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The offer of medical services depends on medical personnel and more than this, on the management in the medical field since any resource not managed well or not managed at all is only a lost one, regardless its value. Management is therefore the key, the “how to” method of obtaining the desired result. The same approach can be applied into our study in order to reach more productive medical services which to prove high quality to all patients. We need to use and to squeeze the entire force of management tools in order to reach our goal: accessible high qualitative medical services.

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First of all, every organization and therefore also a medical one needs a strategy. Moreover, this has to have a quality part. A regional or national hospital quality strategy is a long-term one, namely a program to increase patient and personnel safety and improve hospital quality. There can be specific strategies in each hospital and strategies to improve quality in many hospitals. A quality strategy differs from a quality tool in being an overall approach an organization takes over a period of time, rather than a specific method for a particular purpose. Thus, a program for external inspection of hospitals is a strategy. A particular method for carrying out inspections is referred to by quality specialists as a tool. It is possible to pilot-test a tool, but not a strategy. Benchmarking is both a tool and a strategy. WHO (World Health Organization) will even develop a separate policy synthesis of research into quality tools.

The power of medical management resides in setting a direction for the entire medical organization by having a consistent strategy, ensuring adherence from personnel side and permanently improving the way their functions are executed.

Generally speaking, the types of strategies encountered during analyzing specialized literature are as following:

- Total quality management and continuous quality improvement: Total quality management is a set of principles and methods applied in many different ways, originating from organization-wide industrial quality programs. This strategy focuses on attention of personnel and on providing the best patient experience and outcomes. Quality tools are used by multidisciplinary teams of workers to make changes, and the approach is generally thought to require strong management leadership. It is based on a view that quality problems are more often due to poor organization than to individual faults. Continuous quality improvement is the same as Total quality management in most literature, although it sometimes refers to a concentration on multidisciplinary project teams analyzing work processes and using repeated cycles of testing small changes.
- Re-engineering: uses some of the Total Quality Management methods, but includes a more radical redesign of “production processes” which normally involves small-scale and incrementally tested changes.
- Increasing resources: increasing the financing, personnel, facilities or equipment used in a medical organization with the aim of treating more patients or treating the same number faster, better and at lower cost-per-person;
- Large-scale reorganization or financial reform: changing the structure of a hospital or health system so as to facilitate better decision-making or use of resources. Changes in financing methods are made as a way of improving quality;

- Strengthening management: improving quality by increasing management responsibilities, authority or competencies. It is sometimes used as part of other types of strategy. It is useful and can be applied only for medical units managed by professional managers in order to be possible to put more charge and work on them. In cases when manager of the medical organization is a physician as well things are more difficult since the person is overloaded from the very beginning;

- Benchmarking: uses comparative information about quality with additional methods to help providers decide how to improve quality. There are specific methods for identifying, documenting and applying the best practices.

As we can see, more strategies have quality as focus. This is normal and is also a general tendency since competitiveness is higher and higher in medical field also, private medical services having an ascendant trend.

Regarding which strategy is best among the upper described ones, given the lack of evidence it is still considerable discussion about which strategies are or could be effective. One debate concerns “generic” versus “specific” strategies: would more resources carefully allocated do more to raise quality than a specific quality strategy? Many professionals think that increasing personnel, equipment and training is the best strategy. Quality adepts believe that “doing more of the same” can sometimes harm clients which in our case mean patients. They also think that applying quality methods systematically within a strategy is more cost-effective on the long run. This is the most fundamental debate in the field. The debate is especially acute in developing countries, where there is similarly poor and conflicting evidence of the results of different approaches. It is increasingly recognized that quality strategies in these countries supported by donors have not been sustained, exactly the way it happened some time ago into the high-income countries. There is debate about program costs and possible savings or benefits, but no research into the economics of different strategies.

There are more arguments for and against “police, punish and reward” approaches, and “inspire and develop” approaches. Many governments use both, causing problems for the agencies facing both ways: to apply sanctions and at the same time to encourage open sharing of quality performance information. Related to this is the issue of publicizing quality performance data. Critics argue that the data are misleading, easily misinterpreted and subject to falsification by providers and that internal, anonymous distribution are more likely to be effective with professionals. Others argue that public release of data will improve the quality, and that researchers and the state have no right to withhold data about poor quality that the public needs to protect itself and make informed choices.

But is it appropriate to apply “industrial” quality strategies to health care? It is well known that medical services represent a special “field”, a sensitive and not very flexible one. Once the acceptance of the methods in healthcare grew, the problem now became how the industrial methods are best translated or adapted for this particular environment. Quality experts think that a strategy has to be tailored to specific circumstances, and debate about the point where adaptation loses the “active ingredient” and results in reduced effectiveness.

Therefore, all medical organizations managers should choose the best fitting strategy and obey to it. This means having plans, programs and actions driven into the strategy’s direction. Everything should be done according to it in order to achieve the proposed goal.

In order to achieve the objectives of the strategy, managers of medical organization should keep an eye on performance and strategy adhesion from personnel side.

In recent years, performance monitoring has gained increasing attention as a tool for evaluating the delivery of personal health care services and for examining population-based activities addressing the health of the public. This attention to performance monitoring is related to several factors such as: concerns about ensuring the efficient and effective use of health care funds in providing high-quality care and achieving the best possible health outcomes. Also contributing are a wider recognition that the health of the population depends on many factors beyond medical

care and heightened concern about accountability for use of resources and whether desired results have been achieved.

Performance monitoring means a continuously community-based process of selecting indicators that can be used to measure the process and outcomes of a strategy formulated in order to improve the health of patients by collecting and analyzing data on those indicators, and making the results available to the entire community and especially to those segments of the community engaged in health improvement activities. Performance monitoring should promote health improvement in a context of shared responsibility and accountability for achieving desired outcomes. Many parties within a community share responsibility for health (e.g., consumers, health care providers, businesses, government agencies, public service groups); those with responsibility for accomplishing specific tasks are accountable to the community for their performance

All strategies often include risk management and a wide range of methods from other industries for collecting and analyzing adverse event or near miss reports with a view to prevention.

In all cases management is the key factor that should ensure that every employee follows the strategy settled, the plans and programs established. Medical personnel and administrative one working into medical organizations should be trained regarding the quality methods and the corresponding attitude needed. This attitude should be a real one and not a “theater”, a “role playing” one. In this field real quality and positive attitude matters more than can be expressed and counted in words. Management should do everything needed to also stimulate employees in order to accept change at individual, team, organization and systems levels simultaneously, and point out the need for personnel to feel that they, too, as well as patients, benefit from improvements.

Every manager, be it in a public or a private medical unit should continuously seek for best examples in its field and take the parts that can be “borrowed” and match his/her specific context. An ambitious health strategy is that of the United Kingdom National Health System. Since 1998, this has involved generic strategies of restructuring and extra resources. Specific strategies include national guidelines and standards for clinical care, national inspection and public quality performance reporting, a law giving all medical organizations a “legal duty of quality” and requiring them to implement a quality improvement strategy, clinical governance quality management systems, and a national system for reporting and analyzing difficult events. No evidence of results or costs is reported and no research to gather such evidence is planned. Nearly all medical organizations in the United Kingdom have educational programs, local guidelines, improvement groups, and peer assessment methods, most of them using feedback of performance data.

Knowing that health encompasses physical and psychosocial well-being and not simply the absence of disease, management of medical units should know that their task is not an easy one. Because many factors influence health and well-being, understanding the nature and scope of these determining factors is an essential element in developing health improvement strategies and in determining what indicators may be appropriate elements of a performance monitoring effort. The workshop's opening presentation used the framework of the Health Field Model for examining the determinants of health

Quality means rapid access of the patients to the physician, corresponding consultation, proper treatment/intervention, post-treatment/intervention consultation, follow-up medication or diet, investigation on the problem among other family members if it is the case and other similar aspects that patients consider to be very very important. It's all about life after all!

In these conditions management should be all eyes and ears to every move and every action of the personnel. Not from authoritarian reasons but to have a basis for continuous improvement. After setting a direction by having a solid strategy, corresponding plans and programs management should assure that every employee knows this information and acts accordingly. Quality should be a key word in this area not only because it's a word that should characterize the

entire medical services field but because this is also what the managers would need if they would be patients. The same high quality of medical services would need the medical personnel if they were patients. Quality should be assured by management by hiring the best personnel in the field, by investing in best medical devices on the market and have a continuous improvement approach. A big emphasis should managers put on preventive programs. Growing recognition of the importance of addressing social determinants of health is causing a reexamination of the current focus of public health in Western Europe, Canada, Australia, New Zealand as well as the United States. One major task that managers should address is on making sure that their medical organizations invest the same kind of intense resources into keeping people healthier or helping them return to a state of health and low vulnerability as they do to disease care and end of life care.

Quality means also cutting down waiting lists. This is the main desire of the patients but also of the medical personnel at the same time. Waiting lists are no good for anyone. Patients become nervous as delay time increases and physicians feel pressured since they are making consultations “on row”, the time is passing and the queue of patients seems endless.....Medical organization managers should ensure all necessary resources (medical stuff, administrative personnel, equipment, consumables, strong relations with stakeholders) and find a way to the best scheduling that can ensure diminishing of patients’ waiting lists. This can be done based on the patients’ files and on the market demand. Correlating number of patients and frequency of physician visiting with the number of medical personnel per specialties can bring managers in front of the optimum number of physicians needed for each unit. Ensuring consultation on basis of programming is another good thing that can bring more order and productivity for physicians plus patient satisfaction since waiting time will be close to zero. (appearing only when problems appear within some consults and time needed is longer than time scheduled).

Managers of medical institutions should do everything to prevent and minimize the adverse impact of the actual economic “hurricane” which could devastate the social sector, especially the health of people. Worldwide there have already been unhappy cases of suicide because of loss of job determined by the actual economic crisis. Therefore it is very timely that we explore the ways and means of ensuring that the health systems are protected to the greatest degree possible from the impact of this difficult period.

Before the current crisis, many low- and middle-income countries were roughly affected by increases in food and fuel costs, others prospered during the boom in commodity and oil prices. With a fall in demand, prices have fallen, to the advantage of net importers but at the same time to the detriment of those more dependent on export revenues.

In countries that have been affected by an economic recession, total expenditures for health decreased, but not consistently. Some governments have protected health spending or even increased it, but others have done the opposite. The management in this direction is therefore very important. What managers should take into account is that during a recession, private expenditure for medical services paid directly by patients usually tends to decline (in contrast to public spending), especially if same services are available at lower cost into the public system.

Reductions in total expenditure will have an impact on the structure of health expenditures. The tendency is for salaries to be maintained but for infrastructure and equipment to be financed from the savings category that will equal 0 for a period.

With more and more people working abroad, we can even take into discussion the money sent back into the origin country and spent on medical services. Still, how much is spent on health is uncertain, although one survey from Mexico reported that 57% of remitters said that covering health expenses was the primary purpose of the money sent home. In these conditions, a decline in remittance income may not be reflected in levels of population health.

The economies of many low-income and middle-income countries have benefited from the rapid growth of export industries in areas such as ready-made garments, food, flowers and business processing. Since crisis makes the demand decline, job losses will have direct consequences on

family income and therefore inability to pay for health care. Many of the human consequences of recession are often not visible from the very beginning. In this idea, unemployment may erode women's growing economic independence, which will have its own health consequences. Similarly, coping strategies may exacerbate vulnerability (through, for example, increased exposure to HIV). Reduced spending has impacts on health and education, and ultimately on the well-being of families and the development of the community as a whole.

Decreasing health spending, increased costs of treatment and reduced family income and/or insurance coverage will affect use of health services and their quality. The first effect is the decrease of demand addressed to the private care with a consequent transfer of demand to the public sector. Furthermore, if public services are also compromised, they may not be adequately equipped to cope, and overall quality may decline. This problem will affect all countries in which publicly-funded services are under pressure. Changes in utilization rates – broadly following this pattern – were documented during the 1997–1998 Asian financial crisis. A decline in the use of services by the poor people into these countries was obvious.

The current food crisis in particular has been estimated as being responsible for pushing more than 100 million people back into poverty. This will have negative effects for health and nutritional status. Shortages of food and consequent malnutrition predispose individuals to disease and thus act in vicious concert with the economic recession.

The good part is that leaders in developed and developing countries as well as international financial institutions have made strong public, political commitments to health and development. Health is an intrinsic good and an investment to reduce poverty.

In this context, when revenues and income are decreasing, health should not be forgotten at all. Health is a privilege to which people have a fundamental right, as well as making a significant contribution to economic growth, poverty reduction, social development and human security.

Medical organizations' managers should keep a permanent eye on the crisis effects. They should monitor the changes in employment, housing and income (because this is the first cause of illness); changes in behavior relevant to health, including changes in the use of health services (including mental healthcare) and changes in the behaviors of health workers themselves (including patterns of migration); and changes within the health sector, including the cost and availability of treatments.

Managers should also act especially related to causes and not effects. For example, in case of primary health care organizations the focus should be on the reasons that obstruct accessibility, equity and solidarity. The high rate of maternal mortality is a result of many factors including poor access to care, failure to prevent unwanted pregnancy and women's low status in some societies. All these factors should be aimed by managers and can be exacerbated even in recession times.

Primary health care gives direction to work on health systems, reinforcing the idea of solidarity through progress towards the goal of universal coverage. This is very important since the increasing pressures on public services and the need for ways of reducing exclusion. Pooling risk and resources protects people from huge expenditure and it also facilitates greater allocative efficiency and thus more effective resource use. Primary health care highlights the importance of the social, economic and environmental determinants of health, such as the impact of housing, education, employment and nutrition policy; import duties that affect access to essential medicines and technologies; the restriction on the movement of peoples or goods to prevent the spread of epidemics and the major role that clean water, clean air and access to proper sanitation play in protecting health and prevention.

Managers should consider participative approach in decision making since if the public, civil society and parliaments are involved, decisions on how to make health spending more effective are more likely to be rational and accepted than if they are left to bureaucracies alone.

Managers of medical organizations should use all of their knowledge in order to improve the situation but at the same time to take into account the peculiarities of this field. Every step

towards improvement should be taken only after profound analysis of the information collected and correlated with the context. Physicians should do their best and the same should do managers. For sure that management has the power to change the medical organization into the desired better direction but very important is to have a consultative approach in order to be sure that physicians' opinions have been listened and the solution will have personnel commitment on a long run.

The power of managers of medical organizations is bigger than the one of the regular companies but also more difficult to handle since, more than the fact that is a field with emphasis on interpersonal skills as all services are, medical units are responsible for the lives and health of the patients received. Therefore, managers should act by setting a clear direction, ensuring personnel devotion to it, permanently find out patients' opinion about the services they received into the respective medical organization and steer it towards improvement regarding higher quality and productivity. On short: striving to offer better services.

Managers of medical organizations should be the first to think about methods that can prevent injuries related to people's health in these difficult times. They should find ways to turn threats into opportunities, managing in such a manner that makes possible for the medical personnel to offer high quality and productivity to the "customer King", the patient. All these can be done starting from designing a strategy and ensuring adhesion from personnel side to it, meanwhile permanently improving the way the functions are executed and objectives followed and reached.

Actual crisis situation should motivate medical organizations' managers to fight even more intense for finding solutions of keeping patients with problems addressing to the medical unit, encouraging preventive approach and the motivation of personnel for ensuring patients as healthier as possible. Management functions should be combined with adequate marketing plans, enhanced communication, public relations, benchmarking and open-mindset in order to be able to adapt and develop the medical organization to the challenges that appear and change everyday.

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