctors' reluctance to take on such roles (Forbes et al, 2004; Fitzgerald et al, 2006).

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In contrast, doctors in Poland have reportedly "tended to be attracted to the chief of ward role because of the influence that it gives them" (Polish Hospital Manager), in the way some physician-executives have in the US (Hoff, 1998; Montgomery, 2001). This may be because they have enjoyed a broad range of autonomy, appointed for six years and often holding the role for longer (Sagan et al, 2011). Both the hospital manager and former Vice-Rector interviewed suggested that management roles have historically been attractive as a way to increase Polish doctors' salaries, which were extremely low under communism and for many years afterwards (Whitfield et al, 2002; Dent, 2003). Certainly the lack of financial incentive, in the form of a higher salary, for taking on a

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medical management role in the UK has been cited as a potential cause of doctors' reluctance to take on roles there (Ham and Dickinson, 2008; Ham et al, 2010). However, according to one interviewee, whilst Polish doctors may have been influenced by the financial incentive to take on management roles they have not necessarily had a desire for the responsibility of management, such that many Polish chiefs of ward have been reluctant to make change:

> "they may like the influence and salary, they don't desire the responsibility of the role, owing to the tremendous sense of "solidarity" that exists, and they are more likely to maintain the status quo than to introduce change" (Hospital Manager, Public Hospital)

Given the changes that have occurred in each country in recent years, such as the salary increase for Polish doctors (Kautsch and Czabanowska, 2011) and increasing opportunity for them to work in the private sector, the fact that in the UK the medical academy now advocates doctors' engagement with management and supports management training, albeit under the guise of 'leadership' (Tooke, 2008; Academy of Medical Royal Colleges, 2010; Spurgeon et al, 2011), we were interested to know whether engagement with management may actually be changing.

In the UK, we found that recent work with Medical and Clinical Directors suggests that this group are now fairly well aligned with general managers and with management ideas such as the need to improve the quality of care (Giordano, 2010), with senior doctors having respect for financial professionals (The Audit Commission, 2007). However, whilst a Medical Leadership Competency Framework (MLCF) developed by the Medical Colleges is now officially incorporated into all undergraduate and postgraduate curricula, data collected from 22 postgraduate specialist trainees in the UK suggests that they are not aware of it, unless they happen to be participating in a specific development programme. These doctors did, however, recognise and accept a need to engage with management ideas, although not necessarily to take on executive roles such as that of CEO role:

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

These findings support other work which suggests there is a growing recognition within the UK medical profession of the need to engage with management issues and work in conjunction with managers (Levenson et al, 2008).

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In contrast, in Poland there is as yet no similar profession or policy led focus aimed at developing doctors' management and leadership skills, although public health departments of universities offer post graduate courses in management (see for example, Institute of Public Health, Jagiellonian University Medical College). Here, it seems that other changes may be having an impact on engagement. Firstly, doctors are better paid than they once were (Kautsch and Czabanowska, 2011). Secondly, some Polish doctors are starting to become self-employed, joining with colleagues to form cooperatives who contract their services to both 'public' and 'non public' hospitals (Boulhol et al, 2012), akin to arrangements under the Dutch model (Dent, 2003). It is suggested that such contractual, fee-for service relationships in the Netherlands have kept doctors at "arms length" from management (Neogy and Kirkpatrick, 2009, p.6). Polish interviewees suggested that both of these factors are resulting in doctors being less interested in chief of ward and even CEO posts than they once were, as they now have opportunities for increased income without having to take on the responsibilities of management. Thirdly, it seems that there is a change in the type of doctors now taking on the chief of ward position:

> "Rather than being appointed on the basis of their age and political connections, doctors are now more likely to be appointed on the basis of what they know and can do…..chiefs of wards are getting younger, in their forties and fifties as opposed to their fifties and sixties. Doctors are also taking such posts as a step in their career path, rather than as a position for life as was once the case" (President of All Poland Association of Non Public Hospitals and former Vice-Rector of a University Medical College)

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In addition to changes in attitude amongst doctors themselves, a hospital CEO interviewed suggested that the increase in private hospitals may mean that chief of ward posts are becoming less available than they were previously in public hospitals. Private hospitals, she suggested, increasingly prefer to employ "ward managers" (who may now be nurses) or "doctors managing the ward", with these roles having less power than the old chief of ward role. Interestingly, despite this she suggested that the attitude of doctors towards management in privately owned hospitals was better than she had encountered in public hospitals:

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

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This more positive attitude was attributed to the fact that private hospitals have less of a "them and us" mentality between managers and clinical staff than publically owned hospitals, benefitting from being smaller and a tendency for an "open-doors" policy which enables the CEO and clinical staff talk to each other frequently, such that issues can be solved more swiftly. What then might we conclude from all of this? The next section moves on to discuss our conclusions and the possible implications.

## 4. Conclusions and potential implications

This study found that doctors hold similar types of management roles in Poland and the UK, albeit with differing levels of responsibility and accountability, particularly with regard to financial affairs, and historically different levels of enthusiasm. However, there are signs that engagement with management may be changing in both countries. In the UK, there appears to be greater acceptance of the need for involvement amongst younger doctors. One explanation for this is the fact that the medical academy has recently moved to support engagement, alongside which there is a determined effort to provide management development opportunities for doctors. However, given the lack of awareness of the Medical Leadership Competency Framework amongst postgraduate level doctors, this might suggest that they are aware of the academy's expectations and accept them, but are simply unaware that these expectations have now been formalised.

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Alternatively, other factors may be driving this attitudinal shift. Whatever the reason, one implication of this attitudinal change is that doctors in the UK might engage more readily with management roles in the future. Whether and how they do so may, however, depend on what is driving their acceptance of the need to be involved. It may also depend on whether training and development is sufficiently widespread, and able, to prepare doctors for the management roles they will be required to undertake and to develop the skills and attitudes needed for such roles. At present all of this remains unclear (Noordegraaf, 2011).

In Poland, the expert informants interviewed suggest that medical engagement with management there may, in contrast, be on the decline. This is attributed to new working arrangements made possible by the move to a mixed market, as well as increases in doctors' salaries, which are reducing the financial impetus for doctors to move up the management hierarchy. One implication of the opportunity to work in co-operatives, contracting services to hospitals, is that it might lead to greater stratification within the profession overall, as Freidson (1994) suggested. As traditional management roles are re-shaped within the private sector, doctors there may also find themselves losing some of their traditional influence to other professionals, particularly nurses (Abbott, 1988). This new context may, however, also provide opportunities for a broader sense of collegiality, cooperation and partnership to evolve between doctors and managers, certainly if the CEO of a private hospital interviewed is to be believed. If this is the case, then new, more inclusive and collaborative forms of professional community might emerge, as some have predicted (Adler et al, 2008). This might mean that doctors share influence with others, through co-operation and integration, rather than dominating through positions of authority. In both countries, the full import of changing circumstances has yet to be realised. It might be that rather than seeing convergence, we actually see a switching of positions, with Polish doctors becoming less interested in management as UK doctors become more engaged with it.

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## 5. Limitations and future research opportunities

While this study suggests that medical engagement with management is changing in

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both systems, further work is needed. We have hypothesised, based on interviews with experts in the system, that market changes in Poland are creating conditions which are reducing doctors' interest in previously sought after management roles. However, further work is needed to verify this and to explore how widely this is occurring. In particular, more work to map current medical management roles in Poland and engagement with them is needed, as this has been seriously neglected within the literature. In the UK, while the empirical data collected and an emerging literature suggest that attitudes towards management are becoming more positive amongst younger doctors this needs to be explored in more detail. In particular, the extent of change and what is actually driving it, and whether the current investment in championing medical leadership and educating doctors is able to increase engagement in the longer term. As the UK health system undergoes change, with the introduction of new clinical commissioning groups, the impact of this for medical manager roles will also need to be investigated. As such, our findings suggest a number of avenues for potentially fruitful future research.

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