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THE SECURITY OF THE HEALTH ORGANIZATION MANAGEMENT - THE ROLE OF DOCTORS, PATIENTS AND RELATIONS BETWEEN THEM

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Abstract: The management of contemporary health systems is a problem of many countries, which consists not only of issues related to the establishment of the roles of institutions involved in their functioning, the allocation of funds, asymmetry of information, or access to health services. Problems of the all system often result from faulty management of particular health institutions, and more specifically from the lack of agreement between the management staff, medical staff and patients.
The proposed study is an attempt to systematize the roles assigned recently to physicians and patients on the one hand, on the other – a presentation of non-standard solutions in this area, which are the existing cooperatives in health care in the world. The issue of jointly implemented by both groups of objectives and adaptation of the idea of cooperatives to the management process was justified by the theory of common pool resources and the game theory.
Keywords: health organizations, collective action, cooperatives, management

1. INTRODUCTION

Directing and supervising the functioning of contemporary health sectors is a great challenge of today, requiring extensive knowledge and experience, knowledge of all the details of their operation and understanding the specificity of the market. The management of such a system, in which many organizations, institutions, individuals or social groups are involved, is largely connected with economic analysis, macroeconomic and microeconomic indicators, statistical analysis of data and making appropriate decisions on their basis. However, in the case of a health system, whose functioning can be described on many levels: economic, legal, or sociological, creative management requires from bodies that perform such function great empathy and awareness of how a serious social mission the system has to fulfil. Its social but also humanitarian goals require managers to know and respect ethical standards, the principles of the individual's functioning in society, and above all, the mutual relationships of all stakeholders of the system.

The health system is a very specific system, on the one hand, organizations operating within the structure of the health care system are influenced by social, political and economic factors, making their activity determined by what is happening in the so-called surrounding system. However, the proper functioning of the health system is also determined by, or perhaps first of all, the recognition of its internal environment, including: specific patient-doctor relationships, the complexity of the treatment process, often bringing effects shifted in time, special care and understanding what should accompany the care over a defenceless and sick patient. A significant place in the functioning of the health system is the trust that the patient gives to the doctor, which results from a very large asymmetry of information in their mutual relationships. It is related to the limited knowledge of the patient about the condition with which he/she refers to the beneficiary, the fact of trusting the doctor with his/her health and life, as well as various adherence to the guidelines and the guidelines received from the doctor.

It is not only the group of patients who see the voice decisive in making decisions about health, as well as the functioning of individual facilities, and finally the entire system. The group remains special in the management process, which is the staff of medical facilities. For the most part, they are qualified, extremely well educated and intelligent, but very diverse people, with different moral and ethical levels (which in this case is of great importance) who are not subject to classical hierarchy with respect to e.g. hospital director or manager, what in largely it hinders the whole management process.

2. METHODOLOGY OF RESEARCH

Mutual relationships between various stakeholders in the health system, as well as typical for a given group of behaviours, play a key role in the management of medical entities. Understanding the intentions of each group, as well as the concept of their mutual relationships is not easy, however, the mathematical science, and more specifically the theory of games, facilitates their understanding and description.

Each exchange of services, including health services, can be treated as a kind of game in which each player has different goals and everyone strives to satisfy them even at the expense of another (different) player. Their mutual relationships and choices can be approximated by the so-called Prisoner's Dilemma, considered one of the most important not only in psychology, but above all in economics and social sciences (Malawski et al., 2004).

The Prisoner's Dilemma concerns the necessity of making decisions by two independent players identified in the classic approach with two well-known police criminals. Both of them are detained in custody (for separate purposes) as a result of being caught by the police in a stolen car. Each of them has two strategies to choose from in this difficult situation. He can admit (testify) or admit (keep silent). In the context of mutual relationships between the two players, silence can be regarded as cooperation, and testimony - as betrayal. As a result of the lack of witnesses and other evidence than the stolen car, if both do not plead guilty (cooperate), they will be imprisoned for only one year for theft. In the event that they both admit (betray themselves or a colleague), they will get a prison sentence for 4 years for robbery and theft. If, however, one of them indicates the second as the perpetrator, he will be considered innocent, he will leave the prison and his partner will receive a penalty of 6 years. Due to the fact that the punishment of one player is heavily influenced by what

the other player will say, the optimal solution for each of them, and therefore the dominant strategy is the admission by both players at the same time (betrayal). In other words, the strategy of the lack of cooperation will dominate here (Ahn et al., 2001), in which no player will make his decision dependent on what the other will choose. This is the case, however, in a single game. If players play the game many times, so we have to deal with the so-called iterated Prisoner's Dilemma, the state of balance in the game can be achieved by the mutual cooperation of both players, and the selfish motives of players lose with their altruistic attitude. Achieving cooperation in such a game scheme turns out to be dependent on: the amount of the payout, the type of players, information about the types of players, or relationships that have formed in the course of many games between players (Schmidt et al., 2003).

In the health system you can find very close links with the Prisoner's Dilemma. All players in the system exploit public goods, which are public funds. What's more, the simplest for each of them is, as in the case of the description of classic human behaviour, how to use what is the work of others, and do not bring too much to the common market. I am talking, for example, about the tendency of insurers to pursue their own goals - higher insurance premiums, small sums spent on treating patients, without insight into what will happen to the patient and what expenditures will be required for his treatment. A similar conflict situation can be observed when the clinics increase the number of patients admitted, which may lead to their higher profits, while at the same time exceeding the norm of employee exploitation, reducing their effectiveness, which in turn may lead to deterioration of the patient's health situation. In the context of the mutual relationships of stakeholders of the health system, the idea is to find a solution that would enable their mutual cooperation, strengthening the operation of the system itself, intensified the effects of its functioning, while providing each player with satisfaction, satisfaction of needs and implementation of individual goals.

The conflict that arises in this game concerns the right choice between one's own interest, which translating into the language of economics, can be called individual rationality and common interest. That is why this dilemma can be applied to many situations in economic and social life, where various entities, organizations and individuals derive from and exploit available resources for all. This is so in the case of the exploitation of public goods, natural resources, but also in the case of co-existence on the market of health services of various beneficiaries. This is often called the dilemma of common-pool resources (Ostrom and Gardner, 1993). The concept subjecting such an analysis to the analysis and referring to the management of the abovementioned resources is to a large extent based on emphasizing the importance of relationships between the participants of the game, their mutual relationship and even the need to develop such interactions so that their mutual cooperation becomes possible. However, the level of understanding of the operation of each such system must go beyond the sociological aspect. An important level of analysis of mutual cooperation between people for the benefit of the various general public still affects economic aspects (clearly defined and identified resources, a series of cooperation effectiveness measures), but also political ones (Ostrom, 2009), and cooperation is possible only when all decisions regarding its existence are undertaken without the participation of external institutions. This means that decentralization is a prerequisite for the proper management of public goods and services (Agrawal and Ostrom, 2001).

3. RESULTS

The aforementioned idea of the existence of a cooperative on the exploitation of public goods works not only with respect to natural resources, but also in the health sector, as evidenced by existing and perfectly fulfilling goals and functions of cooperatives in Australia (operating in six regions in the field of medical and nursing care), Argentina, Canada, or Japan, involving millions of people (MacKay, 2007). Countries in which there are health cooperatives are associated in the International Health Cooperative Organization (www.coop.org/ihco), whose mission is to provide high-quality, cost-effective community health care based on the freedom of choice, integration of services, and ethical working conditions (https://ihco.coop/).

As the experience of those countries in which numerous health cooperatives were created, the superior values are self-help, self-responsibility, democracy, equality, equity and solidarity, and a necessary condition - the application of well-established and ethical standards such as honesty, openness, social responsibility and caring for others (http://ica.coop/en/media/co-operative-stories/health-cooperative-federation).

Cooperatives function in accordance with the accepted principles, which include (http://ica.coop/en/media/co-operative-stories/health-cooperative-federation):

voluntary and open membership, democratic member control, member economic participation, autonomy and independence, education, training and information, co-operation among co-operatives, concern for community.

There are three types of health cooperatives: only members of the local community (client or user-owned cooperative), created by workers' cooperative services or hybrid cooperatives, which include patients and providers (multi-stakeholder cooperative).

From among the members of the cooperative, representatives representing a specific management board, the management of the cooperative responsible for its broadly understood functioning at a given time, are elected. His duties also include the employment of managers responsible for negotiating contracts with insurers, government or service providers. In order to become a member of a cooperative, you must buy shares in it, thus becoming its co-owner. Health co-operatives are non-profit organizations. The members of the cooperative are responsible for formulating its mission, goals and type of medical services offered, while assessing the needs of members or the satisfaction test.

4. DISCUSSION

Medical facilities, especially those that generate high costs are in Poland, but also in many other countries, public institutions, so those whose founding body and supervisory body is the government or other public institution. For them, a common strategy, usually generated at the central level, is being developed, which unfortunately does not always meet the expectations or even basic needs of the communities involved in their functioning.

One of the most important groups involved in the operation of medical facilities is medical personnel. The main purpose of their activities and work in medical entities is to meet the health needs of patients, by making a diagnosis, treatment, care or bringing relief in suffering. For managers it is not the easiest group to manage and most problems are caused by doctors - people with high qualifications, a high level of intelligence and clearly defined views. These problems stem from various detailed objectives, which both groups: managers and medical staff have to implement. Both

the group of managers and physicians are, in fact, aiming at the well-being of the patient, and thus the proper functioning of the health system, but then the health system would collapse. If doctors decided that, they would be likely to ensure the collapse of the system (Edwards et al., 2003). Despite the fact that the medical staff is primarily focused on the patient, and the manager is obliged to care for the financial liquidity of the facility, effective use of resources or implementation of the adopted health policy, both these professional groups aim to provide patients with healthcare services. This diversity in the approach to achieving the goals of the superior institution can often be and is perceived by medical personnel as a negative phenomenon, and the attitude of the management is considered to be imperious. However, research indicates that the managerial control of their work has a deeper meaning and may constitute a kind of development opportunity for the doctors themselves (Kuhlmann et al., 2013). Relationships between these different worlds, such as medics and managers, should be called a kind of coordination, and their goals should be called supplementary. Only this approach and the correct relationships between physicians and management imply the organization's success.

Nowadays, especially large medical facilities are characterized by such a structure that puts at the highest management level of managers and management, however, the doctors delegate the functions of managers, medical directors, or branch heads - the head of the department.

There are a number of challenges for doctors in a management position. Among them the most important are: managing colleagues with doctors and achieving the organization's goals. Therefore, they are required to be able to maintain proper, from the point of view of achieving goals, relationships between managers and physicians, diplomatic skills, caution regarding the risk of medical and management risks, and finally organizational education.

Despite the clear diversity of positions occupied by managers and physicians, hence the so-called diversity of cultures of different professions, the main goal of contemporary institutions and their positions should be independent autonomy (Degeling et al., 2003) or engaged management (Mintzberg, 2013), which will enable each group to use their competences and skills to achieve a common goal, impossible to see for each group separately.

Both managers and medical staff seem to be an obvious link in the process of managing medical facilities, at least in the stage of their observable functioning. For a change, the patient who is considered the most important link in every health system, its cause and the main subject through the centuries benefiting from health services, was not rather associated with influencing the functioning of health institutions.

The dynamically changing conditions in which health systems operate, the diversity of environments, development and changes taking place in the patients' environment, however, have an impact on how the patient is perceived by the healthcare provider today, what health rights are available to him and what involvement is expected from the patient himself. The common trend in the health policy of various countries emphasizes the protection of patients' rights and directs their goals in such a way as to satisfy them and, to the best of their abilities, meet their expectations, although diversity in this matter remains large in various countries (Bielecki and Nieszporska, 2017). For the patient's sake, as well as the system itself, a series of studies of the medical services market concerning the satisfaction of health services is carried out,

often combining the assessment of the entire system with the patient's opinion on it (Nieszporska, 2016).

Involvement of patients in the process of providing health services is a common practice today and takes place at various levels. The first of these is the stage in which the patient makes decisions and chooses an alternative treatment path, which often comes down to the decision to initiate therapy or reject it. At this stage, the first conflicts of the beneficiary with the medical staff may appear, which having a wider than the patient's medical knowledge, advocates taking treatment, while the patient himself rejects it. This is often connected with the patient's unconsciousness, his lack of information, and thus the lack of connection between the doctor and the patient. The proper relationships between them means not only empathy, understanding, compassion on the part of the doctor, good communication between them, but also the willingness of the patient to know the treatment options and jointly take the best decision for himself. Involvement of the patient in this area of the system's activity is expressed through the possibility of choosing a provider, participation in medical consultations, creating patient self-help groups, and finally the possibility of lodging a complaint in the appropriate institution, or referring to the patient's rights advocate supported by relevant regulations and laws.

The patient's involvement in the process of providing health services, and thus in the development of the strategy of healthcare entities, also boils down to many other initiatives. Among them, special attention should be paid to engaging in medical research in order to identify the most effective methods of treatment, thus making the consumer a healthcare provider an entity involved in each stage of creating, conducting and disseminating clinical trials.

The next functions of the patient in the management of medical entities are: inclusion in the process of planning, development and restructuring of services, or taking into account the patient's opinion during the evaluation of the facilities. This type of involvement can have an impact on the creation of new sources of information for patients, increased access to services or modification of services offered.

A lot of space in the analysis of the health care market is concerned with the involvement of local communities in making decisions regarding healthcare. The World Health Organization has supported such initiatives for a long time, which is reflected in the recording of the People's Rights and Declaration of Alma-Ata, 1978 as written, “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care”. Today, the involvement of public opinion in sector management comes down to participation in professional organizations, participation in the supervisory boards of local organizations, consultation with the local community, development of the ability to take more responsibility for assessing their own needs and health problems, or assessing the effects and making necessary amendments to the goals and solved health problems. However, as the experience of many countries demonstrates, explicit and legally sanctioning the participation of patients in the process of managing the institution, setting its goals, as well as cooperation with medical staff is possible and works in the aforementioned cooperatives, especially the multi-stakeholder cooperative type. They are working today in the field of: provision of home care services for the elderly and disabled residents of the district (Lund, 2011) day-care, home health care, educational services or other (main) health or social services (*Multi-Stakeholder Cooperatives Manual. Solidarity as a Business Model*).

5. CONCLUSION

The exchange of medical services can be considered as a classic production process. With some outlays (financial, infrastructural, human), the care provider through the diagnosis, treatment or therapy becomes the service provider. The patient, becoming a mode in such a production model, uses services that meet his health needs. The problem, however, is that it is difficult to manage such a process, because although the recommendation of a primary practitioner, for example, applies to a specialist for laboratory tests, only the patient is able to decide whether he or she will actually do it. However, even if he takes up the challenge, he goes to another provider, who having other expenses than the first one is usually not subject to the same superiors, the same management processes and the whole process becomes simultaneously impossible to control.

Therefore, in the process of managing a medical entity, the circumstances of the disease occurrence, the patient's reaction to the treatment process as well as its individual features are not without significance. Similarly, the personality involvement, empathy and substantive skills of medical personnel are of great importance in this process.

In today's medical facilities however, management procedures, treatment plans and clinical guidelines are introduced to improve the management process, which contribute to the transparency of healthcare. However, the key issue remaining in connection with the management of the system is the separation of the institution, organization and perhaps the person responsible for the management process. It can be used by employers, insurance agencies, sickness funds, groups of service providers, state administration at the central or local government level. In the presented paper the role of the patients, medical staff and the relation between them were emphasized in the management process But the model of specific cooperation of all these institutions was also presented. It makes managers, medical personnel and patients directly responsible for the functioning of medical facilities. This is what happens in the case of medical cooperatives. The legitimacy of their functioning on the social and in particular, health is confirmed by numerous cases of such initiatives created and operating in the world but also by the game theory or the common pool resources theory. However, they require from the groups involved: knowledge, willingness, financial, time and emotional expenditures (Hinchcliff et al., 2014), which often involves long preparation of societies, the liberation of their members from ubiquitous indifference, egocentrism and claim.

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