Management Between Autonomy and Transparency in the Enterprise Hospital

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UNIFOB AS

JANUARY 2004

Working Paper 1 - 2004

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Preface

This paper is written as part of the research project Autonomy, Transparency and Management – Three Reform Programs in Health Care (ATMhealth) at the Stein Rokkan Centre for Social Research.

The aim of ATMhealth is to study such processes of reform and change within the Norwegian health care sector, make comparisons with Sweden, Denmark and other countries, and estimate the consequences of such reforms. Three research areas are emphasized:

1) AUTONOMY. The ambition to establish autonomous organizational units, with a focus on the health enterprise.
2) TRANSPARENCY. The dynamics involved in the strive for transparency, exemplified by the introduction of still more detailed instruments for monitoring of performance and quality, as well as patient's rights to choose and be informed.
3) MANAGEMENT. To establish a more professional and distinct managerial role at all levels is a major ambition for most of the recent reform programs.

A comparative research design is employed – regional, cross-national and global – in order to analyze the relationship between reform activities, organizational changes and service provision. The aims are to:

- Generate research on the preconditions for change in health care by the means of comparative research
- General competence development in organization and management of health care
- assist the health institutions in their efforts to improve service delivery and create more innovative structures for organization and management.

The funding for ATMhealth comes from the Norwegian Research Council and more specifically FIFOS, Research fund for innovation and renewal in the public sector. The purpose of this fund is to create a concerted, multidisciplinary , long-term research effort, in order to encourage organizational changes and innovation in the public sector, and create the common solutions for the public sector of the future.

Haldor Byrkjeflot, project director

More information about ATMhealth at:
http://www.rokkansenteret.uib.no/vr/rokkan/ATM/index.html

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Abstract

Better management and new organizational forms have been the preferred solutions in the efforts to slow down the rising expenditures in Norwegian hospitals. This has been explicitly expressed in a new law on health personnel and health enteprises, in which Norwegian hospitals have been required to implement the principle of unitary management. The introduction of unitary management and the belief in a new accountable and empowered manager seems to represent a break with traditional forms of management, like parallel professional hierarchies and representative structures. The authors have studied how a group of clinical managers, all members of the top-management team in a middle sized Norwegian hospital, has adjusted to the new demands for unitary management and the restructuring of hospitals.

A key question is how clinic managers themselves perceive and adjust to the new roles and tasks they have been assigned. Managers try to enact their own importance by implementing performance management. However, this enactment leaves the managers more visible, transparent and vulnerable. The professional hierarchies in Norwegian healthcare have been based on professional imperatives of action and a logic of appropriateness. Another question discussed in the paper is whether these imperatives and logics are now replaced by a new logic of consequentiality, or whether they may continue to exist in a state of competition or in combination with the new managerial logic of consequentiality.

Sammendrag

Satsing på bedre ledelse og nye organisasjonsformer har stått i sentrum for de senere årenes initiativ for å bremse utgiftsveksten i norske sykehus. Dette har bl.a. kommet til uttrykk i den nye loven om helsepersonell – hvor norske sykehus fra 2002 er blitt pålagt å implementere prinsippet om enhetlig ledelse. Introduksjon av «enhetlig ledelse» og troen på et nytt ansvarliggjort og bemyndiget lederskap fremstår som et brudd med de tidligere tradisjoner for parallelle faghierarkier og kollegiale, representative ledelsesstrukturer. I denne artikkelen har en undersøkt hvordan klinikksjefer, dvs. toppledergruppen i et mellomstort norsk sykehus har tilpasset seg i forhold til de nye rammebetingelsene, blant annet foretaksorganisering. Et viktig spørsmål er hvordan klinikksjefer selv forstår og tilpasser seg til sine nye roller og oppgaver. I sin nye rolle som enhetsledere er klinikksjefene underlagt skiftende krav og hensyn. I streben etter resultat og autonomi forsøker de å iscenesette sin egen betydning. Denne iscenesettingen gjør dem mer synlige, transparente og sårbare. Artikkelen drøfter også i hvilken grad tidligere handlingsimperativer og normbaserte logikker (the logic og appropriateness) som var innebygd i de medisinske faghierarkier utfordres, konkurrerer eller alternativt lar seg forene med den nye management logikken, dvs. «the logic of consequentiality».

«Now, I experience my role as leader as much more strategic and change-oriented than before. Clinical directorate managers, in particular, are jointly responsible for developing strategy; what the hospital should do, what the strengths and weaknesses are, and what to build upon in the further development of the hospital. This was not specified in the former structure – until we got the enterprise structure.»

Introduction

The clinic manager quoted above indicates that the conditions for exercising management in the Norwegian hospital sector have changed (cf. also Sommervold 1997, Vareide 2001, 2002). New demands for management were laid down by the Norwegian Parliament when it established that all hospital departments had to implement unitary management from 2002. At least formally, this puts an end to the dual, collegial and representative management structures that have been an old tradition in managing Norwegian hospitals. A trend towards more unified management structures in public services has been recognised also in the other Scandinavian countries (Østergren and Sahlin-Andersson 1998) and indeed in the public sector at large in many Anglo-Saxon (oriented) countries (Clarke and Newman 1997; Considine and Painter 1997; Pollitt and Bouckaert 2000). The introduction of unitary management in the hospital sector can be understood as the implementation of one of a few cornerstone ideas in realizing the idea of performance management, or management by objectives (Drucker 1955), as a basis for governing public services (Gammelsæter 2002). In order to realize performance management, managers must be given full accountability in terms of meeting objectives sanctioned at higher levels of authority. Other cornerstone ideas are the separation of strategic and operational functions, the disaggregation of multi-product or multi-market organization units into more manageable product-market performance units, and market competition.

The aim of this paper is to investigate and assess the role that managers play in realizing performance management as an ideal model of managing public sector service institutions. How do the unitary managers of clinical directorates themselves understand their roles and tasks? Do they experience that the structural conditions put in place actually help them fulfil their roles, or do they, as Mintzberg long ago argued (1979), involve themselves in a giant power game not only between themselves but also in their relations to the headquarters or to other vested interests? Are we witnessing the emergence of a structure in which «the middle line», i.e. unit managers, makes up the key part of the organization to drive it further towards disaggregation and the enhancing of autonomy in performance units? Or do institutional mechanisms dampen their inclination to build up power in their own units? Will the claim for internal and external transparency in the forms of performance tables or opinion polls effectively restrain the ambitions of managers, or will such mechanisms only make them perform better?

Management between autonomy and transparency

The introduction of unitary management into the hospital sector can be understood against the backdrop of the implementation of the idea of *performance management*, or management by objectives (Drucker 1955), as a basis for governing public services. In the wake of the widespread growth of the M-form structure among large commercial companies (Whittington and Mayer 2000), the organization of public services is also becoming ever more based on the idea that organizations should primarily be managed on the basis of setting and meeting performance targets and indicators (Gammelsæter 2002). Although still present, the ideas of the Weberian bureaucracy, which privilege governance by the standardization of procedures and work processes and, in a more recent fashion, professional skills, are not elevated any more as the ideals of managing modern public institutions.

Given this shift in the premise for managing large organizations, a number of actions follow almost logically. First of all, if the unit or organization is accountable according to predefined objectives, and not primarily according to the means and processes by which some ideals are met, its management must necessarily be given great autonomy in finding ways to achieve the objectives. Instead of supervising whether the execution of work itself meets parochial standard procedures, organization owners (or top management) must set clear performance targets for lower level managers, while at the same time giving them the freedom to formulate what their own targets are and *how* the goals sanctioned by their superiors should be fulfilled. This is what is often referred to as devolution or decentralization of decision-making, but it is also a system in which overriding strategy-formulation, performance control and managerial power is retained at the apex of the organization (Drucker 1955).

Second, to achieve performance management, the idea of separation between strategic and operational management is a key requirement. The idea of having top management rule by objectives and results is exactly that it eliminates the need for management to involve itself in rules, details and workmanship at the operational level (Chandler 1962). Without this separation top management will involve itself in operations, and thereby interfere with the freedom that lower level managers are expected to enjoy in their pursuit of better ways of meeting performance measures (Drucker 1955). If top management interferes, how can the unit manager be held fully responsible for the unit's performance?

Third, to ensure that performance management works it is essential that the organization is disaggregated into separate units ('divisions') that operate according to their own specific and measurable objectives. Without such separation, clear objectives are difficult to define, borders of accountability are easily blurred and there is basically no legitimate way to hold managers responsible for results. To prevent infighting between units in the case of confusion, superior senior managers would under such circumstances be forced to consider details, task execution and work processes to evaluate performance. This would lead to the violation of the idea of separation

between strategic and operational management, and effectively undermine performance management.

Fourth, when units are separated, their managers are given full accountability in terms of meeting objectives sanctioned at higher levels of authority. Since managers are measured according to the unit's performance, it is a personal responsibility of unit managers at all levels to take charge so that objectives are met. If necessary they can remove personnel, including managers at lower levels, who are perceived to stand in the way of success. High salaries and performance-related bonuses are frequently justified by personal accountability, the expected motivational effect of profit sharing, and the presumed competition for the best managers.

Lastly, performance management is essentially pointless without competition. Meeting objectives makes no sense unless one knows whether the objective spurs more effort, innovativeness, efficiency and progress, in relative terms. The creation of separate units subjected to goals and comparative performance indicators ideally prepare the ground for comparison. In principle, the units within such a system compete with external competitors, and consequently their performance must be comparable. This is market competition. But the units also compete with each other for internal resources, for instance in terms of investments, or nowadays knowledge, since the owner in the last resort is expected to spend the resources where the returns are highest. If the owner does not allocate the resources according to this idea but according to his likes and dislikes, performance management is in principle undermined.

Although it can be argued that all these ideas are closely related and that performance management cannot be fully realized unless they are all implemented, decision-makers do not necessarily understand this or venture to implement all the ideas simultaneously. The Nordic countries, for instance, are noted for their prudence in implementing what is often referred to as new public management techniques (Olsen and Peters 1996; Christensen and Lægreid 2001). Hence, whereas management by objectives was introduced as a new logic of management in the hospital sector many years ago, the implementation of management accountability culminating in the unitary management model has a more recent origin in Norway. The enterprise reform has been said to diverge from the more prudent Norwegian reform strategy in its devolution of authorities to boards and managers of performance units. Once in place, however, one of the interesting questions is whether the new managers themselves push performance management further in the direction of enhancing their autonomy and their room for competitive manoeuvre.

The elevated focus on managerialism in the literature on public management reform arises of course from the key role granted to unit managers responsible for producing the prescribed outputs in public institutions gradually being based on performance management. As argued above, the creation of autonomous performance units logically implies that management becomes more important and at the same time less restrained by rules and procedures. Management, in this sense, must be understood as less rule enforcement and as an increase in the managers' discretion to influence structures, systems and personnel in ways that enhance the unit's prospects of meeting its objectives, be they financial or qualitative. In this new context it is not surprising if

managers sense the expectations to «manage» in a way that is noticeably different from management in the past.

It is of course not true that managers even in private companies live in a world void of legal or procedural restrictions whatsoever. In the real world performance management leans on many well-known bureaucratic devices, such as line hierarchies and procedures concerning personnel, quality, environment and performance reports and audits. Following the introduction of performance management there has been a growing public interest in the actual performance of public organizations. This is to be expected because the introduction of performance management principles are often legitimized as a way of cutting costs and increasing quality for the client, and in the hospital sector as cutting waiting lists and providing better treatment. To satisfy the taxpayers, the politicians, the patient organizations and the media, procedures for control, performance and evaluation are required. These are devices that provide performance data that is used by management itself in achieving set targets, but they also provide information that public stakeholders must receive in order to review the achievement and increasingly the competitive advantage of public institutions, such as in the hospital sector where the freedom to choose a hospital has been legally enacted in the EU as well as in many countries.

Particularly in public organizations that are susceptible to some sort of political control, the other side of performance management is increased transparency of the organization. It is to be expected that the transparency aspects increase rather than decrease the modern performance managers' discretion and room for manoeuvring. In this sense it can be proposed that the modern managers in public organizations are easily trapped in the tension between autonomy and transparency. The 'entrapment' created by the tension between the quest for managerial autonomy and public scrutiny is susceptible to intensification by internal power games in the organization or sector. If changes in organizations influence the balance of power between vested interests and also bring new interests onto the stage, the performance systems and information produced may become the object of definition, translation, negotiation and outright conflicts that are brought into the public realm.

An issue that is particularly relevant when it comes to reforming public sector institutions is the shift from professional to performance management. There is reason to believe that the introduction of unitary management in institutions that have traditionally been built on dual structures of management, like the hospitals, threatens the power of professional groups, particularly those that have been most powerful in the past. Consequently, modern public reforms have been accused of being based on anti-professionalism (e.g. Ackroyd 1995). Since performance management is closely connected to devices like framework budgeting and accrual accounting, financial matters are easily put at the top of the agenda of the performance manager. Management decisions motivated by cost cutting or earnings potential can run counter to ethical or quality ideals held by the professional workforce, and conflicts may arise. Particularly in institutions based on a public legacy, such conflicts may spill over to the general public, and hence intensify the (apparent) transparency of the institution.

The Norwegian hospital enterprise reform

January 1st 2002, the responsibility for the public hospitals in Norway was transferred from the county level to the central government. Five regional stately owned health enterprises was established, organizing 250 hospitals and health institutions under the jurisdiction of 47 local health enterprises. The local enterprises vary in size, number of hospitals and geographical span.

The transfer of ownership from the counties to the state more or less coincided with the extension of patient rights towards the free choice of hospitals, and the decision to reject the traditional bipartite model of management in favour of a unified management model. Taken together, these reforms can be seen as representing three kinds of ambitions; first, an attempt to establish organizational autonomy by way of devolution of power to enterprise boards, second, an attempt to achieve public transparency by way of supplying the patients with information that makes choice of hospital meaningful, and third, an attempt to achieve more professional and accountable hospital management. Against the background of the traditional public-administrative system for managing the hospital sector, these reforms express an ambitious effort to transform the sector into a more decentralized, transparent and yet well-managed system.

The previous public-administrative system was based upon the idea that the county hospitals should be financed by fixed government grants that was based on «objective criteria» of health needs and equality in service provision, expressed in regional and national health plans. An important precondition for this relatively stable, hospital-based and place-bound system was a centralized employment policy, encompassing professional groups and in particular a medical profession that took a key role in planning as well as in the allocation of positions and resources (Erichsen 1996). Another precondition was the anticipation that the government would finance the deviations that occurred between planned costs and actual costs in running the hospitals.

In contrast, the new enterprises at both regional and local levels are designed as autonomous performance units that are expected to find their own ways of allocating and raising funds. According to this model it is no longer an option to turn to the government for more resources when deficits occur. Instead, the enterprises have to run their businesses almost like private companies; raising their revenues and/or cutting their costs to balance their budgets. It logically follows from this model that managers in hospitals and clinics are expected to behave as active and energetic general managers, i.e. management is their profession and their concentration is on their unit's performance according to agreed upon objectives. It also follows from the model that these objectives are first and foremost financial, and hence quality objectives or the possible professional or public disagreement over what constitutes good health provision is not regarded to be in conflict with the financial targets. Given that information about quality is transparent, the patients' choice of hospital will make sure that the best providers also attract the necessary financial resources.

Hence, the development of the new role of unitary *management* in the Norwegian enterprises, hospitals and clinics can be understood as taking place within a context of tension between, on the one hand, a new structural model that assumes strategic and operational *autonomy* at the level of performance units, and, on the other hand, the pressure to develop information systems and strategies that give the public a much more complete insight into the quality of treatment of the respective service providers, in effect making the hospitals much more *transparent* (cf. figure 1).

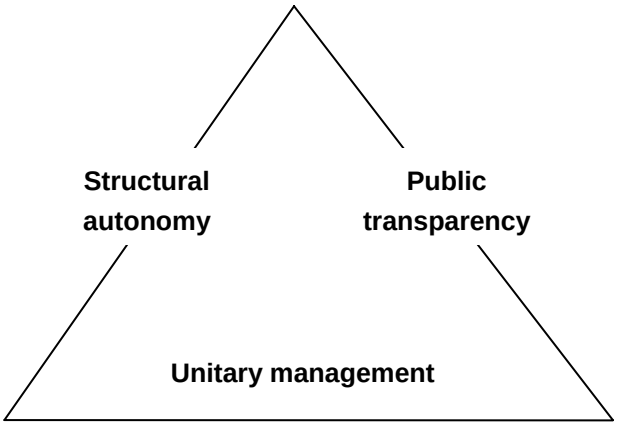

Figure 1

Data and methods

The empirical study reported in this paper is primarily based on observations, one (semi-structured) group interview, and (semi-structured) interviews with individual middle-line-managers (i.e. clinic managers) and general managers in one hospital belonging to one of the regional enterprises in Norway. The data was collected by the first author alone, about one year after the introduction of unitary management in the Norwegian hospital sector. Thus, the collection of data took place during what must be regarded an «early learning phase» of the regional enterprise – characterised as it was by massive organisational change. At this time restructuring, mergers, staff reductions and functional reorganization was commonplace within the health enterprise. At the moment of writing cost reductions amounted to nearly NOK 900 millions (or eight per cent of total budget) and lay-offs are anticipated. The enterprise employs more than 1,800 people and serves approximately 80,000 citizens. The hospital is a specialist clinic and as such serves as a local hospital for 45,000 citizens. It provides emergency treatment and most specialist services. The hospital has a clinical structure, i.e., surgery, medical and psychiatric units, as well as service and operational units (cf. figure 2).

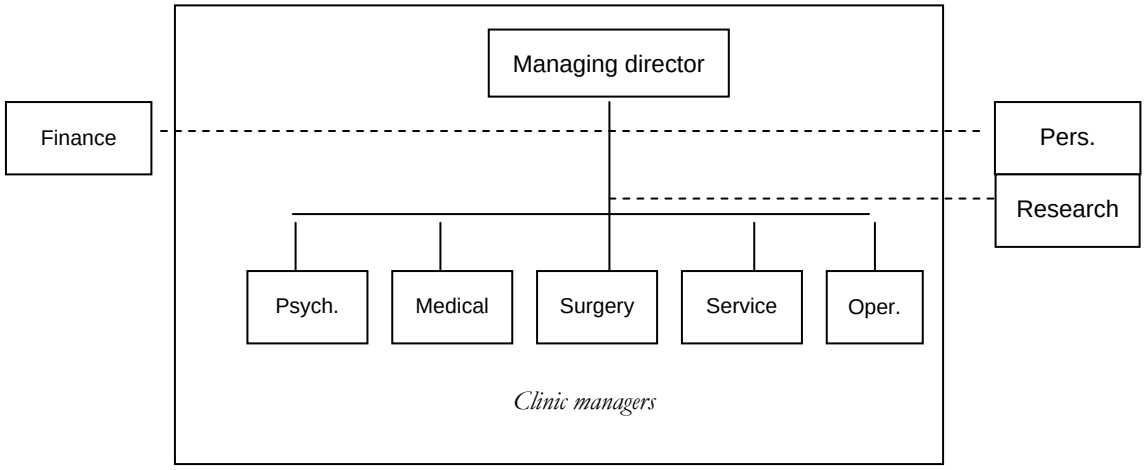

Figure 2

In the semi-structured group interviews the entire group of clinic managers as well as those managing the other units took part (see figure 2). The interview had the form of a «dialogue seminar» in which the individual managers spoke more or less spontaneously and presented different views of the topics listed in the interview guide sheet. The researcher's task was to keep the discussion within the topic framework and to manage the turn-taking in the conversation. The conversation or dialogue went along several lines, i.e. between the researcher and the individual respondents as well as among the respondents themselves. Their contributions to the group interview had the character of an exchange of experiences, a summing up of their role experiences based on their position as managers during the first year of the regional enterprise history. In addition to sharing their experiences in adapting to their new roles, the managers were also asked what they considered to be most important for their style of management, what tasks and focuses they regarded as essential to their performance, and what dilemmas and conflicts they faced. Moreover, they were asked to describe what they considered the extent of their own autonomy and freedom to act, what kind of collaborative relations and integration they experienced within the group of clinic managers, and so on.

The group interview lasted for about three hours, altogether. It was later followed up by a supplementary interview with two of the clinic managers, representing the psychiatric unit and the service unit. The supplementary interview lasted for roughly one hour and a half and broadly took up the same topics as the group interview. Still, this interview aimed more specifically at elaborating and clarifying central questions in relation to the new managerial role which the interviewer felt he had not grasped sufficiently in the group interview.

In addition to the hospital managers, the regional enterprise chief executive and several other enterprise managers (section managers) have been interviewed. All the interviews were taped, transcribed and analysed in their entirety. The interview data have been supplemented by available secondary data, including documents about the organization development process that the hospital had been undergoing for the last couple of years. These are management documents, strategic plans and job descriptions. The translations of any quotes later in the paper are ours.

The new definition of hospital management

Interestingly, the change from the previously bipartite structure (parallel hierarchies) to a unitary structure of management was introduced before the decision to transfer the ownership of the hospitals from the counties to the state. Unitary responsibility in management was introduced in a new law about specialist health services that was put into effect on January 1st 2001 (cf. § 3–9 on hospital management). The consequence was that all hospitals and hospital units had to appoint one person to be ultimately responsible for running the unit.

The introduction of unitary management can be seen as a logical act given that the Norwegian parliament in the late 1980s decided that the modernization of the state should be premised on the principle of performance management (Gammelsæter 2002). In the late 1980s and the beginning of the 1990s the discourse about management in the public sector was much influenced by the followers of the American management guru (in Norwegian private companies) George Kenning who was propagating that management must be treated as a profession and that any manager had to be completely accountable for the performance of her/his unit. Prominent private sector opinion leaders (including the chief executive of the Norwegian employers' association) attacked the way the public sector was organised and run, and the discourse of management in the public sector had to consider whether private sector ideas were appropriate for the management of public institutions.

This was evident when in 1990 a committee appointed by the Ministry of Social Affairs (the Andersland committee) proposed that the Kenning-style of management was to be introduced in the hospitals (Byrkjeflot 1999). The committee claimed that there were serious management problems in the health care sector and that these were rooted in the fact that management historically had been a function of the professional authority of doctors and their monopoly of managerial positions in the professional hierarchy of hospitals. However, the proposal was met with substantial resistance among the doctors, and it was dismissed, at least temporarily. Some years later, however, although in a slightly new disguise, similar ideas about management was put on the agenda by the so-called «the Patient first!» committee (NOU 1997:2):

> «*The committee regards the function of management as crucial with respect to the idea that hospitals should always take responsibility for the needs of their patients. The committee emphasises that the proposed changes to a great extent call for a new style of hospital management. Since the manager is running an organisational unit – management should not be restricted to one particular professional group. Management should be unitary.*» (NOU 1997:2, chapter 10.1.1)

The momentum of these management ideas was confirmed when the parliament in 2000 adopted the Specialist Health Service Act and was again confirmed when the Ministry of Health in the preparation of the ownership reform interrelated the questions of ownership, responsibility and management:

> «*The Ministry of Health regards it as essential that the framework for hospital management is clearly established. This is particularly important with regard to ownership, as the enterprise reform is expected to contribute significantly towards a clarification of terms. However it is equally important to define and specify the responsibilities which will be placed with managers at different levels within the hospitals.*» (Ot. Prop. 66 (2000–2001) About health enterprise 27.2., our translation)

It is beyond doubt that the reformers view the development of a new management role as one of the pillars of the Norwegian hospital reform (Vareide 2002). Management is regarded a profession in its own right that is not derivative of any other profession, including medicine in the hospital sector. Rather than being related to any other profession or professional peers, management, and the individual manager, are expected to be loyal to the organisation alone (Byrkjeflot 1999). Personal qualities and moral imperatives are aimed at a will to lead, to take charge and to exert influence on behalf of the well-being of the organization itself.

Making sense of the new definition of management

How then has the new definition of hospital management been translated, interpreted and implemented at the clinic level in the local health enterprise? The clinic managers find themselves in an intermediate position between the managing directors representing the board of the enterprise one the one hand, and the producers and providers of health services on the other. However, whereas in the past the parallel clinical management can be seen as an extension of the dominating professional groups (i.e. doctors and nurses) producing the services, the new model places the unitary clinic manager much closer to the managing director, obviously by degrading the benefit of any specific professional affiliation for the will and capacity to manage. As several of our respondents point out, the new position of clinic manager aims at cultivating the managerial role – not the professional role – to perfection. According to the managing director: «*An ideal for running a clinic is that you want to take on a leadership function, i.e. that you possess a combination of enthusiasm and the will to manage, and that you have the required professional ballast.*» The meaning of «professional ballast» is questionable. The recruitment pattern in our case shows that the new unitary clinic managers are recruited from different health professions (nurses, physicians, physio-chemists) but always with additional qualifications in administration and management. Their professional background is probably important in terms of making them more acceptable among the professionals, but as one clinic manager stresses, they understand their role not as a mix between professional and manager but as a full-time management occupation detached from the medical professions: «*You choose either to go into management, or to remain a medical professional.*» (Clinic manager)

Despite this understanding of the role, the clinic managers in their strife towards cultivating management find themselves in a field of tension between professional and managerial concerns:

> «*As a clinic manager you cannot opt out of management – which is what we do in a very specific sense – both management and administration, but in a field of tension between professional and superior managerial concerns.*» (Clinic manager)

The new understanding of hospital management also involves the idea of «responsibility management». The clinic managers sense the expectation to take responsibility for defining objectives and strategies and for the results that is achieved by their unit. They must demonstrate how they meet objectives and be prepared to take the blame if anything goes wrong. This contrasts with the understanding of how the clinics were managed previously when responsibility was experienced as more fluid, diffuse and «*schizophrenic*»:

> «*In a way we have to focus on management and try to make managerial decisions trickle down a system which previously also was financially managed, but in which one did not pay too much attention to financial conditions. As a former ward chief physician I have lived through a time when one used to go around saying: being a physician as well as a manager makes you schizophrenic. One has now defined the clinic manager as a purely administrative position, so that unit managers* at lower levels in the hierarchy can step back and focus on professional concerns. (Clinic manager)

Allegedly, the power and responsibility of the staffs also have been affected by the new understanding of management, with less involvement in decision-making and more focus on management support. This is how one of the staff managers experiences the new era:

> *"The present management system assigns a leadership function to the clinic managers and a definite 'provide for and implement' role to the staff functions. The division lines are clearer now. In the old bipartite system it was much less clear who was in charge at ward level. There used to be two people (managers) and it was not clear who did what. Quite often at the staff level, we made a mess of things and took on managerial functions that strictly speaking belonged to the ward manager.*» (Staff manager)

The managers' understanding of their new role(s) does not in all respects correspond with their experience of how things work, however. In particular, they experience that their room to manoeuvre as autonomous managers are constrained and hence their expectations of being fully in charge is not met, at least not yet:

> «*There is still a long way to go before decision-making authority is delegated to the clinic manager level. We are too strongly controlled financially and the budgets are so detailed that every single little pair of tweezers is included in the budget with the result that you have little room to manoeuvre.*» (Clinic manager)

Moreover, the constraints on the clinic managers' autonomy is not merely a consequence of restricted delegation. The influence of their relatively autonomous subordinates, basing their power on vested professional authorities, also restrains them. Thus, the tension between management and profession is not done away with:

> «*Sometimes it makes you smile at the fact that you live in quite a difficult world as director and clinic manager and in addition have a manager focus. You have to supply a service where others define the service and the quality of the services and you have no chance to set the price for the services. You have managers below whom you tell to keep the budgets, but you haven't managed to get them to do it yet and it's impossible to keep the budgets. They don't want to keep to the activity targets that have been set. They say yes, but in reality they have no intention of doing it. I don't put much effort into keeping within the budgets because their tradition is that they ask for more money next year. Really I should have sacked a couple of my section managers last year because they hadn't kept the budgets.*» (Clinic manager)

The distance between the understanding of the new roles assigned to them by the hospital reformers, and their conditions for fulfilling these roles, puts the clinic managers in a slightly «absurd» situation; they are expected to manage with responsibility and discretion, but at the same time they experience a number of organizational framework conditions that they cannot influence, as this clinic manager asserts:

> «*It's the conditions for action that is decisive. When it comes to authority, that's quite clear. That has always been clear in hospitals. But taking responsibility and doing something with it is a huge challenge. We live in an absurd situation as clinic managers.*»

So what do clinic manager do to diminish the distance between the expectations they meet of making discretionary decisions and being accountable, on the one hand, and the obvious constraints that threatens to make discretion and real influence an «absurd» illusion on the other? How do they react when they are accepting responsibility for the results of the clinic without possessing the sufficient administrative power, authority and budget control over subordinate units?

One strategy that turned up in our case was to direct more attention towards the earnings potential of the clinic. When the costs are hard to control, boosting the inflow of funds is one obvious alternative. At least some of our clinic managers reported creative initiatives towards boosting the income of the clinic. One of our respondents explains this as follows:

> «*What tricks do you use to make things work with the reforms – then you come back to 'what's in it for me?' There's of course no doubt that you use the dynamics and the upheavals in the health sector to obtain results in your own clinic. So it's suddenly the case that you have to produce more. If not you'll be squeezed out. That's used consciously. That's the technique, of course, here.*»

Another explained the following about the basic philosophy linked to enterprise management:

> «*From whatever company in the private sector you will be able to recognise the principles of value-based management. … Value-based management means that you emphasise management principles that focus on value creation. It's not ethics and morality but it's a matter of enforcing management indicators and putting greater pressure on increased value creation. What's interesting is value creation – that happens out there in every single hospital.*»

The earnings strategy

In March 2003 a leading Norwegian newspaper revealed that our case hospital had reported a strikingly large number of children having their tonsils removed and at the same time coded the patients with the additional diagnose of sleep apnoea (snoring): «*Removed tonsils, added snoring and earned 4 million kroner*» (Aftenposten 12.03.03). By investigating the Norwegian Patient Register the newspaper uncovered that the combined diagnosis of tonsillectomy and sleep apnoea occurred in 105 cases for the whole country in the first eight months of 2002. Our case hospital had reported 58 out of these 105 cases.

When the newspaper documented that the top management in the health enterprise had recommended that all hospitals in the enterprise entered agreements with a doctor

at the National Hospital who had developed a system for recoding diagnoses in ear, nose and throat, the disclosure assumed major public attention. The recoding strategy was undertaken to increase the income of the hospitals, in effect amounting to several million Norwegian kroner. As part of the agreement the 'consultant' (the National Hospital doctor) was to receive a ten per cent commission from the additional income that the hospitals received.

The Minister of Health and the ministry appointed an external firm of auditors to investigate the case.[1] When SINTEF-Unimed later investigated the annual accounts of hospitals around the country where the refunds from the state had risen most, questions were asked about incorrect coding in fourteen local health enterprises altogether. For the time being, a government committee is investigating six different instances of doubtful coding.

The scope of the coding scandal has been extended since the Ministry of Health and the government started their investigations in the spring of 2003. A total of 19 hospitals (local health enterprises) have had to explain their sudden swings towards more profitable diagnoses and treatments.

A concluding discussion

Without proposing that dubious coding practices have become the order of the day in the Norwegian enterprise hospital, nonetheless the question has to be raised whether the expectations that seem to be embedded in the new definition of management and the understanding of the enterprise organization structure explain the occurrence of bold earnings initiatives, like the effort to exploit the DRG financing system.[2] The enterprise structure, the introduction of the unitary management model and also the patient choice of hospital, a device that encourages competition, are most appropriately seen as a further step in the accomplishment of performance management in the Norwegian hospital sector. Management by objectives, the DRG-system and framework budgeting were implemented earlier. Now, by setting up an enterprise structure that underlined the financial autonomy of the hospital and rejected the bipartite management model that involved the doctors in the running of the clinics, in favour of professional managers that were expected to rectify the budget control problems and at the same time reduce patient queues, the responsibility of the future performance of the hospital sector was put on the shoulders of the new elite of professional managers. Despite the

1 For a time there was also the possibility that the health region's management would be reported to the police. When the health director was made aware of the case, he wanted to report the management to the police immediately to safeguard data and documentary evidence. However, the ministry, which appointed a firm of auditors to look at the case, stopped this immediately and then later the government appointed a committee of enquiry. The committee concluded later (in a report and letter to the health enterprise 12.06.03) that the enterprise, due to illegitimate coding, should repay the illegally obtained refund amounting to 2 847 340 ,- NKr.

2 In Norway previous refunding practices and framework financing have been replaced by fixed rate contracts through so-called diagnosis-related piecemeal financing (DRG). About 50% of the hospitals' revenue is now determined on the basis of the number of patients who receive treatment, while the remaining revenue is obtained from framework financing.

experience that their influence on their subordinates in practice was very constrained, this new elite of managers – our informants in any case – accepted that this was the newborn understanding of management in the hospital sector. In order to be considered a successful manager you have to accomplish both budget control and improved treatment and processing capacity at the clinic, hospital and enterprise level.

In accepting this definition of management, the new managerial elite already likened their position to management as is was understood in the private sector, alluding to popular ideas like «value based management», which is primarily associated with making values for the shareholders. In so doing, the new managerial class runs the risk of violating the value systems and practices of the medical profession, focused as it is on the professional task as opposed to the interests of the owner of the hospital. Historically, the medical profession in Norway, the «medicracy», has been accused of appropriating the health bureaucracy (Berg 1987; Vareide 2001). It has also appeared to be more or less «anti-capitalist», aloof from financial realities and considerations of cost, yet with a professional mandate to manage in a system in which it was the professional status that counted above everything else. Management was based on the «logic of appropriateness» rather than the «logic of consequentiality» (March & Olsen 1989; Vareide 2002; Zeuthen Bentsen 2003). Accordingly, the medical practitioners have historically paid little attention to coding practices after the introduction of the DRG-based piecemeal financing system on July 1. 1997. It has been claimed that hospitals lose a lot of money because of the physicians' lack of inclination to deal with coding in a proper fashion. The times seem to have changed, however. It is not only the enterprise management that focus on value creation through benign coding. Also consulting firms have entered this market, offering software that guides the operator through the DRG system by asking questions about additional or borderline diagnoses that may be added. The physicians' new context invites them to make the most of their medical discretion.

Whereas at the outset there seems to be a gulf between those who practise management and those who practise medicine (Gabe, Kelleher and Williams 1974), the coding scandal could be taken as an illustration of how the new tier of managers degraded the trust and legitimacy that historically have been vested in the medical profession. If we keep in mind that these managers were once health workers and professionals themselves, however, focus might be directed towards how the incentives and expectations that are embedded in the reforms of the hospital sector influence the actors within the system. There is no reason to doubt that these managers were well aware of the professional values of their professions, yet they accepted that in the new system these values must be tamed – or balanced – by the values of professional performance management. One interesting question, then, is whether these managers in fact end up as deserters from their profession(s) or are able to maintain the position of being both professional managers and professional health workers (Llewelyn 2001), not merely in their own eyes but more so in the apprehension of their subordinates.

Our primary data does not give us precise information about whether the illegitimate coding practice in our case hospital was disclosed as a result of divergences between the medical professions and the enterprise management. This is not unlikely, however, According to rumours, medical professionals had for a long time felt themselves to be on the defensive in relation to the new, non-medical management elite. Moreover,

doctors and other professionals were professionally amazed and annoyed by the high profits the hospital made. The high profits at the clinic were hard to explain professionally, and many saw the coding practice as unfair in a political situation where health institutions were threatened by layoffs, mergers, shut-down or other initiatives at reorganization. In fact, the other units within the health enterprise had denied the offer of using the coding consultant from the National Hospital.

None the less, the occurrence must be understood in the light of the tension that exist between the ideas of the new organization model and professional management, and the idea that public hospitals, and indeed the entire health sector, must be more transparent in order to provide the basis for patient choice and the control of public finances. Contrary to most private companies, the enterprise hospital must release a series of performance data about its business, including the DRG, patient queues, patient laytimes, patient complaints etc. The media, researchers, patient organizations, the Ministry of Health, the Public Accounts Committee and other stakeholders are scrutinizing these data more or less on a regular basis. And again contrary to most private enterprises, and for reasons we have already mentioned, the health sector cannot count on the same level of loyalty to management from the operating members of the organization, particularly in times of contested change. Therefore, to get away with large-scale cheating or dubious practices is probably more difficult than in the private sector, although the outward ethical values may be the same. The consequence is that the harsh constraints that the hospital and clinic managers meet in their strife to master the new management role not only emerge from internal traditions and legacies. The public quest for transparency easily entraps the «autonomous» and «accountable» manager in the tension between internal and external constraints. It is a reasonable to conclude that what happened to our informants was exactly that.

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