IMPACT OF HEALTHCARE REFORMS ON MANAGEMENT PRACTICE

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Introduction

The aim of this study is to identify the impact of reforms as perceived by healthcare managers in various levels and settings on their management practice, with a view to informing debate on policy and practice.

This collaborative research project between the Health Systems Research Centre UL and the HMI is the first comprehensive insight into health reforms in Ireland from a management perspective. It was inspired by some international work on the impact of reforms on clinical practice in the UK, Australia and New Zealand (Perkins et al 1997), in other key domains (Ovretveit 2002; Degeling et al 2003), and a comprehensive body of work undertaken by the National Institute of Health Research / Service Delivery Organisation in the UK (Walsh and Rundal, 2001; Iles and Sutherland, 2001).

This summary aims to identify what has improved, disimproved or had little or no substantial change since 2004.

Method

A survey instrument was developed and tested in consultation with members. The survey of managers in membership of the HMI or eligible therefor was conducted online during September/October 2009.

A 5-point scale was used to rate change in various dimensions of management practice. These are summarised in respect of key areas reported as clear improvement, clear disimprovement, or little or no change. As a guide, clear dis/improvement is indicated by a clear majority (53% or more) of those who expressed an opinion reporting either dis/improved or greatly dis/improved or a mean outside the range 3.3-2.7 (3 = no change). Otherwise there is considered to be little or no change.

Findings

The total number of participants was 462 of which around 40% were members and 60% eligible non-members. This constituted a response rate of 33% while 27% fully completed the survey. The participants comprised HSE 73%, Voluntary Hospitals 18%, and others 9%.

A model of the health system’s management components (figure 1) connects the survey elements and provides a template to locate the findings.
Cross-sector differences are more pronounced and thereby more revealing than differences between background discipline or other distinctions. An overview of responses for the HSE and other sectors is described below.

**HSE**
The above model is elaborated in the findings for each of its elements as follows.

**Individuals’ Engagement (1 in figure 1)**
Of immediate note is the similarity reported between deterioration in individual managers’ sense of engagement with the organisation, and strong corresponding views on disimprovement in the culture and overall governance of the HSE.

**Culture (2)**
There are major concerns regarding *values* at most levels of the HSE. In particular, a clear disimprovement in *trust in* and *collaboration/cohesion across the organisation* is indicated. Public trust was even lower than internal trust!
Although organisational communications with patients has distinctly improved (59% report improvement), there has been little or no improvement in communications with local and national media. In relation to communications with staff, although there are divergent views at all levels, local level notes a net improvement (53%) whereas area and region show disimprovement, with no change at corporate level.

*Corporate leadership style* is oriented to the autocratic (56%) and authoritative (17%). This lies in contrast with predominantly democratic (34%), transactional (22%), and autocratic (18%) style attributed to the immediate supervisor. Transformational leadership is the least indicated at 7%.

![Dominant Leadership Style: HSE managers](image1)

![Dominant Leadership Style: Corporate style by level](image2)

Figure 2. Dominant leadership style from the perspective of individual managers: (a) corporate and immediate supervisor, and (b) corporate style by level.

*Organisational control* is polarised at the extreme of being more highly centralised, and prescriptive (as opposed to empowered). This resonates with financial and employment authorisation being substantially limited, eg 51% do not have any budget, while 19% reported a budget of €10 million or more, and this in an organisation with an annual budget circa €16 billion (see figure 3).

A disimprovement in *Values* is reported by 52.4% as against improvement 28.9%, and in *Beliefs* 47.7% disimprovement as against 22.7% reporting improvement.
Governance (3)

Corporate structure, lines of authority and accountability, and lateral role relationships, all reported major disimprovement at all levels.

In contrast clear and substantial improvement was reported in the quality approach and clinical governance across all levels, although there was no clear improvement in service governance.

Functions (4)

With regard to resource capacity currently available, while there is a clear improvement in Medical Technology, there is little or no improvement in ICT and Estate, and a major disimprovement in both the overall scale of funding (64%) and personnel (60%). The operation of Function activities, including management capacity of systems and performance, shows no real improvement. Specifically, there is a very clear disimprovement in the operations of HR (55%).

Performance Management (5)

There is strong concordance on improvement in performance-standards, indicators and measures. However, no change was noted for shared goals and agreed targets. Regarding corporate accountability (for all of these and related objectives), 36.9% reported improvement, while 23% indicated no change, and 40.1% reported disimprovement, 43% of which reported great disimprovement.

Regarding the planning cycle, availability of relevant data, information & data analysis, and monitoring improved substantially, with little or no change in adoption & implementation, and due process. There was some disimprovement in the involvement of relevant parties and the availability of substantive choice. On balance, however, there is no clear change overall.
Quality/performance improvement (6)

Quality improvement activity overall has distinctly progressed, particularly that driven internally with 64.5%, and external showed clear improvement with 55% reporting improvement or great improvement. However, performance improvement (individual and organisational learning, and sustainable achievement) showed a clear disimprovement, in particular from area, region and corporate levels.

In specific areas great progress was reported (75%+) for internal quality activity in respect of Risk Management, Patient Safety, Hygiene Audit, and Health & Safety, followed by Care Pathways, and Clinical Audit, with a slight improvement in service audit, and peer review. Staff input showed no change overall. In externally oriented activity, hospital accreditation and critical events investigation improved greatly, and there was clear improvement in department accreditation, with no clear improvement in professional licensing, external evaluation, and patient/community input.

National Services (7)

Within the sample of care categories considered, some progressed very well (Cancer, CVHD), yet there was little or no change reported overall for others (MH and ID).

It is generally agreed strongly across all sectors and levels that primary care improved substantially (70%). Tertiary care shows a clear if small improvement. However, community care, continuing care, and secondary care show no clear improvement.

External integration shows improvement in access to primary care (61.1%) and referral from primary care (57.1%). There was no clear change in internal and external integration of services for any modality. In particular, there is no clear improvement in access to community and continuing care, or access to and discharge from secondary or tertiary care.

Voluntary Hospitals and others

The highest improvement in all elements was reported by the Private Sector (PS) followed by the Voluntary Hospitals (VHs) although they are slightly shaded by the Non-Statutory Agencies (NSAs) for Governance.

Individuals’ Engagement (1)

The engagement of individual participants by the VHs improved substantially in respect of input to local policy and practice and service and business plans, and decision-making scope, but shows little or no improvement in respect of relevance of given targets, clarity of given role and of accountability. In contrast, there was a major improvement in all aspects of engagement by the NSAs and PS.
Culture (2)

There is little or no improvement in internal or public trust for the VHs, but also no substantial deterioration either. In the NSAs and the PS there has been considerable improvement (over 70%). There has been clear and substantial progress in collaboration and cohesion (of all types) across these sectors (over 65%).

In leadership style, VHs report similar proportions of democratic, transactional/managerial, and autocratic corporate styles (27%, 24%, 27%). NSAs report autocratic style 50%, while PS report nil autocratic and instead 57% democratic. The immediate supervisor style is predominantly democratic across all these sectors. Transformational leadership in the non-HSE sector averages 6%.

Centralisation and prescription has increased in the VHs and NSAs. In contrast, the PS are slightly more decentralised and empowered. This resonates with financial authorization, which is indicated in budgets assigned for VHs to 62% of managers, NSA 87%, and PS 100%. Assigned budgets of €10million and over is indicated for 29% in VHs, 47% in NSAs and 56% in PS (see figure 5).
Governance (3)

This improved solidly for example structural and lateral role relationships, with great improvement in quality approach, clinical governance and service governance.

Functions (4)

All Functional operations (systems and performance) improved substantially over all these sectors. Resource capacity currently available shows no net change overall. However, within this broad indicator there are still major concerns about the availability of financial and human resources, especially at upper management levels in the voluntary sector.

Performance management (5)

This improved across all these sectors. It included shared goals and agreed targets and corporate accountability for them, with great progress in standards, indicators and measures (80%). Coverage of diverse perspectives in performance indicators showed solid improvement (70%).

Planning cycle showed clear improvement over all items (mentioned earlier) eg monitoring and information availability, involvement of relevant parties, and availability of substantive choice.

Quality and Performance Improvement (6)

Voluntary Hospitals and Private Sector lead significantly on internal quality improvement activities (64%-100%), and also to a lesser degree in respect of external activities. Performance improvement recorded substantial improvement across these sectors (66%-76%).

National Services (7)
Overall, perceptions of national care categories distinctly improved, as did both primary and tertiary care, but community and continuing care and secondary care show little or no change. Furthermore, integration within and between modalities shows little or no improvement.

**Conclusions.**

There are paradoxical findings in the HSE responses. On the one hand there is a matched deterioration in individuals’ sense of engagement with general disimprovement in most aspects of culture and governance, resources and functions. On the other hand, there is improvement in performance management (apart from certain important phases of the planning cycle), quality improvement (internal more than external), and the main service categories other than mental health and intellectual disability and integration within and between services.

The Voluntary Hospitals, Non-Statutory Agencies and Private Sectors’ better individual engagement correspond with most aspects of culture, governance and functions. The Private Sector followed by the Non-Statutory Agencies show more positive indications than the Voluntary Hospitals. These sectors nevertheless all share a clear improvement in performance management (including planning) and substantial improvement in quality and performance activities.

There is a definite concordance with the HSE view of service improvement nationally. The Private Sector, followed by the non HSE Sectors, shows a more positive overall integrated profile and performance. It is of course recognised that they are generally less complex and diverse organisations and do not experience the same direct impact of the reforms as the HSE. All share concerns about resource availability but the HSE and Voluntary Hospitals are probably more sensitive in that regard. The common improvement in performance and quality activities may be attributed to central direction and public demand in the light of critical incidents on such matters. They, and other dimensions, particularly in the HSE, also raise issues of sustainability and effectiveness over time.

There are stark contrasts in culture and governance as between the HSE and other Sectors although they mostly share a common perspective regarding the status of national services overall.

The foregoing managerial perceptions from different sectors and levels of the health care system have real implications that should be addressed at policy level and lead to an early review of the role of management and leadership style in the HSE in particular. Drawing from the outcomes of the research as a starting point, questions should be asked and answered on certain fundamentals such as trust and control.
References

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