



Governance: Blending Bureaucratic Rules with Day to Day Operational Realities

Comment on “Governance, Government, and the Search for New Provider Models”



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Abstract

Richard Saltman and Antonio Duran take up the challenging issue of governance in their article “Governance, Government and the Search for New Provider Models,” and use two case studies of health policy changes in Sweden and Spain to shed light on the subject. In this commentary, I seek to link their conceptualization of governance, especially its interrelated roles at the macro, meso, and micro levels of health systems, with the case studies on which they report. While the case studies focus on the shifts in governance between the macro and meso levels and their impacts on achievement of desired policy outcomes, they also highlight the need to better integrate the dynamics of day to day operations within micro organizations into the overall governance picture.

Keywords: Health System Governance, Macro-Meso-Micro Levels, Bureaucratic Rules, Front Line Staff, Culture, Trust

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Health reforms in many countries have flowed from a desire, reified by an organizational paradigm, to reduce the dominance of government bureaucracies over health systems in command and control frameworks. Over the last two decades, these reforms have evolved and a degree of policy learning has taken place. This is manifested by the increasing focus on concepts such as governance, stewardship, and solidarity. This is because the impact of health reforms, in particular market or competitive oriented policies was not clear, or perhaps even comfortable to contemplate. In recent years, the implications of reforms for governance, the shifting roles of governments in health systems, and accountability for the results of reforms have begun to be more closely examined.

The paper by Saltman and Duran² points out that health systems, like ships, have levels. Governance is found at the *macro*, *meso* and *micro* levels of the system, and the nexus among them. The authors stress the meso level, where

“the admixture of managerial decision-making with policy-tied issues of multiple stakeholders results in two different types of performance indicators. While, traditional, mostly macro level concerns about equity and access remain valid at the meso level, a key meso level focus is on the internal operational factors that actually produce and deliver services: the day to day efficiency and effectiveness of clinical teams, departments and clinics for example.”

Moreover, the authors attend to the additional dimension of public vs. private meso level organizations, and the challenge of molding governance to cope with the different traditions, motivations and cultures of these two sectors, and to try to align both of them with policy goals set at the macro level.

The problem dealt with in the paper is that the health system is

not a ship or a boat that is being rowed, but, rather, a complex, adaptive system. During the 1990s, this type of new public management (NPM) model looked straightforward across many countries: the United States, the Nordic countries, the Netherlands, Germany, and Israel to name several. But, as those of us who followed its implementation in these different regimes and cultures noticed almost immediately, and to our delight since it offered much material for health policy analysts to work with, the form it took varied widely. Not all the skippers limited themselves to steering, and not all the rowers simply played by the rules. In some countries, the rowers were limited to not for profit firms, and in others private enterprises were admitted. In some cases, the “breakup” of a government monopoly on finance and provision of healthcare led to markets in which highly concentrated firms dominated. Unresponsive government bureaucracies gave way to rigid budget holders, less concerned with satisfying clients as with guarding budgets or even gaining surpluses. For governments, setting the rules of covered benefits, pricing and quality assurance turned out to be much more complex than drawing clear a plimsoll line above which the ship cannot sail, though the latter is what many policy-makers and their advisors pretended and perceived themselves as doing.

Enter Governance, along with its companion terms Stewardship and Solidarity. The health system had now become littered with multiple stakeholders, often in conflict with one another. The injection of market mechanisms brought on by NPM has created strong incentives to cream skim, attract custom by offering a broad array of services including the latest medical technologies, cut costs by denying those very same services, negotiate hard bargains and offer citizens narrow selectively contracted provider networks

and also offer freedom of choice. The rules of the game instituted by government, or the sponsors, or whoever else was governing the system, proved inadequate to steer any ship through these currents of conflicting interests.

Saltman and Duran, long time observers of these trends, are not satisfied to watch these rowing or sailing matches as passive observers. In the best tradition of academic policy analysts, they are the Coast Guard, monitoring, intervening and attempting to keep the boats afloat with insights gained as the journey unfolds.

In their introduction to *Governance: Government and the Search for New Provider Models*,¹ the authors state that, “the article finishes by observing that good governance cannot be reduced to a set of arbitrary bureaucratic rules but rather needs to be grounded in the day to day operational level if it is to have the desired effect on health sector reform outcomes.” This implies, as others have noted³ that there is a gap between macro policy measures and the front line of healthcare providers. In other words, the aspiration of NPM to separate government from the day to day activities of front line providers is not achievable. The challenge is to identify new models, some of which are likely evolving in the wake of NPM inspired reforms, for mediating this top-down bottom-up tension in order to achieve the degree of coherence necessary for achievement of health policy goals.

To fulfill this mission, Saltman and Duran provide case studies from Sweden and Spain, regarding reforms in primary care and the hospital sector respectively. In the Swedish case, the reforms were aimed at improving the responsiveness and continuity of primary care services. From 2007, in a number of Swedish counties, citizens were granted the opportunity to choose among not only public primary care clinics, but also private ones. This apparently led to increased access, but questions remained as to continuity of care and its quality, particularly in private clinics, especially those based on a for profit financial model. Not as many publicly employed primary care doctors left public employment as policy-makers might have anticipated. Perhaps this is due to a misreading of the relative weight of financial incentives compared to longstanding traditions of social solidarity and belief in public provision of healthcare on the part of physicians.^{4,5} Government succeeded in steering the system towards increased diversification of meso level providers and patient choice, both values that, apparently, could not be produced by governance within a command and control system, or even in a decentralized, but totally public system due to various bureaucratic obstacles. On the other hand, the entrance of new primary care “owners,” especially private ones, into the system raises issues of transparency and accountability that remain unresolved. In other words, the mechanisms of governance are unable to guarantee these key values.

Turning the Spanish case, the governance shift involved granting increased autonomy to public hospitals. Spanish policy-makers experimented with four different models: Public health enterprises in which staff are non statutory and reimbursed on a performance basis; Foundations which are not for profit organizations that can decide on their own basket of services and investments, and staff are not statutory; Consortia, which result from mergers of public authorities, have autonomy to sell services beyond the public basket and

staff are not statutory; and Administrative Concessions, in which a private company builds and operates the hospital, and staff have the option of remaining statutory or moving to non statutory status. One aspect of governance that has been problematic according to the authors is the lack of evaluation of the results of introducing these new institutional arrangements. Supporters of the reforms argue that the new models demonstrate increased efficiency and higher patient satisfaction rates. Opponents, apparently including professional unions, argue that the semi-autonomous hospitals have higher costs.¹ To the reader, this is not surprising, as all the models convert statutory workers to non-statutory status, but the authors do not highlight this aspect.

This last point highlights an undercurrent of conceptual tension in the paper. As mentioned, the authors state clearly at the outset that they focus on the meso level. But in their own words it is at the meso level that macro policy interfaces with internal operations and “at the meso and micro levels, in particular, management as well as policy decisions become inexorably intertwined as part of institutional governance.”¹ This suggests that, for example, how meso level organizations govern their relations with the micro level, primarily front line physicians, nurses and other providers, would be addressed more explicitly. This is not so much a critique as to point out that the paper suggests that more work needs to be done to assess the implications of governance shifts between the macro and meso levels on what actually happens at the micro level. As pointed out elsewhere, if front line providers’ socialization and perceptions are disparate from the intentions of policy changes at higher levels of the system, this must be attended to by governance in order for reforms to have their desired impact.^{4,6}

This returns us to the authors’ point that “good governance cannot be reduced to a set of arbitrary bureaucratic rules.” Their case studies illustrate that behavior of individuals, such as physicians, in reacting to new rules are sometimes difficult to anticipate, for example Swedish physicians in deciding whether to abandon the public sector for more private employment relations. How does front line staff react to non-statutory status in the Spanish case? And, as the authors point out, what is the impact on quality and continuity of care of the managerial steps taken by meso level organizations to increase efficiency? It is beyond the scope of this commentary to answer these questions. However, it appears that relative to the macro and meso levels, less is known about the perceptions and responses of micro level actors regarding changes in governance. How do physicians react to having their performance measured? What are the implications of policy changes for professional roles, for example the shifting of more responsibility to nurses, nurse practitioners and physician assistants? How does governance manifest itself in the modes of communication between meso level managers and front line providers? Indeed, how much of change in delivery systems is initiated top-down and how much emerges from the coping of front line providers with shifting environments – more competition, constrained resources, technology change- as well as with the top-down policies themselves? There is a nascent literature on trust in health organizations, intrinsic vs. extrinsic motivations, the use of big data in health management, and continuous

quality improvement. But this literature remains tentative and inchoate, and certainly not well-integrated with the literature on governance illustrated by the paper by Saltman and Duran. All of this suggests that good governance in changing health systems under persistent pressure to contain costs while improving access and maintaining quality and equity, requires a smooth meeting of top-down policy initiatives, that inevitably take the form of rules such as incentives and regulations, with bottom-up innovations in micro delivery systems involving front line staff. Solidarity and trust appear to have a role in enabling the stewards of the system to induce good governance. Dealing with these elements coaxes analysts and policy-makers to venture beyond the boundaries of clear, if illusory, bureaucratic rules and bottom line measures, into the realm of culture, norms, and values that are more difficult to define, measure and manage. But that is where good governance lies.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

DPC is the single author of the paper.

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