JournalScan

Respecting political dynamics in health care

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The articles collected for this issue relate to political dynamics within health organisations. The term politics is used in the sense of "the often internally conflicting interrelationships among people in a society" (*American Heritage Dictionary of the English Language*, 4th edition). In this case the society is health care. There is a tendency in a lot of articles to dismiss such conflict as interpersonal professional intransigence or as inherent resistance to change, rather than to acknowledge the validity of alternative views or to see social settings as inherently political arenas. But as the articles below show, political dynamics are central to organisational life.

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Tensions in change

An article in the *British Journal of Management* shows the capacity of political forces to undermine change if they are not openly acknowledged and negotiated. Researchers followed the implementation of a Personal Medical Services pilot of which "the professional, organizational and managerial objectives . . . were the focus of an evaluation [that took place] between 1998 and 2001". A range of data was collected including unstructured discussions, observation, discussion papers, notes from meetings, and emails.

Researchers soon found that "very few people had an involvement in the drafting of the document that formulated the aims of the pilot. In the early days of the field work it became apparent that the changes ushered in by the pilot had generated feelings of resentment amongst many staff who reported that there had been little communication or consultation about the planned changed. The nurses in particular had felt alienated by the way the changes were initiated and felt that the doctors had been seen as the only stakeholders whose commitment had been sought."

The researchers found most of the drive for the initiative came from the "general manager of Maryport Group Practice (MPG)". His powerful position came "as a result of his management of fundholding in the 2.5 years prior to the pilot and increasing dependence of the practice on his skills". Six months into the pilot, however, he resigned and four months after that the nurse manager also resigned.

These two resignations exposed fundamental tensions in the structural design of the pilot which were never effectively resolved. In terms of nursing management, the West Cumbria health care trust had assigned MHS (Maypole Health Services, a newly created entity) "absolute clinical control" over nursing staff and envisaged itself being "no more than a staffing agency". In practice, however, this proved to be an unworkable arrangement. Since the trust remained the employer of the majority of nurses at the site (except the practice nurses), it sought compliance with *its* policies regarding clinical governance and risk management, for example. Once the nurse manager resigned and was replaced by a non-clinical and non-managerial appointment of "nurse facilitator", the trust MHS tensions were exacerbated. Nurses were never clear from which organisation top down management was coming. They were not sure of the boundaries between their employment as a nurse by the trust and managerial directions of those within MGP (the practice).

The second major tension in the design of the pilot concerned the position of MGP as the legal entity of the new organisation (the NHS could not recognise MHS as a legal entity). This meant that, although the application document vested the management board with an executive role in the pilot, the partnership (i.e. the doctors) always felt that they were responsible for the overall management of the pilot and never acceded authority to the board. As long as the first general manager remained in post, the partnership were themselves controlled. But when he resigned and was replaced by an "operational manager" (the term was meant to signify a post with less "authority"), the tension between MHS and MGP became real rather than latent. MGP reported to the management board [of MHS] that it would "not lose its dominant role in management and will retain its reserve powers in financial matters".

"At a stroke the new decision making structures established by the pilot were made to look weak and perfunctory and the vision of an integrated and multidisciplinary health care service with corporate management accountable to a board proved incompatible with a medical partnership model of organizational governance."

The authors considered eight factors that might help explain the failure of the pilot, taken from Pettigrew, Ferlie and McKee's concepts of receptive and non-receptive contexts for change.

- Quality and coherence of policy
- Key people leading the change
- Environmental pressure
- Supportive organisational culture
- Effective managerial/clinical relations
- Cooperative interorganisational networks
- Simplicity and clarity of goals
- The fit between the change agenda and the locale

The factors offer valuable points on which change situations can be mapped, but it has to be understood that none are static and relationships between the variables will vary from place to place and from time to time. There are inherent internal tensions within organisational situations and the political balance that negotiates them is always liable to change, as it did following the resignations of key members of staff in the example discussed. It is the pattern of dynamics between factors that is important.

The authors say "very little is given in the social world: so what looks like a clear set of aims and objectives in an application document" may not be so in practice. Given these tensions, an objective "still has to be implemented" and strategies for doing so have "frequently to adapt to circumstances in doing so".

▲ **Newton J**, Graham K, McLoughlin K, *et al*. Receptivity to change in a general medical practice. *Br J Manage* 2003;**14**:143–53

Marginalising the professional view

Readers may question the methodological rigour of an article where the data presented are from teams in which the author has worked ("the interviews and observation were overt, and the intention was to draw from the tradition of social anthropology and ethnographic observation"), but Malcolm Carey's account of his professional life offers a powerful account of what he sees as "de-skilling". He and colleagues offer testimony to academic descriptions of change in the profession: "a work culture haunted by perpetual change", "the ever more clearly defined and hierarchical lines of rank", "the top down push for a sense of personal efficiency and effectiveness", and "the labyrinth of convoluted technical procedures that now tailor the occupation".

The key change has been the "marketization" of care. "Legislative instruction embodied in the NHS and Community Care Act

1990 [meant] local authorities sold off many of their core services such as residential and children's homes and day centers, leaving care managers with little choice but to purchase from the ever expanding, and expensive, independent care sector."

The paper identifies four main areas that together have overwhelmed a professional notion of social work:

- procedure has become the core component of care management,
- management styles are related to ensuring the completion of process,
- budgets not training or professional skill are the dominant force in decision making, and
- there has been a deterioration in "the quality of available services that are accessed by clients".

It is argued that "clear procedure has merged as a prerequisite for 'good practice'". The majority of a care manager's time is spent within an open office setting, and therefore away from the community. As well as the time completing the dreaded forms, there is also a substantial period of time taken up by faxing, photocopying, and writing letters, etc. A newly qualified social worker is quoted as saying: "*I've only just qualified but already I'm thinking of ways out. I might try teaching children with learning disabilities as then I would actually be helping the people I intended to when I first started the social work course. This is not social work, it's an office job*".

The enforced imposition of an alien culture and vernacular, namely that of the market and the relentless drive for cost cutting and efficiency, has only led to further confusion and anger felt by practitioners. Many of the care managers the author interviewed had entered social work due to personal experience, such as parenting disabled children or caring for people with a terminal illness. Initially their motivation was apparently driven by an ethos of care and compassion. New idioms, such as those of efficiency and economy, which have now possessed social ace, therefore appear insensitive, inappropriate and vulgar—especially when they nearly always imply an encouraged drive for cost cutting an a quest for cheap and often poor services.

It can be argued that care management in practice is removed from the definitions of social work as regards the influence of values and theories as they are designed within textbooks, academic papers, or in college and university departments that teach the Diploma in Social Work. Courses imply that "advocacy and user empowerment work would follow qualification. For many, such emancipatory schemes suddenly appear as mere fantasy in view of the daily grind in the office."

▲ **Carey M**. The anatomy of a care manager. *Work, Employment and Society* 2003;**17**:121–35

Supporting multi-perspective analysis

An article in *Social Science & Medicine* written by three health economists begins from the premise that while "economic analysis can provide useful analysis into priority setting in health care", the problem is that this analysis is normative—tells decision makers what to do—and does not engage those affected by these decisions or the marginal political issues so central to resource allocation. The researchers set up an economic model for the 20 divisions of general practice in Queensland, Australia to decide through a process of "group deliberation" how funding arrangements for allocation between divisions might change. The overall pot of money would not be increased. The authors presented economic analysis and models of each potential option to aid decision making.

The paper "focuses on the politico-economic issues in negotiating with the various competing interests". Economists are fond of game theory and the main worry within health organisations was the knowledge that the analysis would create "winners and losers"—in economic speak, a "zero sum game". The authors say the key to a successful outcome in this scenario lies in a "process of mutuality", seeing the aim as producing the best outcome overall. The main interest of the researchers was in observing how the game would play out because consensus "would require some participants to act against what could be seen as their self-interests". Each division had a veto over reform; agreement had to result.

The process involved in undertaking these deliberations was designed to be both consultative and participatory. Workshops involving all divisions were held as well as the formation and meeting of working groups who looked at aspects of the funding formulae and non-formula based options, such as "changing divisional boundaries" and "consolidation of divisional activities (such as payroll and other administrative services)". Participants were asked to consider issues beyond their own localised interests.

Following initial discussions, three options for resolving these problems were put forward for further investigation and debate: centralising group buying, amalgamation or collaboration, and funding formulae reviews (analysis of weightings and base grants). Surveys were sent to all divisions which asked, among other things, the implication of gaining or losing $50 000. "Smaller divisions commonly responded to the first hypothetical situation (gaining $50 000) by indicating that they would hire more staff, take out vehicle leases to travel to outlying areas, and offer more practice support services—in particular information technology. The larger divisions generally indicated that they would consolidate or undertake more strategic work. With respect to the second hypothetical situation (losing $50 000), most divisions indicated they would cut down on population health services or programs. Some smaller divisions reported that they would become unsustainable under such a scenario." A second survey found that the undertaking of core activities per division was $400 000 per year. "At that time there were six divisions receiving funding less than that amount."

A discussion paper was circulated that highlighted six options. Five entailed a reallocation from larger divisions to marginal/smaller divisions and one entailed the opposite. Explicitly identified in this discussion paper was how much each . . . would gain and lose under each option. The options were then discussed in a meeting. "Several larger divisions felt that whilst smaller divisions clearly required additional funding, the larger divisions should not be financially penalised for their efficiency and ability to achieve economies of scale." In time, discussing various options, divisions came to the view that neither large nor small divisions should lose out on the basis of the funding formulae; instead, "the emphasis [was on] restructuring within the marginal divisions, along with financial incentives for doing so".

Ultimately, the consultative process was unable to come up with an agreed recommendation for specific changes to the formulae. Given that the federal government offered no additional funding, this outcome could possibly have been anticipated as any change would create winners and losers. However, "one of the important implications of this process was that it initiated a degree of change in relationship between divisions by exposing some of the opportunity cost of this reform process".

The main value of the work has been as "a means of conveying to participants the nature of the choices involved—in effect, setting out the 'rules of the game' to participants". "Furthermore, this process was iterative whereby respondents were made to reflect as a group on their responses and to some extent justify and debate them. As a result, participants were pushed into considering issues that, from the point of view of their own short term interests, would not necessarily have entered into consideration. It did not force them to abandon self-interest. Instead it enabled them to be more sophisticated in their pursuit of it by bringing to bear the external constraints that determined whether an option was feasible."

The value of the process was "to bring to the forefront a number of other options such as amalgamation and consolidation [which] prior to the undertaking of this exercise . . . would have been less acceptable to the marginal divisions".

▲ **Jan S**, Dommers E, Mooney G. A politico-economic analysis of decision making in funding health service organisations. *Soc Sci Med* 2003;**57**:427–35

What does senior management support for quality mean in practice?

Experts routinely identify "the support of management" as one of the key "principles underlying successful quality improvement efforts". The aim of a paper in the *Journal of Healthcare Management* was to identify and define aspects of this role in practice.

The authors selected hospitals for their research to represent a range of sizes and geographical regions in the US and interviews were conducted with physician, nursing, quality management, and administrative staff.

Respondents' descriptions of the nature and level of management involvement and support for quality improvement efforts differed substantially among the study hospitals yet, from these positive and less positive accounts, several common roles and activities characterised senior management support as seen by people within organisations.

- Personal engagement of senior management was described as paramount to the success of quality improvement efforts in the sense of advocacy of improvement efforts, participation in quality improvement teams, and dissemination of quality improvement data.
- Senior management relationships with clinical staff differed widely from cooperative and respectful to polarised and strained. "Several respondents . . . noted difficulties when medical staff perceived senior managers' goals to be divergent with their own clinical goals". One says of a manager with whom he had a particular problem: "To me, his was an obstruction. He wasn't a doctor. He didn't understand what we were talking about. Yet he had the power to make decisions."
- Progress in promoting a quality improvement culture was seen as mixed with regard to "goal setting and the degree to which quality improvement was integrated into overall organisational goals" and "norms regarding collaboration across departments and disciplines". Often teams regarded efforts as "separate from the larger organizational goals".
- Support of quality improvement with organisational structures was regarded as important by nearly all those interviewed, but differed markedly. Some concentrated quality improvement as corporate targets slightly removed from teams, while others were decentralised and not necessarily connected to wider aims. It was rare for these levels to be connected.
- Procuring organisational resources is seen as a key senior management role in supporting organisational improvement. Staffing is seen as a problem. A nurse specialist interviewed said: "over the last year we've been so short staffed that one goal was just to get the necessary things done". The lack of information was commented upon too: "the hardest thing for me is not having the kind of data I want" (director of physician quality management).

In comparing successful and less successful hospitals, "differences were apparent in the areas of advocacy for quality improvement, relationships with clinical staff, norms regarding interdepartmental and multidisciplinary collaboration and procurement of organizational resources".

The authors consider that "management support is a multifaceted concept that encompasses a variety of aspects of administrative activities, roles and interventions". Those seeking to assess the level of management support for clinical improvement might learn from this study.

▲ **Bradley E**, Holmboe E, Mattera J, *et al*. The roles of senior management in quality improvement efforts: what are the components? *J Healthc Manage* 2003;**48**:15–28.

What does public sector improvement mean?

"In the last two decades there has been a pandemic of public sector reforms. Governments across the globe have reorganized and restructured public organizations in an effort to produce better services. The current Labour government in the UK is engaged, as are others, in this quest for public service improvement. Indeed, the Blair government has stated that delivery on its pledge to raise service standards is the single most important criterion for judging the success or failure of its second term of office. This has triggered a vigorous policy debate on the most appropriate path toward higher performance . . .[but] there is a prior question that has so far received little attention: what is public service improvement?" The author writes about the Performance and Innovation Unit within government, the Prime Minister's Delivery Unit, and the Commission for Health Improvement. "None of these bodies has produced a comprehensive definition of the concept that is supposedly central to their missions."

Although the author believes them to be distinct, he notes that concepts of organisational effectiveness and public sector improvement have come to be seen as synonymous. The question this raises is that "public sector improvement . . . is usually concerned with the performance of multi-organisational networks rather than the achievements of single organisations". Nevertheless, the paper discusses the strengths and weaknesses of five approaches to public service improvement.

- The goal model "is the oldest and, on the surface at least, the simplest model of organizational effectiveness". "Over time, these goals may change or be embellished but they continue to guide the strategic direction of an organisation [and] the extent to which such goals are attained can be used to assess the degree or success of failure". "Public services are clearly expected to achieve something and to produce tangible results that satisfy key stakeholders". There are three key problems with the model:
  - public sector organisations may not have goals that are expressed in legislation or other documents;
  - goals that are explicit are likely to be broad statements of intent rather than concrete objectives;
  - within these there are "a multiplicity of goals".
- The systems resource model says "an organisation is effective if it has the ability to exploit its environment in the acquisition of scarce and valuable resources" or that "organisations that obtain the biggest share of available resources . . . are deemed to be the most effective". The problems are that "the survival of growth of public organisations is no guide to whether services are improving" and the "ability of a public organisation to acquire resources is also likely to reflect its political support". "Nevertheless, the . . . model does highlight an important policy issue. Does an injection of extra resources lead to service improvement?"
- Internal processes model uses "organisational attributes as proxies for effectiveness", such as their information and budgeting systems or personnel practices that promote job satisfaction and employee welfare. "The presumption in these cases is that particular sets of internal processes are strongly related to organizational performance. The problem is . . . that evidence to substantiate this view is not available."
- Competing values model "is an attempt to synthesize elements of the three models" already discussed and "assumes that all organizations face conflicting criteria of performance". Models trade off a matrix of external or internal power against control and flexibility over processes. "The model's strongest contribution to an understanding of public service improvement is that the *contradictions* between different interpretations of effectiveness become explicit".
- The multiple constituency model "abandons the search for universal criteria of organizational effectiveness. The simplicity and order of the competing values framework is replaced by the complexity and mess of practical politics" as the "model assumed the performance of all organizations is judged by a variety of internal and external groups". "Even if all stakeholders use similar criteria, the relative weight that they attach to each one is likely to vary. Furthermore, the criteria and weights shift over time as preferences change and as the balance of power alters between groups."

How can public service improvement be defined? The author dismisses the utility of the systems resource and internal process models as "largely concerned with potential sources of improvement rather than improvement itself" and the variables they consider "at best, rough proxies for higher service standards rather than direct measures of this concept". "The competing values model is also weak because it draws substantially" on the previous two. "By contrast, a combination of the remaining two models is a positive basis for defining and measuring public service improvement."

The strength of the goal model is that it emphasises the "content of improvement" involving concepts "that are likely to be valued by all stakeholders, even if they disagree about the weights that should be attached to them. This 'realist' view of social phenomena compensates for the weakness of the multiple constituency model which assumes that improvement consists only of the subjective impressions of powerful stakeholders. In effect, the goal model pulls the multiple constituency model back from the brink of the postmodernist morass of extreme relativism. The

strength of the multiple constituency model is the recognition that concepts of improvement are political rather than technical. The model illuminates the process by which improvement is defined, rather than the content of the definition. This effectively compensates for the weakness of the goal model which neglects the origins of public service improvement criteria."

"Taken together, the goal and multiple constituency models imply that a working definition of improvement must incorporate both the substance of organizational achievements and the inherently political nature of judgements on success or failure."

▲ **Boyne G**. What is public service improvement? *Public Admin* 2003;**81**:211–27

Conclusions Political dynamics in organisations cannot be ignored. There needs to be greater consideration of differences in change and quality improvement initiatives.

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