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## Title page

**Medicine and management in European healthcare systems: how do they matter in the control of clinical practice?**

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## Medicine and management in European healthcare systems: how do they matter in the control of clinical practice?

*Ellen Kuhlmann, Viola Burau, Christa Larsen, Roman Lewandowski, Christos Lionis, and José Repullo*

During recent years, management has brought tighter controls into all areas of clinical practice, responding mainly to financial shortages coupled with increasing public demand for quality and safety of care. Management is not simply expanding and creating new roles for non-clinical managers, but doctors, too, are charged with managerial responsibilities. Consequently, the boundaries between medicine and management are no longer sustainable and this, in turn, may have complex implications for control and leadership in clinical practice.

The notion of control, as defined here, includes a wide range of bureaucratic measures and managerial tools, such as target setting; performance indicators; and interventions for which doctors have oversight, such as evidence-based clinical guidelines or continuing professional development. The pros and cons of managerialist regimes in clinical practice, as well as the challenges of managing doctors, are widely debated. A growing body of literature reveals the problematic outcomes of new managerial tools, which include standardisation, evidence-based medicine, and target setting, as well as financial incentives and new managerial roles (Galloway, 2009; Knorrning et al, 2010; McDonald et al, 2008; Minhas, 2009; Timmermans and Amelung, 2009).

But what is next in exploring how the transformations in medicine and management matter in the control of clinical practice? If medicine and management are no longer sitting on 'different planets', it is time to move beyond the 'either-or' questions of professional or managerialist controls and, instead, explore the connections. There is an urgent need to develop and implement models that are able to effectively connect professional self-governing and management-based controls in clinical practice. The way forward is informed by rich case-study material from Denmark, England, Germany, Greece, Poland, and Spain. Research was carried out by the authors and includes analyses of policy documents and primary and secondary sources.

### Where are we now?

Across European healthcare systems the attempts towards tighter control of clinical practice seek to improve both cost-efficiency and quality of care. Thus, two key areas in need of control can be identified:

- Control of budgets: In many countries, this has taken the form of DRGs, and the focus is consequently on the organisation. In addition, pay-for-performance schemes and other financial incentives that are more directed at individual professionals are also relevant;
- Control of quality and safety of patients: Examples of this type of control are diverse and may even include organisational restructuring and the creation of new institutions. But evidence-based medicine and clinical guidelines are key strategies in

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2  
3 all countries, primarily nurturing individual approaches and the self-governing  
4 professional controls of doctors.  
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7 These examples highlight the fact that medicine and management are 'twin forces', and as  
8 such indicative of new emergent controls. In both areas, the self-governing professional  
9 controls and more individualised strategies co-exist with tighter organisational controls. What  
10 matters is the relative balance between the two and the specific composition of the toolset of  
11 controls. Some illustrative examples reveal different patterns of control in European  
12 countries. Some illustrative examples reveal different patterns of control in European  
13 countries.  
14

### 15 16 **Variations on the theme**

17  
18 In Denmark, quality standards have evolved from the bottom up, beginning in hospitals. This  
19 has been further developed by a national programme and includes accreditation processes  
20 of self-evaluation by the organisation and external evaluation by a professional accreditation  
21 association. Consequently, managerial and professional controls are more integrated, but the  
22 balance is shifting from the individual professional towards organisation-based criteria of  
23 quality control.  
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28 • *Control is linked to integrated approaches but focuses more on the organisation than*  
29 *on individual doctors.*  
30

31  
32 The NHS in England counts as a prime example of the implementation of new managerial  
33 regimes. Within this context, target setting and standardisation are key to improving both the  
34 quality of care and budget control. Doctors have widely adopted these strategies without  
35 significant conflict, and individual professionals and organisations may collaborate towards  
36 transformations of the content of targets and standards.  
37  
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40 • *Control focuses more on the organisation together with strong centralised controls*  
41 *and some individual incentives.*  
42

43  
44 Managerial controls in Germany focus mainly on doctors, and in turn, doctors use the new  
45 managerialism strategically in order to reinforce their self-governing capacities. Examples of  
46 this include the introduction of clinical guidelines and continuing professional development  
47 (CPD) as a mandatory requirement by law. In this situation, existing working groups  
48 established by doctors ('quality circles') were assigned to approve CPD, which subsequently  
49 expanded rapidly. This self-governing professional control co-exists with a number of new  
50 budget controls, such as DRGs, that are more focused on the organisation.  
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54 • *Control focuses more on individual doctors, but budget controls shift the focus*  
55 *towards the organisation.*  
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58 Efforts towards clinical management have been reinforced in Greece and in Poland, but a  
59 number of new mechanisms of control in which doctors still have oversight have been  
60 established. Doctors are, to a large extent, the key players who shape the outcomes of  
control in clinical practice. However, this pattern may co-exist with other forms. For example,  
health authorities in Greece have recently gained oversight of the improvement of both

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3 budget control and quality of drug prescriptions; by contrast, budget control in Poland is  
4 coupled with the commercialisation of hospitals and a DRG system, thus reinforcing market  
5 control.  
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- *Control is more focused on individual doctors and self-governance than on organisational innovation, but it co-exists with both market control and more centralised state controls.*
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14 Restructuring of hospital management in Spain primarily includes financial management,  
15 such as the management contracts linked to a DRG system. This restructuring, however, is  
16 accompanied by organisational change in the top management and the medical hierarchy as  
17 well as new efforts to rebuild medical professionalism towards leadership. There are also  
18 innovations in management, such as the introduction of a pilot scheme with more integrated  
19 management or new forms of clinical leadership that improve doctors' budget responsibility.  
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- *Managerial and professional controls are connected and re-connected in different ways, including more integrated management and other organisational innovations.*
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### 27 **What next in researching control?**

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29 The case study material reveals that no uniform model of control emerges across European  
30 healthcare systems. At the same time, we can observe in all countries a co-existence of self-  
31 governing professional controls and managerial controls that may be targeted at individuals  
32 and organisations and may also be linked with markets and hierarchical state controls. What  
33 matters in the control of clinical practice in European healthcare systems is the specific  
34 composition of a set of controls and how they are connected and re-connected and may  
35 create new more 'hybrid' patterns of controls.  
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39 These emergent patterns of control may be linked to the institutional framings of medicine  
40 and management to some degree, as shown in our examples, but other conditions, including  
41 the subject area of control and the time-specific frame, are also relevant and might even  
42 override the institutions' importance. Consequently, researching control presents new  
43 challenges. First, the new connectedness of medicine and management calls for a more  
44 dynamic and reflective theoretical approach to control that moves beyond the assumption of  
45 contradicting logics; this also brings a transformative potential of professionalism and  
46 'hybridization' of control into perspective (Kirkpatrick et al, 2009; Plochg et al, 2009). Second,  
47 comparative research draws heavily on typologies and indicators that were created at the  
48 level of health systems (Wendt et al, 2009). But the management of medical performance  
49 focuses on organisations and professional groups, and therefore calls for new approaches,  
50 including qualitative methods, meso-level comparison, and actor-centred dynamics.  
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53  
54 We suggest exploring the emergent patterns of control more systematically by focusing on  
55 the *organisational settings* in different European healthcare states and the actors involved in  
56 the transformations. Organisations are the 'switchboards' of clinical practice, where 'medicine  
57 meets management' and control is made and re-made. Using cross-country comparison  
58 adds further value by filtering out how organisational settings matter in relation to the wider  
59 architecture of healthcare states. Finally, this will help to outline future avenues for 'medicine  
60

and management' that are likely to create more sustainable and integrated controls in clinical practice.

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