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TRYING TO UNDERSTAND THE RELATIONSHIP BETWEEN ADMINISTRATION AND CIVIL SERVANTS: THE CHALLENGES OF RESULTS-BASED MANAGEMENT IN PUBLIC HOSPITALS

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Abstract

Our study has thus prompted us to propose a reversal of management logic in hospitals. The idea is to overhaul an organization based on the *ex-ante* setting of rigid plans, with the determination of precise objectives (whether in terms of activity, teaching or research), deadlines and predefined indicators. It is also a question of reviewing the application of pure incentive and self-control logic (in the sense of Drucker) to public hospitals. In this context, decentralization means not only giving greater autonomy to operational staff, but also enabling department managers to meet in privileged forums for discussion and the forging of bonds of trust, thus fostering the alignment of their individual strategies. In this way, the clusters can become the very place where the hospital's objectives are set, and where shared projects emerge from departmental needs.

Keywords: Administration- Civil Servants- Results- Management- Tarification on Activity

1. INTRODUCTION

In the history of organizations, there are tools and changes which, once in action, can leave lasting effects on management. Such is the case of the Tarification on activity (T2A) reform in French hospitals, introduced in 2005. The aim of this financing method was to achieve a more equitable distribution of the overall hospital expenditure envelope, and to increase the strategic autonomy and medical-economic efficiency of the facilities concerned (Moisdon, 2010).

At the same time, the Ministry of Health introduced the creation of activity clusters in 2005[1], one of the aims of which was to develop hospital management in line with the introduction of this new financing method. In fact, in the face of the possibility of initiating the construction of an internal cost accounting system, the prospect emerged of contractual management within establishments between management and the poles, set up as responsibility centers grouping together several departments.

Cluster contracts must include quantified objectives that will be monitored. Management delegation, i.e. a budget envelope managed autonomously by the cluster, may be granted by the establishment's management. These measures were strengthened in 2009 by the HPST law, notably by reinforcing the role of cluster heads in operational management.

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After several years, it is clear that the clusters have not succeeded in establishing themselves in the hospital network as recognized and legitimate management spaces(Burnel, 2017)(Vallejo et al., 2020). More recently, a series of crises has helped to call this internal governance framework into sharp question: crises of health, attractiveness and meaning. As a result, a movement proposing a rethinking of the polar structure has emerged, advocating a revaluation of the role of the service as the asserted basis of hospital organization (Michot et al., 2019). One of the manifestations of this critique is the report by Prof. Claris (2020)[2] which, while highlighting the loss of attractiveness of public hospital practice, denounces the progressive devaluation of the service in governance. The COVID pandemic has further called into question the relevance of clusters, all the more so as one of the measures of the Ségur de la santé, taken up by the Rist law of April 2021[3], is precisely to "rehabilitate the role and place of the service within the hospital to put an end to the excesses of the HPST law", by enabling each health care establishment to propose and adapt its internal organization to the local context.

We can see that the clusters have not achieved their objective of strengthening their steering and integration role, and it is therefore envisaged to reposition the departments as the basic structure of the organization by giving them greater autonomy. Nevertheless, the hospital continues to be a highly compartmentalized environment, with each department concentrating on its own operating logic, which represents a barrier to cross-functionality, against a backdrop of declining attractiveness.

While the new legislation does not break with the principles of rationalization, contractualization and accountability that have guided public hospital reforms over the last few decades, it does refocus the department at the heart of the management dialogue. This raises the question of how to adapt this governance framework. Faced with this dialectic, it is important to understand: 1. what are the reasons behind the difficulties encountered by activity clusters in establishing themselves as management forums in hospitals? 2. What are the issues involved in implementing results-based management in an organization characterized by the great autonomy of professionals in the performance of their activities? 3. What is the role of supra/inter-departmental organizations such as hospital clusters?

2. THEORETICAL POSITIONING

In Mintzberg's typology of structural configurations, the hospital is traditionally described as a professional bureaucracy (Mintzberg, [1978] 1982), characterized by the prominence of its operational center. The main standardization mechanism in this organization concerns the qualification of operators, since the complexity of work processes and the difficulty of measuring outputs and results render any system of performance monitoring or procedure standardization ineffective. This gives professionals considerable autonomy. The absence of a measurement system that can adequately account for professional activity thus limits the scope for planning and control analysis. It is precisely this contingency factor that seems to have been modified by T2A. With the creation of

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activity clusters, we are faced with the possibility of promoting a divisionalization of the hospital. In the divisionalized structure, autonomous units, called "divisions", are linked by a central administration, called "headquarters". The prevailing coordination mechanism in this case is standardization by results, which consists in determining the results of work in advance by setting performance targets that the operational units must achieve. This requires the development of a powerful technostructure - such as the management control function, capable of setting up a steering system - but also of operational managers, who have the control and legitimacy to manage their scope autonomously, based on a principle of responsibility. This is the theoretical framework for the operation and function of the division manager.

It's worth asking what lies behind the idea of "steering by results", before understanding the issues involved in transferring such a mode of coordination, well established in certain industrial and consumer sectors, to a professional-type organization. In fact, the idea has its roots in the notion of *management by objectives.*

(MBO), introduced by Peter Drucker in 1954. This form of management was a response to the Fordist model of bureaucracy that had marked the first half of the 20th century, which was hampered by the problem of costs and the difficulty of coordinating work within organizations whose main contingency factor was size.

MBO consists of four complementary parts: centralized determination of corporate objectives; decentralized definition of operational objectives and task organization; measurement of performance against objectives; and a results-based incentive system. The founding principle rests on the idea that, in order to achieve the organization's overall performance imperative, the work of each individual, and in particular that of each manager, must be oriented towards the objectives of the whole, so as to prevent professionals from slowing down or preventing the achievement of general goals by pursuing their own notion of "a job well done".

At the time, Drucker predicted that the "new technology" (the ability to produce ever more precise measurement information), would enable more effective self-control, reinforcing each worker's "natural" drive for excellence. If used properly, this technology would lead to a considerable advance in management efficiency and performance, through a *self-control* mechanism. Self-mastery means stronger motivation, and replaces management by domination. This mechanism is stabilized by what Drucker calls the "*manager's letter*", the precursor of the agent-agent contract, enabling the latter to control himself what he does to achieve the results that are expected of him (and that have been set, frankly and mutually wisely), so as to be held accountable.

The problem of the gap between individual and organizational expectations is a common one in professional bureaucracies, with a multiplicity of individual strategies driven by individuals holding a high degree of recognized legitimacy. T2A, for example, raised hopes of aligning everyone's expectations with a shared notion of performance, leading to the adoption in law of a hospital organizational configuration compatible with this hypothesis: activity clusters.

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3. REASONS FOR FAILURE

How, then, can we explain the failure of this method of hospital governance and structuring? The first, and perhaps most instinctive, reason is that the work of care is quite simply incompatible with the idea of performance in its purely medico-economic and accounting dimensions. Indeed, strategy in the sense of "a single, integrated decision-making structure common to the entire organization" loses much of its meaning in a professional bureaucracy.

Firstly, because this "production" is difficult to measure, and it is now clear that T2A has not played a role in clearly clarifying what performance is. Several authors have studied the clusters, seeking to analyze the roles of the new players, particularly that of the cluster manager (Valette & Burellier, 2014)(Kletz, 2014)(Grenier & Berardini-Perinciolo, 2015). These studies emphasize the management of paradoxes by the nursing profession, and an attempt by the State to delegate medico-economic thinking to doctors, both understood as key issues in New Hospital Governance (Valette et al., 2018).

Hospitals are characterized by a professional logic that is progressively "diffracted" into a large number of elements, splintering delegation arrangements into multiple, highly differentiated activities. Care professionals are thus placed in a perspective of intense reciprocal prescription, leading to an entanglement of processes. What links actors from different reference universes is an organic solidarity that is difficult to formalize. And yet, professionals are in no way accustomed to taking

This is an essential prerequisite for optimizing patient care in hospitals. Moisdon (2012) calls this non-information symmetry, as opposed to the classic notion of information asymmetry, the inability of the technical regulation system to establish a consensus between managers and professionals regarding activity performance. Another reason may be linked to the difficulty of agreeing on accounting targets in hospitals. Indeed, this idea comes up against a paradox: that of wanting to transfer a constraint of an economic nature applied to medical management, without accompanying it with a process of reinterpretation on the part of the actors concerned, trained and socialized in a world where the quality of care provided to patients is valued above all else (Moisdon, 2017). From this perspective, the cluster finds itself in the position of a simple transmission belt, at once *top-down* on budgetary constraints, and *bottom- up* to escalate requests from units and services, while being unable to foster effective reflection around process revision, in a spirit of coordination and resource sharing (Vallejo et al., 2020).

Finally, as a primarily administrative structure, the cluster rarely achieves legitimacy in the field. The logic of its perimeter and its functions are very difficult to understand for staff who are the furthest removed from management spheres, who find in the department a fundamental collective of action, unequalled by the cluster, as well as a major identifier of their practice discipline and profession. This is the level of reference at which the institutional benchmarks necessary for socialization and team spirit are set. It would appear, therefore, that the cluster's issues are confined to purely administrative matters, peripheral to what constitutes the core of the business, combined with a lack of

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sustainability of the structure (renewed and remodeled every four years), all of which are barriers to the construction of a cluster organizational identity. We find ourselves in a situation where the boundaries of what even constitutes "the division" are difficult to identify, which poses a further challenge to their constitution as legitimate management areas.

Overall, the cluster faces a twofold difficulty: that of the divisionalization of the hospital structure on the one hand, and the coordination mechanism associated with this structural type on the other - the standardization of results. If the clusters have failed in their role of steering and integration, then it is envisaged to reposition the departments as the basic structure of the organization, giving them greater autonomy. The hospital thus continues to be a highly compartmentalized environment, with each department focusing on its own operating logic, which represents a barrier to cross-functionality.

What remains of these management structures when their basic premises seem to be collapsing? In other words, what is the place, if any, of supra/inter-departmental organizations in the hospital? This is what we will try to understand through our case study.

4. METHODOLOGY

Our empirical sources come from a work of research-intervention (Moisdon, 2015), which enabled us to carry out an embedded case study (Yin, 2018) within a large hospital group. In July 2019, this group, which until then had been driven by a head office, decided to create clusters of its sites. The aim of this governance and structural reform was to establish a less centralizing regime, and to determine a reduction in functions from central management to the directorates of these groupings thus formed, by transferring some of the functions of central management to these decentralized directorates. The evolution of these perimeters was also seen as an opportunity to rethink the creation, governance and operation of the supra-service organization mode, with a change in perimeters and the naming of clusters towards University Clusters (PU).

These were intended to facilitate interaction between groups of departments at different sites within the same group, by increasing their critical mass, enabling them to operate in a more open fashion and strengthen their academic missions within the group's perimeter. In many cases, this meant grouping together several departments, often with different specialties, located in separate establishments.

These departments are then brought together within a single collective which, in addition to having responsibility for a budget and facilitating management dialogue, must find new synergies enabling the creation of cross-disciplinary and innovative collective projects in the medical, research and teaching fields. This represents a change in the raison d'être of this inter-departmental organization, implying on the one hand greater interaction within the hospital group, and on the other a reconsideration of their identification, most often strongly attached to a single practice site. On the occasion of this major reform, the hospital group has called on our research team to conduct a three-year research project,

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starting in January 2021. The aim of the project is to support the transformations currently underway, and to analyze their impact on service provision and on individual, collective and institutional dynamics. More broadly, it aims to understand how the implementation of new hospital organization methods can contribute to the transformation of the healthcare system.

In addition to reading the texts on the reform, we took part in numerous administrative and medical meetings, and visited various sites and departments to understand how they operate. This was accompanied by non-directive interviews, with systematic note-taking and reconstruction, with a wide range of key players: department heads, local and senior health managers, doctors, directors, referral directors for the medical-university cluster, and various paramedical professionals (nurses, electroradiology technicians, and laboratory technicians).

Our intervention is still ongoing, and it's a conscious approach on the part of our team to let ourselves be carried along by the evolving demands of our partners, as well as by the richness of interactions within the organization. We justify this by our constructivist and comprehensive epistemological positioning (Dumez, 2016), anchored in the field, and focused by a dual operational and research objective, characterizing intervention research (Kletz, 2018).

5. RESULTS: A FLEXIBLE FRAMEWORK GIVING RISE TO HETEROGENEOUS MANAGERIAL FORMS AND PRACTICES

A reading of the founding texts intended to guide the creation of the Pôles médico-universitaires (including the institution's 2019 internal regulations) and their more individual empirical exploration reveal two essential phenomena. The first is the re-meaning of a management object within a flexible framework of existence; the second is the consequent appearance of heterogeneity in the managerial forms and practices of each medico-university cluster.

Right from the outset, the texts show a virtual disappearance of the medico-economic control and results-based management dimensions envisaged for the clusters at the time of their creation, in favor of a new vocabulary emphasizing different concepts. These now include: the need for interaction between groups of services, with added value for the customer.

These include: the combination of an intellectual and academic cross-disciplinary approach to research and teaching with a management approach; the reinforcement of care and patient pathways; the creation of career paths and the enhancement of their attractiveness; and the reinforcement of cross-disciplinary links between hospital sites. The absolute absence of any contractual arrangements setting out the objectives of these medical-university clusters is striking.

At the same time, we see the "cost center" logic being overturned in the idealization of these new management areas, as one of the documents states that "the medical-university clusters are not a tool for restructuring and rebalancing the finances of the AP-

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HP; the economic stakes exist and will be met with or without a medical-university cluster". We also note an almost premonitory acknowledgement of what would come in the wake of the Claris report (cf. introduction), as the document stresses that "the unit of organization and exercise of hospital practice remains the department, whatever the nature of this practice (medical, surgical, biological, etc.)".

On the other hand, the texts guide, but do not impose, the way in which the perimeters of these medical-university clusters are to be defined, so that no two different medical-university clusters contain two departments in the same discipline. A number of derogations are possible, however, and the actual architecture of one of the clusters (comprising 7 hospital sites) reveals a high degree of flexibility and a very low level of prescriptiveness. In fact, the 16 medical-university clusters created within the GHU are extremely heterogeneous in terms of size, medical specialties, grouping logic and location (on one or more hospital sites, or even across all the group's establishments).

These differences can be explained by historical and political factors. The medical and paramedical communities of some sites were more inclined than others to participate in the integration movement envisaged by the grouping, and the medical-university clusters therefore had to take on different conformations to adapt to this diversity. Some establishments located at the extremes of the GHU territory favored a scenario with single- or single-site medical-university clusters. Finally, the Covid crisis in 2020 prompted GHU management to promote an organization centered on strong autonomy for each hospital site, which at the time was seen as necessary to cope with health tension. This did not encourage the development of medical-university clusters, which were more focused on cross-functional approaches and so-called "cold" projects.

But when we get closer to the management teams of these medical university clusters, we realize that not only are their forms very different, but so too, and perhaps even more importantly, are their managerial practices. Each in its own way, these departments have taken on multiple configurations, with the *ad hoc* definition of a specific comitology and various functions (e.g. research referral manager; bi-site cross-functional paramedical manager; vice-director of the medical-academic cluster...), in no way determined by the texts, but which have enabled each medical-academic cluster to gradually adapt to its needs. This diversity of management forms and methods makes it difficult to draw any comparisons between these groups, but we can draw the conclusion that they are evolving in a trial-and-error manner, and are constantly searching for meaning.

6. DISCUSSION

6.1 New uses for a management system

Close contact with the various medical-academic cluster managements and the departments that make them up has enabled us to gain a better understanding of the operating logics that underpin the medical-academic clusters, and above all of the way in which the actual action model of these collectives was quite fundamentally removed from the contractualist logic and from steering by medical-economic results. Firstly, the

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absence of a medical-academic cluster contract, and secondly, the development of projects at different levels (medical, teaching, research, managerial) whose objectives were in a state of perpetual construction.

In one of these medical-university clusters, bringing together medical-technical specialties, the aim is to build an organizational identity through an e-learning tool designed to pool the teaching offerings of the various departments. Here, the management team of the Pôle médico-universitaire has succeeded in implementing and federating the work of a project team with representation from the different professional categories and sites involved. The project has proved to be a formidable managerial maneuver, serving as an identity-building tool to affirm the existence of the Pôle médico-universitaire: insofar as it promotes the image within the hospital community of a department that functions well. This prestige is gradually gaining the attention of GHU management.

This same medical-university cluster is also the basis for another, larger-scale project involving four departments in the same diagnostic medical specialty. In this case, we are using this management space to negotiate with management on the acquisition of a costly, high value-added technology, while at the same time planning a new care circuit. This new circuit implies a paradigm shift in the way the four departments work together, putting their potential for collaboration and integration into perspective, and calling for support in the transformation of their professions. Their dynamic not only enables them to achieve satisfactory conformation internally, by carrying out intermediate deliberations as to the priority locations for resource allocation requests, but also acts as a dissemination platform vis-à-vis the hospital community, necessary to gain the support of other specialties as well as to convince the various functional departments involved in the project's evaluation. These aspects point to a role for the Medico-university cluster in steering the transformation and supporting cross-functional projects.

In another medical-university cluster within another site grouping, this time bringing together surgical specialties, we have seen the birth of a consortium between three specialties, located on two different hospital sites, around a frontier organ. The aim of the project was to consolidate and expand the surgical activity around this organ, which was already very strong within two of these departments, by strengthening the technical and scientific synergies between the three. However, on closer observation, what appears on paper to be a collaborative project between specialties, calls for a scientific, managerial and medico-economic justification that is continually being transformed. The consortium has become a tool for raising a department's profile in a competitive environment, a negotiating force with management for the purchase of equipment, and a lever for recruiting new professionals in a context of declining attractiveness and fierce competition. These cases illustrate the way in which the players involved make use of this mechanism, in which services are invited to evolve. As we have seen, the action model proposed by the HPST law, which provides the legal framework for the operation of activity clusters, calls for the signing of a contract delegating a certain number of responsibilities to professionals, who in return must report on the results of their activity

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through performance indicators set *ex ante*. However, this planning and calculating model, reminiscent of that of the large divisionalized company (Mintzberg, 1986), has not yet proved its worth.

This has nothing whatsoever to do with the way in which we have just described the operation of the medical-university clusters.

What we're observing is a far cry from the kind of management that consists of planning, minimizing risk, and moving forward with as little deviation as possible from the initial idea set out in a contract (which, by the way, doesn't exist). In fact, the results of these experiments are often very different from what could be foreseen at the outset, as the consequence of a dynamic network of players faced with an uncertain reality and ambiguous objectives.

6.2 Case Analysis

The two medical/university clusters studied here illustrate the transformation of a legally-defined mechanism, the activity cluster, with the aim of attributing new functions to it: cross-functionality, identification of care lines, pooling of teaching and training provision... This transformation, from a space initially designed to define activity objectives to a space for managing shared projects, is in itself a new development, going beyond the simple premise of results-based management.

The flexible framework in which these medical-university clusters evolve is compatible with what Cazin (2017) describes as a governmentalist regime in hospital policies called "the stimulation of collective exploration". This framework is designed to encourage the emergence and supervision of exploratory partnerships, and is characterized by a hybrid between timid prescription and the withdrawal of supervisory bodies. This regime benefits from the virtues of ambiguity, insofar as it allows for grouping together to explore, while navigating an unstable articulation between several overlapping registers of public action. This helps to explain the wide diversity of forms, contents and managerial styles present within each of these collectives, as we have observed.

Still in this vein, the work of Aubert et al (2021) illustrates how the imposition of the course logic in public action discourse marks the gradual transition between two regimes of health governmentality. In the first, known as rationing, health is conceptualized as a cost, and the dominant rationality is to balance the books. This regime had a profound effect on the beginning of the century, and is well illustrated by the advent of the T2A and its structural metaphor - activity clusters. In the second regime, known as "decompartmentalization", it's the path that becomes central, and we see a semantic shift towards notions such as cooperation and transversality. This regime, still under construction, is also characterized by the emergence of several experimental situations (such as article 51[4]), with the co-construction of systems. We note that the medical-university clusters are precisely at the crossroads of these two regimes, and that the difficulty in grasping this management object is precisely explained by the encroachment of one regime on the other, characterizing an overlap without an explicit break.

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The medical-university clusters thus find themselves torn between at least two different regimes of action: one still pushing them to impose themselves as places of accounting management and steering by results in the hospital; the other as university, research and teaching spaces, encouraging the emergence of cross-disciplinary partnerships and the fluidification of pathways (professional and management).

7. CONCLUSION

Our initial results identify some of the conditions that need to be taken into account if management dialogue is to lead to a convergence of goals between administration and healthcare professionals. These results are useful on a practical level for the design of hospital governance structures, and on a theoretical level, as they provide insights into the search for new modes of hospital coordination.

On the one hand, they show that there is no real standardization by results at the hospital, insofar as management dialogue is reduced to a ceremonial practice; on the other hand, these divisions have created spaces conducive to operational coordination between departments, i.e. they have facilitated mutual adjustment between specialties or functions, more than institutional collaboration (Glouberman & Mintzberg, 1996). This adjustment is possible because the divisional framework is sufficiently ambiguous for professionals to adapt it to their needs.

Our cases also show us that the initiatives that emerge in the field need to find an echo within decision-making processes, and that the mechanisms for evaluating them need to stimulate the creativity of professionals and facility managers. This does not seem to be the case with medico-economic indicators, which would be associated with overall cluster performance. What is at stake is creating the conditions for an appropriate communication channel capable of fostering a balance between administrative links and shared intellectual/medical interests. There are currently a number of networking options available to those working in the field, and there is no magic formula for identifying "the right structure" for the right situation. The current context imposes the need for transversality, the important thing being that professionals can get closer together and break down the barriers to building the bonds of trust needed for long-term partnerships.

However, divisionalization is not without interest for hospital structures, provided it is carried out within a sufficiently flexible framework to allow mutual adjustment. On a theoretical level, this calls into question the link established between divisionalized structure and standardization of results, since the application of this structure in a professional organization reinforces not this mechanism but that of mutual adjustment.

Our study has thus prompted us to propose a reversal of management logic in hospitals. The idea is to overhaul an organization based on the *ex-ante* setting of rigid plans, with the determination of precise objectives (whether in terms of activity, teaching or research), deadlines and predefined indicators. It is also a question of reviewing the application of pure incentive and self-control logic (in the sense of Drucker) to public hospitals. In this context, decentralization means not only giving greater autonomy to operational staff, but

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also enabling department managers to meet in privileged forums for discussion and the forging of bonds of trust, thus fostering the alignment of their individual strategies. In this way, the clusters can become the very place where the hospital's objectives are set, and where shared projects emerge from departmental needs.

Foot Notes

1) Ordinance no. 2005-406 of May 2, 2005, simplifying the legal framework for healthcare establishments, introduced in its Title I what was later known as the "new hospital governance".

2) Mission on hospital governance and simplification entrusted to Pr Olivier Claris, June 2020.

3) Law no. 2021-502 of April 26, 2021 aimed at improving the healthcare system through trust and simplification.

4) Article 51 of the 2018 Social Security Financing Act introduced a mechanism for experimenting with new healthcare organizations based on novel financing methods.

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