COMMENTARIES

Health service structures, management and professional practice: Beyond clinical management

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ABSTRACT

At the heart of the operation of the health system is the relationship between managers and the various professionals who provide clinical services. While there is an inherent conflict between these two groups, this conflict has been avoided in the past by the managers playing a supporting rather than a controlling role. However, the current demands of cost-control are placing managers and professionals into direct conflict; a situation that many organisations are addressing by putting clinicians into management roles. This measure has had initial success in some situations, but it is argued that this success will be limited because clinical departments are not able to address many of the broader issues that affect the performance of health services. This paper proposes an alternative approach that will enable these broader issues to be effectively addressed, and also reduce the structural conflict.

Introduction

Health services are currently in a state of great change and turmoil, driven largely by the need to find more effective ways of using limited resources

to provide for the expanding health needs of the community. Casemix, clinical indicators, funder–provider splits, clinical directorships, output-based funding, capitation payments and general practice fundholding are just a few of the innovations that are changing or may change the way the system operates.

A fundamental issue in this change process, however, is the role of the professional staff and their relationship with management. It is the professional staff who determine the needs for each patient and who satisfy those needs. But it is managers who are being asked to be accountable for overall performance.

This paper sets this issue in an historical context, looks at the way that the relationship has developed and is changing, and considers what the future holds. It also presents an alternative approach for consideration.

Background

The relationship between doctors and managers has always been a problem in health services (Stoeckle & Reiser 1992; Young & Saltman 1985). It is similar in many respects to the relationship between professionals and managers in a number of industries (Howard 1991; Hall 1987; Mintzberg 1979).

This conflict becomes quite understandable when one looks at the underlying characteristics of the situation. Professionals have extensive training designed to enable them to undertake tasks that are complex and uncertain, whether this be in research, engineering, law or medicine. Given this, they need to have the freedom to apply their skills appropriately in each particular situation. While they may use standard procedures and policies, they need to interpret these flexibly in the interests of the task at hand. In this context, much of the involvement of management in their work is seen as unnecessary interference. This is particularly so where they consider that management does not appreciate the complexity of their tasks or that the demands placed on them detract from the quality or efficiency of their work. In other words, they tend to resist control.

Managers, on the other hand, need to exercise their responsibility for the overall performance of their organisations. They must therefore be able to have some type of control over the people who perform the tasks. In doing this, however, they are brought into conflict with the professional resistance to control (Mintzberg 1979).

Behind this conflict are two very different sets of values and ways of thinking. In order to achieve their goals, professionals need to focus their attention on clinical practice, while managers need to consider overall organisational issues. Professional power comes from expertise and professional recognition, while managerial power comes more from position in the hierarchy. Professionals relate to various collegial networks and associations, while the institution is the focus for the manager. In general, authority for the professional comes from scientific evidence and accepted practice, while managerial authority lies more in established policy and managerial accountability. These two very different, and in many ways, conflicting perspectives are summarised in table 1.

Table 1: Contrasts between professional and managerial perspectives

	Professional	Management
Principal orientation	The task at hand The client	The organisation Resource allocation
Source of power	Expertise Reputation	Hierarchical authority Conferred responsibility
Important organisations	Professional networks Associations	Institutions
Authority	Scientific evidence Accepted practice	Policy Accountability

It is not surprising then that relationships between professional staff and management are often rather difficult. They could be said to be marching to very different drums.

This dilemma may be further explored if we look more closely at the nature of managerial and professional activities.

Two aspects of management

We divide management into two components which are characterised by the terms 'control' and 'support'. Control covers activities such as planning, giving instructions and ensuring that the job is properly done. This is probably the most common concept of management. The support side is

more about ensuring that staff have the appropriate training and resources and that there is the proper working environment. Part of the support is merely the recognition and encouragement which is important at all levels of an organisation.

These two components of management usually co-exist and may be difficult to separate. However, the balance between the two may differ substantially. An emphasis on control is more appropriate when the task is highly predictable and can be easily monitored. This type of management tends to be prominent in traditional manufacturing environments, for example. A more supportive management is preferred in situations where there is considerable complexity and uncertainty, or monitoring is difficult to achieve. This would be typical of professional tasks (Mintzberg 1979). The control approach assumes that the primary intelligence is with management, while a support-oriented management relies more on the intelligence of the frontline worker (Walton 1985).

These managerial roles can be illustrated by the development of quality management in the manufacturing industry. Historically, management in this industry has been very control-oriented because the tasks are generally predictable and easily monitored. Total quality management, however, requires people to focus on making improvements – a process that is more uncertain and difficult to monitor. This then requires a change in management style to more supportive roles. Many quality initiatives fail because management is unable to make this change (Grant, Shani & Krishnan 1994). Another example is the impact of electronic networks in large international organisations. These networks have opened up new opportunities for developing international teamwork. Managers who want to take advantage of new teamwork are having to move to a more supportive role because the work of the staff is so diverse that it is unable to be controlled (Stewart 1994).

The concept of accountability also differs between these perspectives. A control-dominated management would look for accountability through quantitative activity reports. On the other hand, a supportive management would rely more on qualitative assessment of the competence and commitment of staff (Bartlett & Ghoshal 1995).

Two aspects of professionalism

Professionalism can also be divided into two broad areas. The first is professional practice, which represents professionals exercising their skills in the interests of their clients. The quality of this work depends essentially on the competence and commitment of the professional and the support that they are given. The other area of professionalism is collegiality. This represents a wide range of collective activities by which a profession enhances its practice, provides support and exercises discipline in various ways. It includes the formal activities of the professional colleges, peer review processes and a variety of informal relationships. Formal professional organisations have always been considered to be a hallmark of professions, and an important stimulant to improving standards of service. Some management experts consider that these collegial processes are the preferred control process for professionals. There is also the suggestion that the use of formal management controls will degrade professionalism (Mintzberg 1979; Benveniste 1987). These four components are shown in figure 1.

Figure 1: Components of management and professionalism

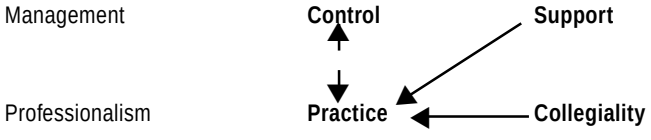
Management	Control	Support
Professionalism	Practice	Collegiality

The development of the relationship

In looking at the classic conflict between professionals and management discussed earlier, we find that it corresponds to the relationship between only two of these components: the control mode of management and professional practice. However, there are other relationships that we can consider. If we look at the health system of 20 or so years ago when funding was not so stretched, we see that managers were not expected to have much influence over clinical practice. Clinical staff were considered able to practise as required because of their training, their professional ethics and the support of their professional colleges. The role of the manager was more in providing the facilities and the services necessary for

the clinician to practise. Therefore clinical practice was controlled principally by collegial processes and management fulfilled more of a support role. This structure, shown in figure 2, minimised the conflict between managerial control and professional practice.

Figure 2: Managerial and collegial support of professional practice

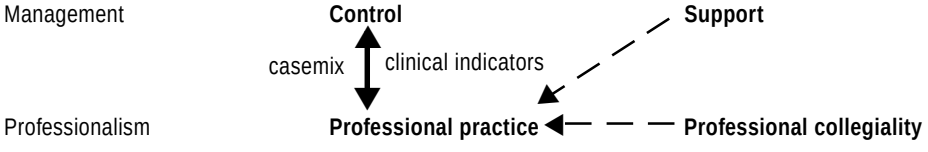


Over the last 10 to 15 years there has been increasing concern about financial control and accountability. For a number of reasons the demand for and the costs of health care services have increased, and authorities are seeking ways to control expenditure. At the same time, public confidence in professional accountabilities through collegial activities has declined (Penington 1990), and many feel that professional colleges have not lived up to expectations. As one author wrote: 'Each doctor had, by virtue of his training, a god-given right to order what care, in what quantities at what time, regardless of effect' (Duckett 1994). Therefore, alternative methods of accountability have been sought, generally through some sort of management structure with supporting policy. To enable this accountability to be exercised, mechanisms needed to be developed. Such mechanisms have usually included some form of casemix for classification of activity and clinical indicators to measure quality. Another component of managerial accountability has been the clarification of the identity and the function of the organisational components for which managers are responsible. Area administrations, funder–provider splits, output-based funding and general practice fundholding are some of the mechanisms used.

Meanwhile, resource constraints are placing limits on the support that management is able to provide for clinicians. Furthermore, the past support that clinicians were presumed to receive from their professional colleges now appears to have been more apparent than real. Although some colleges are now taking initiatives to rectify this, they are a long way from the point where they can ensure the performance of their membership. The recent Baume report (1994), for instance, highlights the lack of effective management of the surgical work force – in its overall supply, its distribution and its continuing performance.

On the other hand, the increasing demand on management that they be accountable for the overall performance of their organisations has placed them in conflict with the autonomy sought by the professionals. Casemix and clinical indicators are the tools for mediating the conflict. This new situation is illustrated in figure 3.

Figure 3: Conflict between management and professionals dominating



This situation has proven difficult to manage (Degeling 1994). The tools have had substantial deficiencies (Stoelwinder 1990) and many managers have not been in a position to adequately assess the work of professionals for which they are expected to be accountable. Further, the centralised management structures have been unsuccessful in influencing professional activities and in responding to the rapidly changing needs of the institutions.

Organisational restructuring

In a response to these difficulties, many hospitals have been re-organised in two ways.

1. They have divisionalised, dividing the organisation up into semi-autonomous sections with their own budgets and accountability for those budgets. Sometimes these divisions are organ or disease-based (for example, heart, kidney, nervous system) and other times discipline-based (for example, medicine, surgery, geriatrics).
2. They have established some type of clinical management where the divisions are directed by a clinical person with financial accountability. This person is usually medically qualified, but may be a nurse or a member of another discipline.

The original models of this configuration were the Johns Hopkins and Guy's Hospitals, but there have been clinical directorates established in Australia, the United Kingdom and the United States (Braithwaite 1995).

A number of positive reports have come from hospitals that have taken these measures. The smaller, more targeted units have been found to be easier to manage. Innovative people have been given the flexibility to develop more efficient ways of operating and this has released funds to develop new programs. In some cases the budget has been further devolved and people at all levels have been able to take valuable initiatives that were previously obstructed by the bureaucracy.

On the other hand, there are reports of considerable problems. Some clinical directors find that it is difficult to satisfy the demands of both management and colleagues. They are subject to the conflict between the two perspectives presented in table 1, generating substantial role conflict.

Why is there this difference? It seems that where the change has been successful, the divisions have been able to improve their efficiency to the point where they have been able to relieve the pressure from management and improve the service to clinicians. While this may have required greater discipline and some sacrifice from the clinicians, it has also improved coordination and provided a better working environment. In this way, clinical management has played more of a supporting role.

The divisions that had problems were those that had not been able to alleviate the financial pressure, and the clinical director was faced with having to modify the practice of their colleagues in some way. If these requirements begin to conflict significantly with the ethical or material interests of other professionals, then the director would need to adopt a managerial rather than a collegial style. This would tend to alienate the staff. Such alienation would be expected to lead to conflict within the division and high stress levels for the director. This represents a poor environment for improving efficiencies.

This interpretation is consistent with the research carried out in the United Kingdom of 60 clinicians who had adopted, or were adopting, some sort of administrative position (Burgoyne & Lorbiecki 1993). The investigators found that the clinicians were able to adopt administrative positions without undue conflict provided 'the conflict between medical need and available resources can be dealt with elsewhere in the system without passing it back to hospitals and clinical directorates'. Thus the clinical management model, it seems, is inherently unsuited to implementing service constraint at the clinical level.

Another problem is also likely to arise. Continued funding constraints are likely to force divisions to make decisions concerning services which will come into conflict, sooner or later, with the interests of the institution

as a whole, the health department, the minister or the community. It is difficult to see the division maintaining its autonomy for long in the face of the combined displeasure of these parties. There may be the opportunity of addressing this situation by changing management, increasing funds or closing the division and diverting services to another institution. There is also the opportunity of recovering by adopting cost-saving measures from other institutions. However, these options may not always be available, nor be of long-term effect.

It can be seen, then, that the success of the division depends on its continuing ability to be innovative and develop more efficient approaches to providing services. This, however, requires resources over and above those required just to provide the services. Management, however, will be continually looking for opportunities to 'realise' savings by reducing budgets, and thus minimising those extra resources. Both demand and costs may also increase. Thus there will be unrelenting pressure for the division to find more ways to improve its efficiency. After a while it will find that the easy gains will have been achieved, and that many of the factors that it needs to influence to achieve further gains are out of its control (see table 2). If there is no way out of this dilemma then it seems likely that more and more divisions will succumb to the vicious circle of the less successful divisions, and the available options for recovery will be reduced.

Table 2: Factors which are difficult to handle purely within the framework of institutional management

1.	Outcomes analysis
2.	Utilisation review
3.	Cost analysis
4.	Service distribution, consolidation etc
5.	Major equipment allocation
6.	Technology analysis and improvement (including information technology)
7.	Service integration
8.	Service quality analysis
9.	Professional training
10.	Manpower planning
11.	Practice guidelines and standards
12.	Peer review
13.	Public education
14.	Legal and policy frameworks

If this interpretation is correct, then the success of the current reforms appears limited.

To move on from here it is necessary to consider structures that are able to address the broader issues. It is necessary to recognise the health system as a system and to make use of its inherent strengths. We need to look at alternative structures that will incorporate the best of what exists and enable greater achievements.

One of the obvious approaches to addressing these broader issues is through central administration. One could imagine, for example, a much more active involvement by state and federal governments in training curricula, manpower planning and practice standards. However, central administrations generally have great difficulty in coming to terms with the complexities of operational issues except in the most simple industries. One of the major challenges of management theory is to find ways of devolving decision-making while maintaining coordination, direction and incentive. Total quality management was, in essence, a means of placing critical production decisions in the hands of the frontline workers. What it seems is needed is a means of involving people from the frontline service function in a process that can address these broader issues. The following outlines a proposal that might contribute to achieving this.

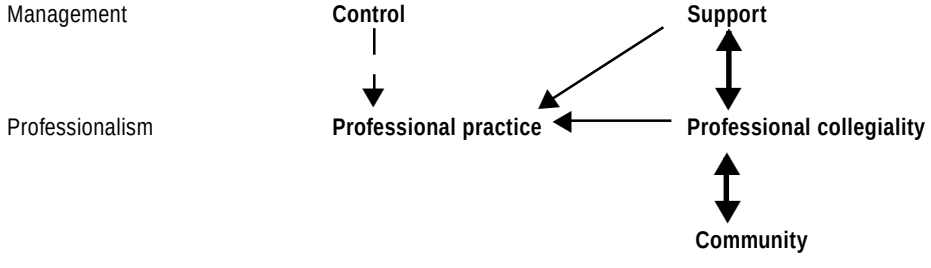
An option

Currently, most of our attention has been focused on the management of specific administrative units such as areas, hospitals or divisions. We are expecting efficiencies to come principally from the better management of these units. An alternative approach is to consider specific services such as cardiac, geriatric, obstetric, cancer or dialysis. This is not to presume centralised management or any particular structure. It just raises the issue of what is the best means of providing these services within the current and future contexts.

In asking such questions there would be the opportunity of getting together the various professional groups, community and customer groups, as well as the State health department. They would be able to look at the way services are provided, what standards could be expected, how performance could best be monitored and how the services could be improved. Cost could be determined and compared with performance data.

Centres could benchmark each other, comparing both their costs and performance data in the context of their special circumstances. In this way they could work collaboratively to develop better and more efficient ways of operating. They would not be limited to the simplicities of casemix, but would be able to develop and adapt their measures to address the issues that were most important. This would provide a framework in which most of the issues listed in table 2 could be effectively addressed. If this type of activity was carried out in more than one State, then there would be scope for mutual benefit and possibly coordination between States.

Figure 4: An alternative configuration



This process would constitute a link between management and professionals as shown in figure 4. Management, in the form of the health department, would be working with the professions in their collegial processes, setting standards, monitoring performance and addressing all the system-wide issues that are currently very difficult to address. The process would ensure the performance of the clinical departments themselves and establish the basis of their funding. This funding might be a budget which is administered through the hospital. Alternatively it could be simply a cost financing, whereby departments would be continually striving for the 'minimum appropriate' expenditure, rather than a fixed budget. This expenditure would then be benchmarked at regular intervals against other departments. The hospital management would be relieved of the contentious task of allocating funds, and be able to focus on supporting these departments by providing the infrastructure, administering the finances and coordinating the different departments. Managers would be monitoring the performance of the departments, but not making decisions about how they actually operated.

Similar issues arise with other large service organisations in industries

such as travel, retail and banking. Some of them have achieved impressive economies by looking at a basic unit of service, finding the most effective method of providing that, and then disseminating this method across the system (Quinn & Paquette 1990). If done properly, this then empowers staff to use these systems to address the particular needs of clients efficiently with minimal managerial control. Standards are maintained and promoted by extensive information sharing. This proposal uses similar principles, but takes the specialist department as the basic unit and looks at how it can be operated most effectively. If the performance at this level can be promoted by networking between departments, then the need for managerial involvement is reduced.

This, then, represents a systemic model of how a health service might operate. There is a close cooperation between professional organisations and the health department, and together they monitor and promote the performance of each specialty on a statewide basis. The strength of the model depends on the power of such collaborative statewide processes to improve performance and to disseminate the best practices throughout the system. There would also be savings at the hospital level through a simpler management structure and reduced conflict.

This arrangement would, of course, provide a very much different political framework. Professional staff would be more autonomous and have less interference from their management. They would therefore be able to concentrate on the needs of their patients within the agreed standards. They would, however, be paying more attention to assessing their performance and comparing it with other departments. Hospital managers would be concentrating on providing infrastructure and coordination. They would not be placed in direct conflict with professional staff as they would not have to make funding allocations or operational decisions for them. However, they would not have the comprehensive authority that they previously had. The health department would be much more in touch with clinical activities, but would need to work more closely with professional groups. Professional groups might lose some autonomy in that they could not be as independent. However, they would have much more influence in policy-making and influence over the practice of their members.

An important element of this proposal is that decision-making would be structured to enable decisions to be made in a more appropriate way. Too often under the current situation people are asked to make decisions that they do not have the information or expertise to make, or are made responsible for situations over which they have little control.

This structure would have implications for the roles of some people. For instance, managers would no longer be able to see themselves as totally in charge, and clinicians would not be able to see themselves as totally independent. Instead, everyone would need to see themselves as fulfilling different but complementary roles in a coordinated service. Some people may need to develop new skills to cope with these changes.

In this way everyone would win or lose a little. However, there would be an overall gain because the health service would be operating much more smoothly and efficiently, and would be more openly accountable.

This, of course, is a very basic picture. Many issues need to be worked out. For instance, the process of getting the parties together to review performance would not be simple. However, there are elements of it already in place. In New South Wales, diabetes professionals and consumers have met with department staff to establish a common set of performance indicators (Colagiuri 1994). A number of statewide decisions on tertiary services have been made in conjunction with the relevant professional groups. There have also been trauma programs developed on regional bases. On a broader scope, anaesthetists monitor their performance on an Australasian-wide basis (Runciman et al. 1993), and informal professional networks have always played an important part in the provision of health services. There is, therefore, some practical base for such approaches. The model could also be introduced on a small scale, taking a specific speciality first, then it could be developed to other specialities as the process is refined.

Of course, all this does presume that there are enough conscientious professionals and managers interested in promoting the performance of their services in such a cooperative way.

Conclusion

The traditional conflicts between doctors and managers are inherent in the different perspectives that arise from their respective tasks and responsibilities. In the past the division of responsibilities avoided this problem, but current policies of driving performance through hospital management are placing doctors and managers directly in conflict. While there have been a number of methods and measures developed to manage these conflicts, they are not likely to be viable in the long term.

However, different approaches to the management of the health system may provide better options. A proposal for managing each specialty service

on a statewide basis would provide a much more effective structure to promote the performance of these services. It would provide a framework for addressing many system-wide problems, would largely resolve the conflict between professionals and management, and would also promote more efficient services. This proposal draws on and integrates the best of traditional professionalism, quality management, human resources management, and experiences in the management of distributed service industries.

Acknowledgements

I would like to thank those who commented on earlier drafts of the paper and contributed valuable comments. Particularly I thank Ms Judith Cornell of the New South Wales College of Nursing, Dr Neil Paget of the Royal Australasian College of Physicians, and Dr Kerry Biggsworth, recently of the New South Wales Department of Health and now of the Premier's Department.

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