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NEW METHODS FOR ASSESSING
DEVELOPING COUNTRY HEALTH SERVICES
MANAGEMENT NEEDS



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PREFACE

This report contains a selective survey of studies from three dominant perspectives on managerial effectiveness in delivering health services in developed and developing countries. Most often the need for assessing a managerial situation has originated in the heat of daily problem solving within a given health system. Often, too, managers themselves have initiated the studies in an attempt to confront and come to grips with the vexing realities of both rural and urban health services. Management in developing countries especially has had to address issues related to primary care, immunization, water supply, family planning, nutrition, and sanitation programs, as well as operation of clinics and hospitals or administration within a health ministry.

While day-to-day problems confronting the health manager or administrator are readily perceivable, there is much confusion about what it means to "diagnose" managerial practice or effectiveness, especially within the context of a health setting. A diagnosis carried out by the physician typically involves developing the case history of a patient, evaluating that person's physical condition, and often conducting tests to narrow the field of symptoms and to determine possible causes. Applying this procedure to a study of management, particularly health care management, is difficult because there are so many possible approaches to choose from and many of these are untested. Some studies may concentrate on individuals who manage, or the organizations which they manage, or on

a whole complex of people, institutions, and community forces affecting health services delivery. Few of the studies described in this report have received significant attention among health workers.

In 1977, officials of the Agency for International Development (AID) approached the Association of University Programs in Health Administration (AUPHA) because AUPHA's mission to promote education in health administration throughout the world seemed appropriate to AID's need for specialized expertise. A recurring problem was confronting AID in its funding of health, population, and nutrition programs. How could the managers of relatively new or established health programs in host-country organizations determine areas of managerial weakness and how could these individuals subsequently improve managerial processes or structures? Members of the AID Administrative Development Office and the AID Health Office envisioned a project to study, develop, and test methods appropriate to conducting management assessments in developing country health programs, methods readily adaptable to the unique circumstances of individual countries.

AUPHA agreed to undertake the project. The problem was judged significant and the lack of a systematic review of existing subject matter became quickly apparent. AUPHA would collaborate with its affiliated programs and with developing country health services administrators, planners, and managers. Currently, the project is monitored by the AID Office of Rural and Administrative Development in Washington, D.C.

This report has become the first of a series to be developed by AUPHA as a resource for health services administrators, planners, and managers in the developing world. AUPHA aims to provide a unique bank of information about an array of management technologies which eventually may be shaped into appropriate tools for management study in a wide

range of health settings.

The intended audiences for these publications have assumed responsibility for difficult management decisions affecting the lives of human beings in small communities or in whole nations. Their resources are constantly shrinking, management techniques which are useful to industry may be a liability in their health systems, and often the only solution to problems is a person's own inventiveness. Then there are a myriad of nearly intractable operational problems! All the more reason why AUPHA intends to make the published works from these collaborative efforts available to all health administration specialists who share AUPHA's concern for the development and use of sound health management technologies.

For thirty years, AUPHA has acted as a catalyst among those who teach health administration and those who practice it, encouraging them to attack difficult, neglected problems in the health services of all countries. As a consequence, the problems and processes of administration, planning, and management become clearer, and change is possible.

This first report has lent itself to two volumes: Volume one presents the state of the art and synthesizes recent attempts to provide cohesive and new methods of assessing health management assessments and volume two contains standardized abstracts of present literature and relevant interviews. The authors have made every attempt to create a comprehensive and critical review of managerial assessment methodologies in the health sector.

Materials for this report were collected through numerous face-to-face conversations between project participants and practicing health administration specialists in over a dozen countries. The assistance of these professionals is acknowledged as the key contribution to the accomplishment of this project.

At the Agency for International Development, the continuing

concern and assistance of Dr. Nicholas Luykx, Dr. Charles Briggs, Dr. Lee Howard, Mr. John Alden, Dr. Norman Nicholson, and Ms. Monteze Snyder were crucial to the progress made thus far with these difficult problems. A committee of health specialists drawn from AID regional and central health offices and from the Office of International Health, U.S. Department of Health, Education, and Welfare (DHEW), has supported and participated in the work of the project at each step of the way. Participants in that committee have included the following individuals: AID Africa Bureau--Dr. Thomas Georges, Dr. Charles De Bose, and Edward Parfrey; Asia Bureau--Dr. Donald MacCorquodale and Robert Mehan; Latin America Bureau--Barbara Sandoval; Near East and North Africa Bureau--Alan Randlov; Development Support Bureau Health Office--Irving Taylor; and DHEW--Dr. Kenneth R. Farr.

The AUPHA advisory committee is chaired by Dr. Gordon Brown, with Dr. Gary L. Filerman, Dr. Arnold Kaluzny, and Mr. Peter Sammond. Preparation of the final report was guided by Elaine L. Frost, who as editor contributed greatly to improving the clarity and editorial style of the final product. Development and preparation of the analytical tables was completed by Kathryn Cannan. Project secretary at AUPHA is Fontaine Evaldo.

In a real sense, this assembled knowledge stems from the cooperative efforts of all these people who share a concern for any problem that inhibits the labor of health specialists in developing countries who plan, organize, and are responsible for the health services of their people.

EXECUTIVE SUMMARY

Throughout the world, pressure is increasing to improve management practice and performance. Health services researchers, providers, and funders all perceive the need for systematic methods of assessing health care management. In many developing countries, this pressure is felt by those who wish to extend health care to rural poor and by those who must respond to their own organizational or external donor-agency pushes for better managerial performance. Unfortunately for the men and women who seek sound management in the health field, there is no generally available and acceptable method of achieving this goal.

The purpose of this report then is to begin to identify appropriate and inappropriate methods of assessing health program management and to aid in the recognition of a useful assessment. Several issues are examined, including:

- o How useful to donor agencies or host-country programs is a particular assessment and how effectively will it resolve management problems?
- o How transferable is a given management methodology to the unique situation of a developing country?
- o How does one distinguish general program evaluation and managerial assessment?
- o How can dissimilar approaches to managerial assessment be integrated?

- o How can both organizational and administrative problems and solutions be identified through managerial assessment?

This report does not focus only on studies that deal with managerial assessment, but also on those that include general program appraisal and systems (operations) evaluation having some relevance to managerial assessment. Few of the studies reviewed address the needs of developing countries. In actuality, most of the work concentrates on general performance appraisal, and management assessment receives only indirect attention.

In the health field, managerial performance has had little examination. The materials in this state of the art review therefore represent new attempts and methods of examining management activities. A selective sample of studies were chosen which show promise for the development of appropriate management assessment techniques. Study findings point to at least two reasons for development of managerial assessment methodologies appropriate to a variety of health settings: 1) Methods of analyzing the overall health system should be strengthened, and 2) such methodologies should serve as a training mechanism to aid in improving health management.

In this report, managerial assessments are seen from three dominant perspectives:

- o Individual,
- o Program and institutional,
- o Community and national.

Each category has its own way of defining and solving health management problems. From an individual perspective, management has been studied in terms of: materials and facilities, human resources, finance,

patient and client, institution, and community relations. Managerial assessments at the individual level concern and may have been initiated by both individual managers and small management groups at various organizational levels (executive officers, department heads, operational staff, and so on). Program or institutional studies see management within a specific institutional context such as hospitals or family planning clinics, and community and national studies chiefly include assessments of management across a variety of institutional levels. Methods used in these assessments have included longitudinal and cross-sectional comparisons of health services institutions.

At the program and institutional level, managerial assessments may have been called for by either internal or external parties. Internally, evaluation departments or administrative personnel have initiated assessments. Externally, funding agencies or institutions such as professional associations, regulatory groups, educational societies, and research organizations may have sponsored studies, some prepared by independent consultants. Often the sponsor of an assessment has defined its purpose--internal sponsorship looking at program needs (that is, the need for a new building or training program), regulatory agency sponsorship supporting cost-control efforts, or professional association sponsorship clarifying the impacts of a given program so that its membership can be better informed.

Managerial assessments can be either direct or indirect, direct as a means of evaluating management activities or indirect as part of an overall assessment of an institution or program. Interest in and application of management assessment have been worldwide, with the most significant development of these methods occurring in the

last 5 to 10 years. Governments, international agencies, and countries themselves (usually with the support of international agencies) have also stimulated managerial assessments at the local, regional, or national level. Sometimes an assessment of management appeared as a subtopic of a geographic health study. In fact, until recent years, management as a concern in the health field has received scant attention. Most studies emphasize assessment of clinical activities.

Reasons for those existing management assessments fall into two categories: improvement of donor programming (funding and program opportunities) or of health status. Most of these assessments have occurred in developing countries during the last decade.

The authors approached this study by surveying existing literature on their subject and whenever possible, discussing the main issues with experts. In addition to searching library resources, project staff members visited twelve developing countries in Africa, Asia, the Near East, and Latin America to observe managerial assessment first hand. They then established an abstracting process that would clearly present a critical analysis of each relevant study, and finally they proceeded to synthesize their abstracts. Each study selected for abstraction was systematically reviewed for the validity of its methods and the utility of its assessment. The authors wanted to know whether proper instruments, data collection methods, controls, samples, and analyses were used and if conclusions were well documented. The authors also sought to determine whether the studies provided management data that would give direction to donor-agency and host-country programs and policies. In addition, the costs and benefits to both the

program under study and its sponsor were identified wherever possible.

To predict the future of health management assessment practices is difficult. Continued diligence in assessing the full range of management activities, such as formulating policy, drawing up plans, making decisions, and implementing and evaluating program operations, is needed to ensure that sound guidance is provided to management personnel. A welcome stage in managerial assessment studies is the emergence of a common set of names for managerial and administrative activities and problems.' This may encourage health workers to become more fully aware of and to share their management experiences with a view toward improving health services in all countries.

CHAPTER ONE
HEALTH MANAGEMENT ASSESSMENT IN PERSPECTIVE

Within the last twenty years, the transition from colonial rule to effective local operation of developing country health services has produced an enormous number of new approaches to planning, developing, and directing the systems to deliver these services. As increasingly greater parts of the underserved population of a country are provided health and related services, the combined problems of resource shortages, complex logistics, and disease prevention place an increasing burden on those in managerial positions. The operation of even the most simple, locally supported primary health program faces mounting managerial difficulties. This report documents a selection of new attempts made in recent years by those charged with operating health delivery systems to find better ways of assessing emerging problems in their administration, planning, and management.

In all countries, people want access to quality health care. National development programs demand the health sector to give better service to more people; standards are rising (Clinton, 1979). Often health services delivery problems in developing countries are not simply the result of technological difficulties. Rather, they are directly tied to behavioral and managerial problems. In Africa, for instance, health administrators are aware of and concerned about managerial capacity,* and several

*Personal interviews overseas by staff of the Health Management Assessment Project were the source of these findings in this report.

African countries are addressing the problem. For example, there are university-affiliated and private institutes for training students in management. These programs are expanding as the need for well-trained managers grows.

Diagnostic Methods as Management Tools

The expanding requirements for competent managers in the health field call for new and more appropriate management technologies. The key question is: Which methods function best for diagnosing management problems or needs in a health care delivery system? A review of a wide range of sources shows that attempts have been made to develop and apply a great assortment of diagnostic methods.

What do these assessments look like? A formative answer is the rationale for this report. Many assessments transpire under rather adverse conditions: tight time schedules, difficult logistical arrangements (transportation is often a problem), and language barriers (many developing countries are multilingual), among others. A World Health Organization approach to assessment, including managerial assessment, involved evaluation of primary health care projects in Iran (Andreano, et al., 1976). A team of four consultants, accompanied by staff from the primary care projects, spent three weeks assessing four projects at the request of the Iranian Ministry of Health. The following statement summarizes their experience:

To evaluate such projects, given the constraints of the time available; physical distances within and between projects; language; cultural and environmental differences; presents a formidable task. It necessarily requires: a very flexible approach; the use of information from sources not usually employed, which has to be checked for reliability; and a certain reliance on general and perhaps superficial impressions (Andreano, et al., 1976, p. 3).

If assessments are to become entirely successful in developing countries, data sources must be reliable and sufficient in number, manpower in the country must be made available to help with assessment, and the political climate ideally should be a stable one.

Despite the varying levels of success realized in the application of recent methodologies, these techniques have contributed to a strengthening of systems analysis procedures. The following three examples illustrate ways in which this has occurred:

- o Diagnostic methods have enabled more systematic identification of management problems. In some noteworthy cases, actionable remedies and options for problem solution have been presented.
- o Diagnostic methods have contributed to the determination of programming needs and funding opportunities.
- o Diagnostic methods, when tested and applied, have exposed managers to new ways of evaluating performance.

Managerial assessment technologies are methods of identifying management activities and problems, as well as solving those problems. A typical assessment may encompass a wide variety of approaches, some of which concentrate on management while others deal with management as part of a program, institution, or sector.

Reviews of Previous Assessments as Basis of Report

The aim of this report is to present assessments of three distinct levels of health services, which combined form an integrated health services system. These are seen hierarchically within a complex structure, and include: the individual, program or institution, and community or national levels. Each more complex level contains the elements of the previous one; assessment methods employed at the most basic level can be used at higher levels. For example, group interaction methods used to assess an

individual's managerial performance can also be employed to assess individual managers at the institutional or national level (a Ministry of Health, for example). Insight can be gained by assessing one level or all three collectively.

A key task in preparing this report involved a lengthy survey of managerial assessment studies, many of which were identified during discussions with health specialists and educators in the United States and abroad. Although the focus was on health managerial assessment methodologies, an effort was made to review more general studies to see if assessment technologies existed that could be usefully applied to the health field. The most valuable sources were those assessments that actually documented methods, findings, and recommendations in contrast to theoretical or philosophical musings on how one might go about doing an assessment. Studies were readily classifiable into those that represented actual, theoretical, philosophical, and political applications. Too often, studies were poorly documented, and described only management practice at various levels of health services integration, not management assessment methodology. At a later stage in the survey, three more meaningful study categories were established: current health management practice, health management assessment methodologies, and managerial assessment methodologies from other fields. These categories were then subdivided into studies at the individual, program and institutional, and community and national levels.

Another formidable step in preparing this report involved developing a systematic method for abstracting 72 selected studies (see Figure 1-1).^{*} Methodologies were

^{*}Because we are not dealing with a pure science that can be subjected to rigorous analysis, the methods used to review the studies, while systematic, are not entirely free from human bias.

FIGURE 1-1
OUTLINE OF ABSTRACT CONTENTS

Title: Name of the study or project
Year: Year completed or published
Sponsor: Funding agency
Author: Writer(s) of the study. Indication of background materials used is noted in brackets following the author(s) name
Type: Organizational level that was subject of the assessment
Purpose: Object of the assessment
Scope and Level: Horizontal and vertical organizational levels focused on in the assessment, such as: institutions, programs, sectors, countries; executive, staff, operational levels, etc.
Areas: Managerial activities assessed in the study, such as: materials and facilities, human resources, finance, patient and client, institutional, community relations management, etc.
Data: Sources of data used in the study, such as: secondary public, secondary private, survey, interviews, experimental, etc.
Recipient: Audience to whom the study was immediately presented
Programming: Indicates whether or not the study was part of an on-going health program or whether it was undertaken in response to a special request

Methods

1. Instruments: Techniques used to organize and analyze data, for example, Likert scales, surveys, questionnaires, etc.
2. Data Collection: Process used to gather information.
3. Controls: Methods used to check the validity and reliability of data
4. Sample: The individual cases chosen for the population from whom data was collected
5. Analysis: The techniques used to gain insight to findings, described as follows:
 - o Qualitative/inductive--generalization from limited observations to overall programs and characteristics

Figure 1-1 (Continued)

- o Qualitative/deductive--presentation of subsystem behavior based on total system characteristics or attributes
- o Quantitative/inductive--extension of sample derived numerical results to population
- o Quantitative/deductive--application of population-wide recorded data to units within the population
- o Combination of the above

6. Documentation
of Conclusions: Inclusion of supporting
evidence for the conclusions

Findings and Recommendations

1. Findings: A summary of the principal management problems and areas of unrealized potential found in the assessment activity
2. Recommendations: Activities suggested to remedy problems found as a result of the assessment procedure

Utility

The degree to which the assessment meets the user's goals. For donor agencies, this is usually described as the degree to which an assessment provides information for donor programming and funding opportunities. For health services staff, this is described as the degree to which the assessment provides direction for improvement of management practices as viewed from their perspective.

Costs

The monetary and non-monetary expenditures incurred during and as the result of an assessment exercise.

1. Program disruption: The cost of having to divert staff from normal activities to participate in an assessment exercise

Figure 1-1 (Continued)

2. Direct costs: The amount of time invested in an assessment.
3. Externalization of evaluation function:
The degree to which assessments carried out by people external to a program/institution come to be seen as the responsibility of these external assessors and not the responsibility of the managers themselves
 - o Evaluation covered several topics that should be part of normal program control and evaluations (inventory levels, performance against goals, etc.)
 - o Evaluation covered topics that could be handled by a qualified evaluations department (in special program meeting objectives, search for operating problems with program units, etc.)
 - o Evaluations covered topics requiring either special expertise or an independent perspective

Benefits

The advantages accrued as the result of an assessment exercise

1. Feedback: The extent to which management problems are identified in the assessment
2. Practicality: The degree to which the assessment procedure can be replicated by the program or institution's staff
3. Involvement of Host Program Officials: The degree of participation by health officials in stages of assessment activity
4. Donor Programming: Refers to whether or not the assessment provides information that gives direction to donor agency programs and policies. Included would be data on host-country management needs and data for determination of donor policies
5. Program Descriptions: Presentation of the objectives, structure, and activities of the program/institutions assessed

Figure 1-1 (Continued)

- | | |
|--------------------------|--|
| 6. Remedies and Options: | Presentation of corrective alternatives based on problems identified in the assessment |
| 7. Benchmarks: | Management performance standards used in the assessment |
| 8. Trends: | The description of management behavior within an overall context |

reviewed in terms of appropriate use of instruments, collection of data, data controls, methods of sampling, analysis, and documentation of conclusions. Instruments, or techniques used to organize and analyze data, were reviewed to see whether or not they were tested or even included in the study. Sources of data and the personnel used to collect it were investigated to see if any data collection patterns could be found. Controls, or methods used to check data validity and reliability, were evaluated in terms of biases; for example, were multiple sources used (to avoid source bias) and were self-evaluation checks made (to avoid self-evaluation bias)? Sampling methods for each study were also listed to see how individuals were chosen and from whom data were collected. Evaluation of a study's data analysis focused on the type of statistical or other techniques used to gain insight and obtain findings and on the method of analysis. The final test to evaluate methods was whether the conclusions were supported in light of the data collected and analyzed.

Next, findings and recommendations were listed for each study to see the types of management problems isolated as a result of assessment activities and to identify trends. Useful questions were: Can any connection be spotted between assessment method and the types of management problems found? Is there any relation between findings and the type of recommendations made? Because most of the studies were nonexperimental, the more technical criteria used to determine external validity were not applicable.

The last area of inquiry concerned how useful the study was to the program investigated or to sponsors of the study. In other words, did the assessment meet the goals of those who initiated it? Utility was evaluated from the standpoints of program disruption, direct costs, externalization of evaluation function, feedback, practicality, donor programming, program descriptions, remedies and options, benchmarks, and trends.

Outline of Chapters

Assessment of management performance at the individual level forms the basis of chapter two in this report. Many of the studies reviewed at this level are behaviorally oriented; they do not assess management in terms of how well a program is functioning but in terms of how well managers work together to accomplish goals.

Chapter three deals with the program and institutional level where an organization is chiefly involved in the actual production and delivery of health services. This review did not include health-related programs that are secondarily engaged in the provision of health services. Instead, the majority of the studies covered assessments performed in hospitals (chiefly in the United States), clinics, and family planning programs (mainly in developing countries).

The community- and national-level studies, described in chapter four, present methodologies used to assess management performance in organizations that provide support to health services in the form of resources, information, policies, and so forth. These studies were initiated for the most part as part of large-scale planning activities conducted for the purpose of securing donor assistance or designing significant new national programs. In these studies, managerial assessment was just one part (if included at all) of a larger procedure used to assess the entire health sector of a developing country.

Following chapter four is a discussion of some of the significant organizational and administrative problems and solutions found in these assessment studies. The sixth chapter is future oriented and seeks to bring together some significant issues for the reader. A companion volume contains appendices and a bibliography. Appendix A contains abstracts of the managerial assessments. These constitute the data base for chapters one through three on assessment activities. A listing of resources for health services managerial assessment is presented in Appendix B.

CHAPTER TWO

ASSESSMENTS OF THE INDIVIDUAL MANAGER'S TASKS AND ROLES

How individual managers contribute to organizational performance may be critical to the success of health services. The studies reviewed in this chapter diagnose the activities of individual managers and management groups. This is in contrast to the program-level and national-level studies reviewed in the following chapters where the role of the manager does not receive as much emphasis.

At present, no evidence conclusively demonstrates the optimal time to begin diagnosis of a management problem. Some authors assumed that gross management problems existed in programs and that national priorities needed reevaluation, and therefore the contribution of the individual to overall performance of a health system should not enter into a diagnosis. Proponents of assessments at the individual level hold that people make a system work. Any attempt to assess health services management should, from their viewpoint, include analysis of the individual manager's tasks and roles.

Field of Study

Eight studies included in this chapter exhibit a range of attempts to assess the individual's performance in a health organization. Studies not included in this chapter, but relevant to the topic, are those that have investigated managerial roles without proposing assessment methodologies (see, for example, the work of Hatch, Conant, & Holland, 1976). Six of these studies addressed

individuals within a particular country setting and two were multinational comparisons (Harari, 1974; Ugalde, 1978). With the exception of two of the studies which were done in 1967 (Takulia, Taylor, Sangal, and Alter) 1970 (Byham), all were accomplished within the last five years. Five of the studies dealt with executives, while the other three focused on entry and mid-level managers (Byham, 1970), expert consultants (Harari, 1974), and general managers (Cohen and Uphoff, 1976).

The eight studies reviewed in this chapter fell into two categories. (Figures 2-1, 2-2, and 2-3 capsule the principal elements of these studies.) The categories were based on the approach used by the researcher to diagnose managerial activities. These two categories are identified as traditional and behavioral. Used here only for ease of reference, they are not terms found in the general literature. Diagnosis generally involved three activities:

- o Sponsoring and planning assessment,
- o Collecting and analyzing data,
- o Identifying and preparing findings and recommendations.

Each of these steps can be accomplished in a variety of ways. The choice of a method or steps depends on factors such as the objective of the appraisal, the resources available for assessment (money, time, and personnel), and the point of view of the researcher (psychological or sociological approach, for example).

The traditional category contains studies that employed interviews, reviews of documents, and questionnaires as the data collection method. The data analysis step was often qualitative, descriptive, and reliant on expert judgment. Consultants analyzed data and presented recommendations and findings, with little participation from staff. In contrast are the two studies (Byham, 1970; Pointer and Strum, 1978) in the behavioral category

Figure 2-1

Categories and settings for Assessments of Individual Managerial Performance

Study*	Study Category	Individuals Assessed	Institutions or Programs Assessed	Sector	Country Group**
A1 Byham, Byham, & Wettengel, 1970	Behaviorist	Low & Mid-level managers: volunteers	Local institutions & national agencies; other organizations	Health	High-income (developed)
A2 Cohen & Uphoff, 1976	Traditional	General management	Rural development projects	Rural	Low-income
A3 Harari, 1974	Traditional	Technical assistance experts	National & local governments	General government	Low-income
A4 King's Fund Working Party, 1977	Traditional	Senior management	National agencies	Health	High-income (developed)
A5 Kuhl, 1977	Traditional	Chief executive officers	Local institutions; local group health organizations	Health	High-income (developed)
A6 Pointer & Strum, 1978	Behaviorist	Staff & line management	Local institutions	Health	High-income (developed)
A7 Takulia, Taylor, Sangal, & Alter, 1967	Traditional	Physicians	Local centers	Health	Low-income
A8 Ugalde, 1978	Traditional	Top level managers	National agencies	Health	Lower middle-income

* All assessments studies have been abstracted fully in Appendix A, Part 1.

** Categories used were defined by the The Overseas Development Council. Because some high-income countries have a PQLI (Physical Quality of Life Indicator) less than ninety, even though the per capita GNP is greater than \$2,000, they are designated "developing" countries. The PQLI is a composite score which takes into account a country's infant mortality, life expectancy at age one, and literacy rate. (McLaughlin, Martin M. The United States and World Development. Agenda 1979. Praeger Publishers. New York: 1979).

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Figure 2-2

Methodologies for Assessing Individual Management Performance

Methodology Study	Step 1	Step 2	Step 3
	Preparing and Planning Assessment	Collecting and Analyzing Data	Presenting Findings and Recommendations
A1 Byham, 1970 (Behaviorist)	Candidate for assessment identified by qualified experts; certain managerial skills suggested by organizations in keeping with their own goals	Qualitative data collected by experts from candidates through job simulations, interviews, leaderless group discussions, and management games Experts discuss results qualitatively	Findings and recommendations communicated to candidates personally by experts
A2 Cohen & Uphoff 1976 (Traditional)	"Participation" conceptualized by authors and individuals postulated for assessment that would measure unique aspect of rural projects	Quantitative data collected by authors from projects' written accounts, then interpreted qualitatively	Findings and implications for policy prepared for sponsor by experts
A3 Harari, 1974 (Traditional)	Instruments for measuring attitudes and motivation pre-tested; samples of technical assistance experts selected by author according to nationality and experience	Qualitative data collected with self-administrative, structured questionnaire; interpreted quantitatively and qualitatively by author	Findings comparing the assessed groups written for sponsors by author
A4 King's Fund Working Party, 1977 (Traditional)	Management defined by its functions, areas of expertise of top health managers by research team in order to relate to educational needs	Quantitative data collected and interpreted qualitatively by team from personnel records and other secondary sources	Both findings and recommendations written for sponsors by authors
A5 Kuhl, 1977 (Traditional)	Health managers sampled according to size of their work setting in order by author to relate roles to educational needs	Qualitative data collected and interpreted quantitatively by author through self-administered, structured, and open-sided questionnaire	Both findings and recommendations written by author for sponsor
A6 Pointer & Strum, 1978 (Behaviorist)	Self-assessment instrumentation and methodology for field testing on health care providers in various roles and administrative levels previewed by author	Qualitative data collected with structured, self-administered questionnaire; to be organized and interpreted quantitatively and qualitatively by author	Findings to be presented during workshops by consultants to those evaluated; recommendations to be generated at that time
A7 Takulia, Taylor, Sangal & Alter, 1967 (Traditional)	Six health occupational groups at varying hierarchical levels sampled by author to determine opinions and attitudes	Qualitative data collected by one author during personal interviews using open-ended questionnaires and reviews of documents; by several qualitative interpretations by authors	Both findings and recommendations written by author for sponsor
A8 Ugalde, 1978 (Traditional)	Access to government-level decision makers and documents in two countries established in advance for assessment of health decision-making processes by author	Author collected qualitative data through interviews, observations of meetings, and review of documents; interpreted data qualitatively	Both findings and recommendations written by author for general readership

Figure 2-3

Utility of Individual Management Assessment Studies

Utility as judged by:	Personnel Demands	Direct Costs	Externalization of Evaluation
A1 Byham, Byham, & Wettengel, 1970	Staff and operational personnel	Specified, but depends on length of time and number of candidates for assessment	Could be handled by evaluation department
A2 Cohen & Uphoff, 1976	Unknown	Not indicated	Could be handled by evaluation department
A3 Harari, 1974	Operational personnel	Not indicated	Could be handled by evaluation department
A4 King's Fund Working Party, 1977	Staff	Not indicated	Could be handled by evaluation department
A5 Kuhl, 1977	Staff	Not indicated	Could be handled by evaluation department
A6 Pointer & Strum, 1978	Staff and operational personnel	Not applicable	Self-assessment
A7 Takulia, Taylor, Sangal & Alter, 1967	Unknown	Two years	Could be handled by evaluation department
A8 Ugalde, 1978	Staff	Twenty-two months in first country; two months in second	Special skill or independent perspective required

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Figure 2-3 (Continued)

Utility as judged by:	Feedback	Replication	Participation of program personnel	Information to donors	Program description	Remedies and options	Benchmarks	Trends
A1 Byham, Byham & Wettengel, 1970	Actionable	Replicable by special expert	In data collection and feedback	Yes	Yes	Yes	Explicit	Longitudinal
A2 Cohen & Uphoff, 1976	Actionable	Replicable with conventional skills	As objects of study	Yes Yes	Yes Yes	Yes Yes	No standards implied	Longitudinal
A3 Harari, 1974	Both actionable & non-actionable	Replicable with conventional skills	As objects of study	Yes	Yes	Yes	Implicit	Cross-sectional
A4 King's Fund Working Party, 1977	Actionable	Replicable by special expert	In design and data collection	Yes	Yes	Yes	Explicit	Longitudinal
A5 Kuhl, 1977	Both actionable & non-actionable	Replicable with conventional skills	As objects of study	Yes	Yes	Yes	No standards implied	Cross-sectional
A6 Pointer & Strum, 1978	Actionable	Replicable by special expert	In data collection and feedback	Yes	Yes	Yes	Implicit	Cross-sectional
A7 Takulia, Taylor, Sangal & Alter, 1967	Both actionable & non-actionable	Replicable with conventional skills	As objects of study	Yes	Yes	Yes	Explicit	Cross-sectional
A8 Ugalde, 1978	Both actionable & non-actionable	Replicable by special expert	As objects of study	Yes	Yes	Yes	Explicit	Cross-sectional

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that employed similar diagnostic procedures, but went one step further by including more active modes of assessment. They were more active in that participants were observed as they actually performed management exercises (Byham, 1970) or participants were directly involved in all three steps of diagnosis (Pointer and Strum, 1978). Three studies that are representative of the assessment work done at the individual level will be reviewed in the following paragraphs. The methods, findings, recommendations, and utility of the studies are presented to give the reader further insight into the range of assessment activities that have been attempted at this level.

Traditional Assessments

In 1967, a team of four evaluators (a social scientist, two physicians, and a statistician) conducted a study of health centers in India with the objective of identifying administrative problems. The role of the health center doctor was examined by using two approaches: personal interviews (with physicians, administrators, legislators, and teachers) and reviews of administrative documents.

Method. A flexible, open-ended questionnaire was used because facts and opinions were sought from extremely varied groups (Takulia, et al. 1967, p. 20). This data collection method is quite useful, especially when the evaluator is working in unfamiliar situations where cultural and political differences necessitate using tools that are adaptable to many situations. Another method suggested in this study, one typical of assessments done in developing countries, is the use of opportunistic samples. Because of logistical problems (transportation, language, and so on), persons interviewed were often chosen on the basis of availability. In this study,

the authors tried to minimize the bias resulting from their sampling procedure as follows:

. . . the interviewer carefully explained the non-governmental sponsorship of the study and the scope of information needed. He assured respondents that their responses would be completely confidential. The interviews did not always proceed smoothly. Sometimes the interview had to be cut short or modified according to the temperament or mood of the respondent and the time available. (Takulia, et al., 1967, p. 22).

The evaluators analyzed the data by working out a code of expected responses. The opinions of the physicians were used as a guide against which other groups' opinions were compared. This was done because "...it seemed reasonable to assume that they know most about what is going on and what may be possible in the future" (Takulia, et al., 1967, p. 23).

Findings, Recommendations, and Utility. In the traditional category of assessment studies typically, an organization's staff has little involvement in the analysis and presentation of recommendations and findings. Time constraints common to many donor-financed assessments do not encourage learning exercises. An exception to this are studies with a problem-solving approach where generic methods of identifying and solving problems are actually taught to managers as part of the assessment process. The work of the Instituto Centroamericano de Administración de Empresas (INCAE) organization in Latin America exemplifies such an approach (INCAE, 1975). Although details are not presented, the authors of the Indian study mentioned that findings were reviewed by health administrators and medical educators. The review included discussion of findings, implications, and the development of recommendations by personnel of the host organization. As chapters three and four demon-

strate, this is a marked departure from consultant-dominated ways of presenting findings and recommendations. Research in managerial behavior has shown that participation of people in activities affecting their work often leads to better accomplishment of tasks because people feel that they have had a say in the process. This concept is relevant to the context of a health system and can play an important role in the degree of implementation that results from assessment tasks.

Recommendations that "...can be translated into economically and administratively feasible proposals..." are highly desirable (Takulia, et al., 1967, p. vi). These are an important feature of any assessment methodology. Obviously, recommendations are of little use if the manager cannot act on them due to insufficient resources and vagueness of recommended activities, for example. Even in this study, where the evaluation team was aware of the need for practical recommendations, they nevertheless made proposals that appeared infeasible because they would require large sums of money. Perhaps they felt obliged to echo similar recommendations made several times before by governmental and nongovernmental groups in hopes of eventual implementation.

Behavioral Assessments

A second method of assessing the managerial performance at the individual level is the behavioral approach. Two studies that reflected this departure from traditional methods thrust organizational personnel into a much more active role even though they were the objects of the assessment.

Method. The Health Services Management Assessment Process (HS-MAP), developed by Pointer and Strum (1978), is an example of this approach. The authors call their approach a social-psychological one which they state "...

holds that change efforts are most effective and efficient when groups are employed as both the target for assessment and the means of change" (Pointer and Strum, 1978, p. 10). In keeping with this theory, the authors suggest that members of a management group should conduct the data-collection, learning, problem-solving, and action-planning processes, with the assistance of a trained consultant (Pointer and Strum, 1978, p. 12).

Although results of this approach are not available (the method is being field tested in 1979), the proposal has implications for managerial assessment attempts at any level of a health system. Research (in psychology, sociology, and so on) has shown that when people are allowed to actively participate in an exercise, tasks are better learned. In turn, the likelihood that recommended activities will be implemented is increased. Assessments in developed and developing countries are often impossible to duplicate without a consultant's help because they allowed no staff participation. Staff were not taught how to collect data, how to analyze it, and how to identify problems for themselves. Development of self-assessment approaches such as Pointer and Strum's may increase the active involvement of managers in the assessment process.

Assessment centers (Byham, 1970; Finkle, 1977) offer another approach to judging the performance of individual managers. Although this is not a self-assessment method and involves a greater reliance on an "expert" evaluator, it does allow participation activities that the "traditional" methods seldom include. The assessment center is a program in which participants are evaluated for promotion, training, or placement by specially trained managers who act as assessors. A variety of assessment techniques are used in which "live" management situations are staged (interviews and psychological tests are sometimes included). Commonly used simulations include

management games, fact-finding exercises, in-basket tests, and leaderless discussion sessions. Assessors observe and record their observations of participants as they complete the exercises, which may last from one to three days. Usually, there is one assessor for every two participants and assignments are made so that assessors see different participants in each exercise. At the end of the sessions, assessors discuss their observations and come to agreement on a final assessment of each participant's strengths and weaknesses. With this profile, the management potential of the individual is determined.

Findings, Recommendations, and Utility. The assessment center method has been applied in a variety of settings including government jurisdictions in three countries and organizations such as the New York City Police Department and the American Telephone and Telegraph Co.

Results have been good: Management development is enhanced; candidates and the organization learn about the participants' strengths and weaknesses so that promotional and management development decisions can be made. Published validity studies of the procedure show that the method produces stronger results than those found with tests and panel interviews. These validity studies support the view that better than most other available techniques, assessment centers meet the need for a flexible, job-related, evaluation that is fair to all participants (Byham and Wettengel, 1974, p. 364). Because assessment center exercises provoke a variety of behaviors, far more data is obtained from them than from more traditional methods (Byham and Wettengel, 1974, p. 358).

Nowhere in the studies reviewed for this report could be found documented the use of the assessment center as a method of appraising developing countries' health

services. Although the benefits from an assessment center could be realized in all countries, perhaps the costs of setting-up a center have out weighed the benefits in developing countries. Program length, location, and number of participants available can affect costs. At the American Telephone and Telegraph Co., for example, which has regional centers, total costs per person have been about \$500 (Byham and Wettengel, 1974, p. 160). Modifications of this method could decrease costs while maintaining, if not increasing, most benefits.

Summary

This chapter should give a sense of the types of assessments currently used to evaluate an individual's managerial performance. The review has shown that there are at least two categories of assessment types offering a variety of methods used to diagnose management.

The "traditional" type is often employed in developing countries by foreign advisers and is a practical way of identifying managerial problems and recommending alternatives. One shortcoming of some of the traditional assessment methods is the lack of opportunities for an organization's staff to actively participate in the assessment process. As a result of their passive involvement (which is often limited to data collection and making logistical arrangements), staff often regard assessment not as a management responsibility but as something to be done by outside experts.

The "behavioral" type of assessment affords active participation by staff. Use of self-assessment procedures and participation of managers in simulated exercises are two typical behavioral approaches. Some of these techniques eventually may prove valuable to management assessments in developing countries.

CHAPTER THREE

ASSESSMENTS OF PROGRAM AND INSTITUTIONAL MANAGEMENT ACTIVITIES

Organizational, rather than an individual manager's, performance is the basis for assessments reviewed in this chapter. Here the focus is on the success or failure of programs and institutions in meeting their goals and objectives, whereas studies aimed at the individual manager's level sought to improve or identify strengths of managerial skills and strengths.

The studies emphasized in this chapter represent a second, ascending level of integration in a health system, the program and/or institution. In conducting an assessment at this level, authors followed the same orderly procedure of collecting and analyzing data, identifying problems, and presenting findings and recommendations. The outcomes, or corrective action, in most cases deal only indirectly with the individual manager. The need is "to cure" the organization.

Some Pertinent Statistics

Sixteen studies constitute this chapter's review of program- and institutional-level assessments. (See abstracts of studies in Section 2 of Appendix A, and Figures 3-1, 3-2, and 3-3 for summarized comparisons of studies.) In terms of health organizations assessed, five reports examined hospitals, six covered health clinics (mainly family planning clinics), four looked at specific health projects, and one dealt with correctional institutions. With the exception of three of Reynolds'

Figure 3-1

Setting for Assessments of Program and Institutional Management Activities

Study*	Study Category	Individuals Assessed	Institutions or Programs Assessed	Sector	Country Group**
B1 Addo, 1976	Needs	All workers, including management	Private clinics	Health	Lower-middle-income
B2 Ando, year not indicated	Needs	All workers, including management	Family planning clinics	Health	Lower-middle-income High-income (developing)
B3 Andreano, Cole-King, Katz, Rifka, 1976	Needs	All workers, including management	Primary care projects	Health	Upper-middle-income
B4 Bainbridge & Sapirie, 1974	Generic	All levels of management	Project planning & administration	Health	Low-income Lower-middle-income Upper-middle-income High-income
(developing) B5 Detroit Hospital Council, 1978	Cost control	All workers, including management	Local institutions	Health	High-income (developed)
B6 Griffith, 1978	Cost control	All workers, including management	Local institutions	Health	High-income
B7 Imboden, 1978	Generic	All levels of management	Government agencies or projects	Government	Low-income Lower-middle-income Upper-middle-income High-income
(developing) B8 INCAE ¹ , 1972-75	Needs	Program workers, including management	National family planning programs	Health Health	Low-income Lower-middle-income Upper-middle-income High-income (developed)
B9 Medicus Systems Corporation, 1978	Cost control	All levels of management	Local institutions	Health	High-income (developed)
B10 Medicus Systems Corporation, 1979	Cost control	All levels of management	Local institutions	Health	High-income (developed)
B11 PRIDES ² , 1978	Needs	All levels of management	Local & national programs & institutions	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
B12 Reynolds, 1970	Generic	Not indicated	Family planning programs	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
B13 Reynolds, 1970	Generic	Not indicated	Family planning programs	Health	Lower-middle-income
B14 Reynolds, 1973	Generic	All workers, including management	Family planning programs	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
B15 Reynolds, 1976	Generic	Top-level management	Local & national correctional institutions	Government	High-income (developed)
B16 University of Michigan, 1976	Cost control	Top-level management	Local institutions	Health	High-income (developed)

All assessments studies have been abstracted fully in Appendix A, Part 1. Categories used were defined by the The Overseas Development Council. Because some high-income countries have a PQLI (Physical Quality of Life Indicator) less than ninety, even though the per capita GNP is greater than \$2,000, they are designated "developing" countries. The PQLI is a composite score which takes into account a country's infant mortality, life expectancy at age one, and literacy rate. (McLaughlin, Martin M. The United States and World Development. Agenda 1979. Praeger Publishers. New York: 1979).*

¹Instituto Centroamericano de Administracion de Empresas.
²Programa de Investigacion y Desarrollo de Sistemas de Salud.

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Figure 3-2

Comparison of Methodologies to Assess Health Programs and Institutions

Methodology Study	Step 1	Step 2	Step 3
	Preparing and Planning Assessment	Collecting and Analyzing Data	Presentation of Findings and Recommendations
B1 Addo (1976)	Not indicated	Interviews and questionnaires. Qualitative, descriptive analysis. Data collected by a national	Findings and recommendations identified by a national
B2 Ando (not indicated)	Not indicated	Questionnaire and Likert scale.	Findings and recommendations identified
B3 Andreando, et. al. (1976)	Evaluation team briefed by Health Minister. Project characteristics and objectives identified in a group meeting	Quantitative interviews, document reviews, observation of activities. Qualitative and quantitative data collected by consultants and nationals	Information reviewed and summarized by evaluation team. Results presented in a workshop
B4 Bainbridge & Sapire (1974)	Initial problem outlined; terms of reference defined, schedule formulated	Interviews and document reviews. Qualitative and quantitative data collected by small working groups	Products of the analysis are specified
B5 Detroit Hospital Council (1978)	Not indicated	Questionnaire. Qualitative and quantitative data collected and analyzed by administrative staff and cost containment committee	Survey reviewed by cost-containment committee and cost-containment opportunities identified
B6 Griffith (1978)	Not indicated	Reviews of hospital statistics. Quantitative and qualitative. Data collected and analyzed by administrative staff	Not applicable
B7 Imboden (1978)	Needs of information users identified and capacity use information assessed	Approaches to data collection and analysis reviewed	Guides to evaluation presentation mentioned
B8 INCAE (1978)	Not indicated	Qualitative. Data collected by consultants	Findings prepared and identified
B9 Medicus Systems Corporation, (March 1978)	Not indicated	Questionnaire. Qualitative and quantitative. Data collected by executive management team	Responses summarized by administrative staff and reviewed by a board level committee
B10 Medicus Systems Corporation, (June 1978)	Introductory and executive guide material to be read prior to completion of audit questions	Questionnaire. Qualitative and quantitative. Data collected by executive management team	Management report prepared by the ARA
B11 PRIDES (1978)	Scope determined and participants selected for coordinated Orientation session given to participants	Questionnaire. Qualitative. Staff prepared in orientation sessions for data collection	Not indicated
B12 Reynolds (1970)	Design of evaluation systems discussed	Alternatives for data collection and analysis presented	Not applicable
B13 Reynolds (1970)	Activities and contents of evaluation selected. Objectives of evaluation identified. Method selected	Not applicable	Not applicable
B14 Reynolds (1973)	Activity of analysis identified. Objectives defined and performance measures selected	Process analysis. Quantitative and qualitative. Interviews and observation of identified activities.	Activity's strengths, weaknesses, and significant attributes evaluated
B15 Reynolds (1976)	Evaluation topic selected. Evaluation plan developed	Quantitative and qualitative. Evaluations conducted by administrators or consultants	Findings are presented to decision makers
B16 Univ. of Michigan (1979)	Not indicated	Mainly quantitative analysis	Not indicated

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Figure ●-3

Comparison of Utility of Health Program and Institutional Studies

Utility as judged by:	Personnel Demands	Direct Costs	Externalization of Evaluation
B1 Addo, 1976	Staff and operational personnel (data collection)	Not indicated	Not applicable
B2 Ando	Operational (staff interviewed)	Not indicated	Could be handled by evaluations department
B3 Andreano, et.al. 1976	Staff and operational (staff observed and interviewed)	Three weeks	Could be handled by evaluations department
B4 Bainbridge & Sapirie 1974	Small working groups	Not indicated	Not applicable
B5 Detroit Hospital Council 1978	Staff	Not indicated	Internal evaluation
B6 Griffith, 1978	Staff	Annual collection of data for minimum of four years	Internal assessment
B7 Imboden, 1978	Not applicable	Not indicated	Internal assessment
B8 INCAE, 1972-5	Staff and operational personnel	Not indicated	Not indicated
B9 Medicus Systems Corporation, March 1978	Staff and operational personnel	Not indicated	Internal assessment, with some consultant help in implementation
B10 Medicus Systems Corporation, June 1978	Staff and operational personnel	Not indicated	Internal assessment, with consultant interpretation of findings
B11 PRIDES, 1978	Staff and operational personnel	Not indicated	Internal assessment
B12 Reynolds, 1970a	Staff personnel	Not indicated	Could be used as part of internal assessment
B13 Reynolds, 1970b	Staff personnel	Not indicated	Could be used as part of internal assessment
B14 Reynolds, 1973	Not indicated	Not indicated	Could be used as part of internal assessment
B15 Reynolds, 1976	Staff personnel	Not indicated	Internal assessment
B16 University of Michigan, 1979	Not indicated	Not indicated	Not indicated

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Figure 3-3 (Continued)

Utility as judged by:	Feedback	Replication	Participation of program personnel	Information to donors	Program description	Remedies and options	Benchmarks	Trends
B1 Addo, 1976	Actionable & nonactionable	Replicable with conventional skills	Only in data collection	Yes	Yes	Yes	Explicit (comparative) and implicit	Cross-sectional and longitudinal
B2 Ando	Actionable	Replicable with training	Not indicated	Yes	Yes	Yes	Explicit (comparative)	Cross-sectional
B3 Andreano, et.al. 1976	Actionable & nonactionable	Replicable with further documentation & conventional skills	Passive (objects of study)	Yes	Objectives & internal program structure	Yes	Explicit (comparative)	Cross-sectional
B4 Bainbridge & Sapirie 1974	Not applicable	Replicable with conventional skills	Not applicable	Yes	Yes	Yes	None	Cross-sectional
B5 Detroit Hospital Council, 1978	Actionable & user identifies feedback	Replicable with conventional skills & special preparation	Not applicable	Yes	Not	No	Implicit	Not applicable. Current situation is focus
B6 Griffith, 1978	Actionable	Replicable with conventional skills	Not indicated	Not applicable	Not applicable	Yes	Explicit (universal & comparative)	Comparison with standards. Cross-sectional & longitudinal
B7 Imboden, 1978	Actionable & nonactionable	Replicable with conventional skills	Not applicable	Yes	Yes	Not applicable	Not applicable	Not applicable
B8 INCAE, 1972-5	Actionable & nonactionable	Replicable with further documentation	Participation in execution of study	Yes	Yes	Yes	Not indicated	Cross-sectional & longitudinal
B9 Medicus Systems Corporation, March 1978	Actionable & nonactionable	Replicable with conventional skills	Participation in execution of study	Not applicable	Yes	Yes, remedies & options are implied	Explicit & implicit	Comparison with standards. Cross-sectional & longitudinal
B10 Medicus Systems Corporation, June 1978	Actionable & nonactionable	Replicable with conventional skills	Participation in execution of study	Not applicable	Yes	Yes, implied	Explicit & implicit	Comparison with standards. Cross-sectional & longitudinal
B11 PRIDES, 1978	Actionable & nonactionable	Replicable with conventional skills	Participation in execution of study	Yes	Yes	Yes	Explicit	Comparison with standards. Longitudinal
B12 Reynolds, 1970	Actionable & nonactionable	Replicable with conventional skills	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
B13 Reynolds, 1970	Actionable	Replicable with conventional skills	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
B14 Reynolds, 1973	Actionability dependent on mix of alternatives	Not applicable	Not applicable	Yes	Yes	Yes	Not indicated	Not indicated
B15 Reynolds, 1976	Actionable & nonactionable	Replicable with conventional skills	Participation in execution of study	Yes, possible for this purpose	Not applicable	Yes	Explicit (comparative and universal)	Not applicable
B16 University of Michigan, 1979	Not indicated	Replicable upon further documentation	Not indicated	Not indicated	Yes	Not indicated	Not indicated	Comparison with standards. Cross-sectional & longitudinal

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works (Reynolds, 1970a, 1970b, 1973), all were done within the last four years. In fact, nine were compiled as recently as 1978-79. These assessments were developed or applied globally; one was centered in Africa, five in Latin America, six in the United States, one in Asia, and one in the Near East. Eleven studies used or proposed use of experts, or consultants, for the implementation phase of the assessment. Less than half of the studies explicitly called for participation of a program or institution's staff in either the design or implementation of the assessment.

Three categories allow classification of these studies. They are 1) "needs" studies, 2) generic studies, and 3) cost-control studies. Studies investigating needs would help an organization identify opportunity areas that could contribute to further developing the health care system. The majority of these studies came about in developing countries. The second category, or generic studies, would present guidelines and general recommendations about appropriate ways to assess a health program or institution. All of the studies in this category concern developing countries. They differ from needs studies in that methodologies were not specifically tailored to any one country, institution, or program. The final category, or cost-control studies, grew from recent desires to bring sound economic planning to the health sector. In contrast to the other two categories, cost-control studies were developed in the United States, and are currently being field tested and implemented across the country.

Needs Studies

All five studies, illustrating assessment from a needs perspective, are responses to the existence of problems in

the development of health programs or institutions in developing countries. Those responsible for health management sought to improve their own health programs. This is in particular contrast to cost-control studies, which, instead of identifying areas for development, isolated operations that could be curtailed or redesigned so that the health system could be reduced.

The assessment methods used in the needs studies are less systematic and more country specific. Their express purpose, again, was to identify areas of development specific to each situation. They did not have as general a mandate as the cost-control approach that could lead to fairly detailed, systematic evaluation methods with wide applicability.

Other factors characteristic of needs studies include the use of assessors who are often outside experts, acceptance of qualitative measures, and concern with social impacts of health policies and programs.

Methods. In 1976, a four-person World Health Organization (WHO) team went to Iran to evaluate primary health care programs in three provinces. Team members were two health economists from the United States and England, a WHO education specialist, and a WHO public health administrator. Their objectives were: 1) to define goals in quantifiable terms, 2) to develop evaluation methodologies, 3) to determine which methods would most likely achieve agreed upon goals, and 4) to identify the most appropriate primary care model for national implementation (Andreano, et al., 1976, p. 1). The authors opted for a flexible approach to counterbalance the constraints typically faced by a foreign evaluation team in a developing country. These constraints included tight time schedules, transportation and language problems, and environmental and cultural

differences. The team therefore had to turn to extraordinary sources such as their own general and perhaps superficial impressions (Andreano, et al., p. 3).

Staff from the primary care clinics under study accompanied the team throughout the twenty-two day investigation. Clinic staff could provide language interpretation and assist in data collection. A feature of needs studies is this degree of involvement of program staff. Seldom, however, are staff personnel consulted in the design, implementation, or analysis stages of evaluations. This situation is similar to that found in traditional approaches to assessing individual managers' performances where consultants are responsible for evaluation and staff serve only as information gatherers or givers.

Because quantitative data were rarely available, the authors were forced to adopt qualitative evaluation methods, consisting of five basic steps. First, the team called a meeting with health managers to identify essential features of the clinics. Secondly, the team collected data using interviews, observations of activities, and analysis of records. Unfortunately, this and many other needs studies did not include actual examples of data collection instruments.

An exception was the Programa de Investigación y Desarrollo de Sistemas de Salud (PRIDES) project done in 1978 in Cali, Colombia. The method of administrative diagnosis (MEDA) included use of a "formato". This was a series of questionnaires with a two-sided page of questions for each management area. One side contained a general definition of the management area. The other side listed three alternative situations for a particular management activity. The user could elaborate on the definition and determine which of the three situations was

most applicable. Besides being a helpful method for problem identification, the clear documentation of the instrument enables others to test and further develop it.

In the Iranian study, the authors attempted a cost analysis but unstandardized records and incomplete assignment of costs made analysis nearly impossible. After the second step in their assessment, the team began making informed judgments about the character and quality of the clinics. Next, they evaluated project characteristics and using a specified set of criteria, determined project quality. The fifth and final step was a workshop held at the completion of field work. All who had taken part in the evaluation, attended this session.

The steps delineated in this study are similar to those used in most evaluation methodologies, with at least one exception. In the Instituto Centroamericano de Administración de Empresas (INCAE) project, the authors interrupted the sequence of problem identification followed by presentation of management findings and recommendations (INCAE, 1975). The authors first substituted a training program in problem-solving techniques designed for managers, and then allowed these managers to evaluate their own programs, using standard methods. Such an approach, the authors believe, lends itself to continuing management education and to development of meaningful self-assessment modes of evaluation. More than this, managers become better qualified in the context of their own responsibilities in their own countries.

Findings, Recommendations, and Utility. The salient feature of the WHO study (1976) of Iranian clinics was the use of a workshop. Responses and comments from health managers were solicited although time constraints did not allow this feedback period to be as thorough as the evaluation team had hoped for. Nevertheless, there

appeared to be good correspondence between the findings and recommended corrective actions. Where "no ready solution" was apparent, the authors frankly admitted it. The evaluation team believed their workshop successful because the audience unanimously adopted the preliminary proposals for implementation of findings. The team also suggested that their methodology might be used as a guide for the development of a continuing education system for health programs in Iran.

Generic Studies

Evaluation studies by Imboden (1978), Reynolds (1970a, 1970b, 1973, 1976), Bainbridge and Sapirie (1974), and Andreano, et al. (1976) are examples of generic approaches to the assessment of health services programs and institutions. The term "generic" implies that these studies do not propose cookbook methods that could be used as guides for any program evaluation. Essentially, these studies present conceptual frameworks (Reynolds, for example) or more defined procedures, with frequent reference to methods tailored to local situations (Reynolds (1973), Bainbridge and Sapirie (1974) and Andreano et al. (1976). In Reynold's manuals (1970a, 1970b) for evaluating family planning programs, he reminds users that his frameworks can be applied in many places but the substance of an evaluation should be program specific and accurate for the individual programs.

Generic studies are best recognized as guidelines and procedures for determining evaluation methods suited to a particular environment. These studies emphasize the need to adapt assessment methods to the social, economic, and political context within which a particular program or institution functions. All of the studies surveyed in the generic category are addressed to developing country health services management.

Method. In A Management Approach to Project Appraisal and Evaluation, N. Imboden (1978) illustrates the generic approach to evaluation. Instead of proposing a specific and rigid framework for his study, the author presents various concepts and frameworks, thereby highlighting factors important to the choice and construction of the ultimate evaluation framework. The author calls for a critical analysis by managers of development activities to identify their information needs and then to efficiently use the information generated (Imboden, 1978, page 7). Project analysis included the determination of:

- o Expected contributions of alternative actions to various goals,
- o Costs-benefit effects of the various actions,
- o Conceptual framework designed to monitor and evaluate the proposed action.

To complete the last step, the manager determines the information needed, who should receive that information, and the degree of confidence required. Once these determinations have been made, an evaluation system can be chosen which provides the necessary information, takes into account available resources, and is cost-effective (Imboden, 1978, p. 131-134).

Findings, Recommendations, and Utility. The Imboden study shows that many of the evaluation approaches in use today do not allow for adaptation to the information requirements of managers in development activities. Often, too, evaluation results are not used for decision-making.* In discussions with health managers during field visits, Imboden (1978) found that many times evaluation methods were used only once. That is, the methods were used once to meet the requirements of a donor

*The authors of this report found this to be true in many of the books surveyed.

agency, then shelved. Imboden theorizes that evaluation results are often irrelevant to real concerns and issues. Nevertheless, evaluation is possible if a compromise is made between technical rigor and available resources. Finally, Imboden advises that frameworks must be tailor-made because each program is different, and this conclusion applies in developing and the more developed countries of the world.

Cost-Control Studies

A third category of studies to enable program and institutional evaluation are those concerned with cost control. All five studies included in this survey were designed in the United States as part of current efforts to better manage the rising cost of health care. Sponsors of these studies were the American Hospital Association, the Blue Cross Association, Michigan Health Data Corporation, and the Detroit Hospital Council.

Method. The American Hospital Association (AHA) study (Medicus Systems Corporation, 1978a & b), currently being market tested (during summer 1979), will serve as an example of cost-control research. Presented in the study is a hospital evaluation method called the Program for Institutional Effectiveness Review (PIER). PIER was designed and field tested twice by AHA consultants in several hospitals in the United States. In contrast to the methods used in the generic category, PIER uses a step-by-step questionnaire for data collection. This document contains factual and value judgment questions for each of five management areas. The factual questions are completed by appropriate hospital management staff. Then, both sets of questions are completed by board members, other administrators in the hospital, and the medical staff. Although there is not full participation of staff in all phases of evaluation, staff

is not merely relegated to data collection activities. Responses to the questionnaire were sent to AHA for analysis. A management report, prepared by AHA for each hospital evaluated, contained comparison data and industry norms, trend analyses, and identification of management educational needs.

Findings, Recommendations, and Utility. Because the AHA study is still in progress, findings and recommendations are not yet available. However, the project manager of PIER indicated that PIER users believe PIER to be basically a sound method. One change to increase the usefulness of the methodology might be to specify goals within the audit. These would help clarify alternative remedies for identified problems. If one were to attempt to apply PIER in a developing country, the approach would definitely require adaptation. In fact, a certain degree of adaptation was required when PIER was used in some U.S. hospitals.

Summary

This chapter has identified three categories of studies that use different methods and tools for assessing the management of health programs and institutions. In all three categories, managerial practice is evaluated in terms of the overall performance of a health program or institution. Instead of regarding individuals' managerial behavior, these assessments investigate organizational performance. Principal issues in these works include whether goals and objectives are accomplished, whether patients receive adequate care, if costs are more successfully controlled in one institution than in another, and so on. The tasks and roles of individual managers comprise only one unit of a properly working organization.

One category of studies explored organizations from the perspective of needs. Methods suggested in these documents typically were implemented in developing countries in response to a desire to improve the health programs or institutions of a given country. Qualitative measures were implemented by foreign consultants in the needs studies. Generic studies were concerned with adaptation of evaluation methods to specific environments. Use of cookbook assessment methods for any circumstance was rejected in these studies and general, adaptable methods were proposed. Finally, cost-control studies tended to use questionnaires that were applied in a variety of hospital settings. Systematic assessment methods that comprehensively evaluate program and institutional performance are characteristic of cost-control studies.

The use of any of these studies is dependent to a large extent on the purpose and environment of the program or institution to be evaluated. Above all, this chapter gives visibility to the wealth of options available to health services managers who wish to assess their own health services program or institution.

CHAPTER FOUR

ASSESSMENTS OF HEALTH MANAGEMENT ON COMMUNITY-WIDE AND NATIONAL SCALE

Assessments of health management on community-wide and national scales build upon the methods used to appraise individual and program or institutional levels of competence. These studies consider all health services in a geographic locality and therefore are the most complex forms of health management assessment. To accomplish a comprehensive, national-level health services assessment, for example, one would seek information about all levels of health services management from delivery unit managers, to top administrators of programs and institutions, to health ministers who are responsible for setting health system policy.

The forty-seven studies cited in this chapter depict attempts to evaluate health delivery systems or health status of the total population in developing countries. (See Appendix A, Section 3, for abstracts of community-wide and national-scale health assessments. Figures 4-1, 4-2, and 4-3 give comparative information about these studies.) These studies are principally health-sector assessments funded by the U.S. Agency for International Development (AID). Many other references, which were eventually abstracted, were discovered in the course of formal interviews. By no means, however, is this survey inclusive of all work on this subject.*

*Unfortunately, there are few formal mechanisms for exchanging information among those interested in managerial assessment of health services in developing countries. As a result, although the authors have

Figure 4-1

Setting for Community-wide and National Level Assessments

Study*	Individuals Assessed	Institutions or Programs Assessed	Sector	Country Group**
C1 Asayesh, 1974	Not indicated	National family planning programs	Health	Upper-middle-income
C2 Beckles, 1975	Not indicated	Public & private delivery	Health	Low-income
C3 Blevins, Gallivan, & Haverberg, 1978	Not indicated	Public Delivery	Health & Nutrition	Lower-middle-income Lower-middle-income
C4 Brown, 1973	Not indicated	Local institutions & national agencies	Health	Lower-middle-income
C5 Bumpus, et. al. 1975	Not indicated	Public providers	Health	Upper-middle-income
C6 Cathcart, 1978	Not indicated	Local institutions & communities	Health	Lower-middle-income
C7 Cross, et. al. 1977	Not indicated	Ancillary services	Health	Low-income
C8 Cross, et. al. 1977	Not indicated	Local institutions & national agencies	Health	Low-income
C9 Daly, et. al. 1975	Top-level management	Local institutions & national agencies	Health	Lower-middle-income
C10 de Leon, 1963	Not indicated	Local institutions & national agencies	Health	Upper-middle-income
C11 ESCAP ¹ , 1977	All workers, including management	Multi-nation family planning programs	Health	Lower-middle-income Upper-middle-income High-income (developing)
C12 El-Zein, 1973	Not indicated	Local institutions & national agencies	Health	Low-income
C13 Emrey, Farr, Sarn, 1976	Not indicated	Local institutions & national agencies	Health	Upper-middle-income
C14 Emrey, Gallivan & Russell, 1977	High-level management	National health planning	Health	Lower-middle-income
C15 Family Health Care, Inc., 1976	Not indicated	Regional & national agencies	Health	Upper-middle-income
C16 Family Health Care, Inc. Africare, 1978	High-level management	Local institutions & national agencies	Health	Low-income
C17 Family Health Care Inc., 1978	High-level management	Local institutions & national agencies	Health	Low-income
C18 Family Health Care Inc., 1978	Not indicated	Local institutions & national agencies	Health	Low-income
C19 Family Health Care Inc., 1978	Not indicated	Local institutions national agencies	Health	Low-income
C20 Family Health Institute, 1978	High-level management	Public delivery & support agencies	Health	Low-income
C21 Filerman, 1977	High-level management	Multi-nation delivery	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
C22 Garcia-Erazo, 1967	Nursing management	Local institutions	Health	Upper-middle-income
C23 Gutierrez Sanoja, 1965	Upper-level management	Regional & national delivery	Health	High-income (developing)
C24 Howard, 1970	Not indicated	National agencies	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
C25 Huss, 1975	Upper-level management	Local institutions	Health	Low-income
C26 Institute of Medicine, 1979	Not indicated	Local institutions & national agencies	Health	Low-income
C27 Kwang-Woong Kim, 1974	Lower-level management	Regional family planning programs	Health	Lower-middle-income
C28 Laskin, 1977	Not indicated	Local institutions & national agencies	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
C29 Lopez, Alvarez, & Rivera, 1978	Not indicated	Regional sanitation services	Health	Lower-middle-income
C30 Mahfouz, 1973	Not indicated	Local institutions & national agencies	Health	Low-income

Figure 4-1 (Continued)

C31 Manetsck, et. al., 1971	Not indicated	Regional programs	Agriculture	Lower-middle-income
C32 MPSSP ² , 1974	Top-level management	Local institutions & national agencies	Health	Lower-middle-income
C33 Ministry of Health 1978	Not indicated	Local institutions & national agencies	Health	Lower-middle-income
C34 Ministry of Health, 1977	Not indicated	Rural & family services	Health	Low-income
C35 Poyner, et. al., 1976	Top-level management	National policy	Nutrition	Upper-middle-income
C36 Robinson, 1975	Not indicated	Local institutions & national agencies	Education	Low-income Lower-middle-income Upper-middle-income High-income (developing)
C37 Ruiz, Askin, & Gibb, 1978	Not indicated	Local institutions & national agencies	Health	Lower-middle-income
C38 Schieck, Hill, Parker, & Long, 1978	Not indicated	Local institutions & national agencies	Health	Lower-middle-income
C39 Taylor, Dirican, & Deushcle, 1968	Not indicated	National manpower planning	Health	Upper-middle-income
C40 TSSEPC ³ , 1975	Top-level management	National programs	Nutrition	Lower middle-income
C41 USAID ⁴ , 1978	Not indicated	Local institutions & national agencies	Health	Low-income
C42 USAID, 1975	Not indicated	Multi-nation agencies	Health	Low-income Lower-middle-income Upper-middle-income High-income (developing)
C43 USAID, 1974	Not indicated	Local institutions & national agencies	Health	Lower middle-income
C44 USAID, 1976	Not indicated	Rural provincial agencies	Health	Upper-middle-income
C45 USAID, 1979	Not indicated	Local institutions & national agencies	Health	Lower-middle-income
C46 USAID, 1976	Not indicated	Local & national programs	Nutrition	Lower-middle-income
C47 WHO ⁵ , 1978	Not indicated	National planning	Development	Low-income Lower-middle-income Upper-middle-income High-income (developing)

* All assessment studies have been abstracted fully in Appendix A, Part 3.

** Categories used were defined by the The Overseas Development Council. Because some high-income countries have a PQLI (Physical Quality of Life Indicator) less than ninety, even though the per capita GNP is greater than \$2,000, they are designated "developing" countries. The PQLI is a composite score which takes into account a country's infant mortality, life expectancy at age one, and literacy rate. (McLaughlin, Martin M. The United States and World Development. Agenda 1979. Praeger Publishers. New York: 1979).

1 Economic and Social Commission for Asia and the Pacific

2 Ministerio de Prevision Social y Salud Publica

3 Technical Secretariat of the Superior Economic Planning Council

4 United States Agency for International Development

5 World Health Organization

Figure 4-2

Comparison of Methodologies in Community-wide and National-level Studies

Methodology Study	Step 1 Preparing and Planning Assessment	Step 2 Collecting and Analyzing Data	Step 3 Presentation of Findings and Recommendations
C1 Asayesh, K.A. (1974)	Not indicated	Data collection method not indicated. Qualitative analysis supported by statistical data. No formal instrument.	Findings are presented, no recommendations. Presentation method not indicated
C2 Cathcart, H.R. (1978)	Not applicable	Data collected as part of a tour to China. Qualitative, descriptive analysis. No formal instrument	Findings are presented, no recommendations
C3 DeLeon, J.P. (1963)	Not indicated	Data collection method not indicated. Qualitative analysis supported by statistical data. No formal instrument	Findings and recommendations are presented. Presentation method not indicated
C4 Economic & Social Commission for Asia & the Pacific (1977)	Steps: study framework-study design;-revisions;-adaptation of design in preparatory meeting	Interviews and reviews of clinic records by study team. Quantitative analysis	Findings and recommendations are presented. Presentation method not indicated
C5 El-Zein, A.H. (1973)	Not indicated	Data collected as part of a visit to Qena by the author. Qualitative, descriptive analysis. No formal instrument	Findings and recommendations are presented. Presentation method not indicated
C6 Filerman, G. (1977)	Not applicable	Qualitative, descriptive review of topic by author. No formal instrument	General findings and recommendations are presented
C7 Garcia-Erazo, A. (1967)	Not applicable	Qualitative, descriptive review by the author. No formal instrument	Findings and recommendations are presented. Presentation method not indicated.
C8 Gutierrez, J. (1960s)	Not indicated	Qualitative, descriptive review by author. No formal instrument	Findings and recommendations are presented. Presentation method not indicated.
C9 Howard, L. (1970)	Not applicable	Qualitative, descriptive review by the author. Statistical data included. No formal instrument	Findings presented, no recommendations. Method not indicated
C10 Huss, C. (1975)	Not indicated	Questionnaires, case studies, administrative audits, interviews, workshops, and observation of activities were used to collect data by the author. Qualitative and quantitative analysis	Findings and recommendations are presented. Method not indicated.
C11 Kwang-Woong, K. (1974)	Advisory Council was responsible for over-all project control, including adaptation of method in preparatory stages	Questionnaires, surveys, and Likert scales were used to collect data by host country participants. Qualitative and quantitative (correlation & regression) analysis	Advisory Council analyzed findings and processed policy recommendations.
C12 Lopez, L.G., et.al. (1978)	Diagnosis included review of history of sanitary problems, definition of administrative, technical, and operational norms and training.	Instruments not indicated. Data collected by host country participants. Descriptive analysis not documented	Findings and recommendations not presented
C13 Mahfouz, M. (1973)			
C14 Manetsch, et.al., (1971)			
C15 Ministry of Health—Lampang Health Development Project	Not indicated	Not indicated	Findings are presented, no recommendations.
C16 Ministerio de Prevision Social y Salud Publica, (1974)	Not indicated	Qualitative analysis by host country participants. Instruments not indicated	Findings and recommendations are presented. Presentation method not indicated

Figure 4-2 (Continued)

C17 Robinson, B. (1975)	Not applicable	Various instruments are discussed. Qualitative and quantitative analysis	Not applicable
C18 Taylor, C., et. al, (1968)	Not indicated	Data collected by consultants and host country participants, using questionnaires and interviews Quantitative analysis	Findings and recommendations were presented with health officials' participation
C19 U.S. Agency for International Development (USAID) (1976) Health Sector Assessment & Strategy	Detailed work plan prepared by consultants	Instruments not indicated. Data collected by consultants with host participants	Proposal states that findings and recommendations will be presented
C20 USAID. Health in Africa (1975)	Not indicated	Instruments not indicated Qualitative analysis by a U.S. Task Force	Findings and recommendations presented. Presentation method not indicated.
C21 USAID. Africa HSAs (1977-78)	Not indicated, except in Sudan where consultants met with MOH officials for planning	Interviews and reviews of documents for in-country and desk studies. Qualitative and some quantitative analysis by consultants with little host participation.	Findings and recommendations presented usually to MOH and AID officials. Presentation method not indicated
C22 USAID. Latin American HSAs (1974-8)	Early HSAs indicate little planning. Later ones had planning phase done by consultants	Interviews, document reviews and some observation of activities. Combined qualitative and quantitative analysis (six studies) and qualitative only (six studies) by consultants with increased host participation in more recent studies	Findings and recommendations presented. Method usually not documented, but probably presented to MOH and AID officials
C23 USAID. Near East HSAs (1976-9)	Not indicated except Jordan where consultants planned in-country and developed assessment guide	Formal instruments seldom used; if used, not included in study. Qualitative and quantitative analysis by consultants (except in Jordan where hosts participated)	Findings and recommendations presented. Method usually not documented, but probably presented to MOH and AID officials
C24 World Health Organization (1978)	An advisory committee would determine object, purpose, scope and constraints for evaluation	Interviews and document reviews by program managers Combination of qualitative and quantitative analysis	Findings and recommendations presented by users of the method (regional directors and program managers)

Figure 4-3

Comparison of the Utility of Community-wide and National-level Studies

Utility as judged by:	Personnel Demands	Direct Costs	Externalization of Evaluation
C1 Asayesh, K.A., 1974	None involved	Not indicated	None involved
C2 Cathcart, H.R., 1978	None involved	Two weeks	Topics were covered that should be part of normal program evaluation
C3 Deleon, J.P., 1963	Staff personnel	Not indicated	Not indicated
C4 ESCAP, 1977	Not indicated	Not indicated	Topics could be part of normal program evaluation
C5 El-Zein, A.H., 1973	None involved	Not indicated	Special expertise or independent perspective required
C6 Filerman, 1977	Not applicable	Not indicated	Not indicated
C7 Garcia-Erazo, 1967	Staff personnel	Not indicated	Topics could be part of normal program evaluation
C8 Gutierrez, 1960s	None involved	Not indicated	Special expertise or independent perspective required
C9 Howard, L., 1970	None involved	Not indicated	Not indicated
C10 Huss, C., 1975	Operational personnel	Sixty personmonths	Not indicated
C11 Kwang-Woong, K., 1978	Operational personnel	Not indicated	Not indicated
C12 Lopez, L.G., 1978	Operational personnel	136 personmonths	Not indicated
C13 Mahfouz, M., 1973	Not indicated	Not indicated	Topics could be part of normal program evaluation
C14 Manetsch, et.al., 1971	None involved	Not indicated	Special expertise or independent perspective required
C15 Ministry of Health, Thailand, 1978	Not indicated	Not indicated	Topics could be part of normal program evaluation
C16 Ministerio de Prevision Social y Salud Publica, 1974	Staff personnel	Not indicated	Topics could be part of normal program evaluation
C17 Robinson, B., 1975	Not indicated	Not indicated	Not indicated
C18 Taylor, et.al., 1968	Staff personnel	Not indicated	Special expertise or independent perspective required
C19 U.S. Agency for International Development (USAID) 1976	Not indicated	Not indicated	Not indicated
C20 USAID, 1975	None involved	Not indicated	Special expertise or independent perspective required
C21 USAID, African HSAs, 1977-78	None involved	One to four personmonths	Topics could be part of normal program evaluation
C22 USAID, Latin American HSAs, 1974-78	None (seven studies) Operational staff (four studies)	Not indicated	Topics could be part of normal program evaluation
C23 USAID, Near East HSAs, 1974-78	None (five studies) Not indicated (one study)	One to twelve personmonths. Not indicated (four studies)	Topics could be part of normal program evaluation (six studies). Special expertise required (two studies)
C24 World Health Organization, 1978	Staff and operational personnel	Not applicable	Could be part of normal program evaluation

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Figure 4-3 (Continued)

Utility as judged by:	Feedback	Replication	Participation of program personnel	Information to donors	Program description	Remedies and options	Benchmarks	Trends
C1 Aayesh, K.A., 1974	Actionable	Replicable with qualified personnel	Passively involved as objects of study	Not indicated	Yes	None	None	None
C2 Cathcart, H.R., 1978	Actionable, some non-actionable	Not replicable	Passively involved as objects of study	None	Yes	None	Comparative norms	Longitudinal comparisons
C3 Deleon, J.P., 1963	Actionable, some non-actionable	Not replicable	Participation in design and execution	None	Yes	None	Implicit	None
C4 ESCAP, 1977	Actionable	Replicable with specially qualified personnel	Participation in design and execution	Yes	None	Yes	Comparative norms	Cross-sectional comparisons
C5 El-Zein, A.H., 1973	Actionable	Not replicable	Passively involved as objects of study	None	Activities described	Yes	Implicit	None
C6 Filerman, 1977	None identified	Not applicable	Not applicable	Yes	Yes	None	None	Cross-sectional comparisons
C7 Garcia-Erazo, 1967	Non-actionable	Not replicable	Participation in design and execution	None	Yes	None	Implicit	None
C8 Gutierrez, 1960s	Actionable	Not replicable	Passively involved as objects of study	Yes	Program structure defined	None	Comparative norms	Longitudinal comparisons
C9 Howard, L., 1970	Non-actionable	Not replicable	Not indicated	Yes	Not indicated	Not indicated	Implicit	Longitudinal comparisons
C10 Huss, C., 1975	Actionable	Replicable with specially qualified personnel	Participation in design and execution	Yes	None	Yes	Implicit	None
C11 Kwang-Woong, K., 1978	Actionable	Replicable with specially qualified personnel	Participation in design and execution	Yes	Yes	Yes	None	None
C12 Lopez, L.G., 1978	None identified	Replicable with conventional skills	Participation in design and execution	Yes	Yes	None	None	None
C13 Mahfouz, M., 1973	None identified	Replicable with specially qualified personnel	Not indicated	Yes	Yes, in general terms	None	Implicit	None
C14 Manetsch, et.al., 1971	Actionable and non-actionable	Replicable with specially qualified personnel	Not applicable	Yes	Yes	Yes	Not	Not applicable
C15 Ministry of Health, Thailand, 1978	Actionable	Replicable with conventional skills	Not indicated	Yes	Yes	None	Implicit	None
C16 Ministerio de Prevision Social y Salud Publica, 1974	Actionable and non-actionable	Replicable with conventional skills	Participation in design and execution	Yes	Yes	Yes	Comparative norms	Cross-sectional, longitudinal comparisons
C17 Robinson, B., 1975	Method could identify problems	Replicable with conventional skills	Not indicated	Yes	Yes	Yes	Not indicated	Cross-sectional, longitudinal comparisons
C18 Taylor, et.al., 1968	Yes, with specially qualified personnel	Participation in design and execution	Yes	Yes	Yes	Yes	Comparative norms	None
C19 U.S. Agency for International Development (USAID) 1976	Non-actionable	Not replicable	Passively involved as study objects	Yes	Yes	None	Implicit	None
C20 USAID, 1975	Non-actionable	Passively involved as study objects	Yes	None	None	None	Implicit	None

Figure 4-3 (Continued)

C21 USAID, African HSAs, 1977-78	Actionable & non-actionable	Not replicable	Passively involved as study objects	Yes, except for one study	Yes	Yes--2 No--4	Implicit for 5, none--1, explicit--1	None--4 Longitudinal--2 Cross-sectional--1
C22 USAID, Latin American HSAs, 1974-78	Actionable & non-actionable	Not replicable, --9. With qualified personnel--3	Passive--7, Design and execution--3	Yes, except for one study	Yes	Yes--5	Implicit	None--9 Longitudinal--3
C23 USAID, Near East HSAs HSAs, 1974-78	Actionable & non-actionable	Not replicable, --3. With qualified personnel--1 With conventional skills--1	Passive--5 Not indicated--1	Yes	Yes, except for one study	Yes--3 No--3	Implicit	None--5 Longitudinal--
C24 World Health Organization, 1978	Not applicable	Replicable with conventional skills	Would participate in execution	Yes	Yes	Yes	Comparative norms	Cross-sectional Longitudinal

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Key Study Topics

Of the forty-seven studies, twenty-three were national health-sector assessments, seven were multinational health assessments, eight dealt with single health programs or health problems (nutrition, family planning, for example), and five addressed the health system within a region of a country. The remaining four studies assessed sectors other than health--education and agriculture in these cases--and they are interesting because of the methodology they convey. In terms of their methodology, forty studies relied on data collection in the field. The remaining seven derived exclusively from secondary sources. Six of these were no more than descriptions of a health system and did not appear to warrant much consideration in this report.

Study Methods

While studies reviewed here do not readily lend themselves to categories, they do illustrate approaches to a management assessment:

- o Reliance on secondary sources. These desk studies serve as background information for general audiences or researchers about to undertake field research. The AID/DHEW Syncrises series typifies such studies.
- o Reliance on expert evaluators. Use of interviews, personal experience, direct observation, and published sources is frequent. Studies of this nature vary greatly and, consequently, so does their quality. One such study was prepared by Cross, et al. (1977a) on supply logistics in the Sudan (see abstract C7 in Appendix A, Section 3). The researchers delivered a competent piece of work because they described the system itself,

attempted to collect studies representing a serious effort to assess the health situation and program needs of a region, province, or nation, they inadvertently may have excluded some relevant studies. They do, however, intend to update their report periodically as one means of encouraging the dissemination of this subject matter.

and made pragmatic recommendations. Replication by anyone other than a researcher, however, seems unlikely.

- o Inclusion of host-program collaboration. These assessments were based on national surveys executed by operational personnel. Not all were able to meet the ambitious objectives established (see reference to Westinghouse Health Systems, 1978, in the bibliography for a review of these health-sector assessments.). Where such assessments did succeed, they provided fresh and inclusive data on the health status of the society and an evaluation model suitable for incorporation in the program. Less systematic was their approach to data gathering on administrative functioning. Some areas of administration (notably logistics) appear to have been studied rigorously, while others such as supervision were pursued less so.
- o Orientation to specific managerial action. Only one study fell into this category. It illustrates sound methods and a high degree of utility for both donor agency and program managers.

Even though these four assessment approaches vary as widely as the purposes and resources of their investigators, a model type does emerge. That is, an investigation from the top management level down conducted in a limited time by North American experts or consultants.

If the experts pursued a systematic approach to their assessments of health systems, the documentation fails to show it. Primary reliance appears to have been placed on the impressions of a trained observer; as a result, replication in all but a few of the studies would be nearly impossible. Most consistent reliance was placed upon the personal interview for primary data. Only in eleven studies were data gathered via some kind of formal survey (rarely described); however, as the Westinghouse Health Systems Study (1978) suggests, the survey data may have been collected and then disregarded.

While the methodology within these studies was rarely

constant, one interesting observation can be made about it. Considerably more rigorous methods are applied in the study of a nation's health status than in the study of the health system. Although authors were usually silent on the process employed to arrive at conclusions concerning health system functioning, the common absence of detail (save an occasional supporting anecdote) suggests an impressionistic approach to the system's assessment. In contrast, a serious effort was usually made to establish, in precise fashion, the health needs of a nation. Had researchers employed the same methodology for assessing the functioning of the health system as they did for estimating the status of the population's health, they would have concluded that some people were sick, that something should be done to alleviate this, and no more!

This marked difference between the approaches taken to health needs as opposed to health system functioning reflects the state of the methodological art in the two areas. Cumulative advances in epidemiology and demography have led to convergence upon a set of methodological principles and a widely shared vocabulary. These enabled the researchers to convey principles economically and precisely. By contrast, the study of organizations has not progressed to the same level of agreement in choice of methods. Even where there is faltering agreement (in the private sector's profit-oriented enterprise), the transferability to social services is suspect.

The heart of the problem may reside in uncertainty about appropriate outcome measures and, even where they can be agreed upon, the benchmarks that truly judge performance. Social programs do not suffer equally from these problems, however.

Of all the studies reviewed, assessments of family planning programs displayed the most rigorous methodology. Direct evaluation of these programs is

facilitated because activities (promotion and service) may be evaluated against program results (extent of population practicing contraception) which, over the course of time, may be tested against impact (declining birth rate, reduced birth complications, and so on). The quantifiability of these indicators and the high likelihood of their causal relationship is fairly unique to population studies, in contrast to studies of health systems.

What criteria did the researchers who prepared these studies select to assess program effectiveness? First, most health sector investigators attempted to collect impact data (administrative statistics and records, for example). They invariably accompanied presentation of these data with disclaimers about accuracy. Most studies then turned to issues of program performance. A typical analysis began with a review of resources or inputs (physicians or hospitals, for example), then tackled problems of performance appraisal by looking at outcomes. Sensitive to the futility of assessing performance by activities, most authors did not present activity data (the plausible exceptions being length of hospital stay and number of births in health institutions), but rather chose to analyze formal systems. Such an examination included individuals manning the system, timeliness of data within the system, coverage, inclusiveness, and so forth. Because the attributes of a well-designed and implemented control, personnel, logistics, or budgeting system are fairly well known, they can be easily evaluated. Such an approach led, predictably enough, to recommendations in fourteen studies for funding of "system development", areas where the system fell short of optimal design.

In developing a suitable assessment methodology, however, the researcher must be cautioned against equating

the degree of a system's development with management performance. Two seemingly unimpeachable assumptions made in a systems review approach--that the name of the system (accounting, personnel, and so on) denotes its true function, and that functions can be accomplished only by the system so designated--may seriously undermine a health-sector assessment.

That successful organizations may exhibit internal chaos is a phenomenon not peculiar to the developing world. There are many exceptions to the maxim that orderliness is conducive to effectiveness; in fact, the humorist Parkinson has proposed that well-ordered formal systems are concomitants of stagnation and decline.

That bad systems bespeak bad performance was not supported in the majority of the studies reviewed. Six studies, however, did look for concrete evidence of the connection between administrative functioning and performance. For example, one study examined supply logistics by checking a sampling of service units for their adequacy of materials. Another examined the payroll system; interviewees responded that their checks arrived erratically and usually late. A third looked at budgetary controls and determined when budgeted funds would be depleted.

Two final points need to be made about the methodologies favored in these forty-seven assessment studies. With few exceptions, the data collected on management performance are impressionistic. This deficiency leads to vague, nonspecific findings. In addition, the object of investigation is most often the system and not the system's performance. As a result, problems between systems may be underreported and informal systems may remain undetected.

Study Findings and Recommendations

The assessment methodology employed can bias the results in any study. Trained observers may vary in what they sense, perceive, and record. For example, one frequently employed contractor found the planning function in a shambles wherever visits were made and put reform of that function at the top of a list for change. Other contractors showed less willingness to accept this judgment. The dominant finding in twenty-nine of the reports surveyed was a problem or problems in the central office. Among all the reports, the most frequently cited problem was inadequate information systems followed by general lack of administrative competence. The most popular intervention recommended was administrative systems development.

Often, the logic of an assessment may have induced the author to identify certain management problems before others. For example, most researchers would attempt to economize their own efforts by seeking out extant information. Frustrations with the quality and inclusiveness of the data generated by the programs may account for the fact that inadequate information systems were the management problem cited most often.

Results From an Individual Perspective: Studies focusing on individuals encompassed four management positions: policymakers and top, middle, and lower management. Eleven problems were attributed to policymakers, for example, lack of strategy, unclear policy, and absence of formal coordination with other institutions. Twenty-one problems were linked with top program management, eleven with middle management, and two with delivery unit or lower management.

Notably absent in these studies is a clear correspondence between findings and recommendations, as had been found in organizationally focused studies. Only

two recommendations suggested intervention at the policy-making level (where eleven problems had been identified) and two more proposed action at the middle-management level (where twenty-one problems had emerged). Does this mean that the authors of the assessments believe these groups to be capable of solving their own problems, once they were identified?

In contrast, thirteen interventions (largely training) were suggested for the eleven problems uncovered at the middle-management level, and two for the two problems identified in the management of delivery units. This unevenness is interesting, particularly when the authors of six studies lamented the assigning of top positions to individuals whose formal training was exclusively medical (and probably oriented to curative services) yet did not propose managerial training as an alternative in five of those six reports. Perhaps the authors were being tactful, or did not perceive an appropriate response to this problem. Perhaps, too, they held that top management cannot be taught how to manage whereas the technical skills requisite for middle- and lower-level managers are teachable.

Results From an Organizational Perspective:

Organizational studies dealt with three administrative levels: central offices, regional programs (though not all programs followed a regional structure), and local service delivery units. Twenty-nine studies identified administrative problems in central offices, five found defects at the regional level, and seven identified problems at the local level. Recommendations for solutions were in rough proportion to the problems found: sixteen recommendations for implementation at the central level, five in regional offices, and two directed at delivery-unit management.

Roadblocks to Assessment: Frequently, there was no

correspondence between the identification of problems and subsequent recommendations within a study. Some studies made few, if any, recommendations. Others dedicated themselves exclusively to that task. Neither approach was necessarily inappropriate given the nature and purposes of a study.

Table 4-1 demonstrates the failure of many studies to correlate problems and recommendations. For example, although sixteen studies pointed to problems with supplies, only four made recommendations for change. Thirteen stud-

TABLE 4-1

CORRELATION BETWEEN STATEMENTS OF PROBLEMS AND
RECOMMENDATIONS IN COMMUNITY-WIDE AND NATIONAL HEALTH
MANAGEMENT ASSESSMENTS

<u>Issue</u>	<u>Problem</u>	<u>Recommendation</u>
Institutional Policy	4	3
Planning	13	15
Coordination	9	0
Supply	16	4
Supervision	10	5
Financial Administration	15	9
Information Systems	22	17
Management Style	3	1
Organizational Structure	10	10
Personnel Administration	10	7
General Competence	20	6

ies identified problems in planning activities, and fifteen suggested solutions for their improvement! The authors in two of the studies simply failed to identify the problem clearly.

The comments on organizational structure are also interesting. Six studies cited overcentralization as a problem (only one addressed the administrative capability of field offices should decentralization occur), six complained of fragmentation, and seven studies proposed further differentiation of the central office's organizational structure. Either a variety of opinions or highly variable circumstances exists in this area, or both.

The picture emergent from Table 4-1 is consistent with the theory of management development which proceeds from the top down to lower management levels. One must improve planning--and its supporting data collection activities --and strengthen the key administrative functions of personnel, supply, and finance. The whole organization will benefit from improvements in many structural levels, and some of those levels may profit from more enlightened supervision.

Utility of the Studies

The utility of the assessment studies presented in this chapter lend themselves to four criteria:

- o The recommendations for change must be specific and capable of translation into action.
- o The recommendations for change must be implementable through modes normally available to managers.
- o The assessment process itself should stimulate managerial capacity for self-evaluation.
- o The assessment should help managers focus on issues of key relevance to their programs or institutions.

Further discussion of an assessment's usefulness requires knowledge about what purpose the audience(s) had

for commissioning a given study. The underlying purposes could not be readily deduced from this collection of documents. At most, three audiences could be identified-- program officials, donor agencies, and students of international health problems. The assessments prepared for program officials and donor agencies give some clues about motivations for the design of the assessments themselves.

Program Officials and Purposes: Program managers appear open to constructive criticism and seriously interested in improving performance. Many may deny openness, and in the absence of this character trait, independent assessments and direct assistance are likely to be unproductive. Assessments will fail, too, if any of the following purposes prevail:

- o To eye-wash by accentuating the positive,
- o To white-wash by ignoring the negative,
- o To posture by pretending to undertake research in a spirit of open scientific inquiry,
- o To stall by buying time until the problem has solved itself.

If program officials were to turn to the forty-seven studies cited in this chapter, would they find the recommendations sufficiently specific to be translated into action? Of forty-one assessments considered, recommendations were judged not sufficiently specific in twenty-three; they were believed specific in fifteen instances (the question did not apply to three studies).

Apart from specific recommendations, if an assessment clearly and specifically lists a program's problems, it may assist program officials in developing their own corrective actions. In fact, such nondirective assistance may even be superior to specific recommendations.

In responding to recommendations, the program official can exercise three options for corrective action. The first is via existing control mechanisms: Supervisors may be dispatched or system function can be streamlined, for

example. The second option is to reallocate existing resources; reallocation often increases tension and resistance within an organization but is, at least nominally, within the purview of top management. The third option, often exercised when reallocation of resources is so extensive that it cannot be accomplished under present policies, involves shifts in planning.

For the most part, these studies tended to favor problems that could be solved best in the future. Seven studies cited problems that could be corrected through normal control mechanisms. Ten elucidated problems that might be surmounted by an immediate reallocation of resources. Seventeen identified problems that would have to be addressed by revised planning. Ten studies mentioned problems that had multiple solutions. Finally, there were two categories of problems involving non-implementable feedback. The first category of problems was stated in such vague terms that follow-up action by program officials seemed unlikely. A second category of management problems required only additional resources for resolution, however, these resources might be unavailable.

Program officials may find studies useful if they identify problems of such key importance that their resolution is given priority. Importance may have been implied by the researchers; however, nineteen studies do not mention explicit priorities. Eight studies cited problems that merited top priority because the troubled function was of central importance.

A hallmark of good management is the ability to identify problems and to undertake constructive assessments. Unfortunately, twenty-eight studies do not lend themselves to replication by program officials. Prepared by experienced observers, these studies are closer to an art form than a systematic procedure. Ten studies appeared to employ methods which other qualified individ-

uals might successfully utilize. Three studies used methods which could be adopted easily by host program personnel. One study contained methods usable by qualified individuals and program officials.

Another goal of the assessment process is its acceptance in normal managerial activities. Ten studies involved host program personnel in both the design and execution phases. Staff were involved only in the execution of the research in five studies, and in two, the model for assessment simply was described to the hosts. In twenty studies, evidence suggests that program personnel were only passive subjects of the assessment.

In the majority of studies reviewed, improving managerial capacity through self-assessment was not a highly desired goal of the assessment process.

Donor Agencies and Purposes: If program officials are not especially well served by these studies, the studies' sponsors fared somewhat better. A guiding, if not primary, purpose of the studies was to aid international funders (in most cases, AID) in framing appropriate support and interventions for evaluated programs. As these studies were not specific proposals for action, the recommendations were necessarily general. In the thirty-five studies where it was possible to identify interventions, thirteen recommended support of administrative training activities; fourteen cited a need for systems development; and eight called for funding of additional studies. Twenty-four of the assessments identified program needs to which funders could respond, and seven made comment on funders' policies. In all cases, the benefits of sound assessment methods and findings are desired by both donor agencies and program officials.

Third-party descriptions of a program can also be beneficial to donors and program managers. An independent perspective can help managers clarify some inter-

relationships or view their own efforts in a different light. Donors can benefit to the extent that they can facilitate understanding of the dynamics of a health program, the selection of appropriate interventions, and the provision of timely assistance. Twenty-three studies described program objectives; twenty-four discussed the internal structure of programs; and fifteen described the nature of relations among various health services delivery agencies. Fourteen provided some detail on program activities down to the operational level. This feature --information on program goals and structure--may be the consistently strongest aspect of these studies.

The following synopsis of a study advocating specific managerial action may illustrate a methodology that signals many of the problems as well as the potential benefits of community-wide and national-scale assessments.

In 1977, the Economic and Social Commission for Asia and the Pacific (ESCAP) studied the organizational determinants of program effectiveness (see Appendix A, Section 3, Abstract C11). This study, conducted by four national family planning programs (in Korea, Singapore, Philippines, and Malaysia) sought to measure the effectiveness of their programs and to seek the environmental and organizational correlates of program success. This task is admittedly easier for family planning than general health programs. The methodology is described in sufficient detail, and the study itself follows more rigorous social science methodology and greater precision than most of the other studies reviewed in this chapter.

Nevertheless, two problems became apparent in the statistical analysis used. First, the evidence for most findings was supported only with simple bi-variate correlations. Because of the discouraging tendency of social phenomena toward collinearity, more powerful analytical

methods, such as partial or step-wise regression, may have led to findings with more meaningful statistical correlations. Secondly, statistically significant findings were presented in the body of the text for each country and it was difficult to ascertain whether these findings were representative of general trends or flukes. Flukes they may be, for when tabular data were presented for three areas of the research (logistics, organizational climate, and staff attitudes), only twenty-two percent of the hypothesized relationships achieved statistical significance (with $p=.05$ or less).

As a result, selection of questionable output measures and naive application of statistical methods limited the utility of otherwise excellent research. Furthermore, the explanatory power of social science data, chronically low, may not encourage program administrators to make radical changes on the basis of such studies. A pragmatic official would probably be unimpressed that leadership style accounts for one percent of the variance in clinic productivity. In fact, the official may grow uneasy when he or she finds in the same report that contraceptive shortages, low salaries, and delays in delivering equipment and pay-checks are all associated (significantly and positively) with improved performance!

Does this argue for a retreat to impressionistic description? Although the descriptive aspects of the study are excellent and should prove useful in calling program officials' attention to stock depletions, delays, understaffing, and so on, the analytical work should not be ignored. Consistency among some of the findings regarding urban-rural differences suggest various administrative treatments that many program managers may find intuitively attractive and reasonable to implement.

An identifiable strength of this study was abundant, useful management information either directly presented or

implied. As examples, cost effectiveness indices were computed for every clinic; breakdowns in supply were identified; utilization of space was documented; and attitudes of clinic staff toward the work and administration of the program were collected. These indicators, and others not cited here, are in themselves fairly unique in program evaluation. While the great majority of the studies reviewed have made vague references to these tasks, rarely did they make clear that hard data were obtained. Thus, the ESCAP study provides an instructive model.

A second strength of this particular study was the degree and nature of involvement of host-country officials and personnel. In three countries a Study Advisory Council (SAC) was created; its membership was drawn from section chiefs in programs and agencies related to family planning. The SAC served to direct the design and implementation of each study and to review study results. Academic researchers and a Family Planning Program Director served as study directors and as Executive Secretary of the SAC. This mix of personnel is a departure from that employed in the health-sector assessments where the national assessment team was formed with an eye to preserving the autonomy of the team. Further, the ESCAP study should allay fears that if the evaluation is not autonomous, the health-sector assessment will be a "white-wash". The Westinghouse Health Systems critique (1978) stated that autonomy was obtained at the price of decreased institutional support to achieve and sustain changes. Unfortunately, there are no data to indicate that greater involvement of the host institution in the ESCAP study led to a higher rate of adoption of recommendations. There is, however, evidence that host-program supervision of this assessment did not thwart analysis of sensitive areas or impede publication of

critical findings that implicitly found fault with management.

Conclusions

Community-wide and national-level assessments reviewed in this chapter can be classified into four methodological groups--desk studies, field studies performed by outside consultants, field studies requiring collaboration between outside experts and program personnel, and studies oriented to specific managerial action. The majority of the studies viewed the health sector from the top down. The assessments were often done in stringent time frames by North American experts who used few formal survey methods and tended to collect impact data focused on formal health systems. This methodology has resulted in authors' recommendations, which, although relevant, are difficult to implement because of their vagueness. A typical recommendation is to "develop the health system" or increase human and financial resources. Often an evaluation of a formal system will overlook or underreport intersystem problems.

In terms of their usefulness, the studies were less beneficial to program officials than to donor agencies. Managerial capacity can hardly grow when offered non-specific recommendations or faced with vaguely identified problems. The studies also failed to provide program officials with replicable methods, and they allowed only low levels of program staff participation. In contrast, they clearly identified program needs that donors could respond to and they presented detailed descriptions of program objectives, structures, and interrelationships.

CHAPTER FIVE

ORGANIZATIONAL AND ADMINISTRATIVE PROBLEMS AND SOLUTIONS

In the process of testing and applying managerial assessment methods in the health field, certain problems have occurred that pinpoint areas of concern for the investigator and the subject. Some general problems were identified during the course of this survey and these could transpire at any stage of work. One of these is the motivation for seeking an assessment. The investigator should be aware of what has triggered the desire to appraise a program because motivations will influence that person's judgment about the proper type of assessment. In many of the developing country studies, the Ministry of Health requested evaluation assistance, and the task was therefore to ascertain the Ministry's interests and objectives. However, if a foreign source of financial support triggers the assessment of a health program, then only managerial assessment tools relevant to financial analysis may be employed, perhaps with emphasis on the more favorable aspects of the program. In cases where the Ministry of Health proposes to use assessment results as part of its next five-year plan, a much broader approach encompassing financial, institutional, human resources, and other types of analyses is required. A future orientation would be proper here.

Depending on the political, organizational, and environmental climate of a country, true motivations for a health assessment may not be readily or clearly expressed. People may feel threatened by the unknown

aspects of an assessment. Managers may fear that an assessment will expose sensitive information. They may think that the assessment represents outside regulation or interference. An assessment may create an atmosphere of uncertainty. Doubts may grow as managers face undefined outcomes. How can assessments be designed to avoid threatening individuals and the organization as a whole? How can a high degree of uncertainty be dealt with?

Feelings of being threatened will grow in an atmosphere of poor communication or where information is deliberately withheld. Use of unobtrusive approaches and inclusion of program staff in all stages of work may help reduce anxiety. Opponents also attack assessments because they foster a high degree of uncertainty and this uncertainty may outweigh the net benefits (Imboden, 1978). There are ways to cope with uncertainty. Known or anticipated obstacles should be acknowledged frankly, realistic time frames should be established, and analysis and information gathering should be thorough. Caiden and Wildavsky (1974) suggest conversion of obstacles into opportunities whenever possible. Investigators and subjects need to work at developing positive attitudes toward constraints which inevitably come with assessments.

Definition of Goals and Scope

One of the first tasks confronting an investigator is the need to define health services goals. Goals are often good indicators of problem areas; goals and objectives are set to meet specific problems and needs. The investigator's problem is identification of salient goals given the often conflicting and changeable aims and desires of interest groups (management and others). Thoroughness is the key here. Efforts must be made to confer with the most knowledgeable and widest range of sources. Problems arise from attempts to exhaust all prime sources

of information, especially in a national study in a limited period of time. A related difficulty is in identifying sources who represent a true picture of the health system. The possibility of learning only about goals relevant to top management is real. How can the investigator ascertain what goals are really representative of health needs? Even though evaluators may lack the time or resources to meet with other than Ministry-level or executive-level managers, an effort should be made to confer with a liberal member of the organization being assessed or a clergy member who, representing a wider constituency, can articulate a sense of the goals and objectives of the total health sector.

Another task facing the investigator is the definition of the study's scope. For example, should the assessment focus on a narrow area such as management evaluation or should it assume a broad approach like program or sector evaluation? Determining scope largely depends on the purpose of the assessment. The current trend is to try to account for impacts on and relations between various sectors of a health system; this is known as multisector planning.

The evaluator also must decide the appropriate level of health services staff participation. How the mix of participants can be controlled depends on the assessment's objectives and the organizational climate. Consideration should be given to:

- o Organizational affiliation of potential participants,
- o Credentials,
- o Interest,
- o Stature.

These areas are fairly self-explanatory except stature, that importance of position which may ensure continuity of personnel, if it is a desired goal. Stature implies

leadership ability, leadership to effectively guide the project through to completion. The evaluator will recognize a good mix of participants by traits of working well together and complementing each other's interests and capabilities.

How much money to spend is another question to be answered during the planning stage of an assessment. Assessments that become a financial burden will lose support. Both parties to an assessment, investigators and subjects, play a role in ensuring that needed finances will be available. The investigator should not plan an overly ambitious procedure, and should use cost-estimating methods that produce accurate estimates. The assessment sponsor must be sure that the required resources are available before the proposal is accepted.

Collection and Analyses of Data

As data were collected and analyzed, some problems appeared fairly frequently in the assessments of managerial capacity, particularly at the organizational/administrative levels. Judgments must be made about matching complex data collection to analysis needs. Understanding the purposes of the analysis is paramount. Too often, assessment activities have resulted in massive accumulations of information that no one knew how to handle after it was assembled. There must be a clear relationship between the goals of the project and complexity of data required to reflect those goals. As part of the planning stages, the assessment team may investigate the types of data accessible and the organization's willingness to provide various kinds of information. If the assessment team must proceed with data sources that are somewhat unreliable, then they must construct measures to compensate for such weak reporting.

Identification and Preparation of Findings

Two tasks at the conclusion of an assessment project are to identify and prepare findings. Problems related to these tasks include how to avoid threatening people, how to keep the study practical, and how to spot a management opportunity when it presents itself.

Findings often touch on sensitive areas. Can they be presented in a nonthreatening manner? Emphasis on the learning experience of the assessment can serve to decrease anxiety. The process and the final product of the assessment should show clear benefit to all. Whether findings and recommendations are presented in writing or during a group event, they should never assign individual blame.

The degree to which findings and recommendations are practical is also relevant to this stage of assessment. How can they be translated into local action? Clear, concise statements of problem areas and concrete recommendations would be a step in the right direction. Remedies and options should be defined in light of the resources (human and economic) that are at management disposal. Findings and particularly recommendations should also be proposed with knowledge of the political ramifications that may result. Ugalde and Emrey (1979) state that because bureaucratic processes are not understood well enough to ensure that evaluation outcomes will be implemented, knowledge of bureaucratic decision making is a requirement for engaging in the assessment process.

At the conclusion of an assessment and at any stage of the process, one task above all others will test the imagination and insight of the assessment team. Among myriad threads of relevant and extraneous data, how does one recognize a management improvement opportunity and how does one present it in such a way that it will be perceived as an improvement opportunity by the individual

manager, institution, or nation? Indeed, the challenge of improving managerial performance in the health system can only be realized if the assessment becomes a shared experience for all parties involved.

CHAPTER SIX

CONCLUSIONS

New methods for assessing health services management are being developed and applied in a few countries of the world. When problems hampered these evaluation studies, solutions were sometimes discovered and often they led to the rethinking of assessment methods. Feedback is an important follow-up to implemented recommendations, and more and more studies are demonstrating the value of such communication. Response from users in developing countries indicates that there is a continuing and increasing interest in the practice of assessment in a health services milieu. In fact, much of the current work has resulted from the expressed interest of developing country managers in employing valid assessment tools.

The outlook is optimistic. Today, the general field of management can be discussed, taught, and even assessed! Along with this acceptance of management as an identifiable and professional field of endeavor, is the belief that management can and should be evaluated. Evaluation can serve as a tool to improve management practice and it can strengthen health systems analysis. A carefully developed assessment methodology is a practical aid to refining managerial performance.

Patterns

Certain categories of assessment methods have been noted in this report. One point is readily made at the start: Managerial assessment methods vary greatly and

many of the studies selected for this report display a high degree of innovation.

Two types of assessment instruments were found; those that promoted use of relatively fixed, systematic assessment steps, and were called "cookbooks"; and those that proposed general methods or presented ways of choosing appropriate methods, called "guidelines". Cookbook studies were most frequent in Western countries where a relatively standard approach to accomplishing managerial tasks has been developed and where a certain degree of predictability exists in the health system. In contrast, guideline studies were commonly developed by investigators who were aware of the more variable, less fixed environments within which health services management works in developing countries. Such methods are welcome innovations because they promote generic approaches that are defined in terms of and adapted to local situations, or they present more fixed approaches giving direction as to appropriate situational use (with final choice of method left to whoever initiated the study).

An example of the cookbook approach is the American Hospital Association's Program for Institutional Effectiveness Review (PIER) (Medicus Systems Corporation, 1978a,b) which uses a questionnaire format to survey several management areas. This instrument is designed to be useful to hospitals throughout the United States. It is especially appropriate in this context because the health care system of the country has certain rules, regulations, practices, and some certainty about the future not found in developing countries where changes and innovations make predictions more difficult. While the audit questionnaire could be used in developing countries, its results would be much different from results expected in the United States.

Reynolds' (1970a, 1970b) family planning evaluation

work in Latin America illustrates the flexibility of the guidelines approach. He has developed a series of steps to be taken when selecting and designing an evaluation procedure. The steps take into account the need for selecting an assessment method that is appropriate to program needs. For example, a complex computerized statistical analysis of patient utilization rates is not required or even possible where data collection methods are poor.

Basically, there are two schools of thought use two different approaches to general management assessment. One uses tools such as cookbook questionnaires and an investigative team launches a systematic attack to identify management problems. The second school of thought favors problem solving from within, especially in developing countries, where management personnel are taught problem-solving techniques that can be used to identify and solve their own managerial problems. Which method is most advantageous depends on the environment within which one is working. Self-assessment methods are coming into favor even though their use to date has been limited. These methods help decrease the tendency of some users to view assessments on a continuum from bothersome to threatening. A self-assessment method avoids the intrusion of an outsider and also may convince management that assessment is indeed a managerial responsibility and that it should be part of the whole cycle of management activities.

This report has presented assessment from three dominant perspectives--the individual, the program or institution, and the community or nation. There were few studies to be surveyed at the individual level of assessment. A possible explanation is that in the past, program assessments were preferred because programs were the units funded by donor agencies. Now, although donors

and program staff are still concerned about program evaluation, they realize that managerial capacity is an important ingredient in a program's success. Today, too, the functioning of a country's entire health system is of interest and studies dealing with this complex subject are aided if authors have a good grasp of organizational behavior theories.

Impacts

We have seen in this selective review of new assessment methods that attempts can and have been made in a variety of settings, institutions, hierarchies, levels, and so on, to assess health services management. Many of the attempts have proved beneficial and the experience gained in some instances points to areas in need of further attention. One of the main benefits has been the recent push to develop systematic means of identifying management strengths and weaknesses. Diagnosis of management problems can contribute to better delivery of health care and ultimately affect the improvement of health status. Other benefits identified were training in use of methods and determination of funding opportunities.

Emphasis should be placed on encouraging information exchange. The authors of this report found many instances where assessments were being designed and used in a vacuum with little input or sharing in the learnings of other experienced in this field. Information exchange would increase opportunities for sharing knowledge and contribute to development of a common assessment terminology.

Encouragement should also be directed to the use of management diagnosis methods which can be adapted to needs of the particular user. Participation of users throughout assessment activities has not typically been part of the process and should also be encouraged as a means of

training users and as an important attribute of a self-assessment procedure. Self-assessment methods are among the more recent innovations and represent a means for developing country managers to begin to assume responsibility for their own assessment and decrease dependence on external evaluators.

Future

What will future models of health management assessments include? Those that combine management technology and problem-solving approaches will be excellent for developing countries because they can be adapted (through problem-solving techniques) to local situations. In addition, those models featuring self-assessment methods will grow in popularity because they permit less dependence on external, consultant aid. Such appropriate management technologies will reinforce the individual manager's role in the evaluation of program and institutional performance.

The possible benefits from these futuristic models should be significant. Management capacity and effectiveness will be increased. The individual manager will be able to diagnose managerial problems, and with this increased responsibility and control, will be able to respond better to external and internal demands. For these models to be fully developed, however, social and behavioral scientists interested in them will need encouragement from within their organizations to work for the improvement of specific managerial assessment methods. Now and in the future, those who are committed to developing suitable models for management assessment studies need to clearly and carefully document their work and ensure that its quality is measurable in terms of substantive recommendations flowing from thorough, systematically assembled findings.

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