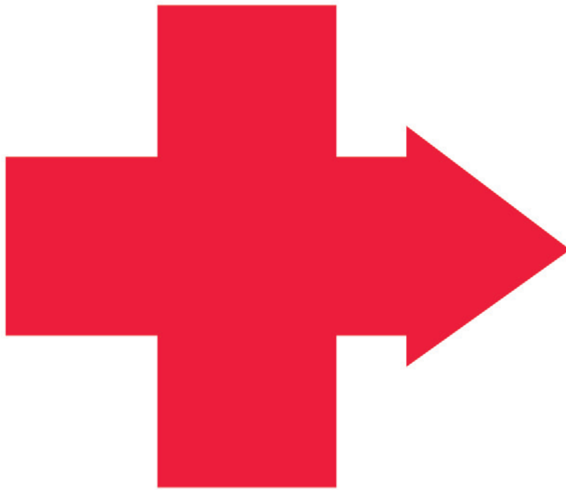
European Health Management in Transition



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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HEALTH MANAGEMENT 2.0

Transformational Leadership for Challenging Times

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emerald
PUBLISHING

United Kingdom – North America – Japan – India
Malaysia – China

Emerald Publishing Limited
Howard House, Wagon Lane, Bingley BD16 1WA, UK

First edition 2021

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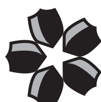
British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-80043-345-8 (Print)
ISBN: 978-1-80043-342-7 (Online)
ISBN: 978-1-80043-344-1 (Epub)



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He is the past President of EHMA board and chair of its scientific advisory committee. Federico is Editor-in-Chief of the journal *Health Services Management Research* and associate editor of BMC HSR and MCRR. He has published 10 books and over 150 journal articles.

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

ACKNOWLEDGEMENTS

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.

Further, much credit goes to the health leaders and managers we worked with over the years. Every research, consultancy, training programme designed, developed and conducted with them was an extraordinary learning experience. Thank you, for your trust in us, for your insights and for your collaboration.

Finally, we must give thanks to the whole of the Team at Emerald Publishing for the fantastic support they have given us and in particular to Jen McCall who ensured we got things off the ground and to Kim Chadwick for seeing us to the finishing line.

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