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# Strategic Change in the Irish Health Services: Comparative Case Studies in Planning

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**STRATEGIC CHANGE IN THE IRISH HEALTH SERVICES: COMPARATIVE CASE STUDIES IN PLANNING**

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**ABSTRACT:**

This paper reports on a study of the implementation of service planning in the Irish health services in the context of significant managerial, organisational and environmental change. One of the central mechanisms of the Strategic Management Initiative (SMI) is the devolution of accountability and responsibility from the centre to executive agencies. Service planning in the Irish health care sector is seen as part of this strategic planning ethos.

This study in examining the function and implementation of the service plan in the Irish health care system drew comparisons with the Canadian experience. A multiple case study design was utilised. Key research questions were tested through analysis of legislation and documentation as well as qualitative interviews with middle and senior management throughout the health care system. The choice was made to study the dynamics of strategic change in their setting by investigating a number of health boards during 2004-2005. The focal points of analysis were structured around three cases in the Irish context and one case in the Canadian context, 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 organisations in the health care system, and examining the legislative influence.

The study narrowed down the conceptual framework to two key problems with the Irish experience; firstly, the lack of capacity built up in the system to deal with change brought about by the service planning process and secondly, the limits of the control system; the legislation itself, in terms of its strategic intent. This has resulted in the service planning process operating in the Irish health care system with a purely control focus; a financial control focus. This paper focuses on the first key underlying problem, as the policy for change in itself is not sufficient; capacity for change in the healthcare system is required for implementation of this process (McKevitt 1998, Pettigrew, Ferlie and McKee 1992). This paper reports on the assessment of capacity for change throughout the Irish health care system. Crucial to the Irish health service planning process is the need for strategic coherence and needs based analysis, as well as recognition of the nexus of relationships at the heart of the delivery process. The Canadian study is used as a comparator in this regard. Models and frameworks, which analyse both the control mechanism and the capacity for change in the health care milieu, are presented with which to compare the findings of this study. The implications for practice derived from this analysis are presented.

**INTRODUCTION**

This paper focuses on the strategic implementation of service planning in the Irish health services in the context of significant managerial, organisational and environmental change. It is divided into four sections; the first section identifies the overarching key research themes and issues that arose from the literature review/context. It proffers the potentially significant findings and assertions emanating from this review and an explanation of the development of one of the key research propositions. The second section sets out a conceptual framework for subsequent analysis based on a multiple case study approach. The third section details the methods employed in the fieldwork, including the identification of cases and the sources of evidence. The fourth section gives an overview of the preliminary findings.

**Background**

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, transparency and freedom of information' and forms the backdrop to the Irish public service reforms in the last decade. One of the central mechanisms of the Strategic Management Initiative (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 the strategic planning ethos emphasised in the government's SMI and of course the Health Strategies that followed. That our health services need to be strategically managed and planned is not in doubt, given that 'health' represents a large proportion of the Irish government's spending. The 2007 allocation for

the health services of over €14 billion was announced in November 2006, an increase of 11% on the previous year's figure (Department of Finance 2006). How this strategic management of our health services can be achieved, is the focus of this study.

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 1998:26). It represented some changes in the framework of accountability for health services management. Its focus was to improve financial accountability and obliged health boards to produce an annual service plan as well as to secure the 'most beneficial, effective and efficient use of resources' (DOHC 1996: Section 2, 1 (a)). However, it was not explicit about how this was to occur. The assumption was that the rhetoric of both the Health Strategy and its successor strategy in 2001, 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. Therefore, disconnecting those that craft the policy and from those that implement it.

Therefore, one of the issues that arise is that the legislative framework underpinning service planning ostensibly functions as a controlling rather than an enabling mechanism for strategic planning in the Irish healthcare system. As McKevitt (1998b) noted in his critique of Irish healthcare policy, legislation proposed and enacted on foot of the 1994 Health Strategy focused on organisational and structural change rather than on the strategic deficits in healthcare policy.

In his foreword to the Health Strategy of 2001, the then Minister for Health and Children, Michael Martin was explicit on the importance of a long term strategy, the second National Health Strategy, to underpin planning of services and 'service planning' and to guide policy makers and service providers towards delivery of an articulated vision. This vision was to encompass the key principles of equity, 'people centredness', quality and accountability. The ability of the service planning process to be strategic in aligning this vision and its strategic objectives in the resulting service plans is a theme is crucial to this study. As Hrebiniak and Joyce (1984) cited in Asch (1989:400) note, short-term objectives or aims support and are critical to the achievement of long term strategic ends. The problem can be the lack of integration of and consistency between long-term and short-term plans and their objectives in the management and control system, which is needed for the successful implementation of strategy. For this success, there needs to be recognition of the complexity of the healthcare system, as well as its multiple stakeholders and a strategic control system that can underpin and pull together this planning process.

Despite the possible difficulties in alignment between the control system (the legislation) and the service planning process itself identified so far, how has the change process with the introduction of the service planning process evolved? The Report of the Commission on Financial Management and Control (2003:57) noted that service planning had developed in a fragmented way throughout the country and that the service plans from the different health boards differed substantially in format and content with very weak or no

links between activity and funding. Therefore, crucial to this study is the Commission's contention that there has been difficulty in implementing service planning in the Irish healthcare system. Given this assertion, this study sought to examine not only the legislation and its intent, but also the capacity for change in the Irish healthcare system in implementing service planning, and it is the latter examination that will be the focus of this paper.

**THEORETICAL FRAMEWORKS**

The process and implementation of service planning was examined using competing theories of change processes. The examination of change processes in organisations and society at large has been an important topic of research in recent years according to Lapsley and Pallot (2000) with a variety of theoretical approaches being used. For the purposes of this paper two strands in particular have been focused on; that of New Public Management (NPM) and Pettigrew, Ferlie and McKee's (1992) Receptive Contexts for Change Framework.

Service planning; the reform of the health services in Ireland 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. The intention of NPM, according to Osborne and Gaebler (1992) being to

make fundamental changes to management structures, processes and practices in the public sector. Their recipe or toolkit, from which managers of public sector organisations can change their organisations, is predicated on the belief that efficiency gains can be made by importing private sector management styles and techniques. However, the consequences and impact of such reforms can be examined using an alternative framework, such as 'new institutionalism' (Scott and Meyer 1994, Scott 1995, DiMaggio and Powell 1983, 1991) (this aspect of the present study was dealt with in an earlier paper; Byers 2006).

Moss, Garside and Dawson (1998) note that the organisational change that is called for in reforming can be seen as a key to improvements in health care, but issues arise regarding implementation of that change. The first issue arising will be the focus of this paper and relates to change in professional organisations that have developed particular sets of values and ways of working. The belief in rational planning according to Boyne (2000) is at the heart of many of these administrative reforms, such as the NPM approach, and often these reforms are applied according to Lawton, McKevitt and Millar (2000) within a system of top-down control. Little attention is given to enabling the providers to respond to the new environment, to skill or re-educate managers and professionals to cope with new frameworks or ways of working.

This issue is particularly pertinent to this facet of the present study looking at the organisational capacity for change in the Irish health services. In this regard, Pettigrew's research into large-scale strategic change in the NHS and the resultant model from his

work is a particularly useful construct to use for the analysis of change. Pettigrew and his colleagues (1985, 1987, 1991 and 1992) have developed a number of iterations of a framework for analysis. They posit that the analytical challenge is to connect up the content, contexts and processes of change over time to explain the achievement of change objectives. They identified eight interlinked factors, which served to differentiate the higher from the lower performers:

1. the quality and coherence of policy generated

2. availability of key people leading change

3. long-term environmental pressure

4. supportive organisational culture

5. effective manager-clinician relations

6. co-operative inter-organisational networks

7. simplicity and clarity of goals and priorities

8. the fit between the change agenda and the locale

This framework was considered pertinent to this study as it allows for analysis of the organisational capacity to manage strategic change at the level of the Street Level Public Organisation (SLPO, McKevitt 1990, 1998a, 1998b), in other words at health board or service delivery organisation level. These competing as well as complementary theoretical perspectives were examined as a backdrop to the present study and paper.

**SETTING THE SCENE**

An examination of the legislation and policy leading up to the inception of service planning in 1996 was undertaken as part of a wider study, to determine the strategic

intent as well as the type of control system that has developed in Irish health care. From 1970 till 1994 the development of the healthcare system comprised of ad hoc decisions over time, small incremental changes in terms of reports or initiatives. Healthcare reform as evidenced in Ireland had not been as extensive as that experienced in the UK (Millar and McKevitt, 2000). This review of developments identified a fundamental problem; in that the values inherent in the health care system were not explicit. The Irish health care system had developed without a clear mission, and that decision-making was highly centralised. This has significant relevance to this research; in that there was no overarching strategic direction decided on for planning in the Irish health services.

The use of a comparator case for the Irish study was made to add explanatory credibility to the study's findings. The Canadian experience in strategic planning and management as well as legislative underpinnings adds useful depth to this study. Canada's health care system was chosen for comparison for a number of reasons, which include Canada's success in terms of collaboration and integration in their health care system, their use of information technology and success in data capture for planning their health services. The 1984 Canada Health Act is underpinned by a number of key principles, which have become enshrined in Canadian health care. The Act 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'. Another interesting distinction is that Canada has become an increasingly decentralised federation since the early 1960s (Marchildon 1995), in comparison to Ireland's increasingly centralist stance.

In contrast to the Irish developments, the Canadian system has developed in a decentralised fashion with local control and consumer choice and its health legislation emphasises a clear set of national priorities that serve as an underlying rationale or mission for the current system.

## CAPACITY FOR CHANGE

The focus of the legislation and of service planning initially was the setting up of a suite of relationships with the DOHC in which administrative control could be exercised. It was devoid of the detail on how the service plans were to be developed. The legislation does not provide strategic objectives against which resource allocation and achievement of goals can be assessed and secondly there is inadequate monitoring of professional activity against appropriate policy objectives. This lack of linkage between the strategic and the operational leaves the situation that managing becomes an exercise in resource management unconnected with any overall strategy.

Early reports on the implementation of service planning indicated that little attention has been given to providers to respond to the changes and to cope with the new frameworks and processes. The expectation was that significant working patterns of mutual adjustment built up over years would be altered to accommodate these new demands. Again using the comparator of the Canadian experience; at provincial level in a decentralised system, a different picture emerged; that of a service planning process that is underpinned by commitment to the rights of the service user to participate in developing social priorities.

In the case of the province of Nova Scotia (Canada), Community Health Boards (CHBs) (comprising volunteer members from the community) operate in an advisory capacity to the District Health Authority (DHA) and 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 care planning. The legislation not only mandates community participation in health planning but it directs that the DHA administratively supports the work of the CHBs. The contents of the service plan include a number of components; health services, human resources, financial, CHB support and development, and capital plan. The DHA service plan will also demonstrate that the DHA has considered the Community Health Plans provided to it, and if it has not, it must explain why.

The Canadian service plan has a much wider remit than the financial focus in the Irish case. The DHA must also produce an annual report reporting on its performance, particularly related to the achievement of the objectives previously specified in the annual business plan as well as an audited financial statement. This requirement is seen to be critical to making the business planning process credible, serious and effective (DOH 2002). A further requirement in the legislation is that the DHA must provide information to the public about health care and the health care system and its operations and activities. Again this brings the citizen-client back into the loop in terms of scrutinising the DHA's performance. Crucially, in terms of building up capacity in the system; the change process is continuously evaluated and changes are made to further equip the CHBs and the DHA in the planning process.

A number of key messages can be distilled from the literature and the context. One of the propositions being that the problems identified in the Irish context can be related back to the deficits in the control mechanism (the legislation) introducing service planning, but also a key research proposition which is the focus of this paper; being that the lack of organisational capacity to deal with this new planning further hinders its implementation. Pettigrew, Ferlie and McKee (1992) note that the starting point for an analysis of change in the health service is the notion that having 'correct' policies for change is not sufficient; an organisational capacity to change is also necessary. Indeed, they note that a fundamental problem, in the 1970s was the development within the National Health Service in the UK of service policies for massive change, without building up the organisational capacity to translate this ambitious change agenda into practice. Given the National Economic and Social Council's (NESC 2005) concerns about the reported 'implementation failure' in Irish public governance of overarching strategies and policy, there is a need to explore the capacity for change in the implementation of service planning in the healthcare sector in Ireland.

However, as Dopson and Waddington (1996) warn there is a need to be aware of the unplanned outcomes of implementation and it cannot be assumed that there will be a predictable outcome. Therefore, these propositions although plausible may not be true due to the unanticipated outcomes of a change process in such a complex environment as a professional bureaucracy.


**RESEARCH APPROACH**

The research approach is to adopt the position that historical antecedents and the

chronology and context of change are vital in providing a contextualised study as per Pettigrew, Ferlie and McKee's (1992) seminal work in the health care field. Pettigrew (1990) uses the theory of method of contextualism to guide his research on change, which he has developed over a number of studies including that of strategic change in health care. This approach allows the process of change reveal itself in a contextual manner and is characterised by the importance of embeddedness. Pettigrew (1990) notes, that change in organisations cannot be seen in isolation and is linked to sectoral and economic change. Many case study researchers according to Stake (2000) emphasise the role of theory but the nature of the theoretical perspective required is debated. For some, the theory must make sense of the case as a whole; a bounded system. In this study, the task of theory is seen from a different perspective; that of locating and explaining what goes on within the case (organisation) from a wider societal viewpoint. The proposition is that you cannot understand the intra-case processes without understanding the wider context within which they occur. Given that the impetus for change in the present study is driven by external financial constraints and the imposition of financial controls by the Department of Finance, there is a need to look at this outer context. This conceptual framework of contextualism thus paves the way for identifying these criteria applied by the wider institutional environment and ascertaining their influences using frameworks of control. The temporal aspect is also important as Pettigrew (1990:270) notes to catch reality in flight. The importance of antecedent conditions that shape the present and the emerging future have been outlined need to be taken into account. Thus, in exploring the process of change the context, content and process of such change is explored.

**METHODOLOGY**

There are many valid reasons for doing qualitative research but a crucial one according to Strauss and Corbin (1998) and Hewison (2003) is the nature of the research problem. Thus, the choice of research strategy is governed by the questions the researcher asks. As in the present research, the questions are about the how and why of service planning being implemented and about the process of change itself.

The author took account of the guidance from Pettigrew, McKee and Ferlie (1988) in designing studies of change, who argued that such research; needs to be processual, with an emphasis on action as well as structure, comparative, and pluralist. This pluralism requires analysis of the often-competing versions of reality seen by actors in change processes, operating at different levels with specification of the linkages between them. Thus, the study took into account the historical evolution of ideas and stimuli for change as well as the constraints within which decision makers operate. This study required an intensive focus and lent itself to the use of the case study approach (Tsoukas 1989). The case study approach is pertinent to this research not only because of a processual focus (Pettigrew, Ferlie and McKee 1992) but also for a number of reasons posited by Yin (2003:9); firstly, the nature of the research propositions, being explanatory in nature, along with the researcher being able to access actual events on site, but the relevant behaviours themselves cannot be manipulated. Although case studies can overlap with other methods of research (such as histories), its unique strength is its ability to deal with a full variety of evidence; including documents, artefacts, interviews and observations. Case study inquiry relies on multiple sources of evidence with data needing to converge

in triangulating fashion and as a result benefits from prior development of theoretical propositions to guide data collection and analysis.

**The Study: A Multiple Case Study Design**

The major feature of the research design in this study is that it comprises multiple cases. According to Yin (2003:47) the logic underlying the use of multiple case studies is seen as analogous to that of multiple experiments in that the case must be carefully chosen to predicate similar results (a literal replication) or predict contrasting results (a theoretical replication). Each case study serves to confirm or disconfirm the inferences drawn from the previous ones. The focus of the study initially was the Irish healthcare sector and the implementation of service planning within it. The Irish healthcare sector comprising its health board management structure, 11 health boards in all up to December 31$^{st}$, 2004 (see Figure1 overleaf) is described as an integrated public health care system. The legislation implementing service planning applied across all the health boards.

**Figure 1: Structure of the Health System in Ireland (2000 –2005)** (DOHC (2001)
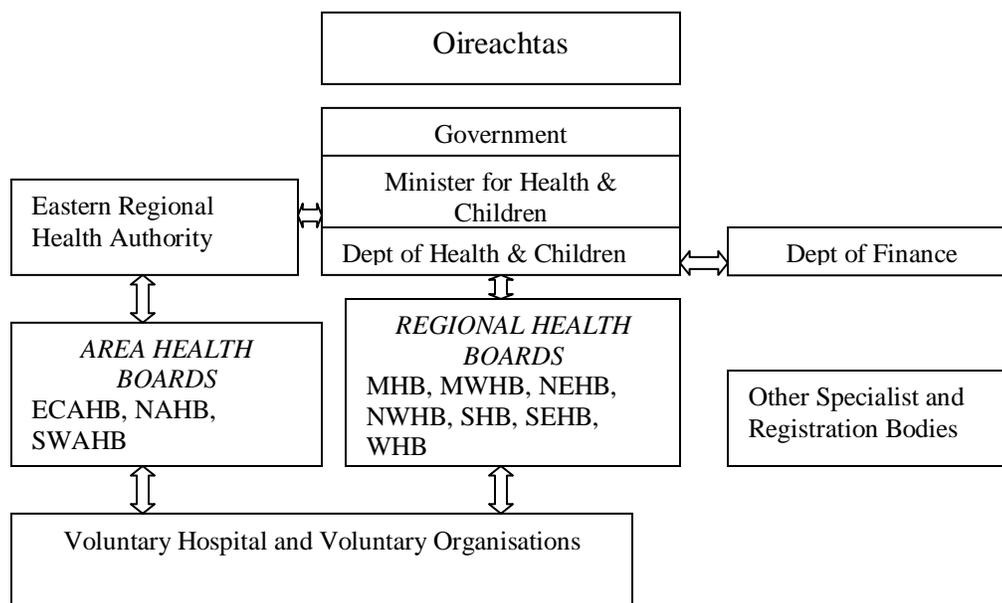
However, in order to examine a contrasting context for and mode of service planning, the choice was made to examine a District Health Authority in Nova Scotia, Canada as a case study. Again in the Canadian case, the health care system is a publicly funded integrated health care system (See Figure 2 overleaf). In this study the choice was made to explore four cases where the focus would be on a greater depth of knowledge and due to the limits of time and resources on the author's behalf. Comparative work of this type does raise methodological concerns according to Lawton and McKevitt (1995), as different organisations or systems can be at different stages in the change process. However, they argue that an in-depth analysis of the cases within a comparative and contextualist framework yields important insights into the processes of strategic change.

**Figure 5.2:    Structure of the Health System in Canada[2]**
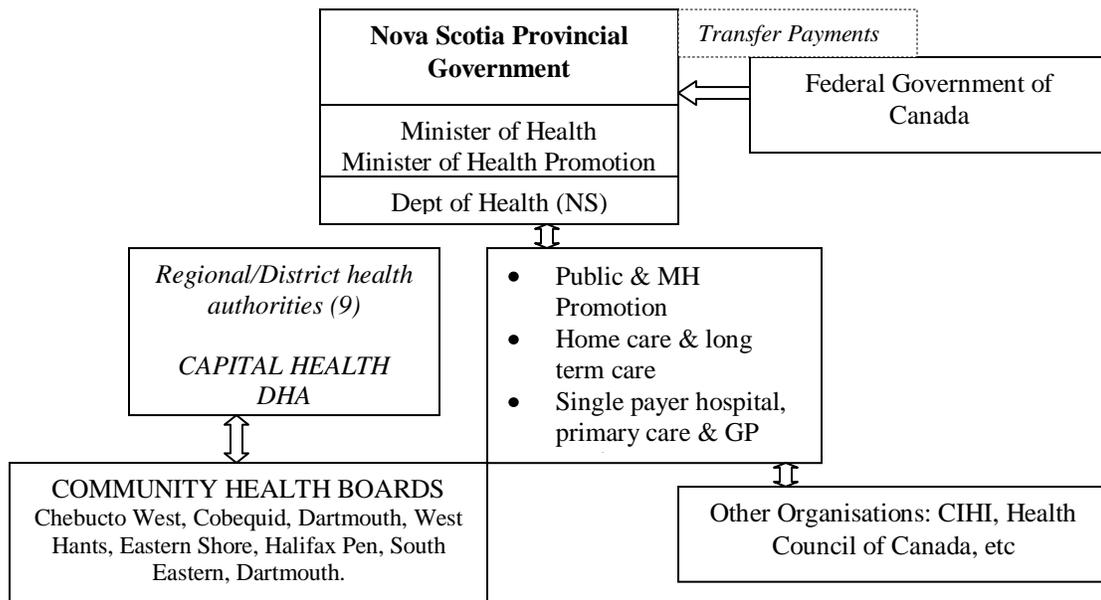


Given the structural organisation of health care in both Ireland and Canada it became apparent that service planning should be examined in its implementation at the Street

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[2] Figure 2 adapted from Organizational Overview of Canada's Health System in Marchildon, G.P. (2005:26). Also Capital Health Organizational Structure (revised Feb 25, 2005)

Level Public Organisation (SLPO) level (health board) with the wider influences of umbrella organisations such as the ERHA and the Department of Health and Children and the Department of Finance, as well as the milieu of other voluntary health care organisations taken into account in the wider or outer context (see Figures 1 and 2). Therefore, through the iterative research process the focal points of analysis emerged and were structured around three health board units (cases) in the Irish context and a district health authority unit (case) in the Canadian context. As already alluded to, Canada is a federation of provinces, and in that regard each province legislates for the planning and delivery of its health care. In this case Nova Scotia is seen as analogous to the Canadian case for ease of comparison. Thus, the design can serve as an important device for focusing a case study enquiry. Looking to the cases in the Irish context using the replication logic it is expected that similar results would be expected for each case (literal replication), given the propositions guiding the research. In the Irish phase of the study the cases, the health boards, were each studied individually and through constant examination of the findings the net was spread further to examine the influences on the health board from the context; the Irish healthcare system. The Canadian case was chosen to contrast with the Irish cases as Schofield (1994:84) describes it; in order to 'shed light on what could be rather than the typical'. As a result of this comparison a theoretical replication could be expected as predicted in the research propositions as the context differs from that of the Irish cases allowing for a divergent development of their planning process. The choice of cases thus allows for a more effective telling of the story.

To understand the process of service planning the present study involved examining in detail the health boards and community health boards in the Irish and Canadian cases. Stewart and Kringas (2003) used the term 'vertical slice' to describe their approach to data collection in case studies of public sector change. This study adopted a similar approach in slicing through the organisations by undertaking semi-structured interviews with respondents at three levels of management; senior management and middle management in each health board and then interviewing top management above each health board (in ERHA and the Departments of Health and Children and of Finance in Ireland, and in the District Health Authority and the Department of Health in Nova Scotia, Canada). The health professionals in this study were analogous to the middle management level represented by the professional heads of discipline or team. Pettigrew et al (1992:4) emphasise the importance of this approach, as the derivation of a plurality of perspectives is gained through interviewing a wide range of stakeholders.

The selection of respondents for interview was completed through a number of means. Of each of the 150 letters written and followed up by on average three phone calls/e-mails; the final number of interviewees in the Irish case was 36. There was a significant difficulty in making contact with potential interviewees. In the Canadian case the response was more positive. Although, arranging interviews at a distance and mostly by letter supplemented by e-mail, of the 24 contacts attempted, 16 interviewees were agreeable and encouraged the researcher's attendance at meetings and planning activities.

The interview questions were derived from the objective of the study, which was to examine the process and implementation of service planning as it was occurring at all

relevant levels of the organisation. This did not require asking about the process of implementation of service planning directly, but rather examining the process of service planning from each participant's perspective. This was done using a standard set of questions with each participant. 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. Thus, a holistic picture was drawn for each participant.

**Interrogating the Cases: Data Analysis**

This study took the position of positing a number of propositions initially in the research on the basis of the researcher's experience and theoretical familiarity. However, the position was to take both an inductive and deductive approach. This research approach draws upon the writings of Strauss (1987), Strauss and Corbin (1998), as well as Yin (2003), Eisenhardt (1989) and Miles and Huberman (1994). The propositions, according to Yin (2003), guide attention to certain data whilst ignoring other data. However, the analysis also allowed themes to emerge from the data in an inductive process. This in turn widened the analysis beyond the propositions, in helping define further the explanations of the data.

In answering the propositions, guidelines were established to guide the initial data analysis. However, the interview questions were left sufficiently broad and not guided by any commitment to pre-existing theory to allow the data and its concomitant themes emerge. In analysing the data from each case the researcher borrowed from the work of Strauss (1987) and Strauss and Corbin (1998).

The analysis after the fieldwork was completed in each organisation, and also when finally completed, was concerned with developing a coding system. This generated thick descriptions of the data. Following analysis of each case study; the results were cross-checked and seven core codes emerged.

**RESULTS AND ANALYSIS**

This paper has focused on one aspect of the wider study of the implementation of service planning in the context of significant organisational change in the health sector. A key proposition of the study looked at the processes underlying service planning in the Irish health care system and proposed that they were unsuitable for the development of a strategic management focus. Underpinning this proposition is the need to build up capacity in the Irish health care sector to deliver on the requirements of strategic planning and to equip and allow the key stakeholders develop ways of adapting to this change. Following this analysis, that the strategic capacity to deliver on the promises of service planning is absent, is not in doubt. Three of the core themes and their sub themes identified in the present study relate closely to the key factors identified in Pettigrew, et al's (1992) eight-factor framework. By using this framework to assist in the analysis of the data, it allows elaboration of what is needed in terms of capacity to be built upon for future planning, and it is used in the main, because of the strong relationship between the themes emerging and the eight factor framework.

In reporting the findings from this study, data emerging from interviews with health professionals at middle management level were treated separately to the data from

interviews with senior management. This was due to the strong finding of a lack of cohesion in the service planning process between these levels in the hierarchy. These disparate views of the service planning process were stark and this arrangement made it easier to make sense of the data. This division in reporting the findings was not necessary in dealing with the Canadian data. Three of the core themes are outlined here:

**(i)	Standardisation**

In this study, the majority of interviews in the Irish context alluded to the policy of standardisation of the service planning process and its lack of coherence as a key factor. At senior management level the understanding of the process, was the emergence over a number of iterations of a mechanistic application of a planning template and set of performance indicators, whilst the health professionals found difficulty in aligning this position with the original espoused devolvement of responsibility for planning and identification of needs down to their ranks. This theme has been identified in previous research on service planning and has been described as a 'lack of clarity of purpose' (Byers 1999, Butler & Boyle 2000).

The health professionals' considered their 'expert' knowledge was not being used in the planning of the services (Pettigrew et al's (1992) factor 8, fit between the change agenda and the locale and factor 5, clinician-management relations). Whilst management viewed the health professionals' contribution as limited due to their lack of planning skills and their fixation on 'wish lists' and problems. The policy being implemented is seen to contradict itself (factor 1, quality and coherence of policy); a high-powered vehicle for

change as well as a strategic management tool that operationally is only a budgetary control operated through a standardised template. This is a crucial deficit for something described as 'strategic' planning (DOHC 1998:26).

The standardisation of the process in the Irish context was seen according to senior management in the Irish context, as environmental pressures (factor 3) brought to bear from the 'outer context' that introduced the service plan as a budget control and were primarily financial in nature.  These pressures need to be buffered with skilful management; otherwise as in the Irish cases you see a range of pathological organisational reactions such as delay and denial and collapse of morale.

In comparison, in the Canadian case, there was a two pronged approach; firstly the importance of population health and the planning surrounding that, at a strategic level and secondly the multiple stakeholder involvement in the annual planning cycle feeding into this and protected by legislation. The policy was coherent and did not contradict itself. The key to this process cited by interviewees was flexibility rather than standardisation. It allowed for good clinical management relations (factor 5) and an appropriate interface between the change agenda and the locale (factor 8).

 **(ii)    Communication**

The second core theme identified in the study, communication, was seen as crucial; in the Irish cases because of its absence, and in the Canadian case because of its successful use. The two factors that of management-clinician relations (factor 5) and inter-organisational

networks (factor 6) identified by Pettigrew et al (1992) were two sub themes identified in this research. Managerial-health professional relations were a significant draw back in the Irish case but did not come up as a difficulty in the Canadian data. In the Irish data the 'them and us' mentality was endemic at all levels of the system. Some health professionals had gone into opposition with regard to service planning, by withdrawing their participation. Health professionals recounted experiences of being cut off from the decision making of the organisation, and that the measures by which they accounted for their service output were crude and inappropriate. At senior management level, it was noted that service planning was in fact to put order and control on the system. However, the main issues arising from this control strategy are; the difficulties in assessing units that do not 'own' some or all of their performance, the lack of clear organisational objectives, inadequacy of IT systems, implications for management style, the relationship between the centre and the periphery, and between the manager and the service provider (Carter 1994:209). All these issues arose in the Irish data and were a problem from the health professional viewpoint. The Canadian data in comparison saw communications as a corner stone of their change strategy.

Pettigrew et al (1992), Strong and Robinson (1990) and Bennett and Ferlie (1994) discuss the segmented culture of the health service; divisions between management and professionals, professionals and professionals, and management and their political masters leads to a system that is highly segmented and hierarchical. The data in the Irish cases also speaks to us of these divisions, and is a crucial factor that needs to be dealt with in the management of the health care system.

**(iii)    Implementation**

The third core theme identified in this study was that of implementation.   The three factors of leadership (factor 2) , simplicity and clarity of goals (factor 7), and a supportive organisational culture (factor 4) identified by Pettigrew et al (1992), were corresponded with sub themes identified in the data in this research.

The second factor; leadership was identified in analysis of the data. However, findings differed greatly between the Irish and Canadian cases.  Leadership in the Canadian case was a multi-layered and pluralist activity with a number of champions emerging with regard to key health or community issues.  Whilst in the Irish data, there was a lack of identifiable leaders and their absence was noted as a deficit in the service planning process by many of the interviewees.   In the Canadian data, the use of a strong communications network was reported as being crucial to dissemination of information and allowing leaders at all levels to work well.  Again the comparison of the two contexts showed a very different profile, with the Irish interviewees in many cases, noting the lack of effective communication both laterally and vertically, as well as the control of information being used to leverage political advantage in certain cases.

An important aspect of implementation of the planning system identified by Canadian interviewees was the simplicity and clarity of goals (factor 7).  In contrast, its absence was noted by Irish interviewees.  Although in the Irish case there was a national health strategy to inform service planning.  It was not broken down to actionable pieces, especially at local level.  The lack of clarity and lack of strategic intent was an issue in

the Irish case, as key issues such as HR, IT and other resources were not included in the planning of services.

In the Irish cases, a supportive organisational culture as a factor in achieving change is notably deficient; in particular, the gap in relations between management and health professionals (factor 5) was identified. It illustrates the classic distinction drawn by Kanter's (1985) typology of integrative and segmented organisations. In the Irish cases there was a strong sense of the importance of hierarchy, which Kanter (1985:76) describes as an elevator mentality where there is 'a dominance of restrictive vertical relationships'.

To conclude, moving from the policy and its coherence, to the communication of the vision, leads finally to implementation. Therefore, in this research, as in Pettigrew et al's (1992) study, the first factor – 'quality and coherence of the policy-analytic and process components' was crucial to the cascade of other factors that followed it. Whereas in the Irish cases, the standardisation of the process was in evidence, the converse was true in the Canadian case, allowing for the flexibility of painting a broad vision and allowing buy in from all the key stakeholders.

**CONCLUSION**

The objective of this research was not seen as a testing of Pettigrew's framework per se, instead the framework was seen as a tool to facilitate examination of the factors that were facilitating or inhibiting the process of change. In this context, the themes that were

identified by the Irish respondents were seen to be hindering change or what Pettigrew et al (1992) would describe as non-receptive contexts for change. In the Canadian context the factors identified by respondents were seen to facilitate receptiveness to change, or were identified as receptive factors. In both Irish and Canadian contexts all the eight factors were seen to be relevant to the research, however there was one exception that was the factor of 'leadership' in the Irish context. It's not that its absence wasn't mentioned, nor that it was not relevant but in order of saliency it was not identified as a strong factor. As Lapsley (2001) notes, the specific circumstances of large state owned bodies such as a health service are such, that they are heavily constrained in policies and practices by government. This circumscribes the actions of individuals and suggests scrutiny of significant interventions as occurred in the Irish context with a national team vetting service plans for conformity (HeBE 2003). The Irish context spoke of policy pushed from government and the external environment by those in management who did not see themselves as necessarily as the champions of the process rather more as the keepers of the process. As a result of the historical context the absence of leadership could be seen by respondents as a 'given'.

To conclude, there is an identified lack of build up of capacity in the Irish health care system in terms of strategic management processes at the local organisational level to underpin the process of service planning. This deficit speaks to us of a policy-implementation gap, one that can be examined by looking at the policy itself; the investment decision legislation that introduced service planning. This research identified a number of areas in which to build up this strategic capacity. In addition, this study by

taking a comparative perspective can suggest areas for improvement from looking to Canada. It is not to say that Canada's health care system is an ideal type, but key areas where they have achieved success is their use of information capacity, communications, as well as citizen participation, and these can be drawn on. In the Irish context a definite information deficit in planning was identified. The lack of facilities to capture data as part of a needs assessment, as well as the lack of interest in such collection was noted. This situation needs to be remedied and the arm of the reform programme, introducing HiQA (Health Information and Quality Authority), is to be welcomed, as the Irish health care system has not been 'evidence based' to any degree. The lack of communication in the Irish context between all levels in the health care organisations (the health boards) as well as poor communication inter-organisationally needs to be addressed. In contrast, this is where the Canadians invested a lot of effort including a large communication function within the DHA itself for both organisational use and that of the citizen-client, areas that need to be built upon in the Irish system. A recommendation in this study for more citizen client participation in health planning in Ireland concurs with much of the recent research on public governance. There is a move towards a new public service, which is built on work in democratic citizenship, community and civil society. As evidenced by the findings of this study, in the Irish context, there is a lot to be learned from the Canadian experience in this regard.

The Health Strategy espouses the need for evidence based planning to underpin the strategic management of our health services. However, governance in Irish healthcare relies on a 'command and control' model (Houghton 2006). This approach to

management of the health services results in a purely mechanistic approach to service planning; filling in the boxes and meeting budgetary targets. That the nexus of relationships in the health care organisation 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.

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