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MAKING SENSE OF HEALTH CARE PLANNING IN IRELAND: THE STREET LEVEL PUBLIC ORGANIZATION (SLPO).

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Abstract

One of the central mechanisms of the Strategic Management Initiative (SMI) (Government of Ireland 1996) is the devolution of accountability and responsibility from the centre to executive agencies. Service planning was introduced in the Irish health care sector as part of this strategic planning ethos. This paper reports on a study that examined both the intent and the consequences of implementing legislatively mandated planning in the Irish health services, in the context of significant organizational change. In an effort to draw broader lessons, a comparison is drawn with the Canadian experience of service planning.

The choice was made to study the dynamics of this policy implementation at a local level by examining a number of health boards in both the Irish and Canadian contexts, as well as accounting for the wider institutional influences; the environment 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, and examining the legislative influence.

This study highlights a number of issues. First, the limits of the control system; the legislation itself, in aligning government policy aims with the planning process, and, second, the lack of recognition of the complexity of the healthcare environment and the stakeholders within it, in attempting to implement policy. This paper posits explanations for the difficulty in aligning strategy and planning in Irish health care after over a decade of service planning.

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

INTRODUCTION

The Strategic Management Initiative (SMI), as outlined in *Delivering Better Government* (1996), gives the Irish 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 over the last 15 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 health sector was seen as part of this strategic planning ethos. That the health services need to be strategically planned is not in doubt, given that

'health' represents a significant portion of the Irish government's current public spending in 2011; namely 27% (DOF 2010). The focus of the study reported in this paper is how the strategic management of the health services in the form of service planning is to be implemented. This paper reports on part of this wider study, and highlights a number of issues that were identified; first, the limits of the control system; the legislation itself, in aligning government policy aims with the planning process, and, second, the lack of recognition of the complexity of the healthcare environment and the stakeholders within it, in attempting to implement service planning. In so doing, the paper utilizes the model of the Street Level Public Organization (SLPO) in order to make sense of the data gathered.

Using a comparative perspective 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 now 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 resource decisions of Irish health care managers'. In comparison, Armstrong, Armstrong and Fegan (1999) note that the Canadian system and its health 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 Marchildon (2005) there is no 'Canadian' health care system, 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 health care systems

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. This health service provision is publicly funded through taxation. Until 2005/6 (the period of this study), the Irish healthcare sector comprised a health board management structure, eleven health boards in all, and is described as an integrated public health care system. The boards were the main

providers of health and personal social care at regional level. Of note to this comparative study, 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 (now since 2005, termed health regions with their local areas) in the Irish context. In comparison to Irish developments, which have focused on increased centralization of services into one national Health Services Executive (HSE), the Canadian system has developed in a decentralized fashion with local control and consumer choice.

Control and strategic planning in health care

Public spending on healthcare in Ireland rose significantly faster than the OECD average in the decade up to 2005 (OECD 2009). At present, the 2011 allocation of €14 billion has been significantly pared down and has seen a retreat from growth in public sector spending due to the severe economic downturn. According to the OECD Public Management Review (2008); health care is one of the most important priorities for many users of Irish public services. Even before the current reductions in the healthcare spend, the demands from the public for further financial resources to be put into the health service still remained strident. However, many commentators began to question the use of the resources already invested (Barrett 2003, Wren 2004). Public debate has raged over the need to catch up and maintain the average EU health spend; however, such increases have not alleviated what is seen as a crisis and lack of planning in the Irish health care system (Tormey 2003, O'Connor 2007, Burke 2009). Much of the research in the health care sector in Ireland has focused on the economic and control perspectives in health policy through an examination of resource allocation or utilization (Nolan, Gannon, Layte, McGregor, Madden, Nolan, O'Neill & Smith (2007) Thomas, Normand & Smith 2006, Thomas, Normand & Smith 2008, Smith & Normand 2009, Brick, Nolan, O'Reilly & Smith 2010, Ruane 2010)

The present Irish health care strategy published in 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 health care strategy to determine priorities and underpin planning, in line with its principles of equitable, accountable, quality focused and people centred services. It also promises to make provision for the participation of the service user in decision making.

Thus, service planning was introduced back in 1998 (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 emphasized. 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 stated principles of the Health Strategy in delivering health 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.

In the Canadian context, Nova Scotia's reform design was brought about for a number of key reasons similar to the Irish situation; to control the rising cost of health care, emphasizing 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 centralized, hierarchical system and a decentralized, participatory system. In contrast to the Irish case, Nova Scotia 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 regionalization 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 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.

THE STREET LEVEL ORGANIZATION: THE EXERCISE OF STRATEGIC CONTROL

Strategic Control of Core Public Services

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.

McKevitt (1998) and 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 exploring the dynamics of service planning implementation at local level by using a number of health boards in both the Irish and Canadian contexts, this study utilized the model of the Street Level Public Organization (McKevitt 1998).

The SLPO model draws from Lipsky's description of the Street Level Bureaucracy, a term he first used in the 1960s to describe public organizations. 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 at the base of the hierarchy (Lipsky 1980). The notion of the street level bureaucracy has been invoked to examine complexity in public sector service delivery (Kernick 2005, Piore 2011, Wellstead &

Stedman 2011). According to Piore (2011) this theory allows us to move beyond standard economic theory and to draw on other social sciences for alternative policy instruments for managing the public sector. Wellstead & Stedman (2011) use the concept to look at the bureaucrat-citizen relationship. Kernick (2005) invokes this bundle of relationships to explore the role of the 'Street level bureaucrats'. His paper demonstrates the difficulties and consequences of applying a linear, rational decision making framework onto such a complex, nonlinear system. All these literatures; managing professions, implementing reforms, involving communities and applying rational planning in a complex system have resonance for this paper.

McKevitt (1998: 25) utilized this 'remarkably useful innovation' and on the basis of field research rejected the term 'bureaucracy' with its connotations of a closed system, and replaced it with 'organization'. His model of the Street Level Public Organization (SLPO) is utilized in this paper to explain the wider environmental context of planning, resource allocation and performance measurement systems. It takes into account the nature of a health care organization, which Mintzberg (1983) classifies as a professional bureaucracy and is characterized by many varied and competing groups.

In health care control of services that are dominated by professionals becomes complex as according to Millar and McKevitt (2000:291) there is potential for conflicting demands and also because the locus of control varies depending on the structural, ethical and financial forces in that environment. In the rationing of resources, these professional specialists exercise discretion and in doing so, have considerable policy-making powers. This raises a number of issues notably how this professional authority can be utilized or controlled in the planning of services. According to Wrigley and McKevitt (1995), the predominant source of power for these professionals over other stakeholders and in particular the citizen or client is that of differential information, as those with professional specialisms in health care have a greater knowledge in these areas than the mass of citizenry. As a result, the standards of the professional bureaucracy instead of being applied from above in terms of senior management, can originate from outside the structure from other operators that join with their colleagues in self-governing associations permeated by a variety of these external professional influences and adopt norms that are not always reconcilable with efficiency objectives (DiMaggio and Powell 1991). Thus, McKevitt's SLPO model (1998) adapted for this study by Byers (2008), can be utilized for the analysis of the heartland of public service delivery, as well as

identifying tensions that arise due to different competing interests (see Figure 1 overleaf).

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 emphasize efficiency and meet the requirements of institutional legitimacy, rather than the interests of the citizen-client. Institutional theorists, such as DiMaggio and Powell (1983, 1991) argue that organizations in the public sector seek to enhance legitimacy by conforming to these social prescriptions derived from the institutional context. This is exemplified most notably, according to Alford (2001), by the succession of system-wide management reforms imposed by governments since the 1970s such as New Public Management. These influences were considered in more detail in the wider study.

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 at health board level. 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.

In the healthcare context the model allows for the 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 how 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.

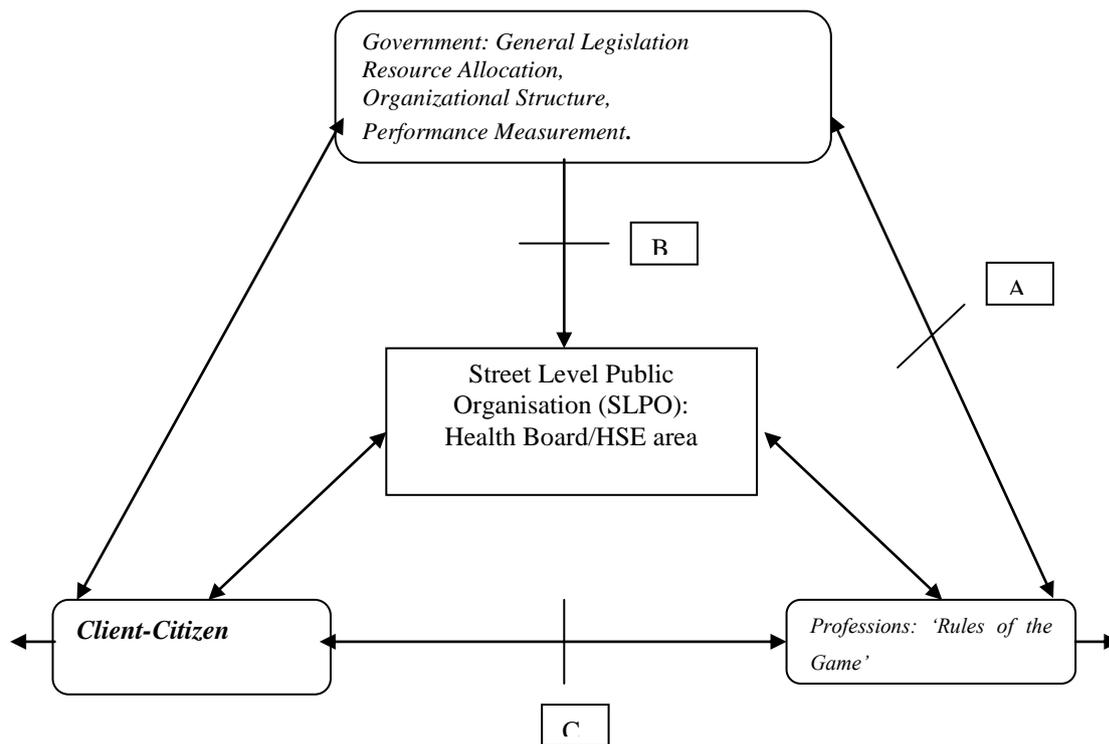


Figure 1 Tensions in the SLPO environment

Source: Byers (2008:112) adapted from McKevitt (1998:99).

Thus an understanding of the Health Board/DHA using McKevitt’s model allows us to determine the capacity of the organization to deliver on service planning as mandated by legislation, as well as delivering on implementation of the National Health Strategy. 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) 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. However, presently in Ireland, the debate about the crisis in health care focuses on the government asserting that many of the problems relate back to poor performance of the professions.

In using 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; as 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 strategic direction of national health strategies 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. As McKevitt (1998:32) points out, in English speaking countries the prevailing culture for professionals features individualism. At times this may function to the disadvantage of the citizen-client and the community.

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 New Public Management doctrine. As 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.

RESEARCH METHODOLOGY

The design of this study is what Yin (2003) describes as a multiple case study. Research

questions were tested using data from a number of sources. Given the structural organization of health care in both Ireland and Canada it became apparent that service planning should be examined in its implementation at the Street Level Public Organization (SLPO) level; the health board/authority 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. 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 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). The final number of interviewees was 54. 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. Using qualitative analysis of interview data, a number of core themes were identified, some of which will be outlined below.

RESULTS AND DISCUSSION

This paper has focused on one aspect; 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 this wider 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 key process identified by interviewees was needs analysis, which

would allow the principles of the Health Strategy to guide the resource allocation process. Another source of tension is point A, relations between central government and the professions, as well as point C, relations between the professions and the community of citizen-clients. These tensions were identified under the core theme of multiple stakeholder involvement. Distinctive to this paper is an outline of these three core themes; control, multiple stakeholder involvement and needs analysis and the SLPO model was used to assist in analysis of this data.

Legislative strategy; control

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 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 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.

Service planning can be seen as part of the New Public Management (NPM) suite of tools. Ferlie, Pettigrew, Ashburner and Fitzgerald (1996) identify four NPM models; the first, an efficiency drive, attempts to make the public sector more business like led by applying crude notions of efficiency. Of all the models the service planning initiative in Ireland seems the closest to this one as it focuses on core themes of increased financial control, stronger managerial hierarchy, a 'command and control' mode of working and an extension of audit. However, there are many differing accountabilities operating in the public sector according to Brinkerhoff (2002), financial accountability being only one of them. McKeivitt (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 is not occurring, as the corporate plan tends to recognize political imperatives only, coupled with the lack of any real citizen-client involvement at any point in the process.

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. A large element is the support they receive to plan and evolve themselves.

Crucial to this process is the legislation that necessitates that the DHA must listen to the CHBs. The DHA has been proactive in terms of marketing itself to the public. It has developed four-year strategies to underpin the yearly planning cycle and it 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'.

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 consultation with key stakeholders including the citizen-client would occur. 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, as you'd have too many views to deal with, right or wrong.

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 some 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, 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 in its planning, consults with the service users and clinicians 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.

Environmental context: determination of service levels and needs

Fundamental to determining priorities in service planning according to the principles of the health strategy is to assess the needs of the population to whom the services are to be delivered. As would be expected the issue of needs assessment (environmental assessment) was a strongly recurring core theme identified in the Irish context. There was a lack of assessment of needs and service level requirements by any other means than whether it was in budget according to the majority of health professional interviewees. In contrast in the Canadian context, needs assessment played a large part in planning of services.

Pettigrew & Whipp (1991) describe environmental assessment as feeding in to strategy creation, by the way in which an organisation at various levels, acquired, interpreted and processed information about its environment. Pettigrew & Whipp's (1991) framework dealt with the need for environmental assessment and the construction of stakeholder networks to inform this strategic process. This is crucial in health care in terms of meeting the needs and purpose of the organisation rather than self-serving ritualistic routines.

Returning to tension point B; the investment decision legislation is meant to facilitate the development of strategic management processes by allowing priorities identified in the Health Strategy to underpin service planning resource allocation decisions. Taking a population health perspective means employing needs assessment as part of the basis for planning. The data in the Irish cases indicated that priorities and planning were not based on

an analysis of needs, but on the previous year's service plan and the limits of the budget allocation. They told stories of knowing the needs and priorities of their service and their care group, and yet, they were powerless in the planning process. They also cited lack of facilities with which to gather crucial data about their services and the pattern of demand and use. That an information deficit existed is not in doubt, it was noted by the DOHC themselves.

Management concurred that there was a lack of needs assessment. In some cases, managers expressed the view that a clean sheet review of services was not feasible or necessary. Again the focus is on the higher ranks in the hierarchy making the key decisions, and cascading them down to the frontline. In the main they saw it is a control process based on politics from above and not strategic thinking. So in the Irish context, a theme of disconnection between the health professionals and management and those above in the DOHC arose. The health professionals felt that not only were the needs they identified for their service not being acknowledged, they were not even sought to begin with. Many health professional interviewees expressed dissatisfaction with the lack of knowledge of their service by senior management.

There has really been no planning and we are not involved...As I said it's all political and they don't want us to be involved but I ask who is it that understands the services. I think it's those that deliver them and we are delivering them.

Head of Discipline (Medicine)

In the main this environmental scanning and needs assessment was an important gap identified by interviewees.

In contrast to the Irish data, the interviewees in the Canadian case described a rigorous needs assessment. At the DHA level, statistical information was available about the health of the population and strategic plans were drawn up by extensive consultation with clinicians and service users. At the CHB level there was further use of statistical data and wide ranging consultation with communities and key community groups. The process included surveying the community, summarizing the findings and then consulting with community regarding ways to tackle the identified needs.

CONCLUSION

At the outset, this paper posited that there were two key stumbling blocks to the successful implementation and communication of healthcare planning in Ireland which included the limitations of the legislation underpinning the planning and management of the health services and the lack of recognition of the complexity of the healthcare environment and the stakeholders within it. In the Irish case there is a ten year old national health strategy without legislative impetus, which has led to little change in the existing patterns of resource allocation and stakeholder relationships. In contrast, in the Canadian case, 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. McKevitt's (1998) SLPO model aided the identification of the pressure or tension points that can occur in a milieu such as health when legislation only reflects budgetary imperatives and there is a lack of recognition of key stakeholders. O'Ferrall (2008) contends that in the Irish context '...public policy outcomes are generally poor, but starkly so in healthcare, in large part because of the democratic deficit in the formulation and implementation of such policies'. In contrast, the Canadian case is an exemplar of what can occur when all stakeholders are involved in the planning and delivery of healthcare.

The findings in this paper have a wider import than just for Irish policy. According to Bourgon (2010), public sector administration has reached a crucial point in its development. She emphasizes the need for governments to build *resilience* in society. A resilient society is characterized by active citizenry and resilient communities which can be tapped and harnessed by governments to draw on collective intelligence, self organizing networks and distributed decision making. Her clarion call is echoed by other academics (Haarman, Klenk and Weyrauch 2010, Osborne 2010); 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, the first important step is for policy-makers to view the health system as a hierarchy of inter-related systems that interact in a nonlinear fashion. The emphasis 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. As Maddock (2002:38) notes public sector modernization requires conceptual modeling which reflects the connection and dependence between forces in order to develop social capital. Thus, in this paper McKeivitt's model (1998) has been utilized to illustrate the need to balance these different constituencies and to identify points of tension in managing core public services in the implementation of Irish health policy.

REFERENCES

- Alford, J.R. (2001) The implications of 'publicness' for strategic management theory, in G. Johnson and K. Scholes (eds) *Exploring Public Sector Strategy*. Harlow: Pearson Education.
- Armstrong, P. Armstrong, H. & Fegan, C. (1999) *Universal Health Care: What the United States Can Learn from the Canadian Experience*. New York: The New Press.
- Barrett, S. (2003) The Task of Irish Health Service Reform, *Irish Banking Review*, December 2003.
- Bickerton, J. (1999). Reforming health care governance: the case of Nova Scotia. *Journal of Canadian Studies*, 34, 2, pp159-90.
- Bourgon, J. (2010) *The New Frontiers of Public Administration; the New Synthesis Project*. Waterloo; University of Waterloo.
- Bovaird, T. (2005) Public governance: balancing stakeholder power in a network society, *International Review of Administrative Sciences*, 71, 2, pp217-228.
- Brick, A., Nolan, A., O'Reilly, J. and Smith, S. (2010) *Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector*. Dublin: Economic Social Research Institute.
- Brinkerhoff, D. (2003) *Accountability and Health Systems: Overview, Framework, and Strategies*. Bethesda: PHRplus.
- Burke, S (2009) *Irish Apartheid; Healthcare Inequality in Ireland*. Dublin: New Island.
- Byers, V (2008) Service Planning and Organisational Change in the Health Sector: A Study in Control. Unpublished PhD thesis, University of Limerick. (SLPO model supervised & adapted with Dr David McKeivitt).
- Champagne, F., Contandriopoulos, A. P., Larouche, D., Clemenhagen, C. and Barbir, C. (1987) Strategic planning in hospitals - a health needs approach. *Long Range Planning*, 20, 3, pp 77-83.
- Dawson, C., Rathwell, T., Paterson, C., Butler, L., Cobbett, S., Pennock, M., Anderson, B. and Kiefl, P. (2004) *Determining the impact of the population health approach by*

Community Health Boards in Nova Scotia. Halifax: School of Health Services Administration, Dalhousie University

Denis, J.L., Langley, A. and Lozeau, D. (1995) The role and impact of formal strategic planning in public hospitals. *Health Services Management Research*, 8, 2, pp 66-112.

Department of Finance (DOF) (2010) *2011 Estimates for Public Services and Summary Public Capital Programme*. Dublin: Stationary Office.

DOH (1970) *Health Act, [1970]*. Dublin: Stationery Office.

DOH (1996) [No.32.] *Health (Amendment) (No. 3) Act, [1996]*. Dublin: Stationery Office.

DOHC (1998), *Strategy Statement 1998-2001: Working for Health and Well-Being*, Dublin: Stationery Office.

Department of Health and Children (DOHC) (1999), *Service Plan 2000 – Guidelines on Format, Process and Monitoring*, Dublin: Hawkins House.

DOHC (2001) *Quality and Fairness: A Health System for You*, Dublin: Stationery Office

DOHC (2004). [No.42.] *Health Act [2004]*. Dublin: Stationery Office.

DOH Nova Scotia (1999) *Minister's Task Force on Regionalization Health Care in Nova Scotia: Final Report and Recommendations*. Halifax: DOH.

Department of Health (NS) (2001) *Health Authorities Act* (January 2001), Halifax: DOH.

Department of Health (NS) (2002) *Guide to the Health Authorities Act 2001*, Halifax: DOH.

DiMaggio P.J., and Powell W.W., (1991) (eds) *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press

Ferlie, E., Pettigrew, A., Ashburner, L. and Fitzgerald, L. (1996). *The New Public Management in Action*. Oxford: Oxford University Press.

Government of Ireland (1996) *Delivering Better Government: A Programme of Change for the Irish Civil Service*. Dublin: Stationery Office.

Health Canada (1984) *Canada Health Act*. Ottawa: Government of Canada

Haarman, A. Klenk, T. and Weyrauch, P. (2010) Exit, choice – what about voice? *Public Management Review* 12, 2, pp213-232

Kernick, D.E., (2005) Facilitating resource decision making in public organizations drawing upon insights from complexity theory *E:CO* 7, 1, pp23-28

Lipsky, M., (1980) *Street Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage.

Maddock, S. (2002) Making modernisation work: new narratives, change strategies and people management in the public sector. *The International Journal of Public Sector Management*, 15, 1, pp13-43.

- Marchildon, G.P. (2005) *Health Systems in Transition: Canada*. Copenhagen: WHO European Observatory on Health Systems & Policies.
- McKevitt, D. (1993) Managing for results: the role of performance measurement in health care delivery. *Administration*, 41, 3, pp307-22.
- McKevitt, D., (1998) *Managing Core Public Services*. Oxford: Blackwell Publications.
- McKevitt, D., Millar, M. and Keogan, J. F. (2000) The role of the citizen-client in performance measurement: the case of the Street Level Public Organization (SLPO). *International Review of Administrative Sciences*, 66, 2, pp619-636.
- Millar, M. and McKevitt, D. (2000) Accountability and performance measurement: an assessment of the Irish health care system. *International Review of Administrative Sciences*, 66, 2, 285-pp296.
- Mintzberg, H. (1983) *Structure in Fives: Designing Effective Organizations*. New Jersey: Prentice-Hall Inc.
- Nolan, B. (ed.), Gannon, B., Layte, R., McGregor, P., Madden, D., Nolan, A., O'Neill, C. & Smith, S. (2007) *The Provision and Use of Health Services, Health Inequalities and Health and Social Gain*. Economic and Social Research Institute Series. Dublin: ESRI.
- Noonan, K. G., Sabel, C. F. and Simon, W. H. (2009), Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform. *Law & Social Inquiry*, 34: pp523–568.
- O'Connor, M. (2007) *Emergency: Irish Hospitals in Chaos*. Dublin: Gill and Macmillan.
- O'Ferrall, F. (2008) The Erosion of Citizenship in the Irish Republic: the case of healthcare reform. *The Humanities Institute of Ireland Seminar*, University College, Dublin 22nd Feb.
- Organization for Economic and Co-operative Development (2009) *OECD Health Data 2009: Statistics and Indicators for 30 Countries*. Paris: OECD.
- Organisation for Economic and Co-operative Development (2008) *OECD Public Management Review: Ireland, Towards an Integrated Public Service*. Paris: OECD.
- Osborne, S. (2010) Delivering public services: time for a new theory? *Public Management Review* 12, 1, pp1-10.
- Peters, J. P. (1985). *A Strategic Planning Process for Hospitals*. Chicago, IL: American Hospital Publishing Inc.
- Pettigrew, A. and Whipp, R. (1991) *Managing Change for Competitive Success*. Oxford: Blackwell Publishers Ltd.

- Piore, M.J., (2011) Beyond Markets: Sociology, street-level bureaucracy, and the management of the public sector. *Regulation & Governance*, 5, 1, pp145–164.
- Ruane, F., (2010) *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*. Dublin: Economic Social Research Institute.
- Ryan, P, Thomas, S, Normand, C, (2009) Translating Dutch: challenges and opportunities in reforming health financing in Ireland. *Irish Journal of Medical Science*, 178, 3, pp245-248.
- Smith, S. & Normand, C. (2009) Analysing equity in health care financing: A flow of funds approach., *Social Science & Medicine*, 69, 3, pp379-386
- Thomas, S., Normand, C. & Smith, S. (2006) *Social Health Insurance: Options for Ireland*. Prepared for the Adelaide Hospital Society. Health Policy and Management. Trinity College Dublin.
- Thomas, S., Normand, C. & Smith, S. (2008) *Social Health Insurance: Further Options for Ireland*. Prepared for the Adelaide Hospital Society. Health Policy and Management. Trinity College Dublin.
- Tormey, B. (2003) *A Cure for the Crisis: Irish Healthcare in Context*, Dublin: Blackwater.
- Wren, M. (2004) *Health Spending and the Black Hole*. Economic and Social Research Institute Paper, ESRI: Dublin.
- Wellstead & Stedman (2010) Policy capacity and incapacity in Canada's Federal Government: the intersection of policy analysis and street level bureaucracy. *Public Management Review*, 12, 6, pp893-910.
- Wrigley, L. and McKevitt, D. (1995) *Professional Ethics, Government Agenda and Differential Information*, Open University Business School, Working Paper Series 95/5.
- Yin, R. (2003) *Case Study Research: Design and Methods (3rd Ed)*. London: Sage Publications.