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MAKING SENSE OF HEALTH CARE MANAGEMENT: THE STREET LEVEL PUBLIC ORGANIZATION (SLPO).

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Abstract

Public service reform in modern economies has placed an emphasis on effective planning and management of service delivery to the citizen-client. This paper draws on the concept of the Street Level Public Organization (SLPO) to examine the problem of government's top down implementation of planning reform in the delivery of public services. It does so, by exploring the implementation of strategic planning in the health sector and drawing upon field work from such implementation in the health services in Ireland and Canada. The SLPO model (McKevitt 1998) is used as an explanatory tool to add to the public sector reform debate. One issue that emerged from this review was the lack of recognition of the complexity of the healthcare environment and the stakeholders within it, in attempting to implement planning reform. The approach to management of key stakeholders such as health professionals and their clients, according to Taylor and Kelly (2006) is bolstered by the belief that professional discretion is held to be an obstacle to public service reform. Thus, requiring top down systems and management to reduce the scope of such discretion, so as to standardize responses to service need and control demand. However reform of the healthcare system cannot be reduced to a mechanical exercise which consists of implementing a rational plan to improve the effectiveness of resource use, but is a difficult process of negotiation between the key actors as defined by each society's history and culture. This paper posits explanations for some of the difficulty in aligning strategy with responsive planning in public sector reform.

Key words: service planning, policy implementation, control, street level public organization

INTRODUCTION

Service planning is part of a cluster of health sector reforms introduced in Ireland in the last decade and a half. This paper seeks to utilize McKevitt's (1998) model of the Street Level Public Organization (SLPO) to explore the tensions and difficulties in implementing public sector reform in the health services and to add a more coherent response to the critique of neoliberal reforms. Research that focuses on the street level perspective according to Brodkin (2011a:i199) aims to reveal the organizational mechanisms that link or delink the opaque spaces between formal policies and outcomes. In so doing, this paper draws on field work examining the strategic implementation of service planning in the Irish health services. It poses questions about the ability of the control mechanism, the legislation that has introduced the top down implementation of service planning reform to deliver on strategic planning in the healthcare sector. It also questions the organisational capacity of the healthcare sector in Ireland to manage the espoused strategic change. A comparison is drawn with the Canadian experience (in Nova Scotia) in both these regards.

This paper is divided into five sections. This section introduces the paper and the healthcare context. The second section explores the theoretical and explanatory constructs; the new public management (NPM) influence in the public sector, the management of control and implementation of strategic planning and the implications of the control function in public sector reform by using the SLPO model. The third and fourth sections draw from research in street level public organisations in Ireland and Canada with an outline of methodology, results and discussion. In so doing, this paper seeks to make a conceptual bridge to draw attention to the need for increased flexibility and a wider recognition of all the stakeholders in

the reform process. As Piore (2011:162) exhorts: such a concept (the SLPO) can 'become a bridge over which the sociological imagination enters the public policy debate'.

Looking at the healthcare context; in Ireland, the Government, the Minister for Health and the Department of Health (DOH) are at the head of health service provision. Until 2006, the Irish healthcare sector comprised a health board management structure, eleven health boards in all (now termed health regions with their local health offices), and is described as an integrated public health care system. The boards (SLPOs) were the main providers of health and personal social care at regional level. Of note to this comparative paper, is that Canada's health care system is highly decentralized with the provinces (and territories) primarily responsible for health care (Marchildon 2005). Most public health services are organized or delivered by regional (or district, in the case of Nova Scotia) health authorities that have been delegated the responsibility to administer services within defined geographic areas by their ministries of health at a provincial level. For the purposes of this study a District Health Authority (DHA) in Nova Scotia was chosen. This formed an interesting comparison with the Health Boards in the Irish context. In comparison to Irish developments, which have focused on increased centralisation of services, the Canadian system has developed in a decentralized fashion with local control and consumer choice.

The Strategic Management Initiative (SMI) (1996) forms the backdrop to the Irish public service reforms over the last 16 years. One of the central mechanisms of the SMI is the devolution of accountability and responsibility from the centre to executive agencies. Service planning in the Irish health sector is seen as part of this strategic planning ethos. The Irish health care strategy (2001) was explicit as to the intent of service planning; which was to introduce strategic planning into the health care arena. Inherent in such a promise is the use

of the strategy to determine priorities and underpin planning, in line with its principles of equitable, accountable, quality focused and people centred services.

Service planning was introduced back in 1998 (1996 Health (Amendment) Act) in the health care services in Ireland to function as 'a strategic management tool' (DOHC 1998). The crucial link between resources and clear objectives was emphasized. The legislation was welcomed by politicians and seen as a control on health spending. It represented some changes in the framework of accountability for health services management and obliged health boards to produce an annual service plan as well as to secure the '*most beneficial, effective and efficient use of resources*'. However, it was not explicit on how this was to occur. The assumption was that the stated principles of the Health Strategy in delivering health services would emerge through implementation of the Act at health board or DOHC level. There was a disconnect between those that crafted the policy from those that were to implement it.

This paper also draws on the Canadian experience of service planning. Whereas, according to McKevitt (1993:311) the Irish health care system and its legislation (1970 Health Act and successor 2004 Health Act) has no '*strategic framework that would guide the allocation process, provide for a control system responsive to agreed objectives and give legitimacy to the resource decisions of Irish health care managers*', in comparison, Armstrong, Armstrong and Fegan (1999) note that the Canadian system and its legislation emphasizes a clear set of national priorities that serves as an underlying rationale for the health system. The Canada Health Act (1984) sets out the primary objective of Canadian health care policy, which is '*to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers*.'

According to Dawson, Rathwell, Paterson, Butler, Cobbett, Pennock, Anderson and Kiefl (2004) the focus of the planning reform in Nova Scotia was on integration of health services under a regionalization umbrella and with a population health focus. The structures recommended to achieve these goals were a network of local Community Health Boards (CHBs) with voluntary participation from citizens under the umbrella of District Health Authorities (DHAs) (analogous to Irish Health Boards). The CHBs operate in an advisory capacity to the DHA and legislation mandates that their 'Community Health Plan' must be taken into consideration by the DHA in preparing its annual service plan. The DHA's function is that of policy implementation and evaluation (DOH 1999). This has paved the way for needs based planning in the Nova Scotian health services, an aspect of planning that is notably absent in Irish health planning.

LITERATURE REVIEW - THE STREET LEVEL PUBLIC ORGANIZATION: THE EXERCISE OF STRATEGIC CONTROL

NPM and the implementation of reform

In order to contextualize this paper; service planning, the reform of the health services in Ireland as well as those in Canada can be seen as part of a wider set of public sector reforms which are characterized by the umbrella heading 'New Public Management' (NPM) (Hood 1991, 1995). Lapsley and Pallot (2000:215) acknowledge this broadly based international movement, which they describe as '*propelling public sectors of many economies towards convergence on how best to manage their activities'*. Though, they also differentiate between intentions and consequences. According to Osborne and Gaebler (1992), the intention of NPM is to make fundamental changes to management structures, processes and practices in

the public sector. However, the consequences of such reforms can be examined, as in this paper, by taking a street-level approach (Brodkin 2008).

Hardiman and MacCarthaigh (2008) note that central to NPM based reforms have been methods of identifying optimum levels of autonomy and control in the discharge of public management functions. However, there are contradictions in decentralising management functions and increasing autonomy in areas such as budgets, and yet reaffirming central control through standardisation of control processes in order to manage the process. Mulgan (2002) identifies the ambivalence of NPM towards political control and accountability, in that the implementation of reform is the responsibility of those that were not involved in its crafting in the first place. This creates problems for the politicians in seeking to develop a system of oversight and control to guard against inefficiencies, which according to Hood (2004), instead of simplifying bureaucracy leads to an increase in its complexity.

A central theme of service planning is the delegation of authority and increased accountability; underpinned by the principle of subsidiarity i.e. that decision making should be as local as possible. Saltman, and Figueras (1997) note that the decentralisation of organisational structures is a recurrent feature of health service reform. As a result of this devolution, there is an increased emphasis on performance management and the development of sets of performance indicators as a means of maintaining control. Brodkin (2011b:i254) notes that this new managerialist focus on performance is based on a flawed understanding of how the street-level organization really works and is over optimistic in its expectations of performance measurement as a control. This commitment to performance indicators has been highlighted in the Irish context by the Department of Health.

Strategic Control of Core Public Services; The Street Level Perspective

The key functions of a public service manager are to identify service users' needs, manage delivery of services to target these needs, and make resource allocation decisions to support service delivery. However, part of a public service manager's role is also to control service delivery to ensure that broad policy objectives are delivered upon in terms of measurable services to clients. The control function in healthcare is critical for both government and for the public service managers that manage the delivery process. Yet, the bureaucratic discretion of this public service manager or public service professional can be seen as the 'nemesis' of accountability (Brodkin 2008:317). Thus, managing such discretion lies at the heart of the control and oversight strategies employed to improve accountability. However, there is a risk to undermining professional judgment, responsiveness and innovation if control is not managed successfully.

McKevitt, Millar and Keogan (2000) argue that service delivery in core public services such as health care is most appropriately seen as an outcome of relationships between providers and the customer, client and citizen, involving a set of processes. Taking the health care system as an open system, the control system becomes complex when it recognizes all these stakeholders. Legislation forms one part of the control function, administrative control as well as professional regulation is also integral to the process. In this paper the dynamics of the implementation of service planning legislation and policy are explored through the use of McKevitt's model of the Street Level Public Organisation (SLPO) (McKevitt 1998) which facilitates a structure for what Brodkin (2011b:i255) would describe as understanding '*street level logic of choice and constraint*' when dealing with implementation of new managerialist reforms.

The SLPO model draws from Lipsky's (1969, 1980) concept of the 'street level bureaucracy'. He sought to find a viable means of measuring the impact of government upon people and noted that one of the least studied areas was the interaction between 'clients' and government officials who deal with them in the course of their jobs (Lipsky 1969:1). He describes 'street level bureaucracies' as hierarchical organizations in which substantial discretion and decision making authority lies with the line agents; the front line or operating core (Lipsky 1980). These individuals, such as health professionals and health services managers, as in the case of this research, when faced with problems such as a lack of organisational or personal resources, and conflicting or ambiguous role expectations develop coping mechanisms. In the rationing of resources, they exercise discretion and in doing so, have considerable policy-making powers.

What is of significance to this paper from a theoretical view point, is that this 'place'; the street level intersection of client and public service worker is at the core of the policy-implementation space, where policy is '*not best understood as made in legislatures…. because in important ways it is actually made in the crowded offices and daily encounters of street level workers*' (Lipsky 1980:xii). The implementation of policy reforms such as service planning can vary from that which was originally intended or set out in legislation.

The street-level approach to policy research links scholarly work from related fields, such as core public services, street-level bureaucracy, policy implementation and public management (McKevitt 1998, Taylor and Kelly (2006), Brodkin 2011b, Piore 2010). Brodkin (2008, 2011a, 2011b) emphasizes the utility of employing a 'street-level' lens which provides strategies for investigating common questions at the intersection of these different fields. A number of streams of street-level research has developed over time; the accountability of

professionals and the means of organizing this accountability through governance arrangements, the discretion of professionals and its control, as well as the management of the inter-relationships between various stakeholders and the influence of the definitiveness of the policy itself for the implementation process. Hupe and Hill (2007), Day and Klein (1987) and Pollitt (2003) note that accountability of professionals in the street level bureaucracy is essentially multiple rather than practiced only vertically. Hupe and Hill (2007) examine the link between the perspective of multiple accountabilities and contemporary conceptualisations of governance. They note that this complexity results in accountabilities in political societal relations at various places rather than just from the political centre for those at street level – this in turn leads to a number of possibly contradictory action imperatives as street level bureaucrats choose how to act. Hedge, Menzel and Krause (1989) note that in dealing with these accountabilities it is the influence of positive intergovernmental relationships that can shape policy implementation at the field level, as it can have a moderating influence on the perceptions of professionals. Brodkin's (2008, 2011) work looks at accountability and the use of discretion in the 'street level' organisation from the 'control' perspective. She considers some of the common measures of accountability (such as the performance indicator sets as in the Irish case) as being too crude to capture the complex nature of informal practices.

Moving from the accountability perspective, Carrington (2005), Kernick (2005) and Keiser (2010) look at individual discretion itself and emphasize that there is a need for this discretion to allow for flexibility in the work of the organisation. Keiser (2010) notes that street level workers are not only influenced by their own values and attitudes but are influenced by the knowledge and preferences within broader social networks in which they operate. Brodkin (2011b) opines that analysing lower level discretion in policy

implementation should be an examination of what influences or systematizes this discretion. Taylor and Kelly (2006) warn that discretion should be facilitated as increased levels of bureaucracy lead to 'deskilling' of professionals. Brodkin's (2008) literature review of policy and reform implementation at street level highlights two other problems; firstly the need for policy definitiveness rather than ambiguity and conflicting objectives; and secondly, that the problems of legislative politics mean that politicians tend to delegate policy where possible thus pushing conflict and decision making down the line. Thus, implementation becomes policy definition in action; policy as produced. Ellis, Davis and Rummery (1999) note that these problems can be managed by using clear guidelines as well as managerial scrutiny. Finally, the street-level lens has been employed to examine these influences the bureaucrat-citizen relationship itself (Wellstead & Stedman 2011, Piore 2011).

Brodkin (2011a) recommends that this 'street level' lens is necessary to explore the conundrums of discretion and governance in order to develop a deeper understanding of how organizations work, how control can be exercised and how policy can be implemented or produced. Yet, how can these streams of research be conceptualized in to an analytic framework? This paper draws from the work of McKevitt (1998), who adopted Lipsky's (1980) concept of the street-level bureaucracy, citing it as a 'r*emarkably useful innovation'* and on the basis of his own field research rejected the term 'bureaucracy' with connotations of a closed system, and replaced it with that of 'organization'. His model of the Street Level Public Organization (SLPO) (1998) and its adapted form (Byers 2007) is utilized in this paper to explain the wider environmental context of planning, resource allocation and performance measurement systems in the control and management of health professionals and managers.

The SLPO and Tensions in the Environment; Service Planning

The importance of the SLPO model is that it allows consideration of whether there is consistency and coherence between espoused objectives at the national level and implementation at the point of service delivery, such as the aspirations of the national health strategy and its implementation through the service planning process in the Irish case. What is important in the health care context is that the model includes specific influences from the environment that affect service delivery in public organizations in particular. As Bovaird (2005) notes, service delivery in the public domain should no longer be seen as a 'top down' process but should be seen as the negotiated outcome of many interacting systems with interactions with the 'users' of the services; a recognition of the complexity of the environment. The SLPO model employs the concepts and categories of general strategy and in particular focuses on the organization-environment relationship. This model can encompass all the streams of street-level research in one model or framework and allow for multiple influences in the implementation process.

In the healthcare context the model allows for the uneasy relationship between central government and professionals in the SLPO, as well as their professional bodies. It allows for inclusion of the citizen-client. The model shows the important external relationships of the SLPO and how these relationships impact directly or indirectly on the capacity to deliver on their strategies. The essence of the planning and management task is relating the SLPO to its environment (see Figure 1).

Insert Figure 1 about here

There is a dual set of influences in operation in the SLPO. At government level there are a number of modes of influence; legislation, allocation of resources, organizational structure and performance measurement. Then there are the 'rules of the game', which are established by the professions and their associations. These two conflicting influences must be aligned otherwise according to McKevitt, Millar and Keogan (2000) the activities of the SLPO will run wild and undirected. With few exceptions, the normative literature on planning in health care, underlines the necessity for extensive participation by health professionals (Peters, 1985; Champagne, Contandriopoulos, Larouche, Clemenhagen and Barbir, 1987; Denis, Langley and Lozeau 1995), the main argument being that implementation will be facilitated if people feel they were involved in decisions. If the model of control is left at the level of budgets only, it does not control for the effectiveness of service delivery and therefore the citizen-client is left in a weak position. As McKevitt, Millar and Keogan (2000) and Brodkin (2011b) note, any defect in the legislative framework will lead to recurring tensions between central government and professional associations (to point A) in the environment of the SLPOs. If there is a solid relationship between the professions and government then these tensions can be averted (Hedge, Menzel and Krause 1989).

In utilising the SLPO model in this paper, it can be seen that to implement service planning and introduce strategic change, is not solely an organizational issue it has to account for control in a wider institutional context. This institutional perspective is reflected in examination of the control mechanism; the legislation introducing implementation of service planning; if it doesn't allow for strategic management processes because it is devoid of recognition of the complexity of the nexus of relationships, the resulting problems are legion ranging from ambiguity in policy aims, problems in relating general guidance, enforcement, and changing resource assumptions. For any strategic and policy driven shift to occur in the

pattern of resource allocation (see point B) there needs to be an explication of that position in the public service delivery and investment decisions legislation. Given the paucity of direction in the Irish service planning legislation it can be posited that the direction of the national health strategy to drive change will not occur, despite the rhetoric of government. As a result another source of tension can occur; that between the professional and the community of citizens (see point C), where lack of control of the professional by central government leads to an erosion of the community's needs and rights.

There is no one best way to reform core public services that will satisfy the needs of government, citizens and providers. Yet, some countries have proceeded on the path to reform that ignores these differing needs and this is due in part to the belief that public organizations are similar in part to private organizations as per the NPM doctrine.

METHODS

The design of the research is what Yin (2003) describes as a multiple case study. The focus according to Yin (2003:12) is on contemporary rather than historical phenomena. By choosing to ask 'how' and 'why' questions the case is more explanatory in nature. If you need to know how and why a programme or process worked or not the case study is a useful method of exploration.

Research questions were tested using data from a number of sources. Given the structural organization of health care in both Ireland and Canada service planning was examined in its implementation at the Street Level Public Organization (SLPO) level as well as accounting for the wider institutional influences; the context in which those cases were situated. This

wider view included looking at other stakeholder perspectives including government and other health care organizations in the health care system as well as examining the legislative influence. Through the iterative research process the focal points of analysis emerged and were structured around three cases (health board units) in the Irish context, and one case (a district health authority unit) in the Canadian context. Thus, this design can serve as an important device for focusing a case study enquiry. This research was carried out over an 18-month period in 2004-2006.

The health board/authority units were studied by taking a vertical slice through the case study organizations and examining perspectives of the planning process from health professional (head of discipline level) up to CEO/ Assistant CEO level, as well as examining the wider institutional context (Departments of Health and Children and of Finance in Ireland, and the Department of Health in Nova Scotia, Canada). Pettigrew, Ferlie & McKee (1992:4) emphasize the importance of this approach, as the derivation of a plurality of perspectives is gained through the interviewing of a wide range of stakeholders. Fifty four semi-structured interviews were carried out. The questions were left sufficiently broad in order to build up a picture of the process as it was occurring and was perceived by the respondents. Transcriptions were contemporaneous so as the findings and other crosschecked notes would be fresh. This allowed for follow up regarding documents or key respondents that were mentioned during the interview. Therefore, data analysis proceeded as data continued to be gathered. Through this process, seven core themes were identified in the wider study, three of which will be outlined below.

RESULTS AND DISCUSSION

This paper has focused on one aspect; the management of the control function within a wider comparative study of service planning in the Irish health sector. The remainder of this paper presents some empirical material from part of this study. The SLPO model allows examination of the consistency between espoused objectives at a national level and their implementation at the point of service delivery. A source of tension is point A, relations between central government and the professions, at the interface of control and discretion, as well as point C, relations between the professions and the community of citizen-clients. These tensions were identified under the core themes of control, 'real planning' and multiple stakeholder involvement, and the SLPO model was used to assist in analysis of this data.

Legislative Strategy; Control in the SLPO

Service planning was implemented throughout the health boards in the Irish context by means of a national template and set of performance indicators. The core theme of control was identified strongly by interviewees in the Irish case and they indicated that control was exercised at a number of levels. There was control exercised from the political environment; the backdrop of constraints under which the system operated. There was also control of the flow of information as health professionals were disconnected from the real information and decision making. Control was exercised through distance, decision makers were housed away from the operating core. Finally, control was exhibited in the format of the service plan and the performance indicators that bore little relationship to the services on the ground and were described by one health professional as serving a legitimizing function in being provided for 'public consumption'. Management concurred that the national service planning

template was curtailing the scope for planning and was allowing only mapping of services into the available boxes. However, the Department of Health and Children (DOHC) noted that this was needed to put 'order and control' on the system. Health professionals spoke of lack of control in terms of their service, due to lack of ownership of the performance indicator (PIs) set they were using. Unless the PIs are recognized as measuring something meaningful by all levels of the organization, they will not increase managerial control. Of consideration, is that the focus on accountability was for the deliverers of the service only, a downward mechanistic prescription, rather than on those that plan and manage the system. The difficulty that emerged is the participants' struggle in grappling with this reality and yet striving to relate service delivery back to the principles and vision of the Health Strategy.

As noted earlier, service planning can be seen as part of the New Public Management (NPM) suite of tools such as Ferlie, Pettigrew, Ashburner and Fitzgerald's (1996) first NPM model which focuses on core themes of increased financial control, stronger managerial hierarchy, a 'command and control' mode of working and an extension of audit. McKevitt (1998) notes that control or strategic control needs to involve control downwards via policy frameworks as well as control upwards by means of managerial feedback from the citizen-clients that the policy is intended to serve. In reality this was not occurring, as the corporate plan tended to recognize political imperatives only, coupled with the lack of any real citizen-client involvement.

In comparison, in the Canadian case, management spoke of the need to seek less control and of being able to view plans through the 'lens of the community'. The Canadian data is positive in terms of the strategic intent of its health planning with the focus on empowerment in the community. It is less about budgetary control and more about flexibility. The majority

of interviewees concurred that the CHBs and their community health plans had improved over the years. Part of that was that the CHB coordinators have become more involved and known in their communities and the process has become more embedded.

Crucial to this process is the legislation that necessitates that the DHA must listen to the CHBs. The DHA has developed four-year strategies to underpin the yearly planning cycle and has been proactive in supporting the community input through the CHBs. The 'bottom up focus' on planning leads to a different emphasis with the process being more 'organic'.

Decoupling Service Planning from Implementation; 'Real Planning' and Professional Discretion

Meyer and Rowan (1991:59) outline how programmes, practices and procedures function as institutionalized myths and thus, when there are conflicts arising from their implementation, loose coupling; building gaps between the formal structures and what actually happens is employed. According to Lipsky (1980) when legislation is sufficiently ambiguous; policy implementation requires discretionary decision making at the coal face of service delivery, thus professionals and managers can 'make policy' through implementation on the ground. Many health professionals agreed that 'real' planning needs to occur in the health service in the vacuum that service planning leaves. In many cases health professionals were bypassing the service planning process and introducing strategic planning at a local level, both at discipline level and in a number of cases at hospital level in response to their lack of belief in the efficacy of the process. Numerous examples were cited by interviewees in the course of the study, of different initiatives that had been set up to facilitate 'real' planning and their use of discretion in decision making.

A communications consultant brought into advise on strategic planning in one health care area explained that health professionals have learned a pattern of behaviour; they '*double think*' and have learnt to subvert the system to get things done. In one case a strategic planning exercise was set up by a local hospital to determine its future. In that particular case the medical consultants had previously pulled out of the service planning process. According to Doolin (2002), where internal operations are mediated by professional autonomy; discretion is used when attempting to deal with pressures brought about by management control in complex and uncertain organisational environments. Some heads of disciplines set up their own planning system because we '*needed to do something badly'* the waiting lists were growing, staff were leaving and there was no real monitoring of their service through the control functions that had been put in place. A number of the health professionals developed their own service plans in order to guide development of their service. Many interviewees agreed, that planning needs to occur in the health service in the vacuum that service planning leaves; what they described as 'the real' planning.

Relationships in the SLPO; stakeholder representation

In order to deliver health services that are guided by the principles of the Irish Health Strategy (DOHC, 2001); a valid assumption would be that there would be consultation with key stakeholders including the citizen-client. However, health professionals as stakeholders in the process, expressed frustration at their needs not being heard or listened to. Control was seen to be coming from above; that priorities were decided either at a national level or at senior management level. There were frequent references to 'them and us'.

We're pushed into a more operational focus – we need to be strategic. We need to be at the front – we need to have an interface with the executive – we don't have it.

Head of Discipline (Nursing)

At a national level, relations between government and the health professions have reached an all time low. In some areas it was acknowledged that there was difficulty in engaging with some professionals in service planning, most notably medical consultants in establishing the business directorate model. In that regard, the healthcare managers are then powerless to define the rules of the game. However, many health care managers expressed the view that they could plan well enough without the health professionals input; that they had all the information they needed with which to plan.

We paid lip service to involvement. It was perceived that expertise was in the core and in a perverse way that it would lead to difficulties to ask too many opinions.

Manager of Care Services

Due to the restrictions of the planning process and the template, some managers felt consultation was superfluous in many cases.

Given that service planning had initially been touted as a means of devolving decision making down the ranks to the health professionals, there was comment on the lack of trust that senior management had in the abilities of the health professional managers. Some of it is due to the imposition of controls from above, and an isolation of the operating core from what management view as the 'real' work of planning and strategy. In the Irish context the lack of client representation in service planning was raised as an issue, due to the inclusion of

consumer involvement as a heading on the new service-planning template, and yet it had not become a reality. There were concerns about the dearth of a wider stakeholder representation at the negotiation table, but some interviewees noted that it was linked to the restrictiveness of the process in general. This leads to tension at point C in the SLPO model, a break in relations between the health professions and the clients they serve. Thus, the health professions come to be seen as self serving and not representing their clients.

With regard to stakeholder involvement in the Canadian context, there is extensive consultation at all levels of the system. The CHBs consult with their communities and community organizations thus, averting the tension at point C. At the level above them, there is consultation with key community, provincial and federal agencies. The DHA itself consults with the service users and clinicians as well as receiving the community feedback. The Department of Health (DOH) consults with the DHA, and the political interests also have their say. Interviewees described a situation of a gradual building up of trust with the communities since the CHBs were mandated by legislation to input into the DHA plan. This was due in part to the clout they could wield because of the legislation, but also to the skills of the CHT team itself.

CONCLUSION

At the outset, this paper posited that the use of the SLPO model (McKevitt 1998) held explanatory power for the issues arising in implementation of reform in the public sector. As Maddock (2002:38) notes public sector modernisation needs conceptual modelling. She goes on to explain how the development of social capital is better encapsulated by models which reflect connection and dependence between forces. The SLPO model can be utilized to

illustrate the need to balance these different constituencies in managing core public services. It allows the researcher to focus on these complex organisations with their competing stakeholder interests. Unlike private sector organisations, the pull of the professional associations and the downward push from central government needs to be balanced to allow for the needs of the citizen-client. The model also borrows from readings in the strategic management literature to account for explanations of NPM type initiatives.

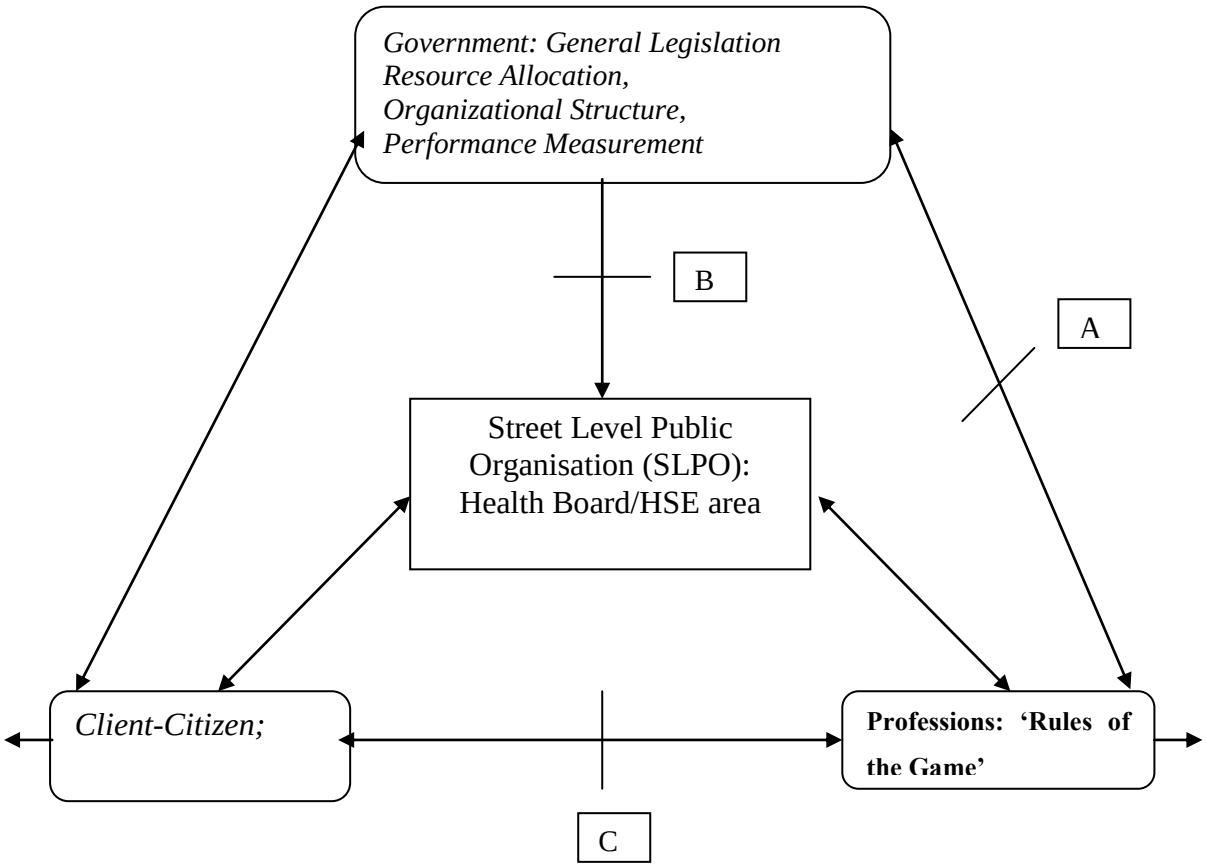
In the present paper, the unique characteristics of this model makes it valuable in locating points of tension and difficulty, as well as identifying key issues in implementing reform in the Irish healthcare sector. Analysing lower level discretion in policy implementation shouldn't be seen as either "compliance" or "subversion" but can be an examination of what influences or systematizes discretion. Brodkin (2011b: i201) challenges researchers that in order to illuminate how organisations work you need to consider their internal dynamics as well as their relationship to the broader political economy in which they reside. She emphasizes that the street level approach to policy research examining what goes on in organisations '*provides a perspective from which to consider the relationship of street level practices to the social and political forces ostensibly at work outside these organizations*'. The SLPO model can offer a framework to add to this debate. Through use of the model, key stumbling blocks to the successful implementation of healthcare planning can be identified, which include the lack of recognition of the complexity of the healthcare environment and the stakeholders within it, but also the limitations of the legislation itself underpinning the planning and management of the health services. The latter stumbling block is mirrored in Brodkin's (2008) earlier research focusing on the management of oversight and control, in which she notes that crucial to marshalling professional compliance, is the need for policy definitiveness. Control can be difficult if there is a failure to provide authoritative law

making. Policies have been developed over time to be politically expedient rather than to facilitate implementation. In the Irish case there is an eleven year old national health strategy without legislative impetus, which is meant to underpin the values in service planning, yet has lead to little change in the existing patterns of resource allocation and stakeholder relationships. In contrast, the Canadian case is an exemplar of what can occur when all stakeholders are involved in the planning and delivery of healthcare. As it is the legislation at federal level articulating the basic principles for health services delivery and the legislation at provincial level mandating community involvement in the planning of services and underpinning its strategic management that averts tensions and allows for needs assessment and health planning that is not vulnerable to the vagaries of political short-termism.

Therefore, frontline discretion needs to be managed in the implementation of policy but recommendations to improve 'command and control' (as in the Irish case) will be less likely to succeed. Using the SLPO model can facilitate what Brodkin (2008) describes as analysis that reaches beyond formal administrative categories to '*unpack the policy experience*'. Thus, the findings in this paper have a wider import than just for Irish reform policy. Haarman, Klenk and Weyrauch (2010) and Osborne (2010) note that the delivery of public services requires negotiation in inter-organizational relationships and multi-actor policy making processes. The Canadian case in this paper speaks to us of this approach. As Kernick (2005) opines, policy-makers need to view the health system as a hierarchy of inter-related systems that interact in a nonlinear fashion. The emphasis needs to move away from linear rational analysis with the emphasis on prediction and control to an appreciation of the configuration of relationships amongst the health system's components and an understanding of what creates patterns of order and behaviour among them.

Appendix 1/2

Figure 1 Tensions in the SLPO environment



Source: Byers (2007:112) adapted from McKevitt (1998:99)

Appendix 2/2

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