Managing for Results:
The Role of Performance Measurement in
Health Care Delivery

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INTRODUCTION

Control of health costs is high on the agenda for debate in every modern country. The specific characteristics of the debate vary from country to country and are related to the economic circumstances of the time, the organisational framework for the delivery of health services, the relative contribution of public and private revenues for health service provision and the role of the State in the organisation of the services. Solutions advanced range from the strategic – a reduction in the health care system – to structural change, to operational improvements such as greater efficiency in the delivery of health services. At the core of health expenditures and the State’s attempt to control their growth is the expectation that the money is being properly managed and that it is effective in achieving its objectives.

The evaluation of effectiveness can take a number of forms. One measure is effective financial control i.e. that the money is spent and accounted for in accordance with legislative or regulatory policy. Another is that the money is used in a manner supportive of the policy of the legislature or control department to achieve specific objectives; for example, that hospital expenditures are properly managed so as to contain overall costs and allow for some re-allocation to other areas of the health care system such as primary and community care. A third measure of effectiveness (and the most intractable) relates to appropriate use i.e. that the money is not being diverted or captured by health care workers (through wage increases or increasing sophistication of equipment) to the detriment of patient care expenditure.

In common with many European countries, the Irish health care system is now under close, if somewhat unfocused, scrutiny from a wide variety of sources. Government, for example, is concerned to reduce expenditure and to ensure effectiveness and efficiency in service delivery. Thus arrangements for the funding and management of the system were examined in the reports of the Commission on Health Funding and the Kennedy reports on acute hospital services in the Dublin Region. One can also point to pressure from consumer and interest groups for increased responsiveness and accountability in service delivery from both providers and management.

This paper examines current developments in health care management in Ireland and the United Kingdom, Sweden and the Netherlands. Its central focus is the strategic framework for service delivery and the role played by performance measurement systems in the control and motivation of administrative and professional staff. It examines the role of legislation in health care strategy. The paper reflects on the link between health care strategies and measurement systems. It reports on some recent British research on performance measurement and on the implications of this research.
CURRENT ASSUMPTIONS

Official thinking in Ireland on health care delivery is influenced by developments in the United Kingdom which has (since 1991) embarked on a restructuring of health care management and delivery variously described as the 'purchaser-provider split', and the development of 'quasi-markets' in service provision through NHS Trust hospitals and GP fund holding practices.

Current developments and thinking in Ireland are based on a number of assumptions about the relationships between funding and management of health services delivery which are thought to provide greater efficiency and effectiveness in the overall system of care. These assumptions, largely untested and not based on detailed research, can be expressed as follows:

(a) that there is benefit to be gained from separating funding of health care delivery from direct provision of services i.e. to encourage the development of hospital budgets for large acute public hospitals which are institutionally separate from general health board expenditure (as recommended by the Commission on Health Funding);

(b) that administrative and managerial structures should be uniform throughout the system, i.e. the public voluntary hospitals should have the same budgetary arrangements as health board hospitals;

(c) that further centralisation of control will result in greater effectiveness, i.e. the proposal to abolish health boards and to set up a Health Services Executive Agency (Commission on Health Funding);

(d) that increased use of performance measurement systems will ensure greater accountability and responsiveness in the system.

In official thinking on health care there is a heavy reliance on structural and budgetary arrangements which, though important as instruments of control, reflect a general propensity to seek solutions that can broadly be described as technical and operational in character. The problem is presented in narrow terms - for example, 'how can we reduce hospital waiting times?' or 'how can we develop performance targets for some aspects of GP practice?' - rather than as an examination of the strategic framework required for health care management.
Neglect of Motivation and Incentives
In addition, while a ritual reference is made to management development and to the need for better relationships between managers and health care professionals, there is a profound neglect of the important motivational and incentive structures underlying health care delivery. For example, the negotiations of new contractual arrangements for both general practitioners and hospital consultants were handled separately and without a coherent policy on the crucial inter-relationships between the two institutional sectors.

In incentive terms GPs now have less motivation to see medical card patients (than they had under the old fee-per-consultation arrangements) thus placing additional pressures on self-referral to hospital accident and emergency departments. Hospital consultants have, through their unregulated access to hospital resources for private patients, incentive to allocate more time to private practice. The tax relief on VHI premia provides an additional State funded incentive for private medical care in the absence of a budgetary control system which would guarantee transparency in the formal separation of costs for public and private users of hospital care. Tackling the issue of information systems in hospitals, without attending to the larger incentive structures, may yield useful financial information; conflicting incentive structures will, however, remain.

THE ROLE OF LEGISLATION

It is clear that other countries, confronted by similar challenges in health-care policy, have responded differently from Ireland and that their legislation is a central component of this response. Legislation is also important in the context of the policy for the re-orientation of health care provision towards preventive, community-based care as it is difficult to see how such a policy could be implemented without legislative statements of its aims and objectives. The European countries examined in this study adapted and changed their legislation to take account of, and give effect to, changes in their health-care investment strategies. Legislation in the public sector provides a framework for management control.

In Ireland the 1970 Health Act represented a departure from detailed provisions of control to one based on the administrative model of ‘staff-line’ relationships. The lack of specificity in the Irish legislation was not a problem as long as resources were available for the expansion of services. In the absence of norms for service delivery, the allocation of extra resources allowed for a build-up of ‘slack’ within the system. The rigid nature of the resource allocation system, both at national and regional level, resulted in disparity in service provision which was exacerbated by the absence of norms and standards in the legislation. Moreover, in a period of retrenchment, the administrative centre had to oversee cuts in services and it could not legitimise its action by reference to legislation.
which defined government policy. This situation marks Ireland as different from the other European countries where there is legislation which defines and describes consensual health-care objectives. In Ireland, there is no formal legislative statement which specifies the strategic objectives of the Irish health care system – that is, unlike a number of European countries, Ireland 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.

INTERNATIONAL EXPERIENCE

A general strategic direction has been indicated by the WHO and adopted by several countries. The WHO strategy for health-care in the year 2000 is primarily concerned with the socio-economic determinants of health status and the reorientation of health service policy towards a preventive, community-based, approach. The policy entitled 'Health for All by the Year 2000' was agreed in 1984. The first target states: 'by the year 2000, the actual differences in health status between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups'. In its suggested solution to this problem the WHO states: 'the target on health inequalities presents a challenge: to change the trend by improving the health opportunities of disadvantaged nations and groups so as to enable them to catch up with their more privileged counterparts. Within individual countries, this implies above all a need for willingness in recognising the problem, for initiative in actively seeking information on the real extent of the phenomenon, and for political will in designing social policies that go to the root of social group formation, in terms of guaranteed minimum income, assurance of the right to work, active outreach services to assist the groups in need, etc'.

It is clear that if Ireland were to seek to achieve these targets, which are primarily rooted in social, economic and resource considerations, legislation would need to be altered, not only in organisational terms, but in ways which mirrored the equity considerations outlined above. However, the WHO programme, which is the intellectual basis of Health - the Wider Dimensions, is not congruent with the stated position of civil servants or politicians when changes in Irish health-care policy provision are mooted.

Thus, for example, the research programme adopted by WHO includes a priority to be given to research on inequities in health. The WHO document states: 'the two basic goals of health-care are to raise the overall level of health and to increase equity; inequities may relate to social status or class, sex and gender, ethnic grouping or geographic location. Three types of research are needed with regard to equity; theoretical and methodological work on concepts and indicators of health inequalities; a better understanding of the factors and mechanisms that create and maintain health inequalities and policy research and
evaluation of programmes aimed at reducing health inequalities.’ In Ireland such data collection is not done on any systematic basis. This contrasts with the Dutch and Swedish response to the challenge posed by economic constraints in health service provision. This disparity also extends to the measurement system used in these countries where there is a clear concern to review the practical effects of health-care policy.

Swedish Example
The Swedish health-care system is a decentralised one with the twenty-three County Councils having responsibility for health-care provision and expenditure, which are primarily based on local taxation. The Swedish policy on health services, which is oriented to the implementation of the WHO ‘Health for All’ programme, began with a series of research programmes in 1978. These were published in 1982, and circulated to politicians, health-care professionals and the public. The act of parliament, which was based on these research proposals and documents, was passed in June 1985. The guidelines underlying the Act HS-90 were: ‘(a) health care must be characterised by active health policies; (b) the need of the population for care must determine the allocation of health-care resources; (c) health-care resources must be weighed against socio-economic and employment goals and limitations.’ The discussion document focused on issues such as socio-economic differences in health-care utilisation, social and occupational distribution of prevalent diseases, and correlation between health hazards and illness groups.

The legislation states that health-care on equal terms requires: ‘(a) equality in the supply of resources available throughout different parts of the country; (b) equality in the utilisation of care between different groups of society; (c) equality in terms of access to care; (d) equality in terms of quality and efficiency of care’. It is important to note that the Swedish system provides a clear example of congruence between strategy, measurement and management. The social and political consensus in Sweden, relative to the aims and objectives of health-care policy, is in marked contrast to the Irish situation.

Lessons from Sweden and the Netherlands
Control in health care yields similar challenges to politicians, civil servants and health care professionals under different financing systems for service delivery. Control, per se, is rectificatory and not restorative; that is, it is about the maintenance of norms, the following of patterns and rules once these have been laid down. Recent research (McKevitt 1990) examined the national health policies of Ireland, Sweden and the Netherlands from a strategic perspective. It found that Ireland, unlike Sweden and the Netherlands, did not adapt to the challenge of control largely because its legislative framework did not contain any explicit strategy, nor were the performance of health service professionals subject to any sustained scrutiny. The Swedish and Dutch systems, in contrast, which differ quite markedly in their financial support for health care, share common features in their concern for explicitness in legislation, their attendance to the
sovereign importance of measurement and information systems and in their willingness to adapt and modify their control systems to refocus their investment decision. It is clear that legislation provides the basic control framework for investment decisions in health care provision ('the rules of the game') and that such frameworks need to be adapted and modified in the context of changing environmental conditions.

The theme of adaptation of legislative control frameworks to suit emergent environmental conditions is quite central to the development of appropriate strategic control at the national level. Thus, for example, the 'greying' of the population and the objective of care-in-the-community impose quite specific policy objectives for both hospital usage and the framework for service delivery. Both Sweden and the Netherlands, in their planning for health care in the year 2000, have looked to divert resources from the hospital sector to other parts of the health care system. Their legislative frameworks are quite explicit in this regard and hence operational control and the measurement system are predicated on the implementation of such policy. There is in the public policy process in these countries an attempt to adapt strategy in the light of changing circumstances. It seeks to adapt to the decision environment of the public sector (macro level) rather than to impose additional pressure on the organisation to achieve change at the micro level.

Thus, for example, both Sweden and the Netherlands have developed and modified their legislative frameworks to incorporate strategic policy at the heart of the control framework. While their legislative frameworks differ greatly - Sweden has a prescriptive legislation outlining its health care strategy, while the Netherlands has evolved a complex series of very detailed regulatory provisions - both countries have made quite explicit strategic choices.

Need for a ‘Mission’
A central proposition of the research already cited was that control of health care required a clearly specified 'mission' or strategy whereby operational management could align investment decisions to clearly articulated programme objectives. The term 'mission' embraces the legislative basis for health care policy, government decisions on service provision and the response of the civil service in the implementation of the policies.

The political decision to invest in the Irish health care services, without clear legislative objectives, severely restricted the State's capacity to control its investment decision. A producer-orientated system resulted and there was no impetus to clarify health care objectives. In the UK the situation is reversed; lacking any updating or revision of its 1946 strategic framework, the emphasis has been on administrative and managerial reform. Similarly, the UK 'policy' process was based on conviction politics, in contrast to the quite lengthy process of research, debate and review of strategic change in other European countries. A central feature of successful strategy is consistency of objectives; the
persistent alterations and change to UK administrative structures in the health care area signal an organisation that has no clear consistent policy. It is hoped that Ireland will not follow the UK model in this respect.

The Irish and UK approach to health policy has shown that the State has been selective in its application and use of the means of influence open to it. Thus, there have been many initiatives in the use of organisational structures, the measurement function and, to some degree the use of resource allocation models (RAWP). What distinguishes these countries from most other European nations is the absence of any use of the means of influence central to strategic direction and control – the formulation of policy limits or “rules of the game”. The concentration on budgets, operational improvements and information technology are important initiatives, yet they do not, in strategic terms, constitute a clear mission or strategy. Wrigley (1990) stated in respect of health care control that:

‘In private enterprise the ultimate control of the working of any particular firm lies with the customers or competitors in the market place, more exactly, with the tastes and budgets of customers, and with the strategy and production costs of competitors. The legitimacy and effectiveness of the control system within each particular firm is derived from this; from the customer’s budgets and competitor’s costs. There is, today, no equivalent source for the legitimacy and effectiveness of the control system in public health care.’

Ireland, therefore, needs to attend to its strategic framework for health policy if it is to have a health care system on a par with other European countries. Failure to attend to this sovereign task will leave the Irish system in thrall to the vagaries of politics and medical interests and the position of managers will be an unenviable one of trying to ‘hold the line’ in a system where control is dependent on the play of competing interest groups.

HEALTH STRATEGIES AND MEASUREMENT SYSTEMS

The test of any strategy or policy is in its implementation: that is, after the policy has been translated into resources (machines, money, people) how successful has it been? One of the key requirements of any strategy is that it incorporates a measurement system that will integrate and measure achievement against plan. In health care, as in other areas of social expenditure, the trend in recent years has been to design and plan performance measurement systems that will track the progress of policy reforms. Leaving aside the many inherent difficulties of how you measure the effects of health care spending, the main burden of effort in performance measurement has been in the increased demands made on the professionals by health care managers and government. Indeed, the new
consultant contract devised in 1991 specifically included the basis for measurement in the practice plans to be agreed between the consultant and the hospital manager. However, little progress has been made on this issue. The UK experience which we will review in this section clearly shows that further developments can be expected in Ireland. Performance measurement and control lie at the core of making strategic plans operational: it is also the place where the voice of the citizen is weakest.

In health care, as in other areas of social expenditure such as education, there is a great disparity between the providers of the services and their clients/patients in respect of knowledge as to the efficacy of the service. That is, in technical language there is information asymmetry in the system and the doctor is placed in a position of trust, or agent, in respect of the patient. The patient/client cannot increase his or her understanding of the service through repeated 'purchases' or through going elsewhere for service, as there is (usually) only one provider (the State) and because of the unusual nature of the services, i.e. purchase and supply are instantaneous, they cannot be separated or stored for future consumption. As a consequence, society usually provides such services through the State and places an important ethical responsibility on medical personnel to act in a professional manner.

This concern is reflected in the development of performance measurement systems, sometimes in co-operation with the profession (Peer Review) yet more often 'imposed' by the management structure (Performance Indicators) and seen as an expression of 'rule by bureaucrats'. If the earlier relationship between the doctors and patients could be described as professional-custodial, the new performance control systems might be seen as transforming that relationship into a manager-custodial one. Indeed, in some measure, the increasing emphasis on improved management (cf. L. Joyce, C. Ham 1990) is now placing quite demanding and conflicting priorities on health care managers.

Performance Indicators
What skills and expertise are required of the management in this environment? How do you allocate resources where there are unlimited demands, conflicting priorities and quite considerable misunderstanding of the doctor-manager relationship? Hospitals, both in the UK and Ireland, have seen a marked concentration on the development of indicators for performance which are largely concerned with resource-input and resource use decisions as a proxy for effectiveness measures. The implementation of such systems, and the various incentive structures underlying them both for doctors, managers and patients, is a useful guide to how technical measures can result in unintended consequences, in particular for the role of hospital managers. A recent study (McKevitt et al, 1993) on the development of performance measurement systems in NHS Trust hospitals examined this process; the study has direct relevance for Irish managers as they try to combine measures of performance which ensure accountability and responsiveness in service delivery. The
debate on the introduction of performance measurement systems (in particular in respect of hospitals and schools) has centred on a number of related themes: that performance indicators have laid too much stress on concepts of efficiency and economy and neglected the measurement of effectiveness; that the measures have been a device for top management to increase central control; that the interests of the citizen/consumer have been sidelined or ignored and that professionals are resistant to the implementation of measures which reduce their autonomy.

McKevitt's study utilised the framework developed by Kanter and Summers (1987) which identifies three major objectives of performance measurement systems in the multiple stakeholder environment of the public services: institutional - measures which are focused on external stakeholders and which are concerned with legitimacy renewal and the attraction of resources; managerial - measures which are concerned with internal allocation of resources and which are focused on managers and professionals; technical - measures which are concerned with the evaluation of effectiveness and quality and which are focused on customers and clients.

Three Key Questions
The study was concerned with three key questions: the source of impetus behind the development of measurement systems; the role played by major stakeholders in their development; the extent to which recent Citizens' Charter initiatives have impacted on the development of measures which focus on service users. The organisations covered in the study included government departments, district and county councils, NHS Trusts and health authorities. The data, based on a sample of Open University students who were taking the MBA in public service management, clearly showed that the primary emphasis of the measurement systems was on institutional measures of performance (some twenty of the organisations). The next major focus was on managerial measures and the data showed that technical measures were dominant in only five organisations.

The primary impetus behind the development of performance measures was legislation or central government initiatives (some seventeen organisations). Senior management were the most important stakeholders involved in the design and implementation of the measurement systems. Clearly the emphasis on senior management involvement is consistent with the data on the priority given to institutional measures of performance.

As the data clearly showed a 'top-down' approach to implementation, what evidence was there to show that service providers and clients accepted that the new measures were meeting their needs?
Results of Study on Measurement Systems
The data revealed the following broad patterns:

- **Professional Suspicion of the Measurement Systems.**
  One manager observed that adopting a patient-centred approach ‘involves giving choice to the citizen which may conflict with the political and managerial constraints of resources’. There was a perception, in some cases, that the development of explicit measures will mean that managers will be more closely involved in rationing decisions which they perceived to be the proper task of politicians.

- **The measures have not been embedded in the organisations and there is a lack of involvement of middle-level managers in their development.**
  One manager observed that an ‘additional difficulty is the suspicion with which such plans are regarded by front line staff... for these plans to be seen as anything other than a cynical way for management to save money they must be owned by more than senior management and politicians’.

- **NHS Trusts perceive a ‘market’ advantage in the development of performance measures, although such measures are primarily of a managerial rather than a technical nature.**
  One manager in a Trust hospital observed that, while it is difficult to develop measures of effectiveness, ‘they represent a potentially unique selling point in the quest for successful bids for additional contracts’.

- **The under-development of technical measures which are focused on the needs of users and citizens can be explained, in part at least, by the lack of appropriate channels for citizen ‘voice’ in the design of performance measures.**
  One manager in a community health care unit reported that ‘users representing individuals, voluntary organisations and other statutory bodies were not convinced of their ability to influence the organisation or monitor its performance’.

Conflict Between Different Measures
The conflict between developing institutional and managerial measures of performance – which are primarily organisational in nature – and the technical measures which are focused on the citizen/client is clearly captured by the following manager whose authority has applied for NHS Trust status:

‘... the organisational performance measures used within the health visiting service reflect mainly institutional and managerial functions which are there to satisfy the interests of Purchasers, Department of Health, levels of management and professionals. The significant stakeholders
whose interests are not really served are the clients. Theoretically, the Purchasers, and soon GP fundholders, act as 'commissioners' for the Clients. However, they also have their own priorities and have to respond to other influences. The technical function of performance measurement is more problematic but it is a crucial indicator of effectiveness and quality: attention should be given to these issues."

‘An additional difficulty is the suspicion which such plans are regarded by front-line staff... for these plans and measures to be seen as anything other than a cynical way for management to save money, they must be owned by more than senior management and politicians.’

**Managers Query Process**

The failure to integrate political and professional decision-making in respect of resource priorities has led to managers querying the legitimacy of a process which exposes them to rationing decisions they consider inappropriate to their role:

‘Stakeholders should be involved in the debate on measuring performance; this may overcome suspicion, create a realistic appreciation of the issues and enhance quality of debate. It may, however, create expectations that resource restrictions are unable to satisfy, and this issue should be clearly exposed in the debate.’

Quite apart from the issue of whether performance targets are adequate as measures of effectiveness and responsiveness, the study clearly shows how managers are distrustful of the implementation process and how the process places them at the centre of the rationing process. The political and medical professions do not appear to be embedded in this process, while the voice of the citizen/consumer is very muted indeed. What are the implications for Irish health care managers as they seek to develop performance measures for their areas of activity?

**CONCLUSIONS**

Simplistic calls for better management in the public sector are usually accompanied by recommendations that private sector techniques are employed to improve public sector operations. Yet these recommendations miss the point: the market cannot operate effectively in health care if its primary objective is the delivery of services that have as their core objectives the creation and maintenance of social interdependence and cohesion. The operation and delivery of health services is, world-wide, primarily a State activity; the focus of our concerns should, therefore, be to improve these services rather than to
sector managers and medical professionals to ensure that their operations are efficient, effective and equitable.

In respect of equitable services the task here is to design performance measures which will monitor the provision of services to the medical card patients (the only approximate target group which could be seen as representative of identified need). Such a system would clearly be part of an overall strategy which sought to allocate scarce resources to best effect. Indeed, such a measurement system and strategic intention would clearly be in line with the policy in the WHO document "Health For All by the Year 2000". The development of performance measurement systems, which are sensitive to the needs and requirements of the citizen/client, is an important part of the accountability relationship between public service personnel and the citizen.

The research reported in this paper raises important questions for managers: why is the citizen’s ‘voice’ excluded from developments on strategy and performance measurement and why do senior managers continue to view performance indicators as instruments of control rather than as a means of furthering the development of responsive and accountable relationships? The Irish health care database is incomplete and primarily financial in orientation: why should there not be a national pilot scheme to develop appropriate, timely and relevant performance indicators that look outwards to the citizen/client, rather than inwards to the managers and professionals? This is not a short-term solution. Strategic redirection of the health services would take at least a decade as the evidence of countries as diverse as Sweden, Canada and New Zealand demonstrate. To contribute to that redirection Irish health care managers and the medical professionals require training and development based on best practice in these countries. It is now time to begin this process which will place the citizen at the appropriate point within health care management - at the centre of the relationship between managers and professionals.

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Erratum
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mimic private sector techniques in the public sector. There is a clear obligation on public
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