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Equity in Health Care Policy: Political Rhetoric or Street-Level Practice

Abstract:

The complexity of the health care milieu necessitates that health policy, legislative objectives, resource allocation models, and management structures be aligned to plan and deliver healthcare services strategically. This paper reports on a study of policy and planning reform in the Irish health care sector. It considers the ambiguity of national health care strategies crafted to underpin this planning in health care service delivery and espousing principles such as ‘equity’ and the actual health policy implementation on the ground. Reflecting on tensions in the Irish health care system, this paper notes the difficulties that can be created for all stakeholders involved in policy implementation. The focus from an organisational perspective is at ‘street-level’. Street-level organisations are pivotal players in the implementation and thus, the shaping of public policy. Taking this perspective allows for the examination of the intersection of new managerialist controls driven by legislation, the espoused health strategy or policy, and the management of discretion of those that work at street-level. Also considered are the wider organisational and institutional forces at play. A comparator case of planning reform in Canada is employed to consider the tensions and constraints that can hinder policy execution and how they can be ameliorated.

Key Words:
Health Policy, Reform, Implementation, Street-Level, Planning
This paper seeks to examine the implementation of healthcare policy in the Irish health services over the past decade and a half through the vehicle of health services reform and planning. Issues that have arisen to date in implementation of Irish health care policy are that laudable aims, objectives and principles are not legislated for and therefore, are never enacted (Byers 2010). Service planning and the delivery of patient-centred care comprise part of a cluster of health sector reforms introduced in Ireland in the last decade and a half.

This paper’s perspective seeks to link the policy and reform imperative that has promulgated service planning with a patient centred focus and actual implementation on the ground. This emphasis on the ‘patient’ in service delivery and equitable access for patients has been present in policy documents and national health strategies for over a decade and a half. In order to examine the progress or lack of progress of such health policy implementation, it is useful to consider the influence of Lipsky’s (1969, 1980) concept of the ‘street level bureaucracy’. He sought to find a viable means of measuring the impact of government upon people and noted that one of the least studied areas was the interaction between ‘clients’ and the public service officials who deal with them in the course of their jobs (Lipsky 1969:1). He describes ‘street level bureaucracies’ as hierarchical organizations in which substantial discretion and decision making authority lies with the the front line or operating core (Lipsky 1980). These individuals, such as health professionals, as in the case of this research, when faced with problems such as a lack of organisational resources, and conflicting or ambiguous role expectations develop coping mechanisms. What is of significance to this paper from a theoretical view point is that this ‘place’; the street level intersection of service user and healthcare professional is at the core of the policy-implementation space. Street-level organizations are pivotal in developing public policy through implementation.

This street-level perspective was developed from growing evidence that formal policy was unable to account for the implementation behaviour of organisations (Brodkin 2008). Research that focuses on the street level perspective according to Brodkin (2011a:i199) aims to reveal the organisational mechanisms that link or delink the opaque spaces between formal policies and outcomes. In so doing, this paper draws on earlier field work examining the strategic implementation of health services planning in the Irish health services. It examines the impact of the control mechanism, the legislation delivering on Irish health policy that has introduced the top
down implementation of service planning reform on the delivery of strategic and patient centred planning, a comparison is drawn with the Canadian experience (in Nova Scotia). It also draws upon a recent pilot study to ascertain the opinion of healthcare professionals regarding the extent of patient involvement in planning and delivery of their health care in light of the patient-centric focus of the last decade of healthcare reform.

This paper is divided into four sections. This section introduces the paper, the healthcare context, the policy and its implementation context. The second section explores the theoretical and explanatory constructs; the new public management (NPM) influence in the public sector, as well as a review of the street-level literature on implementation and management. Then the implications for implementation of policy in this milieu are explored by using the street level lens. The third and fourth sections draw from research in street level public organisations in Ireland and Canada with an outline of methodology, results and discussion. In so doing, this paper seeks to draw attention to the need for increased flexibility and a wider recognition of all the stakeholders in the policy development and implementation process. As Piore (2011:162) exhorts: such a concept the street level organisation(SLO) can ‘become a bridge over which the sociological imagination enters the public policy debate’.

**Irish Health Care Context**

Looking at the healthcare context; in Ireland, the Government, the Minister for Health and the Department of Health (DOH) are at the head of health service provision. Until 2006, the Irish healthcare sector comprised a health board management structure (now termed health regions with their local health offices), and is described as an integrated public health care system. The boards (Street Level Organisations, SLOs) were the main providers of health and personal social care at regional level. The Health Services Executive (HSE) is at present the main provider of health and personal social care. The formation of the HSE was the result of a significant reform programme of centralising Irish health services delivery. To summarise the Irish health care structure as per the OECD (2008;287) review; the ‘HSE is responsible for the management and delivery of health and personal social services within the policy, legislative and resource allocation framework determined by the Minister for Health and the government.’ The Minister is politically accountable for the implementation of policy by the HSE as well as the overall performance of the health service.
Of note in this comparative paper, is that Canada’s health care system is highly decentralised with the provinces (and territories) primarily responsible for health care (Marchildon 2013). Most public health services are organised or delivered by regional (or district, in the case of Nova Scotia) health authorities that have been delegated the responsibility to administer services within defined geographic areas by their ministries of health at a provincial level. For the purposes of this study a District Health Authority (DHA) in Nova Scotia was chosen. This formed an interesting comparison with the Health Boards/Health Regions in the Irish context. In comparison to Irish developments, which have focused on increased centralisation of services, the Canadian system has developed in a decentralised fashion with local control and consumer choice.

**The Policy**

The *Strategic Management Initiative* (SMI) (1994) and *Delivering Better Government* (DBG) (1996) have formed the backdrop to the Irish public service reforms for nearly two decades (OECD 2008). One of the central mechanisms of the SMI is the devolution of accountability and responsibility from the centre to executive agencies. Service planning in the Irish health sector was initially seen as part of this strategic planning ethos. Strategic planning for the health services at a national level is the responsibility of the Health Services Executive (HSE) in terms of a National Service Plan (NSP) and a three year corporate plan, taking cognisance of the DOH’s policy and strategy for the Health Service as a whole. Due to budgetary constraints and a myriad of competing demands, it is crucial in healthcare to be able to identify and prioritise health needs and develop services. In order to achieve this management and planning of healthcare the process needs to be underpinned by a clear strategy and vision. In the Irish healthcare context that strategy and policy has been guided by the National Health Strategy of 2001 (*Quality and Fairness; A Health System for You*) for over a decade. This strategy was explicit as to the intent of service planning; which was to introduce strategic planning into the health care arena. Inherent in such a promise was the use of the strategy in the service planning process to determine priorities and underpin planning, in line with its principles of delivering equitable, accountable, quality focused and people centred services. The most recent Health Strategy; *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015* is also clear on the importance of strategic planning in a system that ‘should empower and support citizens, patients and healthcare workers’.
Implementation of the Policy

Service planning was enacted initially by the Health (Amendment) Act, 1996. Section 6.2 of the Act states that these plans should ‘include a statement of the services to be provided by the health board and estimates of the income and expenditure of the board for the period to which the plan relates’, as well as taking account of the financial limits determined by the Minister for Health. Although, service planning was described by the DOH as a ‘strategic management tool’ through establishing the basic principles of the SMI, as well as involving multiple stakeholders in the planning process; the legislation was not specific on how service plans were to be developed. There was no acknowledgement in the legislation of the strategic principles that would underpin the service planning process, no delineation of the participants and the nature of their involvement and no mention of the use of performance indicators. Service planning became operational at health board/health region level as a set of guidelines and a template. Revised Health Acts in 2004 and in 2013 also dealt also with the provisions to produce a service plan. According to the 2013 legislation a service plan must indicate ‘the type and volume of health and personal social services and… any capital plans for the period to which the plan relates’. Other requirements for service planning do not differ appreciably from that of the 1996 Act and despite advice, there are no provisions for accountability for non-financial performance, other than specifying that it shall ‘accord with the policies and objectives of the Minister and the Government’. These Acts focus instead, on the top down application of administrative reforms and do not deal with the issues such as delivering equitable, accountable, quality focused and people centred services (core principles of National Health Strategies 1994/2001/2012).

Underlying all the difficulties that the Irish health service has faced, and is presently experiencing, is the focus on administrative control since the passing of the Health Act (1970). The Irish health service had developed without a mission, a direction an underlying objective until 1994. However, the Health Strategies of 1994 and 2001 including the National Strategy for Service User Involvement in the Irish Health Services (2008) have never been properly implemented nor any of their principles given any impetus in legislation. According to Smith (2009) as a result of this, the issue of patient equity has continued to grow as a problem. Pillinger (2012) identifies the growing crisis in Irish health care as due to unprecedented funding cuts, a growing budgetary deficit (that rose to €350 million by the end of 2013\(^1\)), long waiting times, a highly inequitable two-tier system and a deterioration in the quality of care. She notes that budgetary cuts are taking place within an already unequal and poor functioning healthcare

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\(^1\) F. Sheahan. HSE has run €350m over its budget for 2013. *Irish Independent* (11 December 2013).
system, typified by lack of transparency, and discriminatory and arbitrary decision-making. The DOH has over the years been strong in the area of policy development. On the other hand, implementation of policy throughout the system has been poor and inconsistent (OECD 1997, O’Ferrall 2008, Byers 2009).

The Canadian experience of service planning and patient involvement contrasts with this. Whereas, according to McKevitt (1993:311) the Irish health care system and its legislation (1970 and now 2013 Health Acts) have no ‘strategic framework that would guide the allocation process, provide for a control system responsive to agreed objectives and give legitimacy to the resource decisions of Irish health care managers’, in comparison, Armstrong, Armstrong and Fegan (1999) note that the Canadian system and its legislation emphasises a clear set of national priorities that serves as an underlying rationale for the health system. The Canada Health Act (1984) sets out the primary objective of Canadian health care policy, which is ‘to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.’ According to Dawson, Rathwell, Paterson, Butler, Cobbett, Pennock, Anderson and Kiefl (2004) the focus of planning reform in Nova Scotia was on integration of health services under a regionalization umbrella and with a population health focus. The structures recommended to achieve these goals were a network of local Community Health Boards (CHBs) with voluntary participation from citizens under the umbrella of District Health Authorities (DHAs). The CHBs operate in an advisory capacity to the DHA and legislation mandates that their ‘Community Health Plan’ must be taken into consideration by the DHA in preparing its annual service plan. The DHA’s function is that of policy implementation and evaluation (DOH 1999). This has paved the way for needs based planning in the Nova Scotian health services which has developed in a decentralised fashion with local control and consumer choice.

LITERATURE REVIEW - THE STREET LEVEL VIEW: MAKING SENSE OF POLICY IMPLEMENTATION

New Public Management (NPM): Policy and Planning

In order to site this paper theoretically; the reform of the health services in Ireland as well as those in Canada can be seen as part of a wider set of public sector reforms which are characterized by the umbrella heading ‘New Public Management’ (NPM) (Hood 1991, 1995). Since the mid-1980s the problem according to commentators (Pettigrew et al 1992, McKevitt
1998), has been the over mechanistic transfer of concepts from the private to the public sectors in the belief that governments, public services and public enterprise lack the capability to get things done. Lapsley and Pallot (2000:215) acknowledge this broadly based international movement, which they describe as ‘propelling public sectors of many economies towards convergence on how best to manage their activities’. NPM is seen as market based ideology invading public sector organisations; a management hybrid that has evolved with a continuing emphasis on core public values. One of the distinctive features of the NPM approach in health care is the belief that the organisation can act as a single entity with a common focus on goals, the institution of a rational planning system and with little conflict of interest (Hardy 1991). According to McNulty and Ferlie (2004) NPM restructuring has strengthened vertical lines of reporting in many public service organisations through the advancement of managerialism and performance measurement. The focus of this paper is the implementation of service planning which originates from this NPM approach. The early studies of the implementation of this general managerial reform illustrated the difficulties and tensions that arose as different constituencies wrestled with the reality of a ‘command and control’ mode (Carney 2006, Lapsley 2008).

Dent, Howorth, Mueller and Preuschoft (2004) note, that while these NPM reform processes may vary in depth and scope they are remarkably similar in the goals they pursue and the technologies they utilize. There may be a number of different facets or ingredients to NPM, but some of the key features include: the move in focus from inputs towards outputs; a shift towards more measurement and quantification (performance indicators); a preference for more specialized lean, flat organisations (Pollitt and Talbot 2003); an increase in contract like relations; the use of markets; an emphasis on service quality and consumer orientation and a shift towards the values of efficiency and individualism (Hood 1991). In a given situation according to Pollitt (2003) the different NPM ingredients can exist from the ideas level to plans and strategies to accomplished processes and practices. Ferlie, Pettigrew, Ashburner and Fitzgerald (1996) identify four models of NPM these can be useful when evaluating the source or impetus for service planning. The first model; the efficiency drive, attempts to make the public sector more business-like. The service planning initiative in this paper seems the closest to this one as it focuses on core themes of increased financial control, stronger managerial hierarchy, a ‘command and control’ mode of working and an extension of audit. Service planning with a patient-centred focus could also be linked with the fourth model. This model is characterised by a concern with service quality, user values and on securing participation and accountability as
legitimate management concerns in the public sector. Though, this concern could be viewed as more symbolic and a legitimatising device by government as it is not explicated in the legislation itself.

**Policy Implementation in Public Services; the Street Level Perspective**

The key functions of a public service manager are to identify service users’ needs, manage delivery of services to target these needs, and make resource allocation decisions to support service delivery. However, part of a public service manager’s role is also to control service delivery to ensure that broad policy objectives are delivered upon in terms of measurable services to clients. The control function in healthcare is critical for both government and for the public service managers that manage the delivery process. Yet, the bureaucratic discretion of this public service manager or public service professional can be seen by some as the ‘nemesis’ of accountability (Brodkin 2008:317). Thus, managing such discretion lies at the heart of the control and oversight strategies employed to improve accountability. However, there is a risk of undermining professional judgment, responsiveness and innovation if control is not managed well.

Lipsky’s (1969, 1980) concept of the ‘street level bureaucracy’ sought to find a viable means of measuring the impact of government upon people and noted that one of the least studied areas was the interaction between ‘clients’ and government officials who deal with them in the course of their jobs (Lipsky 1969:1). He describes ‘street level bureaucracies’ as hierarchical organisations in which substantial discretion and decision making authority lies with the line agents; the front line or operating core (Lipsky 1980). These individuals, such as health professionals and health services managers, as in the case of this research, when faced with problems such as a lack of organisational resources, and conflicting or ambiguous role expectations develop coping mechanisms. In the rationing of resources, they exercise discretion and in doing so, have considerable policy-making powers. What is of significance to this paper from a theoretical view point, is that this ‘place’; the street level intersection of client and public service worker is at the core of the policy-implementation space, where policy is ‘not best understood as made in legislatures…. because in important ways it is actually made in the crowded offices and daily encounters of street level workers’ (Lipsky 1980:xii). The implementation of policy reforms such as service planning can vary from that which was originally intended or set out in legislation. Hupe and Hill (2007), Day and Klein (1987) and
Pollitt (2003) note that accountability of professionals at street level is essentially multiple rather than practiced only vertically. Hupe and Hill (2007) note that this complexity results in accountabilities in political societal relations at various places rather than just from the political centre for those at street level – this in turn leads to a number of possibly contradictory action imperatives as street level bureaucrats choose how to act. Hedge, Menzel and Krause (1989) note that in dealing with these accountabilities, it is the influence of positive intergovernmental relationships that can shape policy implementation at the field level, as it can have a moderating influence on the perceptions of professionals.

Brodkin’s (2008) literature review of policy implementation at street level highlights two problems that are pertinent to this paper; firstly the need for policy definitiveness rather than ambiguity and conflicting objectives; and secondly, that the problems of legislative politics mean that politicians tend to delegate policy where possible thus pushing conflict and decision making down the line. Thus, implementation becomes policy definition in action; policy as produced. Ellis, Davis and Rummery (1999) note that these problems can be managed by using clear guidelines as well as managerial scrutiny.

Brodkin (2011a) recommends that the ‘street level’ lens is necessary to explore the conundrums of discretion and governance in order to develop a deeper understanding of how organisations work, how control can be exercised and how policy can be implemented or produced. Yet, how can these streams of research be conceptualised in to an analytic framework? This paper also draws from the work of McKevitt (1998), who adopted Lipsky’s (1980) concept of the street-level bureaucracy, citing it as a ‘remarkably useful innovation’ and on the basis of his own field research developed his model of the Street Level Public Organisation (SLPO) (1998) and its adapted form (Byers 2007). This model facilitates examination of the wider environmental context of planning, resource allocation and performance measurement systems in the control and management of health professionals and managers. It can also be utilised to examine how principles and strategy in healthcare are translated at the front-line or street level for both health professionals and the citizen-clients they serve.

The SLPO and Tensions; Service Planning and the Citizen-Client

The importance of the SLPO model is that it allows consideration of whether there is consistency and coherence between espoused objectives such as equity and patient-centred service delivery at the national level and implementation at the point of service delivery. What is important in the
health care context is that the model includes specific influences from the environment that affect service delivery in public organisations in particular. As Bovaird (2005) notes, service delivery in the public domain should no longer be seen as a ‘top down’ process but should be seen as the negotiated outcome of many interacting systems with interactions with the ‘users’ of the services; a recognition of the complexity of the environment (Glouberman, & Mintzberg 2001a, 2001b, Denis, Lamothe & Langley 2001, Langley & Denis 2011). The SLPO model employs the concepts and categories of general strategy and in particular focuses on the organisation-environment relationship. This model can encompass all the streams of street-level research in one model or framework and allow for multiple influences in the implementation process.

In the healthcare context the model can account for the often difficult relationship between central government and professionals at street level, as well as their professional bodies. It can also account for the inclusion of the citizen-client. The model shows the important external relationships of the SLPO and how these relationships impact directly or indirectly on the capacity to implement policies. The essence of the planning and management task is relating the SLPO to its environment (see Figure 1).

There is a dual set of influences in operation in the SLPO. At government level there are a number of modes of influence for policy implementation; legislation, allocation of resources, organisational structure and performance measurement. Then there are the ‘rules of the game’, which are established by the professions and their associations. These two conflicting influences must be aligned according to McKevitt, Millar and Keogan (2000). With few exceptions, the normative literature on planning in health care, underlines the necessity for extensive participation by health professionals (Peters, 1985; Champagne, Contandriopoulos, Larouche, Clemenhagen and Barbir, 1987; Denis, Langley and Lozeau 1995, Glouberman & Mintzberg 2001a, 2001b), the main argument being that implementation will be facilitated if people feel they were involved in decisions.

If the model of control is left at the level of budgets only, it does not control for the effectiveness of service delivery and recognition of the very values espoused at a national
level and therefore, the citizen-client is left in a weak position. As McKeivitt, Millar and Keogan (2000) and Brodkin (2011b) note, any defect in the legislative framework for policy implementation will lead to recurring tensions between central government and professional associations (to point A) in the environment of the SLPOs. If there is a solid relationship between the professions and government then these tensions can be averted (Hedge, Menzel and Krause 1989).

In utilising the SLPO model, it can be seen that to implement service planning in line with the principles of the national health strategy (the policy) is not solely an organisational issue it has to account for control in a wider institutional context. This institutional perspective is reflected in examination of the control mechanism; the legislation introducing implementation of service planning; if it doesn’t allow for strategic management processes because it is devoid of recognition of the complexity of the nexus of relationships, the resulting problems are many ranging from ambiguity in policy aims, problems in relating general guidance, and enforcement. For any strategic and policy driven shift to occur in a more equitable pattern of resource allocation (see point B) there needs to be an explication of that position in the public service delivery and investment decisions legislation. Given the paucity of direction in the Irish service planning legislation (Health Acts 2004 & 2013), it can be posited that the policy of using national health strategies to drive change will not occur, despite the rhetoric of government. As a result another source of tension can occur; that between the professional and the community of citizens (see point C), where lack of both control of the professional and that of budget allocation in line with principles by central government leads to an erosion of the community’s needs and rights.

There is no one best way to reform core public services that will satisfy the needs of government, citizens and providers. Yet, some countries such as Ireland have proceeded on the path to reform that doesn’t allow for these differing needs and this is due in part to the belief that public organisations are similar in part to private organisations as per the NPM doctrine. To date, national health strategies in Ireland have been laudable in their aims of putting patients first and delivering services that are quality driven, patient centred and equitable, however, these aims have had limited purchase in practice (O’Ferrall 2008, Byers 2010, Pillinger 2012).
METHODS

This paper draws from field work in the Irish healthcare system; the first a multiple case study approach comparing the implementation of service planning in Ireland with a similar implementation process in Canada between 2004-2006 and an emerging phase of field work (in its early stages 2013-2014) exploring the perceptions of health professionals in practice regarding the extent of patient involvement in planning and delivery of their health care in light of over a decade of healthcare policy promulgating an equity driven and patient-centred approach to service delivery. What is common to both phases of data collection is the examination of the implementation on the ground of the principles of a national health strategy including that of equity and involvement of patients.

Phase 1: Healthcare Planning Implementation in Ireland & Canada

The design of the first phase of research is what Yin (2009) describes as a multiple case study. The focus of a case study according to Yin (2009:12) is on contemporary rather than historical phenomena. By choosing to ask ‘how’ and ‘why’ questions the case is more explanatory in nature. If you need to know how and why a programme or process worked or not the case study is a useful method of exploration.

Research questions were tested using data from a number of sources. Given the structural organisation of health care in both Ireland and Canada service planning was examined in its implementation at the street level as well as accounting for the wider institutional influences; the context in which those cases were situated. This wider view included looking at other stakeholder perspectives including government and other health care organisations in the health care system as well as examining the legislative influence. Through the iterative research process the focal points of analysis emerged and were structured around three cases (health board units) in the Irish context, and one case (a district health authority unit) in the Canadian context. These units were studied by taking a vertical slice through the case study organisations and examining perspectives of the planning process from health professional (head of discipline level) up to CEO/ Assistant CEO level, as well as examining the wider institutional context (Departments of Health and of Finance in Ireland, and the Department of Health in Nova Scotia, Canada). Pettigrew, Ferlie & McKee (1992:4) emphasise the importance of this approach, as the derivation of a plurality of perspectives is gained through the interviewing of a wide range of stakeholders. Fifty four semi-
structured interviews were carried out. The questions were left sufficiently broad in order to build up a picture of the process as it was occurring and was perceived by the respondents.

**Phase 2: Healthcare Professionals Perceptions of Patient Involvement in Planning & Management**

The second phase has begun with a pilot study to ascertain the opinion of healthcare professionals regarding the extent of patient involvement in planning and delivery of their health care in light of the patient-centric focus of healthcare policy over the last decade. The research methodology utilises a survey approach. This survey is being carried out across cohorts of postgraduate students in practice in Ireland (to date n = 53). This research aims to map and understand the benefits of patients being engaged and involved in their health care and the challenges to this engagement from a health professional perspective. This small study is based on an online-survey. Participants were informed about the purpose of the study and its confidentiality. The participants were engaged both in practice as nurses, in a wide range of settings and in professional postgraduate study in university in Dublin, Ireland.

Measures included in the survey included;

(i) **Demographic, Situational and Organisational Factors**

Respondents were asked to indicate their profession and role, years of experience, type of health care organisation and area of clinical specialty in which they worked.

(ii) **Patient Involvement**

A number of items sought to establish if respondents agreed that patient involvement in their own healthcare was important, how it had developed over time and how willing patients were to be engaged. It also sought to ascertain opinions on patient involvement as it could relate to training of health professionals, health and safety issues, particular clinical areas as well as looking at how they perceived factors such as the age of the patient.

(iii) **Patient Involvement – Barriers**

The final section sought to explore the area of possible barriers to patient involvement. Questions required respondents to tick either a yes or no option, to select from a list of options as well as a number of open questions to allow respondents to expand on challenges and or opportunities in the area of patient involvement.
RESULTS & DISCUSSION

This paper seeks to examine the implementation of the principles of national health strategies that look to bring about health service delivery that is equitable and people centred. These strategies have been in place since 2001 (with a recent iteration in 2012). In examining such implementation, the paper draws on two phases of research; the first examining the implementation of service planning throughout the Irish health services (and comparison with the Canadian experience), the second, reports on an emerging study ascertaining the opinion of healthcare professionals regarding the extent of patient involvement in planning and delivery of their health care. One common theme arose in both phases of the research; the lack of real stakeholder involvement.

Relationships in the SLPO; Stakeholder Representation and Involvement

Phase 1

In order to deliver health services that are people centred, equitable, accountable and quality focused as per the principles of the Health Strategies (DOH 2001, DOH 2012), a valid assumption would be that consultation with key stakeholders including the citizen-client would occur. In the Irish cases, health professionals as stakeholders in the process, expressed frustration at their needs not being heard or listened to.

They make decisions about care packages in the community, and the only people at the table that are missing, are the people that are going to be managing that service in the first place. We could have told them it wouldn’t work immediately, but we weren’t allowed in.

Head of Discipline (Nursing)

Control was seen to be coming from above; that priorities were decided either at a national level or at senior management level. There were frequent references to ‘them and us’. In a number of instances in this research, health professionals had withdrawn from the service planning process and instituted their own strategic or ‘real planning’ exercise. In other areas it was acknowledged that there was difficulty in engaging with some professionals in service planning. However, many health care managers expressed the view that they could plan well enough without the health professionals input; that they had all the information they needed with which to plan. Due to the restrictions of the planning process through the use of a service planning template, some managers felt consultation and other information was
superfluous in many cases. Also, it could just lead to information overload.

*We paid lip service to involvement. It was perceived that expertise was in the core and in a perverse way that it would lead to difficulties to ask too many opinions.*

*Manager of Care Services*

Given that service planning had initially been touted as a means of devolving decision making down the ranks to the health professionals, there was much comment on the lack of trust that senior management had in the abilities of the health professionals. This was due to the imposition of controls from above, and an isolation of the operating core from what management view as the ‘real’ work of planning and strategy. In the Irish context the lack of client representation in service planning was raised as an issue, due to the inclusion of consumer involvement as a heading on the service-planning templates, and yet it had not become a reality. There were concerns about the dearth of a wider stakeholder representation at the negotiation table, but some interviewees noted that it was linked to the restrictiveness of the process in general. This leads to tension at point C in the SLPO model (see pg.), a break in relations between the health professions and the clients they serve. Thus, the health professions come to be seen as self-serving and not representing their clients.

Haarman, Klenk and Weyrauch (2010) and Osborne (2010) note that the delivery of public services requires negotiation in inter-organisational relationships and multi-actor policy making processes. The Canadian case in this paper speaks to us of this approach as there is active stakeholder involvement with extensive consultation at all levels of the system. The CHBs consult with their communities and community organisations. At the level above them (Community Health Team) there is consultation with key community, provincial and federal agencies. The DHA itself in its planning consults with the service users and health professionals in planning services as well as receiving the community feedback through the CHBs. The Department of Health (DOH) consults with the DHA, and the political interests also have their say. Interviewees described a situation of a gradual building up of trust with the communities since the CHBs were mandated by legislation to input into the DHA plan. This was due in part to the clout they could wield because of the legislation but also to the skills of the CHT team itself. Whilst in Ireland although service users are included in the template; their role has no legislative basis.
Relationships in the SLPO; Stakeholder Representation and Involvement

Phase 2

The cohort in this emerging study are strong in their support for improved patient involvement in their own healthcare, not only that, but they note the importance of patients being involved in the education and development of health professionals. The message beginning to emerge from this early phase of the research is that there is limited implementation of patient centric policy in certain contexts in the health system in Ireland. Of more significance in the data emerging from the study, is the lack of time that professionals had to engage with patients. This barrier was cited as significant in trying to deliver patient centric care.

*The presence of challenges does not diminish the need to involve - time constraints are the biggest difficulty*  
Nurse (Neurology)

So although policy pushes the concept of patient centred care, the structures and processes of care delivery have not been changed to accommodate this direction in policy. This lack of accommodation in the context to the delivery of patient centred care has been reported by Abelson et al (2007) and Bovaird (2007). McCormack et al (2010) also notes the importance of the ‘care environment’ as an influencing factor in how ‘patient centredness’ is experienced by patients, health professional and carers. Another significant barrier was the lack of organisational support despite policy objectives; the rhetoric (Fooks 2004, Byers 2010). However, this can be due to the unchanging nature of the organisational culture itself. Renedo, Marston, Spyridonidis & Barlow’s (2014) work looks at how patients used elements of organisational culture as resources to help them collaborate with healthcare professionals. Elements included a commitment to action and a constant iteration between data collection and reflection. These require a supportive context and time, which the data in this study indicates are a significant problem for respondents.

Returning to the implementation literature (Lipsky 1980, Brodkin 2011a, 2011b); it would suggest that health professionals exercise considerable discretion at the front-line in implementation of policy. Traditionally the this perspective considered that front line workers employed coping mechanisms to deal with scarce resources (Lipsky 1980) and at times subverted policy implementation in the process. This paper concurs with Nielsen’s (2006)
view that there is a need to consider street level practices as positively motivated, and often in line with the very policy that is being promulgated. The implementation by professionals at the front-line need not be seen as subversion or compliance with policy, but as in this case, a nuanced means of doing the best they can within a constrained environment. The data speaks to us of health professionals who are seeking to engage with their clients and patients but require significant organisational support to do so in terms of time, training and a supportive organisational culture and learning environment (Contandriopoulos 2004, Martin 2008, Renedo et al, 2014).

*Patient involvement is vital for the better delivery of services. We have to know what patients need in order to deliver the best care, not just provide services which suit the needs of the health trust. Patient choice can only be said to be truly given if the services on offer or interventions provided as options are adequately resourced, adequately evidenced based and equally efficacious. We cannot delegate our responsibility for improving the evidence base and quality of the services we deliver to those without the knowledge to make informed decisions. Nor can we assume the needs of individuals without first asking them what they desire.

Director of Nursing*

*Conclusion*

Health service planning and the delivery of patient-centred care with equitable access has been at the heart of national health strategies and policy introduced in Ireland over the last decade and a half. This paper sought to examine the implementation of this healthcare policy through the vehicle of health services planning reform. A key issue in implementation of Irish health care policy to date is that laudable aims, objectives and principles are not legislated for and therefore, are never enacted (Byers 2010).

The unique characteristics of the street level approach and the application of the SLPO model to analysis of implementation in this paper make it easier to locate points of tension in implementing policy in the Irish healthcare sector. Brodkin (2011b: i201) challenges researchers that in order to illuminate how organisations work you need to consider their internal dynamics as well as their relationship to the broader political economy in which they reside. She emphasises that the street level approach ‘provides a perspective from which to consider the relationship of street level practices to the social and political forces ostensibly at work outside these organizations’. However, a core theme that emerged from fieldwork
reported in this paper was the lack of recognition of the complexity of the healthcare environment and the stakeholders within it in implementing policy. The approach to management of key stakeholders such as health professionals in the Irish context is often driven by what Taylor and Kelly (2006) describe as the belief that professional discretion is held to be an obstacle to public service reform. Thus, requiring top down systems and management to reduce the scope of such discretion, so as to standardise responses to service need and control demand. However, in so doing, it veers away from delivering on the very principles that the health policy espouses; that of equitable, accountable and patient centred care.

Through the use of the SLPO model, another key stumbling block to the successful implementation of healthcare policy can be identified; the limitations of the legislation itself underpinning the planning of the health services. Brodkin’s (2011b) street-level research noted the importance of the ‘definitiveness’ of the policy or legislation in implementing reform. Hasenfeld and Brock (1991) concur in identifying ‘policy’ aspects that comprise part of the implementation process, one of which is programme design, essentially policy specifications. In the Irish case there have been a number of national health strategies without legislative impetus, which are meant to underpin the values in health service planning. Yet there has been little change in the existing patterns of resource allocation and stakeholder relationships. In contrast, the Canadian case referred to in this paper, is an exemplar of what can occur when all stakeholders are involved. As it is the legislation at federal level articulating the basic principles for health services delivery and the legislation at provincial level mandating community involvement in the service planning that averts tensions and allows for needs assessment and health planning that is not subject to political short-termism.

As Tritter Koivusalo, Ollila & Dorfman (2010) warn, values, principles and politics matter and they should emphasise the citizen-client voice, as it not only improves quality but creates an accountability mechanism. Irish healthcare policy is replete with promises of equitable and patient centred health services. The lack of multi-stakeholder involvement results in the absence of any needs and evidence based planning. Instead, the reliance on the limits of the legislation, including that of the more recent 2013 Health Act, means that planning health services may never evolve to anything more than a budgetary exercise.
Appendix 1/2

Figure 1  Tensions in the SLPO environment

Appendix 2/2

REFERENCES


