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WORKING PAPER

RECONCILING EXTERNAL LEGITIMACY AND ORGANISATIONAL IMPLEMENTATION: THE CASE OF SERVICE PLANNING IN THE IRISH HEALTH SERVICES

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ABSTRACT

Whereas, in many OECD countries strategic planning in health care has been in evidence since the 1970s, in Ireland the emergence of strategic management processes in health care planning didn't occur until the 1990s. The Strategic Management Initiative (SMI), as outlined in *Delivering Better Government* (1996), gives Government commitment to 'the reform of our institutions at national and local level to provide service, accountability and transparency' and forms the backdrop to the Irish public service reforms. 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 health sector is seen as part of this strategic planning ethos. That our health services need to be strategically planned is not in doubt, given that 'health' represents a large proportion (28.7% in 2005)(DOF 2005) of the Irish government's spending. How this strategic management of our health services in the form of service planning, can be implemented, is the focus of a wider study. In analysing the evidence gathered thus far, this paper focuses on one aspect of this study; that organizations can appear to adopt modern reforms but in practice their implementation is more ritual than substantive (Lapsley 2001). Differentiating between the intentions of government in introducing service planning and the consequences of its implementation, allows examination of the impact of this reform using new institutionalist theory. Deploying this institutional perspective can reveal the use of management practices such as service planning, as legitimating devices. Despite the rhetoric of the national health strategy regarding the inclusive involvement of staff and the wider community, service planning is located within a system of top-down control

INTRODUCTION

This paper reports on part of a wider study looking at the implementation of service planning in Ireland in the context of significant organisational change. The study questioned the ability of the control mechanism that introduced service planning to deliver on strategic planning in the health care sector. It also questioned the organisational capacity of the health care sector in Ireland to manage strategic change. This paper reports on part of the analysis of the data in the Irish case, from the preliminary findings from a wider comparative study.

In the Irish health care sector the Strategic Management Initiative set the scene in the early 1990s for the two health care strategies that were to follow. The present health care strategy published in 2001 is explicit as to the intent of service planning; which is to introduce strategic planning into the health care arena. Inherent in such a promise is the use of the health care strategy to determine priorities and underpin planning. This planning is to support the delivery of equitable, accountable, quality focused and people centred services. It recommends that evidence based and strategic objectives are to underpin all planning and decision making. It also promises to make provision for the participation of the service user in decision making. There is however little evidence in the data gathered in this study of these strategic management processes. On the contrary, the focus is on financial accountability. Thus, service planning was introduced back in 1998 (following the enactment of the 1996 Health (Amendment) Act No 3) in the health care services in Ireland to function as 'a strategic management tool' (DOHC 1998). The Minister of State at the Department of Health (Mr. O'Shea) introducing the proposed legislation described it as emphasising '*planning, strategic management and accountability'*. The crucial link between resources and clear objectives was emphasised. However, the recognition of the complexity of planning in the health care system was not apparent in the legislation. The legislation was

welcomed by politicians and seen as a control and brake 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 rhetoric of the Health Strategy to achieve health services that would be equitable, accountable and quality focused, planned with the participation of users and all those charged with delivering the services would emerge through implementation of the Act, and that the processes for that implementation would be drawn up at health board or DOHC level. There was a disconnect between those that crafted the policy from those that were to implement it.

RESEARCH FOCUS

McKevitt (1990, 1998) notes that in official thinking on health care a heavy reliance is placed on structural and budgetary arrangements, which although important, reflect a propensity to seek solutions that are technical and operational in character. The problem is presented in narrow terms, for example, 'how can we keep within budgetary allocations?', rather than as an examination of the strategic framework required for healthcare management (McKevitt 1998:130). Unlike European countries, Ireland has no legislated strategic framework that would guide the resource allocation process, provide for a control system responsive to agreed objectives and give legitimacy to the resource decisions of healthcare managers. Instead in the Irish context, we have a national health strategy that is without legislative impetus. According to McKevitt (1997), this lack of impetus ensures that existing patterns of resource allocation and stakeholder relationships will be maintained. As a result the service planning process becomes more susceptible to political influences, which are essentially short-term in nature, and do not provide for a strategic management focus.

McKevitt (1998, 2000) argued that service delivery in core public services is most appropriately seen as an outcome of relationships between providers and the customer, client and citizen, involving a set of processes. His model of the Street Level Public Organisation (SLPO) can be used to explain the wider environmental context of planning, resource allocation and performance measurement systems. In evaluating the performance of the SLPO, different control measures are appropriate and vary with the type relationship that is being evaluated. It is noteworthy, that many public organizations favour measures of performance that emphasise efficiency and meet the requirements of institutional legitimacy, rather than the interests of the citizen-client. Institutional theorists such as DiMaggio and Powell (1991) argue that organisations in the public sector seek to enhance legitimacy by conforming to these social prescriptions derived from the institutional context. Institutional theory illustrates how the exercise of strategic choice may be pre-empted, the motivation to adopt imitative behaviours, the private sector being brought to the public. This is exemplified according to Alford (2001) most notably by the waves of system-wide management reforms imposed by governments since the 1970s amplified by mimetic processes across and between governments, many of which fit under the umbrella of New Public Management (NPM).

According to Meyer and Rowan (1991), organizations that incorporate socially legitimated rationalized elements in their formal structures maximize their legitimacy and increase their resources and survival capabilities. DiMaggio and Powell (1991:63) identify three types of isomorphism, as they contend structural change in organizations seems no longer driven by competition but by the need to be similar: *coercive* isomorphism stemming from political influence and the problem of legitimacy; *mimetic* isomorphism resulting from standard responses to uncertainty and *normative* isomorphism reflecting professional values. Public service

organizations may exhibit all these characteristics. It puts into a context, that for Irish healthcare management, the UK NHS remains the major source of ideas and models (Boyle 1997), their business planning approach heavily influencing the introduction of service planning. However, separate to the mimetic thrust and homogeneity of public sector organizations; is the coercive isomorphism exhibited, resulting from pressures that are exerted by government in order to garner external legitimacy. Power is exerted, not via their effect on the task activities of organizational participants, work activities are often decoupled from rule systems or from the accounts depicting them, but on the stakeholders and audiences external to the organization. Their adoption by the organization garners social legitimacy (Scott 2004). However, according to Meyer and Rowan (1991) the struggle to link the requirements of external legitimacy with technical measures of performance leads to inconsistencies. These can be resolved, according to Lawton, McKevitt and Millar (2000) by employing two features, that of decoupling (building gaps between the formal structures and what actually happens) and the logic of confidence (an elaborate display of confidence, satisfaction and good faith).

PRELIMINARY RESEARCH FINDINGS

The design of this study is what Yin (2003) describes as a multiple case study with embedded multiple units of analysis. In the Irish context the choice was made to study the dynamics of strategic change in their setting by investigating a number of health boards. Given the structural organisation of health care in Ireland, it became apparent that service planning should be examined in its implementation at the health board level as well as accounting for the wider institutional influences at the larger case unit of analysis. This wider view included looking at other stakeholder perspectives including government and other health care organisations in the health care system as well as examining the legislative influence. The health board units were

studied by taking a vertical slice through the organisations and examining perspectives of this process from health professional (head of discipline level) up to CEO/ Assistant CEO level. Using qualitative analysis of interview data, a number of core themes have been identified, some of which are outlined below.

Control

Service planning was implemented throughout the health boards by means of a national template and set of performance indicators. The core theme of control identified by interviewees in the Irish case 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 and this corresponds with another theme identified; 'environmental pressure'. 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 in offices that were generally of a higher standard. 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 legitimising 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 using. Unless the PIs are recognised as measuring something meaningful by all levels of the organisation, 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 identified in this study 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.

Strategic Management Processes

Another core theme identified by health professionals and management was the absence of strategic management processes. They spoke of the need for multi-annual planning instead of constant short-term planning. The health professionals emphasised the need for their inclusion in the planning process as deliverers of the service. There was a sense of disbelief in that they needed to provide data on their services to management and yet, were not given tools with which to gather it. Managerialism stressing efficiency and rationality of managing offers a solution to the tribal politics of the health service. However, in the Irish case there was a lack of real concern for measurement and evaluation in planning. This exhibits the propensity of Irish politicians to take solutions off the shelf with out any real regard for their implementation. As one interviewee noted, in the UK they have a 'vision' for health, compared to the short-term political machinations of the Irish system. The DOHC asserts that service planning is a means for delivering planned services taking account of the four underlying principles of the Health Strategy (2001) which include; equity, 'people centredness', quality and accountability. The capability to deliver on this consumer rhetoric requires measurement of process and outcomes as an important part of accountability and yet the existing health service information technology capability is unable to deliver on this. There can be no progress made on equity issues until a valid and systematic measurement system is in place to monitor the operations of the healthcare sector.

Decoupling Service Planning from Implementation; Real Planning

If new institutional theory explains the contradictions between the espoused objectives of service planning and the reality of service delivery, we should expect to see a decoupling between the adoption of service planning and its implementation on the ground. 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. In terms of decoupling, 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 process. Numerous examples were cited by interviewees in the course of the study, of different initiatives that had been set up to facilitate this 'real' planning.

> *We want to try and move towards identifying the needs of people here and the outcomes they want in their lives and then shape the services. We are not constrained by the service plan template; we just do our own planning to achieve that.*

SUMMARY

Differentiating between the intentions of government in introducing service planning and the consequences of its implementation, allows examination of the impact of this reform using new institutionalist theory. Deploying this institutional perspective can reveal the use of management practices such as service planning, as legitimating devices. According to Lapsley (2001) organizations can appear to adopt modern reforms but in practice their implementation is more ritual than substantive. That the nexus of relationships in the SLPO is not acknowledged at the heart of service planning and delivery, means that both the professional service provider who provides the professional services, and the citizen-client who is the recipient of these services is not involved in any way in that process. That lack of involvement results in the lack of any needs and evidence based planning. Instead, the reliance on the limits of the legislation, including that

of the more recent 2004 Health Act, means that service planning never evolves to anything more than a fiscal control measure.

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