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**REVITALISATION, RIGOUR AND RELEVANCE: THE CITIZEN-CLIENT AND PLANNING
IN THE HEALTH SERVICES**

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WORKING PAPER

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. However, ten years since the advent of service planning there has been no real shift in alignment of resources with needs.

How can the strategic management of the Irish health services in the form of service planning be implemented? The focus of this paper is the identification of stumbling blocks to success in this endeavour. These include the limitations of the control mechanism, the legislation, underpinning service planning and the lack of recognition of the complexity of the healthcare environment and the stakeholders within it, in attempting to introduce service planning as a means of strategic management. This paper reports on part of a comparative study of health services planning in Ireland and in Canada. The Irish research is shadowed by a case study in Canada. This paper reports on the Canadian experience of public participation in planning, to align goals and targets with identified health needs in the population. In comparison to the Irish context, the Canadian planning system takes a two pronged approach; a population health planning approach at the corporate strategic level and multiple stakeholder involvement which is protected by legislation, feeding into this system on an annual basis.

Introduction

Whereas, the Irish health care system (1970 Health Act and its 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 resources decisions of Irish health care managers' (McKevitt 1993:311). In comparison, Lassey and Lassey (1997:76) note that the Canadian system and its health legislation emphasises a clear set of national priorities that serve as an underlying rationale for the current 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.' In truth, there is no 'Canadian' health care system according to Klatt (2000), but rather ten distinct provincial systems in a federal system, tailored to the needs of their citizens and to their unique political philosophies. Each province legislates for the planning and delivery of its health care so for the purposes of this study the

Province of Nova Scotia is seen as analogous to the Canadian case for ease of comparison.

An overview of the Irish health care system

The Government, the Minister for Health and Children and the Department of Health and Children (DOHC) are at the head of health service provision in Ireland. Until 2005 (the period of this study), the Irish healthcare sector comprised a health board management structure, 11 health boards in all, and is described as an integrated public health care system. Of note to this case comparison, is that Canada's health care system is highly decentralised with the provinces (and territories) primarily responsible for health care (Marchildon 2005). Most public health services are organised or delivered by regional 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 the Capital Health District Health Authority (DHA) in Nova Scotia was chosen. This formed an interesting comparison with the Health Boards (now since 2005, termed health regions with their local areas) in the Irish situation. In comparison to the Irish developments, which focus on increased centralisation of services into one national Health Services Executive (HSE), the Canadian system has developed in a decentralised fashion with local control and consumer choice.

Strategic planning in Irish health care

In the Irish health care sector 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. 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 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. It 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.

In the Canadian context, Nova Scotia's reform design in the 1990s was brought about for a number of key reasons similar to the Irish situation; to control the rising cost of health care, emphasising the effectiveness of the prevailing model of medical care, the overall efficiency of the health care system and in contrast to the Irish situation, the need to respond to demands for greater patient and citizen involvement in decision-making. Reform of the system involved making a decision between a more centralised, hierarchical system and a decentralised, participatory system. In contrast to the Irish case, Nova Scotia (amongst other provinces) opted for the latter (Bickerton 1999). The focus of this reform reported by Dawson, Rathwell, Paterson, Butler, Cobbett, Pennock, Anderson and Kiefl (2004) was on integration of health services under a regionalisation umbrella and with a population health focus. The structures recommended to achieve these goals were a network of local Community Health Boards (CHBs) under the umbrella of District Health Authorities (DHAs) (analogous to Irish Health Boards). The CHBs are each made up of fifteen volunteer members. Under the Health Authorities Act in 2001, the CHB must prepare and submit to the DHA a Community Health Plan that includes recommended priorities for the delivery of community based health services

and a list of the initiatives recommended by the Community Health Board for the improvement of the health of the community (DOH 2002). The DHA is required to take the Community Health Plan into consideration when preparing their yearly health-services business plan, and, should they fail to include the plans in their service planning, to publicly explain why. Therefore the volunteer CHBs operate in an advisory capacity to the 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.

Research focus

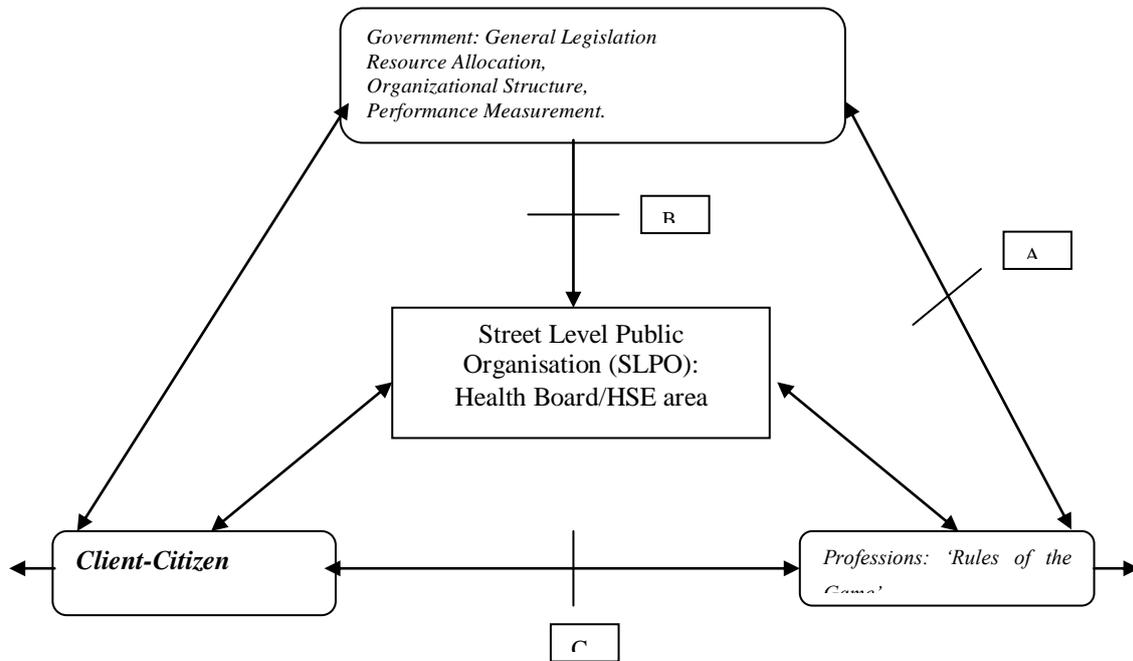
Ireland has no legislated strategic framework that would guide the resource allocation process and provide for a control system responsive to agreed objectives and give legitimacy to the resource decisions of healthcare managers. Instead in the Irish context, we have a national health strategy that is without legislative impetus. As a result the service planning process can become more susceptible to political influences. McKeivitt (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. 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. It takes into account the nature of a health care organisation, which Mintzberg (1983) classifies as a professional bureaucracy and is characterised by many varied and competing groups. The SLPO model allows for analysis of the heartland of public service delivery as well as identifying tensions that arise in the delivery of health care services due to different and competing interests.

Tensions in the Environment; Service Planning

The importance of the SLPO model for this study is that it allows consideration of whether there

is consistency and coherence between espoused objectives at the national level such as the aspirations of the national health strategy and its implementation through the service planning process at health board level.

Figure 1 Tensions in the SLPO environment



Source: Adapted from McKevitt (1998:99)

What is important in the health care context is that the model includes specific influences from the environment that affect service delivery in public organisations in particular. As Bovaird (2005) notes service delivery in the public domain is no longer 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. The SLPO model employs the concepts and categories of general strategy and in particular focuses on the organisation-environment relationship. In the healthcare context the model allows for the sometimes uneasy relationship between central government and professionals in the SLPO as well as their governing professional bodies. It allows for inclusion of the citizen-client. The model shows the important external relationships of the SLPO and these relationships impact directly or indirectly on the SLPO’s capacity to deliver on their strategies. Taking the strategic viewpoint; service planning and delivery in the area of health care is a managed process. The essence of this planning and management task is

relating the SLPO to its environment. In doing so, a number of tension points can be identified. For the purposes of this paper, one source of tension is discussed; that between the professional and the community of citizens (see point C) and thus government, where lack of control of the professional by central government can lead to an erosion of the community's needs and rights. McKevitt (1998) notes the SLPO is a complex institution drawing legitimacy and acceptability from the wider institutional environment and subject to pressures that require an organic mode of management that supports collaboration, trust and openness.

Some Research Findings

The design of this study is what Yin (2003) describes as a multiple case study. The service planning process was examined in its implementation at the Street Level Public Organisation (SLPO) level; the health board level, as well as accounting for the wider institutional influences; the context in which those cases were situated. 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. This paper has focused on only one aspect of the wider comparative study of service planning. Three core themes were identified in relation to the tension point at C; these were stakeholder involvement, needs analysis, and control. Distinctive to this paper is an outline of the first of these themes; stakeholder involvement and the SLPO model is used to assist in analysis of this data.

Relationships in the SLPO; Stakeholder Representation and Involvement

In order to deliver health services that are people centred, equitable, accountable and quality focused as per the principles of the Health Strategy (DOHC, 2001), a valid assumption would be that consultation with key stakeholders including the citizen-client would occur. In the Irish cases, 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'. In a number of instances in this research, health professionals had withdrawn

from the service planning process and instituted their own strategic or 'real planning' exercise. In other areas it was acknowledged that there was difficulty in engaging with some professionals in service planning. 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. Due to the restrictions of the planning process through the use of a template, some managers felt consultation and other information was superfluous in many cases. Also, it could just lead to information overload. Given that service planning had initially been touted as a means of devolving decision making down the ranks to the health professionals, there was understandably a lot of comment on the lack of trust that senior management had in the abilities of the health professionals. This was 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 inclusion of consumer involvement as a heading on the service-planning template (DOH 2000) had yet to become a reality.

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 organisations. At the level above them (Community Health Team) there is consultation with key community, provincial and federal agencies. The DHA itself in its planning consults with the service users and health professionals in planning services as well as receiving the community feedback through the CHBs. 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. Whilst in Ireland although service users are included in the template; their role has no legislative basis.

Discussion

Crucial to examining the role of stakeholder involvement, is the legislation, which in the Irish case lacks strategic intent. In the Canadian case, it is the legislation mandating community involvement in the planning of services and underpinning key strategic management processes, which averts the tension points identified in the SLPO model. Canada deals with these tensions, Ireland does not. Part of the problem in the Irish context is the continuing direct influence of the DOF and DOHC in the day to day running of the health service. This study benefited from employing McKevitt's (1990, 1998) SLPO model. As a result, the finding 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. A decade after the introduction of service planning, further legislative changes have been made with the total restructuring of the Irish health service. Yet, there is no strategic intent in the legislation that would guide service planning. Though using the words 'evidence based', 'population health', 'equity', 'people-centred' and 'health and social gain', there is little evidence in this study that these concepts have gained purchase in the present implementation of policy and planning in Irish health care. In comparison the Canadian data demonstrates a mutual recognition of collective purpose and there is less stress on the professional-administrative divide. This understanding must underpin planning in the health services, as the reliance on the limits of the legislation, means that service planning never evolves to anything more than a fiscal control measure.

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