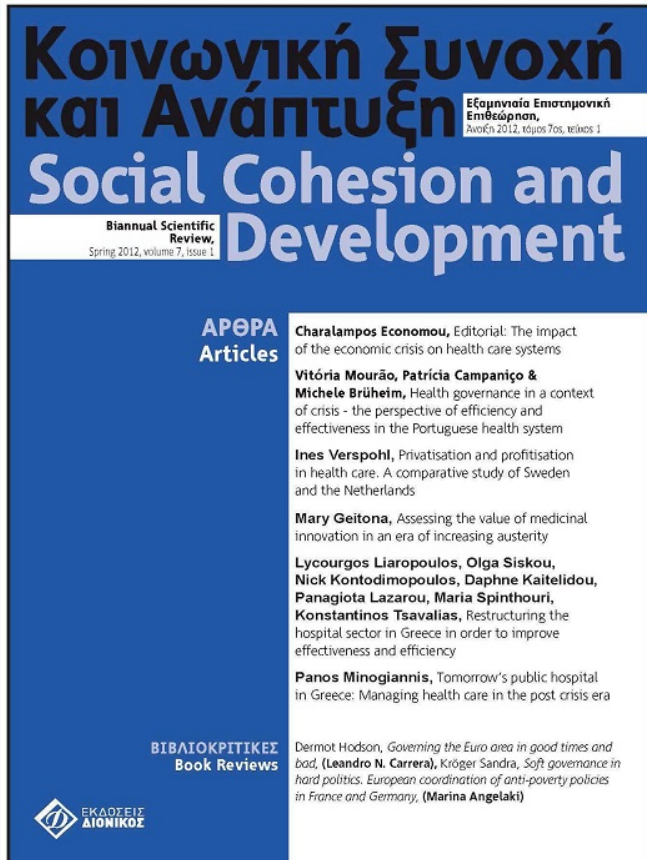


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Tomorrow's public hospital in Greece: Managing health care in the post crisis era

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Το δημόσιο νοσοκομείο του αύριο στην Ελλάδα: Η διαχείριση της φροντίδας υγείας στην μετά την κρίση εποχή

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ABSTRACT

The management of the hospitals (defined as the attempt for optimum performance via appropriate cycles of planning, deciding, evaluating, and reviewing), transcends all the functional parameters of the production and provision of health services. Tomorrow's public hospital in Greece demands a new managerial approach. This approach would sufficiently answer to the main four problematic conundrum of today: the perverse unaccountability of medical subjectivity, the obsolete management model, the lack of human resources management tools and the unhealthy financing of hospitals. Tomorrow's hospital would respect the autonomy of the medical profession while at the same time would demand scientific accountability, would utilize modern organizational tools to manage its human resources in order to produce effectively and efficiently quality services and finally would measure its performance on a case by case basis.

KEY WORDS: Hospital administration, micro-level management, Greece

ΠΕΡΙΛΗΨΗ

Η νοσοκομειακή διοίκηση (οριζόμενη ως η προσπάθεια για την βέλτιστη απόδοση μέσω κατάλληλων κύκλων σχεδιασμού, αποφάσεων, αξιολόγησης και επανελέγχου) τέμνει όλες τις λειτουργικές παραμέτρους παραγωγής και προσφοράς υπηρεσιών υγείας. Το δημόσιο Ελληνικό νοσοκομείο του αύριο θα πρέπει να απαντήσει στις τέσσερις προβληματικές ενότητες του σημερινού συστήματος: τον ιατρικό υποκειμενισμό, το απαρχαιωμένο μοντέλο διοίκησης, την έλλειψη εργαλείων διαχείρισης ανθρώπινου δυναμικού και την προβληματική χρηματοδότηση των ελληνικών νοσοκομείων. Το νοσοκομείο του αύριο θα πρέπει να σέβεται την αυτονομία του ιατρικού επαγγέλματος ενώ ταυτόχρονα να απαιτεί επιστημονική λογοδοσία, θα πρέπει να χρησιμοποιεί μοντέρνα εργαλεία επιχειρησιακής οργάνωσης ώστε να διαχειριστεί το ανθρώπινο δυναμικό του με απώτερο στόχο την αποδοτική και αποτελεσματική παραγωγή υπηρεσιών υγείας και τέλος θα πρέπει να μετράει την απόδοση του σε κάθε περιστατικό. Σε αυτή την κατεύθυνση θα κατευθυνθούν τα νοσοκομεία τα επόμενα χρόνια.

ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ: Διοίκηση νοσοκομείων, διαχείριση σε μικρο-επίπεδο, Ελλάδα

1. Introduction: Modernizing the management of the system as a catalyst for change

Greece faces a multi-level crisis which in so far as the healthcare arena is concerned, presents the country with a window of opportunity not simply for reviewing its problems but for a complete transformation of its management practices. Modernizing the health care system is critical for three reasons: (a) health care expenditures have largely contributed to the derailment of state finances, (b) the crisis and the continuing recession subtracts funds and other resources from the health care system and (c) health care services can assist the population to cope with the overall consequences of the crisis (Matsaganis, 2011). In the international literature, there is much talk about how to reform health systems (Braithwaite et al., 2004; Oliver et al., 2005; Schmid et al, 2010; Maarse, 2006; Nikolentzos et al, 2008). The discourse invariably focuses on topics such as political leadership, organizational transformation, clinical improvement etc. The vacuity of generalization notwithstanding, three categories of reform cover most of the relevant territory. The first is “system-improving” measures, such as the accumulation and analysis of data, electronic medical records, disease management. The second are “system transforming” policies such as explicit priority setting and institutional realignment; what analysts tend to mean by “real” reform because they change the workings of the system not incrementally but “fundamentally”, though not of course completely. It can and most likely encapsulates system improving measures. The third category, which most often is unnoticed, is “system-sustaining” reform. It may sound oxymoronic (reforms are after all supposed to alter the status quo not preserve it), but, nevertheless is of utmost importance in maintaining the viability of health care systems (Brown, 2006). The main, if not only virtue of this typology is to underline the centrality of politics in health care reform. The point is that reform attempts suffer from a large and widening gap between policy analysis and policy practice. Health policy in Greece is increasingly an elaborate structure of ideas set atop rather fragile pillars of political comprehension, and institutional capacity. Put differently, the main argument is that Greece has to both design health policy which can be expected to improve efficiencies and at the same time alter the existing decision making mechanisms of the system in such a manner that will allow such policies to be implemented.

The consensus of analysts about the Greek health care system is that its main characteristic is fragmentation (Oikonomou et al, 2011; Mossialos, 1995; OECD, 2010; Minogiannis, 2003, Tountas, 2006; Tountas et al., 2002; Tountas et al, 2005; Liaropoylos et al., 1998; Kyriopoulos et al., 1993). It does not practically offer single coverage and has multi-fragmented funding and delivery mechanisms (Siskou et al., 2008). It is characterized by its regressive financing with many disparities in access, supply and quality of services. Inefficiencies arise from excessive dependence on expensive inputs. The oversupply of specialists and the lack of nursing staff in Greece is well documented (OECD, 2008; OECD, 2010). The allocations of scarce resources is a result of historical and often political processes and has never been linked to performance standards leading to a system that presents no incentives to providers for effective and efficient health care delivery (Mossialos, 2005; Economou, 2010).

This fragmentation develops in three levels which interact with one another: (a) the structure of the system (funding, staffing, development units, etc.), (b) the management (decision making) and (c) the flow patients and the lack of disease management networks. The reduction of fragmentation in these three levels will most likely result in a modern administration system that is properly institutionalized and has adequate resources to achieve both economic viability and improve population health indicators (Mossialos, 2005).

In this article we will focus on hospital administration, where these three levels converge and reveal all the pathologies of the Greek Health Administration. The first part of the chapter attempts to highlight the problematic aspects of management of public hospitals in Greece in the period prior to the economic crisis. This is followed by an admittedly cursory look to reform efforts of the last two years and their immediate results. We conclude this chapter with a series of further reforms that are necessary in order to establish a clear management structure aimed at improving the quality of services, namely improving clinical effectiveness, efficiency in use of available resources but also patient satisfaction.

2. Before the crisis

The main problem, not only in the management of socially sensitive services like health care, but in terms of the overall Greek public management system is that it has never tried to be financially self-sufficient, through a funding system that would reward the “good players” at either the health professionals and employees level or at the institutional-hospital level. These problems are largely due to the structure of the health system but even more to its problematic administration. Multiple decision-making centers, overregulation, extensive party penetration of public management as well as a truculent and irrational co-management of the system by labor unions are just some of the parameters that lead to inefficient administration of all levels (strategic, supervisory, tactical-operational) (Economou, 2010). The problematic command occurs at two levels: (a) at the macro-level of the administration or what is called the political management of the system and (b) at the Micro-Level administration level at hospitals and other service units. The key point is that policy makers (macro level) must understand the basic principles of health management and aim at a balanced market whereas health services managers (micro level) should understand the constraints within which they have to manage their institutions (Minogiannis, 2003). In this paper, we do not concentrate on the political management of the system but rather focus on the micro level management parameters. Suffice it to say, however, that any attempt for meaningful reform on the problematic micro level management parameters would require substantial political capital.

3. Problematic parameters at the micro level

3.1 There are four main categories of management issues, one has to consider:

3.1.1 Medical subjectivity

A generation ago, the remarkable variation in the delivery of health care across populations was brought to light (Wennberg, 1973). Since then, numerous articles have documented variations across small and large areas in surgical procedures, health system capacity, use of pharmaceuticals, intensity of diagnostic testing and others (Wennberg, 1998; Dartmuth Atlas, 2011; Fiscella et al, 2000; Archer, 2009; Freburger, 2005; Clance, 2009; IOM, 2000). The principal finding of these studies has not changed: for medical care, geography is destiny. Each medical encounter is characterized by four basic parameters: the physician, the patient, the disease and the timing of the encounter. Each one differs if only one of these parameters is different. This is what creates

the great knowledge imbalance between management and the physician community in a hospital setting. Whereas it is important to underline the importance of such differences, one cannot avoid examining the question of medical subjectivity. This medical subjectivity leads in turn to an imbalanced services consumption (via physician agency) which on occasion cannot be justified and leads to elevated costs and inefficiencies. Practically speaking, the same and on occasion better clinical results can be achieved in cheaper ways by certain physicians. This does not negate the fact that each patient is different and hospital management tools must take that into consideration. And it is also rather obvious that the best clinical result may also be the most expensive. The key point is that this is not axiomatic. In Greece, however, this is a discussion that has not even begun both due to professional resistance but also due to the lack of both clinical and until recently even financial information which would have allowed such a discussion to take place based on actual data. The medical community at best is indifferent and at worst promotes medical subjectivity and reformist voices within medicine are often overheard.

3.1.2 Obsolete management model

The Organizational charts of Greek hospitals are governed by a 1987 static statute called the Single Organizational Hospital Framework. If the management system of a hospital cannot follow the scientific developments that have occurred in the past twenty five years, then it is not an exaggeration to call such a system obsolete. The current organizational charts provisions for staffing needs are based on the number of beds of each hospital (rather than its output). Departments that are no longer in existence are still officially part of the organization, whereas others that have come to existence are not provided for. Fundamental operational procedures as well as written open ended job descriptions are nonexistent. Policies and procedures need to be in tandem with the law but also need to be specialized at the hospital level since they are affected by parameters such as the nature of the hospital, the structure of the facility, organizational culture. A single framework could only be used as a guide. Hospital managers should be allowed to adjust their organizational charts in order to achieve their budgetary goals, create networks with other hospitals and other providers, and to achieve economies of scale and speed, in so far as hospital managers are capable to do so. We will return to this point.

Devolving such "power" to the hospital level brings up a relevant management problem which has to do with the existing co-management square in Greek public hospitals. In all world renowned hospitals, there is an open dialogue between management and the leadership of the medical community. These two sides of the square, which exist in all hospitals, share common organizational values and goals and strive for clinical excellence within a financially disciplined environment. This discussion is necessary due to the knowledge imbalance discussed earlier. It is a cliché but it is also true that hospitals are not factories vis a vis they cannot standardize their production processes the same way that a car manufacturer can. Improved coordination, however, is still required in order to achieve economies of speed in hospital output. At the same time, a physician cannot practice medicine the same way his/her predecessors did half a century ago. A modern hospital environment is needed and such an environment needs sustainable financial health. This discussion is being developed in many Greek public hospitals as well. As a result of political party penetration in almost every aspect of Greek public management, however, one also observes the two other sides of the co-management square; unionized physicians and unionized employees. In fact, representatives of both entities have a seat on each governing board by law. The penetration of public management by both party and union interests is the norm in Greece

(Carpenter, 2003). The consequences of this penetration are evident in the lack of accountability in performance results throughout the health sector prior to the memorandum with the troika.

Party penetration is however, evident not only in the union movement but also in selecting hospital managers and members of governing boards. The problem exists when the criterion of party membership supersedes the criterion of proven management ability. In these cases, one is not accountable to one's Board or to society but to the party.

In sum, due to the problematic operational parameters that were mentioned, the organizational model of Greek hospitals is characterized by very little horizontal coordination, and very little standardization of procedures. Problems are not solved as close to the level where they are created but rather are forwarded to the highest hierarchical levels in order to avoid accountability. Finally, staff gets addicted to this non accountability culture of not servicing internal or external clients which eventually leads to an overall decline of the entire institution.

3.1.3 Human resources management

The most efficient utilization of human resources is of paramount importance in achieving any desirable result in health care management, especially during an economic crisis where the available financial resources for health care are rather scarce. Analysts have shed light to the *"black box" relationship between HR and firm performance, always emphasizing the integration of strategy implementation as the central mediating variable in this relationship (Becker and Huselid, 2006). The evaluation of human resources, however, seems conspicuously absent from the Greek health policy agenda.* The problems in human resources management focus on the following four parameters: delayed processes of choosing staff, lack of substantive staff evaluation, a culture of non-accountability, and a steamroller horizontal approach to reward or punishment. Further analysis of the parameter is not required. The management of human resources is a broader issue that should concern not only the health care sector but the entire public sector.

3.1.4 Hospital financing-Hospital cash flow

Until recently, the structure of the financing scheme of the Greek health care system was a source of bureaucracy costs since there were more than thirty social security funds, numerous ministries involved in the pricing and costing of different goods and services, as well as many others in the approval of ordering, purchasing and paying for such goods and services. It is self-evident that timely and adequate financing is the engine of any corporation (public or private). And since resources are rather scarce, an appropriate cash flow must be ensured which would in turn lead to cost savings from the current waste without jeopardizing the quality of care. Hospitals are not allowed to charge freely for their services following negotiations with insurance funds. At the same time, many medical procedures remain without central prices and the ones that had been priced had not even adjusted for inflation since the early 1990s. Couple that with the huge bureaucracy cost of submitting payment forms in different ways for different social security funds, of the numerous relevant inspections as well as of the convoluted and strict procurement process which in turn leads to delays in finalizing the different tender procedures and signing contractual agreements with suppliers, and the bleak picture is complete. The norm is that the hospitals (which are closely monitored by the Ministry) frequently face financial difficulties due to delays in payments by social insurance funds. Even during periods of economic growth, such payments were delayed up to five years from certain funds. This lack of liquidity led in turn to delays in the payments of suppliers who in turn overpriced their goods and services to account for the financing cost. This entire business

relationship is unhealthy, allows much room for corruption, is systemically flawed and needs to be fundamentally altered. Many reforms of the past two years aimed at this target.

4. The memorandum with the troika

In the past two years, the global economic crisis has led to intense and negative ramifications on the Greek economy overall and its health care sector in particular. The sector was not however prepared in any fashion to face such a crisis and therefore health care has been a core focus of the troika's agenda. Under the pressures of the memorandum signed by the country and its lenders, many reforms have taken place greatly improving the overall conditions, especially in terms of the economic survey and the financial result of hospital management. Measuring the financial performance of the system was in fact the immediate priority since the achievement of this self-evident goal was the only means to promoting further improvements to the system. It is not therefore surprising that in terms to the four themes analyzed earlier, the Ministry's efforts focused primarily on the fourth theme dealing with the financial management and cash flow of hospitals.

4.1 *Medical subjectivity*

The cultural transformation that the medical profession needs to undergo to overcome medical subjectivity and practice medicine in a collaborative fashion requires both financial and clinical information. There has not been a significant and systematic effort to either collect the clinical data required or to engage the medical community in such a process. Overall, one can safely conclude that given the surrounding financial environment, such a project was not a top priority. From a normative perspective, one could safely argue that there was enough waste in the system to allow for policy makers to ignore this parameter in the first instance. It remains, however, the key reform necessary in moving forward.

4.2 *Obsolete management model*

There were a number of reforms that took place between 2010 and 2012. The main goals were the optimum allocation of inputs, the most effective utilization of scarce resources and finally the more efficient performance of hospitals. There were a number of mergers - the 131 hospitals in 2010 were reduced to 81, the hospitals that were run by the main social security fund IKA also merged into the NHS, hospital beds were reduced from 46,783 to 36,035 and new organizational charts were proposed by hospitals (MHSS, 2011). These actions, however, neither changed the single organizational hospital framework nor increased the management autonomy of hospitals. The co-management square which we analyzed earlier was also not targeted by any actions and is to date one of the main problems in the daily routine of a public hospital.

4.3 *Human resources management*

Given the economic crisis, the social tensions that arose from it and the political history of the current political system, human resources issues were handled in two basic ways: (a) Horizontal wage cuts for salaried personnel of all levels and (b) attempts to replace as many of the staff that left the system due to retirement.

And whereas 600 physicians and 4,000 nurses entered the workforce in 2011 (MHSS, 2011), the difficult and pressing questions in human resources management were not tackled. No actual measures were taken towards introducing personnel accountability, measure performance, and link such performance to a rewards (positive or negative) system. It is yet another piece of evidence both of the ways that the political development of public management in Greece has led to great imbalances that require major changes and of the institutional resistance to such changes.

4.4 Hospital financing-hospital cash flow

As mentioned earlier, this is the one area that was a priority on the political agenda and where most reforms took place. Admittedly, positive results can be claimed in this area. In terms of both the financial but also the operational management of hospitals, targets were set, a data standardization and evaluation process was introduced, and most importantly the communication between the ministry and hospitals were based on data and actual hospital performance. Some of the systems improving reforms in this arena, as reported by the Ministry of Health (MHSS, 2011) include: (a) The publications of balance sheets for all hospitals and the introduction of the double-entry accounting system, alongside the settlement of hospital debts for the 2005-2009 period, (b) the improvement of the procurement process with new public tenders being held for the first time in the past five years, (c) the introduction of unified diagnosis coding (ICD-10) and a new system of hospital reimbursement based on diagnosis related groups. Perhaps, the most significant measure was the development of a database at the Ministry (ESY.net) where financial information from all hospitals was analyzed on a monthly basis.

These efforts resulted in overall reductions in the main hospital expenditures by 21.22% in 2011. The greatest decrease was observed in surgical materials (-40.8%), followed by the reduction of hospital pharmaceutical expenditures (-23%), laboratory agents (-16%) and finally consumables (-14.7%). At the same time, and to a great extent because of the economic crisis, the number of patients who entered the public health care system increased by close to 10% in both years (2010 and 2011 compared to the previous year). Average cost per patient decreased from 1,228 Euros in 2010 to 1,057 Euros in 2011 (ESY.net, 2011). A criticism has been raised that in the context of recession and austerity, efficiency (measured as health spending per life-year saved) will generally increase as spending is lower and hospital admissions rise, making it an incomplete measure of the performance of the health-care system. Such criticisms, however, miss the key point. The key point has to do with the ability or the lack thereof of the management to even collect primary data, let alone reach measurement of analytical variables. Analysts have often pointed out the marginal role and the low significance that accounting has had in the operations of the Greek national Health System and attribute it to the historically high politicization that characterized the system that placed emphasis not on the managerial dimensions of running public bureaucracies but rather favored political evaluation criteria for public management (Ballas et al, 2004). A strong foundation has therefore been laid that the system can build upon in the future. When one compares the lack of management information systems, the enormous amounts of hospital debts, the lack of public tenders, the overall non-accountability culture that hospital management exhibited up to 2010, these reforms can be judged as the most significant ones in health care in the past twenty years.

A final note should be added for the introduction of DRGs in late 2011. A number of technical problems have characterized this effort. It is essential to understand that the movement from a fee for service system to a DRG system is essential for the financial health of the system. It allows room for hospitals (public and private) to compete with one another for more efficient production

of quality services. It is critical in any attempt to level the playing field. The direction has to be towards improving these DRGs, adjust them to the true costs of Greek health care and utilize them to promote accountability in the system.

5. Moving forward

As important as streamlining the financial performance of hospitals is, it is not merely enough and it is certainly not sustainable if it is not accompanied by interventions in the other three areas of consideration.

5.1 *Medical subjectivity*

Overcoming medical subjectivity and moving towards a more collaborative fashion of medical practice is the direction that the system needs to move towards (Lee, 2010). This requires the collection of both clinical and financial data, the creation of links between the two and the measurement of performance of each provider. For all practical purposes the system needs to move towards a system of dynamic clinical case management whereby a collaborative process of assessment, planning, facilitation, care coordination, and evaluation of medical treatment is instituted. In such a model, hospitals will have to develop ways to measure clinical effectiveness and to link it to financial information on a case by case basis. International clinical protocols should be utilized and scientific accountability for treatment needs to become the norm. Medical boards, especially in areas such as oncology need to be instituted which in turn should assist in compliance of indications in terms of diagnostic procedures, interventional procedures and pharmaceutical treatment.

Such protocols need to be dynamic because medical care is highly innovative, and medical innovation generates considerable uncertainty. That famous gold standard, the randomized controlled trial, is the beginning, not the end of definitive evidence, much of which accumulates in the course of clinical applications (Gelijns and others, 1998). While researchers meticulously gather the evidence on which evidence-based medicine reposes, myriad new drugs, devices, and procedures make their appearance, and evidence on existing ones changes with clinical experience, leaving clinical managers perpetually a chapter or two behind the class. Evidence – and evidence-based medicine – have indeed grown and continue to do so dramatically, but uncertainty grows faster (Brown, 2006). Equally important is that the way doctors think needs to encapsulate the possibility of the exception to a well-known best practice that is based on evidence (Groopman, 2008). Therefore, a new equilibrium must be formed which would allow on the one hand for the flexible application of these protocols and at the same time would account for scientifically justified exceptions to such protocols.

5.2 *Obsolete management model*

The reduction of medical subjectivity is closely linked with improved efficiencies and clinical effectiveness. This will not, however, suffice if the management paradigm of Greek hospitals does not change to a paradigm of quality. Such a paradigm would in turn require amendments to hospitals' organizational charts that will not utilize the number of a facility beds but rather the output of each facility (Ronen, 2006), clear operational manuals with policies and procedures that will be binding at the hospital level alongside job descriptions which cannot be a matter of negotiations with unions.

The selection of Hospital managers must be performed by either a headhunter or by a special task force which will not be prone to party politics and these managers will in turn create two management teams. The first will be comprised by the Chief Executive Officer (CEO), the Quality controller, the Chief operations Officer (COO), the Chief Financial Officer (CFO), the Chief Medical officer (CMO), the Facility Manager, the Chief Nursing Officer (CNO) and the Chief Information Officer (CIO) and will be responsible for the strategic plan of the organization. The second will be the scientific committee of the hospital and would be comprised of section heads under the leadership of the CMO. It should not be a result of election procedures and will serve as an advisory Board to the executive team in scientific matters.

5.3 Human resources management

As mentioned earlier, human resources management transcends all arenas of Greek public management and is in the core of any kind of substantive reform effort. The required actions need to aim towards a new work ethic where performance evaluation and the creation of incentives and disincentives for staff would be the norm. In short, the selection and allocation of staff should be dependent on a clinic's productivity and clinical effectiveness and not based on a static number of allocated beds. The merger of low productivity departments needs to also be considered. The hospital hierarchy must be restored both within the individual department level but also in the entire organization. "Business Contracts" with explicit goals that are measurable ought to form the basis of human resources management. Staff evaluation, granting of tenure as well as participating in reward programs should be linked to the employee performance within such contracts. Furthermore, each hospital should be responsible for extending and/or removing "admission rights" from physicians that are non-tenured.

5.4 Hospital financing-Hospital Cash Flow

As mentioned earlier, the engine to any operation including the production of health care is the financial stability of the institution vis a vis the sufficient financing in a timely manner. This can be based on the introduction of information systems in all operational aspects (Procurement, Diagnosis, Pricing etc.), the transformation of the public procurement process towards a centralized model with a well-developed logistics system and last but not least the improvement of DRGs alongside the introduction of "pay for performance" schemes.

Numerous studies dating back even to the mid 1980s have shown that the introduction of DRGs must be closely monitored since it can potentially lead to an exacerbation of hospital cost inflation (Wennbero, et al., 1984; Rosenthal, 2007). Losses in hospital revenues resulting from the DRG payment system could be offset if physicians and providers in general modified their admission and practice policies to produce more profit, well within the current limits of medical appropriateness. There are a number of analyses in the literature in relation to medical upcoding, changes in admission practices (Wennbero, 1984), and decreased quality of care (Rosenthal, 2007). Effective control of such parameters must be on the radar of health policy makers moving forward with the DRG system. Furthermore, this system is a dynamic one and the DRG costs must be adjusted annually to account for risk, utilization rates etc. Moreover, if a procedure is not covered, the cost should be passed on to the patient (either via private supplemental insurance or out of pocket). Finally, the gradual introduction of pay for performance bonus system whereby hospitals with good quality (both clinical and financial) indicators would receive additional funds should enhance hospital efficiency in the utilization of scarce resources.

Many analysts have presented the need for the introduction of such quality measures both in the Greek health care system (Theodorakoglou et al, 2000) and abroad (Jencks et al, 2009; Widner et al, 2008). The gradual introduction of quality measures which would range anywhere from simple measures such as aspirin or beta inhibitors at arrival all the way to more complex ones such as 30-Day All-Cause Risk Standardized Readmission Rate Following Heart Failure Hospitalization (Hospital Quality Alliance, 2012) should go a long way to altering the management culture of Greek hospitals. And since public hospitals will continue to be pressured to improve their operations both in terms of resources they use and also in terms of the quantity of their outcomes, a pay for performance bonus system should account for improved efficiency results. The assessment of "good players" should entail both the notions of technical and allocative efficiency as they yield complementary information about the management effectiveness of individual hospitals (Athanasopoulos and Gounaris, 2001). Such information would refer to the degree of utilization of production factors, to the particular weight of each factor of production in the formation of the relative efficiency score, to the utilization level of each factor of production, and to those hospital units that utilize their factors of production in an optimal way and constitute models for the exercising of effective management (Katharaki, 2007).

6. Conclusion

The management of the hospitals (defined as the attempt for optimum performance via appropriate cycles of planning, deciding, evaluating, and reviewing), transcends all the functional parameters of the production and provision of health services. Tomorrow's public hospital in Greece demands a new managerial approach. This approach would sufficiently answer to the main four problematic conundrum of today: the perverse unaccountability of medical subjectivity, the obsolete management model, the lack of human resources management tools and the unhealthy financing of hospitals. Tomorrow's hospital would respect the autonomy of the medical profession while at the same time would demand scientific accountability, would utilize modern organizational tools to manage its human resources in order to produce effectively and efficiently quality services and finally would measure its performance on a case by case basis.

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