

INTERCULTURAL REPORT

**HEALTH NETWORKS ORGANISATION
AND
EVALUATION**

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CONTENTS

PART I. SIMILARITIES AND DIFFERENCES IN HEALTH NETWORKING.....	3
PART II. ROMANIAN CULTURE ON HEALTH NETWORKING AND EVALUATION.....	7
PART III “EVALUATION IS NOT CULTURAL IN FRANCE?”	17
REFERENCES.....	25

PART I. SIMILARITIES AND DIFFERENCES IN HEALTH NETWORKING

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INTRODUCTION

Our topic studied at the DRSM, (Direction Régionale des Services Médicaux): “why is there a need for an external evaluation of health networks in Brittany? “ enabled us to go deeper into questions about meanings, definitions of health network firstly in a global context, and secondly in French and Romanian societies.

We examine common trends contributing to the health networks development from new mode of organisations they represented

Firstly, World Health Organisation (1998) define network as grouping of individuals, organizations and agencies organized on a non hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust; previously organized in single-handed practices, physicians now formed networks to provide continuous round-the-clock care to patients under the new reformed primary health care system.

Was this definition provided by the DRSM as a guideline to the work undertaken and therefore represented the official stance or one which the students themselves uncovered/utilised?

What are the novelties of health networks?

The complexity and the high period (*equals time required?*) of following up patients with chronic diseases make the approach difficult and not only the responsibility of only one entity; hence, is necessary a multidisciplinary approach by the implication, collaboration and coordination of many actors placed on the same hierarchical positions.

This new model of functioning for health organizations is not only based on the vertical hierarchical principles; Especially in the countries with a high level of health system’s decentralisation, the current trend is to give professionals more power and responsibilities in coordination on health care provision at local level.

Health networks represent new entities, new organisations and new high integrated organisation forms of all actors involved in a concept of partnership.

Partnerships are complex processes of building and maintaining a coalition of interest; that presume a participation process when two or more parties co-operate and work together so that resources can be used more economically, efficiently and effectively and the common interest is achieved.

What health networks would be the best?

There is no answer for this difficult question, in each country we met a particular type of networking depending on many aspects:

- How the association between professionals is seen?
- What are the needs of the population?
- What are the experiences and behaviours in matter of networking?

In European countries, the concept of health networks is increasing (*reference?*) due to several reasons. The main reason is connected to a trend of high level of decentralization and an empowerment of local initiatives in health sector. It was decided (*by whom?*) to build new innovator approaches and new organizations to enhance coordination of care in a multidisciplinary context. These models are different depending on countries and are embedded with several cultural patterns. They can be formal or informal, based on political or experimental decision, a reality or an ongoing process.

The development of health networks in France came through spontaneous aggregation of patient and health professional around specific public health issues (AIDS). In UK, the primary care model trust is a reality support by the health political policy. In Spain, well known for its high level of decentralization, networks have more informal characters. In Italy, there are local initiatives in some cities. In Romania health networks are not so well developed and local initiatives are very weak but there are many signs of future transformations from informal to formal local health networks.

In USA, networks development was due to private companies' initiatives and high level of competition; Health Maintenance Organizations such as Kaizer Permanente are very powerful in health care system.

Field of health network development in Romania and France

Although both countries have common roots regarding their Latin origins, differences in health care system are important. But do we assist to new trend? (*meaning?*)

On the way to decrease centralization and bureaucracy?

French health care system is complex to understand for a native person, and especially for foreigners. There are many political strata and walls between these layers. Consequently on one hand it's difficult to clarify who are the decision makers and on the other hand the administrative weights become important. As a result, people interviewed told us the weakness of regional power. It often appeared through the sentence "to have the decision, you have to go to Paris offices". The bureaucracy is the Achilles' heel of health care system enlightened by the complexity of role's definition for each institution.

For last years, Romania made important steps in decentralization of health system and this aspect comes to complete the general tendency of Romanian society. Even if all reforming phases were focused on this issue we can encounter yet many difficulties such as the current high level of bureaucracy. The Romanian health professionals which are very task oriented have to confront with many types of reporting for reimbursement and monitoring their work.

The decentralization process is going on and there is already a law project to abolish the District Public Health Directorates (their roles will be assumed by the municipalities).

On the way to a new conception of hierarchical position?

Because health care system is not able to answer to patients and professionals needs, there is a trend to set up new model of hierarchy between the actors.

In France vertical models still exist within institutions (local-regional-national level) and care providers actors (hospitals-primary care, general practitioners and specialists, physicians and nurses).

Traditional hierarchical model is kept although the decentralization level is not finalised in Romania. The Ministry of Health, main health authority, plans, coordinates and makes health policy being accompanied by national representative organisations such as National Health Insurance Funds, College of Physicians, and National Associations of Professionals. The same vertical model exists in France is also present in Romania.

Informal hierarchical positions remain even between different professions (see in Part II: general practitioner vs. surgeon, physician vs. nurse).

Network is a way to bypass this model, and to knock down the walls, to establish a more horizontal approach based on participation of all actors.

On the way to a working together culture?

We noticed during Europhamili session that the interactive approach was useful to confront values and judgements. French personal training educations are used to work in team and to give personal point of view in many situations.

It depends on the field of application, but working team in France exists even if some strong walls in healthcare system are real obstacles for the communication between actors.

The fact that Romanians have a tradition to relate each others based especially on hierarchical positions did not allow them to work jointly on the same positions; they don't have experiences and skills to work and to make partnerships.

From practical work (attending work meetings), we could remark the different approaches on participative manner of decision making process and significance given to patient's representative. Being focused on the criteria's achievement, public debate is rather formal in Romania whereas in France this debate has a more constructive role

On the way to a multidisciplinary culture?

In France, the current education of health professional points out the mono-disciplinary skills. We were told in our interviews that the concept of public health was far from the daily activity of clinician. Therefore the process of evaluation was more understandable for public epidemiologist speciality.

In Romania, the high specificity and specialisation of health professions play an important role in the professionals' behaviours to work in a multidisciplinary context. The physician is only trained by clinical methods (theoretical and practical) and not managerial skills. Hence, they often refer to their job as "My job" and do not accept their job to be overlapped with other disciplines. They remain reticent and do not understand the role and level of implication

of one multidisciplinary approach. This behaviour emerges from the existing of many subcultures of different specialisations.

On the way to increasing involvement of the patient?

The increasing care demanding from patient is a general trend in Europe. The general evolution of the society modifies relation between patient and doctor on to a more equal relation. Patient becomes better informed with more and more education, and thereby more and more requirements. Network could be a perfect ground to allow the patient to feel more involved in healthcare.

Before to improve the level of Romanian patient's participation it is necessary they understand the active role that could be played even in the decision-making process. The current vulnerability of Romanian patient facing the physician is not a real problem if he is considered as a partner. The difficulty of building patient associations derives not only from the population culture but also from a lack of support from competent organisations. Within an integrated model, one of the most currently issues is not only the difficulty of defining but also the manner of interpretation and perception of each role and responsibility.

On the way to an evaluation culture?

Our topic dealing with external evaluation made us considering evaluation values and perception inside new organisations such as health networks, and therefore to notice the differences and similarities of the concept through different cultures.

This term has several meanings depending on which domain we assess, and in which society we live in. It could be reduced in a controlling process or considered in a learning process.

In French health care system the meanings acceptance seems to be closer to control, depending on the referential we are located; things seem look better at the time (See Part III).

In Romanian culture, evaluation means to have the control on the process rather than controlling people, but there are some false perceptions regarding these issues (See Part II).

Whatever the organisations assessed, we have to take into account the sensitivity of the cultural context as every single evaluation system is built on the pedestal composed on traditions, experiences, values, believes.

Joint work: Well organised and well structured, clearly argued with an introduction and conclusion. Cultural implications are well dealt with. 6 marks.

PART II. ROMANIAN CULTURE ON HEALTH NETWORKING AND EVALUATION

Marius Ciutan, Romania

Cultural diversity is present around us. Everywhere people relate each other, we can encounter different cultures.

Culture of health organisations is divided into many subcultures. In a great extent these subcultures depend of what is considered to be the most importance and what are the most capitalized values within a group of people or organisation.

Romanian experience in health networking

In Romania, the high level of inequalities in health care accessibility and the carelessness on preventive care have determined that the reform of Romanian health system to be highly focused on these two main directions.

The introducing of DRG financing system for all Romanian hospitals has not only led to decreasing in lengths of stay but also to increasing of the necessity to solve the patient's health problem in primary and secondary delivery system. If we take into account the necessity to assure the continuity of health care especially for the patient with chronic disease then the task of the non-hospital sectors is very high.

In order to build a real image about networking in the Romanian health sector, firstly it must be defined what is the meaning of health network and how it could be examined and secondly it must to be shown cultural particularities.

network = reseaux = “rețea”

The Romanian term is a general one because “RETEA” means an interlacing of concrete (ducts, ways etc.) or abstract (imaginary lines) elements crossed in a certain plan or space, making the link between different objects and having a constellation's configuration.

- ◇ ~ *de telecomunicații* = the ensemble of telecommunication's lines from a region or country.
- ◇ ~ *hidrografică* = the entirely running water and water collector from a given territory.
- ◇ ~ *de relații* = the structure.

In the Romanian context, the two common points of a network are “ensemble” of elements from a “certain territory”. By analogy a *health network represents the ensemble of elements assuring the provision of health care services in a given territory.*

Each kind of health network has its particular character indifferent on what organisation model is built: a vertical (hierarchical) or a horizontal or a professional dynamic model, which joints the both previous models. In Romania exists all these kind of models but the most developed is the vertical one; on the other side, the horizontal model is weak developed in Romania.

Health care culture

Romania has made important steps regarding the decentralisation of health system, but the process is still going on and many efforts have to be directed towards this ambitious target.

In Romania, the national health interests have been focused on aspects such as health care accessibility and health promotion. At local level, the expressed interests are very limited and local initiative is very isolated due to critical elements such as: low level of real leaderships, low developing of private sector and private-public partnerships, a low developing in medico-social care, a small local initiative and concern on improving quality of health care provision, difficulties in accessing specific health funds at local level.

Management versus leaderships in Romania

The main differences between the both functions are well surprised in the bellow mentioned definitions that are applicable very well in Romanian context:

Manager is a suitable person to manage and coordinate an organisation whose activity presumes precise set regulations, has precise objectives and bets on a positive result both financial and relational. Management is learned and developed by direct practice in relation with the specificity of the activity's area.

Leader means a suitable person to initiate and manage particular structures with implications in many domains and unexpected situations, where the final result is not implicit and where a compulsory quantifiable benefit is not the main goal. Leader is a native and natural person which has particular qualities (charisma, intuition, empathy, militant, bandmaster, innovator, even-minded, new solution, new challenges etc) that will be further developed by exercising his attributions in parallel with acquiring of new ones.

In Romanian health sector have appeared a lot of managers which are trained for occupying strategic position in the top management. Although the new reconstruction of the health system (through international help that has offered financial and technical support) has led to a new health system leadership, this reconstruction has limited managerial experience and knowledge, with trainers using outdated cultural models. Actually, there is a multitude of health managers but a lack of real leaderships.

Public versus private; Private-public partnership

The acceptance and development of the private sector, especially in the crisis times is a beneficent exercise for quickly enhance of quality of health care delivery, to capitalize and to optimise the utilisation of the available resources.

Nowadays, there are many premises and a legal framework for developing the private sector, but only a few hospitals and a sufficient number of ambulatory health facilities are private in Romania. Private-public partnership is not so well developed in Romanian health sector; this modality of association represents and remains at concept level because it is not enough applied especially in the hospital sector. In this sense it must be mentioned that the recent Romanian Hospital's Law stipulates the possibility and provides the legal terms of setting up these partnerships.

National versus Local initiative

In comparison with France, the degree of local initiative is very low in Romania and also almost all health care system can be assimilated with a public system.

Although, there are many local researches on need assessment and health problem priorities, hence the number is very low and often they remain only at the research stage and their results and findings are not fructified because of a lack of funding and a narrow vision of policy-makers. They are not able to manage a good selection of the projects, don't have precise goals and objectives and often, the roles and the implied actors' responsibilities are not always very well defined.

Other particularity is represented by the difficulties in accessing of specific health funds at local level because of the fact that the local priorities emerge from other sectors then health and the level of municipalities' implication is very low (due to a small level of resources).

Medical versus Social care

Although it was widely recognized that social cases represent about 40% by inpatients the legal framework for the creation of social-medical centres was recently introduced in Romania.

But health care for the patient with chronic disease is a global concept that comprises besides medical needs many other social or psychological needs and it seems that last two mentioned are separately treated in Romania by the health policies being placed in a second plan after medical needs.

Professional culture

For a leader, besides an innovator spirit is very necessary to develop professional skills needed in order to act adequately. In Romania, the graduated training of medical doctors is predominantly centralised on achieving of clinical knowledge and practice and not at all on managerial skills. Although, particular specialisations in this area exist, the number of public health and management specialists is very low in concordance with the need of managers.

In order to supply this inconvenient, the Romanian training system provides postgraduate courses but many of these are available only for future hospital directors and these practices have started very recently.

On the other hand health professionals are not enough prepared to take in their responsibility new tasks, especially managerial tasks that imply a series of "time-consuming" or "energy-consuming activities" such as: meetings' organisation, time management or conflict management or management of whole network. The main responsible of this kind of behaviours is represented of the high level of bureaucracy in the Romanian health sector; health professionals have to fill a lot of documents and activities' reports that occupy a great part of their work.

Mainly, the GPs are not only the main actor in the referral health system, but he provides also a lot of medical services to the patient who establishes a special and personal relationship.

They can dedicate up to 20 minutes for each patient in order to provide a complete consultation; in this generous time (comparative with others European practices that allow the dedication of only 8-10 minutes for a consultation) they enter in connection with the social and economical problems of their patients. Often, the patients from the GPs' list appeal their services only for these reasons; sometimes, the Romanian GP plays for their patients multiple roles: family, or social assistant or adviser, advocate or psychologist or a simple person for conversation.

In the past, people used to work together even since Primitive Age when they cooperated in order to assure their food (common hunting). In concordance with the time passing, the common interests of people were increasing. The same trend can be identified in the health sector: if at the beginning doctor acted alone, nowadays it can be noticed a veritable group working for many common interests.

In Romania, in the time being, health professionals are very professional-oriented: they say “My job” and “My patients” and are reticent to share their experiences and often they impart them with difficulty.

They don't have the experience of team working and they are just learning to work together in a team; even in primary care practice the work is not so well divided: the nurse have its task and frequently makes also the GP's task which is very busy with new managerial attributions conferred by the health insurance system. In the relationship between patient and physician we can distinguish two different links:

-the first, the traditional link, is much more trust-oriented and is embedded by a lot of bureaucracy and is grounded on the medical care provision (consultation, referral letters, receipts etc) and on the classical and traditional phrase “doctor knows better”

-the second, the familiar link, is mainly realized through the participation of the nurse in social, economical and personal aspects related with the social life of the patient (communication, information, advising, prevention etc).

Population culture

Generally speaking, Romanian citizens are very self-oriented and usually they do not act together for a common goal or objectives. This feature was found in a study that highlights that the highest scoring individualists are the Romanian, while the lowest scoring Europeans are the French. This conduces to difficulties in negotiating and decision-making process.

On the other hand, population's pressure is not so high and in the time being they don't have enough power to influence political decisions.

They are not so well organized and therefore their reclamations are singulars. The Romanians answer to absents only in crisis time when “the wound is very deeply” (“cutitul ajunge la os”); in general the Romanian is very patient and tolerant; in fact, very frequently patients appeal to health care services in terminal phases of disease when is necessary intervention of hospital cares.

Often, they prefer to be treated by a single doctor in order to avoid waiting lists and hereby to shorten the duration spend at health providers. But they started to be organized in associations and there are premises to exercise their power.

The Romanians have a tradition to build relationships based on hierarchical positions. Some of them were trained or are natural to coordinate, organize and to control others and in Romania there is a less aspiration to form partnerships at horizontal level. This particular tendency has deep roots in individual situations and is strongly linked with previous individual experiences. Even between traditional regions it can meet different working behaviours; the most managerial skill oriented people are those living in the south of Romania (“Oltenia” region) and they often choose to be trained and to work in managerial functions.

Other possible example could be offered by a metaphoric general representation of the roles played by health professionals: while medical doctor represents the brain, nurses that are the main executants could be imagined as being his hands. Grace to this real situation happening in Romania, it seems to be very difficult to change and to improve the role of nurses in health care providing and this difference existed on professional scale is an actual obstacle for the change management.

Types of health networks in Romania

The particularities of the Romanian health sector could explain both focusing on the development of integrated health care network and the lack of a concern on developing local health networks.

Generally speaking, the main difference between France and Romania emerges from the finding that while the Primary Care Sector in France is not so well coordinated (professional-oriented organisations where the GPs are the owners of their surgery and activities), in Romania is enough developed and organised on the gate-keeper model; the GPs hold an important and a central position in the health care delivery system in Romania and there are many mechanisms to control and to coordinate them within an integrated health system.

In Romania, due to a broad development of the GPs sector, the whole health care network is oriented and focused around of two elements:

- patient and his pathology (Fig. 1a)
- GP and his geographical area deserved (Fig. 1b)

Fig. 1a

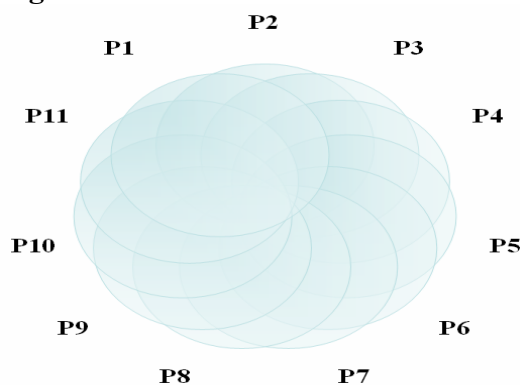
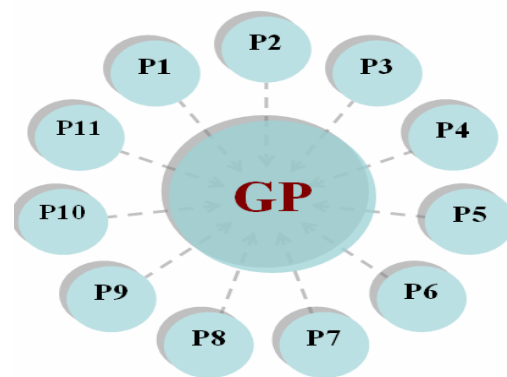


Fig. 1b



Legend:

P1...P11 = the patient with a specific pathology (cardio-vascular disease, diabetes mellitus, cancer etc)

GP = the General Practitioner (the Family Doctor)

Transposed in a three-dimensional image the Romanian model could be better illustrated in a pyramidal system of delivery health care services. In fact, this model represents, the classical referral system that has two features: GPs-centred and patient-oriented.

Most part of the assurance of health care continuity is governed by setting up, implementing and running of the National Health Programmes (NHPs) within a national policy of health reform. The territorial criterion is assured by the patient list system of the GPs and the criterion based on the pathology seems to be assured by the setting up of some special health networks that are created within these programmes.

Actually, there are legal premises for the creation of partnerships but there is no local initiative in order to assure the continuity of care. In the legal norms for applying the 2003 Patient's Right Law is mentioned that: "In order to assure the continuity of health care provision to the patients and the provision of community services after hospital discharging, health facilities establish partnerships with other public and non-public health facilities (from ambulatory and hospital sector) that hold physicians, nurses and other qualified staff".

Integrated health networks

In contrast with French experience where health networks have been representing a continually experiment (spontaneous beginning, experimental financing and now an empirical evaluation), the main types of networking in Romania has derived in political decisions.

Integrated health care network in Romania has some specific characteristics: there is coordination at national level is based on “guide-lines”, conceptualised at national level and provided at local level, defined by the NHPs, has to be implemented at local, respectively regional level.

Networks around of national health programmes

Taking into account all particular aspects described above, the integration of three levels of health care provision opens the way towards new managerial approaches, new information system and new health care organisational process.

For enhancing this system and in order to better manage the main health priorities and to have a good coordination of professionals and following-up of the chronically patient in the whole health system, the Romanian Ministry of Public Health establishes one health program for every identified priority. Prioritisation of health problems is based on local and regional needs assessment and solving them is a permanent process that involves networking activities of different professionals and institutions which deal with provision of specific health care services.

Although this type of networking has multiple advantages it implies also a certain degree of miss-implementation; sometimes, this is happening because the decision-making process does not imply all the actors involved and there are some premises so that medical doctors do not totally follow-up national guide-lines.

Most part of this implementation process depends of the medical doctors’ culture, especially of their belief and their behaviours to comply or not with the guidance received from superior-hierarchical organisations.

This type of network in Romania avoids the appearance of a professional informal conflict and maintains the social hierarchy between different professionals. For instance, similar with other countries, the Romanian GP speciality is placed on a less level then surgical specialities within the top of health professions. In Romania the last choosing of medical specialities still remains the Family Medicine Speciality.

But, the things are in continuously moving and the GP is perceived more and more as playing an important role in providing health care services.

More and more frequently the newest international approaches in this area are assimilated by the top management decision-makers and the new perspectives are starting to be taken into account; the new concepts such as managed care, health network, skill mix, good team or practice are more and more encounter in the knowledge’s pack of the public health specialists and decision-makers.

Networks around of health sectors

In order to assure continuity of care provided to patients with mental health disorder was set up the Mental Health Centres that offer assistance, support and collaboration to the GPs in specific area (National Mental Health Network).

Also, in order to assure coherence with national policies in the health promotion area it was created a network that is founded on District Public Health Directorates’ experience (National Health Promotion Network).

Integrated medico-social care networks

This kind of network has created in Romania twelve years ago and was started as a pilot initiative that could be proposed to the government in order to be financed in public system. It is a local initiative running in Bucharest (4 out of 6 sectors) and coterminous areas and implies conjugate actions of different health and social organisations and NGOs in this area (same networks have been developing in all country; e.g. Communitarian Care Foundation for elderly people, or Hope House of Brasov, Bacau or Arad).

Their services are dedicated to dependent people such as: dependent elderly people, people in convalescence period after certain diseases or people in terminal phases of diseases (cancer, cirrhosis etc). These networks have already established some partnerships with municipalities and hospitals and are subsidized by the Ministry of Labour and Social Solidarity (only for 170 persons meaning 1/12 of all activities). In this context, the medico-social centres were set up in the last four years (102 units and 4028 beds) on the old hospital structure as an alternative of institutionalization and have an important role in the assurance of health care continuity and care of chronically and social cases.

Home care networks

In Romania, home care services were inaugurated and unreel by NGOs. These organisations have developed and supported home care pilot projects for elderly people in many cities: Bucuresti, Piatra-Neamt, Bacau, Brasov, Cluj, Vaslui, Botosani, Pitesti, Alba.

The main objective is to continue these initiatives and to develop networks at national level through an active partnership between My of Health and My of Labour and Social Solidarity.

Formal group practice in primary and ambulatory sector (quasi health networks)

According with the 124/1997 Medical Cabinets' Law the physicians working in individual cabinets can associate themselves and can run within Associated or Grouped Medical Cabinets; this kind of cooperation comes to help professionals to better manage their cabinets (common management and facilities), but also to improve case management.

The lack of the GPs in rural area or the low number of them in this area have led to designing a novelty alternative in order to assure the continuity of emergency and continuously health care provision in rural areas. Thus, in concordance with a legal ordinance of National Health Insurance Found, a lot of GPs in a given rural area can associate each others in order to assure the provision of health care 24 by 24 hours (even on Saturdays and Sundays) through the possibility of setting up so called "The Permanency Health Centres" that are running on the ground of a rotary system of continually health care. This kind of association is based on the contractual principles and has the role to support multifunctional rural health centres (especially for non-hospitalised cases)

Informal health networks

In function of professionals' types which are associating themselves, in Romania there are some specific informal health networks. Often, behind of these associations there are many obscure financial incentives. Usually, the GPs are associating with one or many ambulatory facilities and in this case the medical arguments are predominant, but sometimes are building some informal associations that hide other motivations beside of medical ones.

(between GPs and pharmaceutical units, or pharmaceutical company and health facilities).

An important particular phenomenon is represented by the redirection of patients from the public towards individual and/or private practice (e.g. surgical practice).

This phenomenon is happening in current practice chiefly when a specialist physician which works in a public hospital chooses to consult and to treat many of his patients in a personal private surgery, under the pretext that there are all the needed conditions ("quasi-adverse-selection").

The evaluation

The evaluation process has different connotations in function of the assessed domain, how the evaluation is perceived in the general acceptance of health professionals and how much importance is granted it, and what traditions, beliefs and behaviours for evaluation exist within a certain group.

In general, in Romania, there is a tradition to evaluate all but most times it is a pseudo-evaluation. The Romanians prefer to check less twice before to act. Even between traditional Romanian regions exists cultural differences; for instance, people living in Transylvania are considered wiser than others because always he judges, checks and evaluates all the possible alternatives; from this assumption the Transylvanians are considered wiser but also more slowly in the information's processing.

This behaviour comes to hold the Romanian's custom to check, control and examine as was happened in former period. The Romanian was controlled, examined and evaluated from all angles and this tradition seems to be perpetuated even nowadays, without any complain.

to evaluate = evaluator = "a evalua"

The Romanian term derives from the French term "evaluer" and means to examine by quantitative and qualitative methods; to appreciate; to estimate; to measure; to establish approximately the real value of a good, process or result.

Although this definition allows that the evaluation could be made from both sides: inside and outside of the process, in the collective consciousness there is a border between self-assessment and external assessment.

For Romanians, "*self-assessment*" is equivalent with a report of activities or a simple periodical balance and "*external assessment*" means the evaluation made by a neutral evaluation team. For instance, the National Insurance Fund assesses itself his activity in each year by a special audit department that evaluates the whole organisation activity; the importance of this self-evaluation is significant because the renewing of framework contract of health care provision is found on this assessment. In fact, it is about of the same difference existing between internal and external audit. On the other hand, not always "neutral" means external. In Romanian language the term "**external**" signifies something what is placed outside or in exterior; foreign.

Generally speaking, the religious belief of Romanians is very strong; periodically, they make a self-assessment and go to the church to confess their sins (on the ground of their evaluation) and to receive the Good's absolution.

On the other hand, evaluation does not denote the same meaning with accreditation. It represents a useful tool for accreditation process and very often is linked with the "quality" concept.

The evaluation of the networks within the national health programmes

The Romanian's profile that characterises him as a good evaluator can be met also in the health sector. Each of the Health Programmes (either at national or local level) is equipped with mechanisms of monitoring and evaluating; the monitoring indicators and final evaluation of impact are often built, even if not always they respect the standards of a good quality.

Evaluation is a useful tool to adjust and to prioritise the main problem of Romanian health sector. From these considerations, in the Health Programmes' context, to evaluate does not mean to control the activities of the professionals or health institutions; to monitor and to evaluate means to have the control on the whole process and to be prepared to adapt it in passing of the unreeling it.

In this context, program evaluation is the systematic collection of information about the activities, characteristics, and outcomes of program to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming (Patton, 2001, p. 10).

In contrast, Monitoring is defined as “the continuous assessment of project implementation in relation to agreed schedules and of the use of inputs, infrastructure, and services by project beneficiaries” (World Bank, 1989).

For all National Health Programmes were designed indicators for programmes’ monitoring. These indicators take into account the aspects related to structures, process and results of the program. To have a good monitoring and evaluation of the NHPs, it was set up a special agency suggestively named The National Agency of Health Programmes.

The setting up of new structures is a very frequently practice in the current Romanians’ life, because when the things become very complicated it decides (by a common consensus) to set up or appoint a new agency, institution or committee having the main responsibility to evaluate and to manage this situation. Most of the time this decision is taken in the crisis time in order to pass over this period and because these situations were not happened so rarely we have many health commissions and institutions and agencies very specialized. The crisis moments in the Romanian health sector were numerous and often were linked with a bad functioning of NHPs; the solutions applied have aimed either the augmentation of the amount of money dedicated for program (by reallocating them in the health system) or the transfer of the responsibilities for that program (radical decisions).

The existence of only one institution that deals with the evaluation of NHPs is a favourable argument for a good level of evaluation according as the criteria are respected and according as it assures a standardisation of the evaluation process; so, theoretically speaking we have an “external” evaluation of the NHPs through is assured the assessment is executed on ground of ones criteria that respect the good quality standards (specific, measured, adaptable, reproducible, time specifications). Also, an important argument that these criteria are meeting with good quality standards is the linkage between objectives and indicators used to evaluate the program. But evaluation represents one of the most significant steps among of all the steps of the life’s cycle of a Health Program; the most part of time and effort is consumed in the evaluation process and therefore is assigned a great importance to monitoring and evaluating the NHPs.

But less two questions are arisen from the NHP’s evaluation model:

-In what extend the National Agency of Health Programmes has a neutral position according as the same organisation is the architect, judge and evaluator.

-In what proportion the established objectives of the NHPs cover all needs of population’s?

Perhaps in the future we will have answers according as the minister of health is very involved in the regulation and evaluation of NHPs. Hereby, it has to be mentioned two initiatives carried on in the first semester of the years 2007 that are referred to regulation of NHPs (eleven financed by My of Health and eight NHPs by NIF) and evaluation of them.

So, although these kinds of co-operations are agreed by our society, the facts show us that are not accepted by those who should promote them.

All health systems make options on services offered to their population. Each system has the capacity to choose what and how much to finance depending of the available budget.

In the Romanian health system this choosing is not yet made and there is a big difference between declarative level and factual one.

I think that, in the time being Romania is not yet prepared to experiment new alternatives of providing health care services in primary health care sector (especially, for instance the French experiment of health networks) and is very necessary to pay more attention to decentralisation process and it has to be assigned a bigger decision's power to local authorities.

Although in the period of democracy the Romanians have learnt to be more closed and more confident in the relations with other persons they are not prepared to assume new tasks.

It is a long process to change the Romanian people culture to work together in a common interest and to make them awarded of the fact that the old way is wrong one. Living in a corrupt society seems to be very difficult to change people's mentality because in this type of society the values' system is reversed.

Hence, we can say that Romanian experience in the health care network is insignificant and that French health networks model is a particular one and is embedded of particular aspects.

Romanian networking is a combination of explicit culture, general norms (what is right or wrong is defined at central level) and individual values (what is good or bad) and this culture is instable because the norms don't reflect the values of the group.

An interesting outline of the Rumanian situation, the detail of which I unfortunately did not always understand. However the role and influence of culture was explored well in the sense that a good indication of the imposition of external ideas and the response to these by Rumanians and in particular those involved professionally in health was given. I also appreciated the translation of specific terms, which gave further insight.

Marks: 11

PART III “EVALUATION IS NOT CULTURAL IN FRANCE?”



The way to define the issue

After having chosen our practical placement study: “Why there is a need of external evaluation in health networks “, my colleague and I decided to build up an interview questionnaire: a common framework with relevant questions about perception of evaluation benefits and drawbacks in Brittany. The interviews showed up repetitively the same remarks “evaluation is not cultural in France”, whatever the position of each actor interviewed (doctors, nurses or institutions representatives), it hold all my attention. We collected this perception in different types of interviews (at professional placement, in the institutions, by phone interviews) and in the courses we attended at school (this issue came back at school in unit 5 through a remark made by a teacher). I was again surprised by the association of three keys words evaluation, culture, and France.

A little more explanation of ‘evaluation is not cultural in France’, because of its obvious central significance, would have been useful here.

Was it specific to France, or simply due to the profile of some actors met in our training?

In my past experiences, it hasn’t ever appeared so obvious that there might be a strong link between these concepts. In this particular field, as the only French student among foreigner students (in what might be for me a familiar environment it’s to say the French health sector) things appeared on a different light. The conditions were all gathered to try to visualize my culture from a new vantage point. Thanks to an international environment in my native land, I could look through French healthcare system from outside. I decided to go into thoroughly: Why evaluation seems not to belong to French culture?

My purpose in this document will be to clarify the meanings of evaluation and culture, then to explore Anglo Saxon and Latino approaches, finally to identify the elements needed for an evaluation culture.

O.k. she seems to be doing this (the further explanation) now.

Meanings

Firstly, this question appeared in an English context. Indeed our interviews were carried out, as possible in English. Mostly, health professional’s interviewees were not unfortunately able to talk all the way in Shakespeare’s language, even if they have integrated our European program dimension. The observation by a foreign team led them also to think about a cultural approach of this issue.

To go deeper in our topic, it would be useful to define the terms of our question both in English and in French contexts.

What is the evaluation? A judgement? An audit? A control? An inspection?

Anglo Saxon approach

A common definition of evaluation: *“is the systematic determination of merit, worth, and significance of something or someone... It is an informed act of ascertaining or fixing the value or worth of a given project or product¹.”*

This wide definition is incomplete depending on the field we apply the term. The notions of worth and merit do not exist in every evaluation process.

A more accurate meaning would be: *“Evaluation is the systematic acquisition and assessment of information to provide useful feedback about some object”².*

This last definition, more relevant to our issue, emphasizes information collection and the importance of feedback which could influence the decision making.

We noticed during our placement that evaluation in French could be translated in English into three terms “assessment”, “appraisal” and “evaluation”. This makes confusions. It seems not to exist agreed definitions about the differences.

For instance, regarding medical training assessment, a note of enlightenment was published in the Medical Journal of Australia .Clinicians had to complete a form about the junior staff. An Australian professor³ of medicine proposed definitions to clear up the confusion *“You are confused by the terms and the purpose of the forms and are unsure about how to accurately complete them.*

Assessment is making a judgement about someone’s performance, using defined criteria.

Appraisal is an educational process jointly carried out by the trainer and trainee to review progress and plan educational needs.

Evaluation is the learner’s judgement of the trainer (clinician) or program (hospital, unit).

In “Le Robert and Collins “French English dictionary, evaluation is translated into evaluation, assessment, valuation, estimation and appraisal.

In literature about evaluation’s subject, the three words evaluation, assessment, and appraisals are most frequently indifferently used.

French approach

¹ Wikipedia English : <http://en.wikipedia.org/wiki/Evaluation>

² **Trochim, William** Professor in the Department of Policy Analysis and Management at Cornell University. <http://www.socialresearchmethods.net/kb/intreval.php>

³ Fiona R Lake, MD, FRACP, Associate Professor in Medicine and Medical Education. Education Centre, Faculty of Medicine and Dentistry, University of Western Australia, Nedlands, WA: http://www.mja.com.au/public/issues/182_11_060605/lak10146_fm.html

Frequently given, the definition of evaluation is: “coming from old French value, (i.e. price). It’s the estimation of the worth, measurement of the importance, and effects⁴.”

This wide definition needs to be applied to the context we studied to clear up any kind of confusion.

A simple definition considering the aim clarifies the issue. “Evaluation consists in measuring the gap between objectives and its realizations⁵”.

Nevertheless certain confusion still exists in many people’s mind. As we analyze the definition of evaluation in legal frameworks of health networks, it’s clearly underlined, that it is a condition of financing (one of the titles of Circular N°DHOS/03/CNAM/2007/88 march 2). It actually appeared through our meeting that the boundaries between audit, control, inspection and evaluation are not so clear.

The word audit comes from Latin “audire” and its definition is “to listen, it’s an independent, methodological and documented process in order to collect objective information to define in which extent requirements fit with referential in a precise area.⁶

So there is a tight link with a control of conformity, and it’s a much more normative approach than the concept evaluation.

We also noticed, the complexity of analysis is increased in intercultural study due to the translation, especially when there is no adequate equivalent and beyond the word we do associate others system of value.

Very interesting and useful approach which would seem to support much of our considerations about the interculturality module.

Several meanings regarding the application field

The meanings of words don’t often reach a common agreement in a specific society. These discrepancies might be emphasized according to the field of study they are used.

Evaluation refers to several ones differently and therefore its meaning changes. According to William Trochim⁷, there are two main sets of evaluation: *formative ones strengthen the object being evaluated and summative ones in contrast that examine the effects or outcomes of some object.*

In health care we could distinguish four main types of evaluation:

- evaluation of effectiveness of practises,
- evaluation in a normative framework,

⁴ Ministère du travail, des affaires sociales et des personnes âgées : <http://www.personnes-agees.gouv.fr/renseignements/vocabulaire.htm>

⁵ Cf Guide CAP Réseaux « Repères pour une démarche d’évaluation » version 1.7 décembre 2003 http://www.cocof.irisnet.be/site/common/filesmanager/sante/resauxsante/capreseaux_guideeval/

⁶ Wikipedia france <http://fr.wikipedia.org/wiki/Audit>

⁷ **Trochim, William** Professor in the Department of Policy Analysis and Management at Cornell University. <http://www.socialresearchmethods.net/kb/intreval.php>

- evaluation more focused on the patient,
- Socio economical approach based on efficiency.

These several definitions and wide range of application field included in the concept require being accurate when using the word evaluation.

The use of the language and the swear words

Our language is a part of our culture, and our thinking is strongly affected by the words available, their uses and their meanings.

Consider this point we have to be cautious with the use of words, most specifically in our health care system. Words such as rationing in health care policy can sound more or less positive or negative. Indeed it's quite well perceived in Anglo Saxon countries, but not so well admitted in France, as it's strongly linked to the meanings of shortage, point quite antithetic with the collective idea of universality and equity of healthcare (for example the controversy between every students had existed when rationing word was used for allocation of resources policy in Europhamili program in Unit 5).

The article about economical evaluation from Claude Le Pen (3) illustrates this behaviour. The idea of "forbidden word" appears in the term "trade off" between effectiveness and cost in the French representation of health care public decision even if it's one of the foundation of the economical rationality. In United Kingdom, economical evaluation has been officially recognised and included in public health policy (the leading institution NICE, National Institute for Clinical Excellence went thoroughly in it, influencing the public decision making). These kinds of evaluations have become compulsories in Netherlands since 2006. In Germany and Scandinavia thoughts are going on. Whereas in France and others Latins countries, there is a real difficulty to confront medical benefits and economical costs. It comes from what Claude Le Pen called "*the dichotomic process separating on one hand time of medical decision without economical competencies, on the other hand time of economical decision without medical decision*".

In the event that the evaluation is understood as a control, its perception is actual negative as Schweyer (5) wrote "*control is a swear word... words control and evaluation have a symbolic burden, they represent the authority, and the power*".

Evaluation means an estimation of worth and values, consequently a judgement. In France it could often be received as a control and a call into question.

The representation of the term evaluation seems to be different. These variations depending on languages appear to prove that evaluation is strongly connected to culture.

What belong to culture?

One of many definitions of culture well known is that "Culture consists in the shared patterns of behaviour and associated meanings that people learn and participate in within the groups to which they belong" (Whitten and Hunter) “.

A question appearing frequently either at the practical placement, or in a daily life with the europhamili group, is the spontaneous behaviour to characterize much more the differences according to cultural items rather than the similarities. And on the same time, the following question emerged: these attitudes, situations are either due to personality or to culture? Consequently the boundaries between culture and personality were quite fuzzy. I learnt to be cautious with the answer, and not to have quick judgement to make it clear “*culture is to human collectivity what personality is to individual .., it determines the uniqueness of a human group in the same way personality determines the uniqueness of an individual*” (geert hofstede - 1984).

If the questions need to be asked , there is no accurate answer for every single concerns, but this definition give us some clues to point out what might belong to culture or not .

An Anglo Saxon approach Vs Latino approach?

As we go further into analysis of the initial question regarding evaluation and its empowerment or not in French culture, according to our interviews and the actors pointing out this issue, it was said “*it's much more cultural in Anglo Saxon 's countries*”.

In practical cases, the ways Anglo Saxons and Latins tackle a project appear to be rather different.

In northern countries it's frequent to manage a project, starting from the definitions of the outcomes and the results, and after to implement a methodology for measuring them with logic of transparency and rigour.

The southern countries, seems to have an opposite dynamic. In some European transnational projects we studied about quality management in social field, one of the leader pointed out his experience : “*the first step for Latin countries is to focuse and to confront the values and the principles to define the objective , and it's not unusual to hear : we will see later for the results, we will justify later*”.

This interesting example, mixing both Anglo Saxon and Latino cultures, illustrates two opposite approaches but not antithetic in project management and assessment.

We could obviously see similarities in economical evaluation pointing out two different cultures: Latino and Anglo Saxon, in the previous example. Even if obviously within this two groups, homogeneity of culture doesn't exist.

Some elements of explanations:

Historical and religious background

Could we find in our religious cultural heritage some explanations about our different behaviours regarding evaluation process?

It's worth to precise that Anglo Saxon countries are much more embedded with Protestantism considering individual success highly recognised, than Latino countries and catholic religion giving more recognition for collective action, value and charity.

Healthcare system can be the field where this difference of value is more obvious rather than in more industrial or economical field.

A culture of result versus a culture of context.

The European project mixing Anglo Saxons and Latino countries are sort of laboratories to explore the differences of behaviour.

As one interlocutor explained to us in our cross border study it's important to notice here that quality management, accreditation and evaluation in health care field have been imported from Anglo Saxon countries and have benefits of tremendous adaptations from the original concept. In European project, Latino countries encountered some difficulties to evaluate their project, methodology created and written historically by northern countries which don't fit with their framework.

The Anglo Saxon pattern is much more focused on the results whereas Latino pattern need precise details of the context, the values, and the objectives. This difference of cultural approach influences the discussion: for example a French will need more information description of the context than an English, however an English will ask more indicators, outcome measures, than a French

Behaviour regarding uncertainty

Hofstede developed uncertainty theory to explain cultural differences. It tries to cluster countries regarding its perception of uncertainty establishing a scale of attitude from low to high uncertainty avoidance. He found correlation between this avoidance and power distance in Europe. He splits 17 European countries into two groups: a 10 Germanic and Nordic set and a 7 Latin and Mediterranean's set "*.. The later have inherited from the centralized, structured Roman Empire both a large power distance and a strong uncertainty avoidance. The former lack both.*"

According to English project manager met in the cross border study, this theory is linked with the fact that Anglo Saxon society is more eager to cope with risk management and therefore is a society with "low uncertainty avoidance". In this context the need of results to measure the risk become essential. In Latino countries, where welfare, public assistance and state intervention is much embedded in the society the trend is stronger uncertainty avoidance.

Therefore evaluation in France would be less result oriented and more controls oriented. Consequently, in public institutions there are many control guilds. English teacher, guest in France to attend to a conference on a course of accreditation and evaluation in health care methodology at National Public Health School was surprised about the title of the course, as it would be defined in his country as a control methodology course.

On the way to an evaluation culture?

Beyond the cultural differences regarding the concept of evaluation, both approaches we have detailed previously need from time to time to be confronted in common projects such as transnational cooperation and partnership in Europe. It would be interesting to draw the outline of what an evaluation culture should look like.

Trochim gives us some interesting proposals to think about some shared values:

“Our evaluation culture:

Will embrace an action-oriented perspective that actively seeks solutions to problems ...always attempt to assess the effects of our actions...

Will be teaching –oriented one that emphasizes the unity of formal evaluation end everyday thought. We will encourage everyone to be involved in evaluating..

Will be diverse, inclusive, participatory, responsive and fundamentally non hierarchical...

Will be humble and self critical one, ..Interdisciplinary one, ...truth-seeking one, prospective and finally will emphasize fair, open and democratic processes.”

This interesting task to define what evaluation should look like, gives us some clues to follow a way towards an ideal statement of evaluation culture. Its application depends on the context of the projects.

In a more practical point of view, in an intercultural field mixing health care professionals with different cultural backgrounds, one of the key of success would be confronting values, ideas and contexts to reach a common charter of work.

In France, where culture evaluation seems to have difficulties in developing, it would be interesting to clarify the definition of evaluation, to appropriate the process, thereby not to reduce the concept to a strict control. The approach has to be explained through an effort of information and training in order to involve everybody in a participatory process.

This is a way to solve paradoxical situations we have heard during our interviews such as health care professionals actors involved in diabetes network reported:

“If evaluation would not be compulsory, we wouldn’t use it, but it would be a tremendous mistake “.

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