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**Understanding the difficulties of implementing management delegation in hospitals:  
a reading through the concept of organised anarchy**

**Abstract**

The French public hospital system is in the midst of a restructuring around the questions of the quality of the supply of care and medico-economic efficiency. We mainly make reference to the organisational change known as New Governance, which leads to the setting-up of “poles” of medical activity, in which several care services are brought together. In this context of change, some responsibilities have been devolved to the poles, and thus to the doctors who act as pole leaders, with a view to bringing decision-making down to the clinical level for the sake of efficiency. While studies do indeed identify modifications in the organisation of care activity, decisions remain centralised at the level of the General Directorate. Our aim therefore is to study the effects of the new governance on the devolution of management and therefore of decision-making within the poles, and the factors that act as brakes on the setting-up of a real delegation of management. To do so we mobilise the work of Cohen, March and Olsen (1972). We shall make reference to organised anarchies, a particular model of organisation that makes it possible to understand organisational behaviours. By demonstrating whether the hospital is an organised anarchy, we aim to better understand the decision processes at work in this organisation and so shed light on the brakes on devolution. The research hypothesis is that the new governance accentuates the three characteristics of organised anarchy: ill-defined preferences, unclear technology and fluid participation. Our research was conducted in a large teaching hospital. To carry out this analysis we focus on three activity poles. To understand the decision-making mechanisms, we analyse two specific management processes: staff management and bed management. The data were collected through semi-structured interviews, non-participant observation and document analyses between September 2013 and November 2014. A new phase of fieldwork will start in the first quarter of 2016.

## Introduction

In France as in many Western countries, the health policies implemented since the 1990s have essentially pursued two objectives: controlling expenditure and improving quality of treatment.

As regards the control of expenditure, according to a recent study by the public statistics office (DREES),<sup>1</sup> in 2010 consumption of medical treatment and goods amounted to 9.1% of GDP (as against 2.6% in 1950) (Le Garrec et al. 2013). This increase is to a large extent due to the growth in hospital treatment, which accounts for 46% of health expenditure and continues to grow by 3.5% annually despite the many reforms undertaken to contain it.

The policies implemented to try to hold down this growth in spending seek to make establishments responsible for their own financial management, in particular through decentralisation and contractualisation.<sup>2</sup> They also aim to ensure better coordination among establishments so to create a regional offer of treatment meeting the needs of the population and to encourage in-house productive efficiency.

Governments have also aimed to close the gap in public hospitals between the medical world, mainly preoccupied with research and quality of treatment, and the world of management, mainly centred on the cost of healthcare. This antagonism has often been identified as the root of the lack of efficiency in treatment (Glouberman & Mintzberg, 2001). Two main routes are being explored to try to reduce this gap. First, the North American model of medicalisation of information systems suggested defining treatment costs per pathology so as to make medical activity legible for the manager. The progressive spread of “homogeneous patient groups” (*Groupes homogènes de malades*, GHM) and procedure-based invoicing (*tarification à l'activité*, T2A) for hospital financing is a development of this mechanism (Moison, 2010). Secondly, at the organisational level, the direct involvement of doctors in management decisions is seen as a major tool for reducing treatment costs while maintaining quality and safety. The emergence of the figure of the “doctor-manager”, the promotion of “medical leadership” and more generally the delegation of management responsibilities to doctors can

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<sup>1</sup> *Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques* / Directorate for Research, Studies, Evaluation and Statistics.

<sup>2</sup> The *ordonnances* of 1996 (no. 96-346 of 24 April) set up the regional hospitalisation agencies (*Agences regionales de l'hospitalisation*) so as to better monitor and coordinate hospital activities at regional level. Each establishment, public or private, must draw up a project which is incorporate in the regional health organisation plan (*Schéma Régional d'Organisation Sanitaire*, SROS).

be seen as emblematic embodiments of this tendency (Kirkpatrick et al., 2009). In French public hospitals, this emergence was made concrete with the setting-up of “medical activity poles” (*pôles d’activité médicale*). A pole is a cluster of services which benefits from some delegations of management granted by the Director General of the establishment. The creation of poles aims to bring managerial decision-making closer to clinical level so as to increase the medico-economic efficiency of treatment. The *ordonnance* of 2 May 2005 states that the aim is to “medicalise hospital management by involving doctors – the practitioners – in strategic management.”<sup>3</sup> The HPST Law of July 2009<sup>4</sup> confirmed the principle of medico-administrative governance of health institutions by defining the role of the doctor-pole leader whose task is to steer and monitor the performances and results of his/her pole.

Some years after the *ordonnance* of 2 May 2005 and the setting-up of this new organisation in poles, academic studies report mitigated results as regards the extent of this change for the involvement of doctors (and their teams) in the managerial decision-making process. We are still a long way from the supposedly productive hybridisation of medical and managerial logics. Management delegations remain very limited, since, according to the IGAS,<sup>5</sup> in 2010 only 21% of all establishments had pole contracts (Zeggar & Vallet, 2010). My empirical research highlights the place of decision-making processes at the heart of the problem of delegation. In other words, it is not sufficient to proclaim delegation, even when associating it with a superstructure identifying each agent’s role in the organisational structure, in order for it to become a reality. One has to take account of the way decisions are made and the nature of these decisions.

The reorganisation of hospitals into poles was meant to lead to a delegation of decisions and better adaptation of these decisions to the hospital context. The literature seems to show weak delegation. With a view to understanding, the thesis aims to analyse in what organisational context decision-making in hospitals is structured. Through exploration of this context, the idea is to identify the causes of the hindrances to delegation. It also seeks to understand how the organisational environment influences decision-making. To do this, it mobilises Cohen, March and Olsen’s (1972) theory of organised anarchy, which comprises three characteristics: problematic preferences, unclear technology and fluid participation in decision-making.

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<sup>3</sup> [www.reformes-hospitalieres.com](http://www.reformes-hospitalieres.com)

<sup>4</sup> Loi “Hôpital, patients, santé, territoires”, no. 2009-879 of 21 July 2009.

<sup>5</sup> *Inspection générale des affaires sociales*, General inspectorate of social affairs, an administrative oversight body.

Based on this framework of analysis, I review the literature on the processes of implementing management delegation in hospitals. I then set out the methodology to gather and analyse qualitative data from three poles in a university teaching hospital (*Centre hospitalier universitaire*, CHU). Finally, I present some initial results concerning two decision-making processes: staff management and bed management. My conclusion presents the research perspectives for the continuation of work on the thesis.

## **I. THE HOSPITAL AS AN ORGANISED ANARCHY**

Without making a precise demonstration, Denis et al. (1995) consider that the hospital is the ideal-type of an organised anarchy, since it manifests:

a profound uncertainty in the definition of its goals, multiple and diffuse sources of authority, the presence of numerous factors determining its performance, but which over which it has little control, and, lastly, difficulty in agreeing on the criteria by which this performance is to be judged (pp. 166).

I should like here to go further in using this grill of analysis. Cohen, March and Olsen (1972) extend the work of the behavioural school on decision-making, in particular through the model of the “garbage can” and the theoretical model of organised anarchies.

Organised anarchies have three essential characteristics:

- problematic preferences;
- unclear technology, making it difficult to evaluate the results;
- fluid participation by members in decision-making.

These characteristics, identified by the researchers in the context of American universities, shed a relevant light on the context of French public hospitals and make it possible to understand, in part, the difficulties that organisations having in moving towards a greater delegation of decision-making. Indeed, according to the authors of this model, while these characteristics may be found in any enterprise at any time in its life, or at a particular point in its structure, the model is predominant in public organisations.

### **I.1 Problematic preferences**

In these organisations, their functioning is based on a great variety of inconsistent and ill-defined preferences. There is an incoherent structure, closer to the assembly of ideas, which

discovers its preferences in action. It does not act on the basis of established preferences, a feature which distances it from the classic model of the theory of choices, which attributes to decision-making a series of preferences that satisfies the demands of coherence (Cohen et al., 1972). Christine Musselin (1997) more specifically argues that the difficulty in these organisations stems from the fact that the objectives are in competition but never stably ordered.

In universities, the diversification of their missions has made them increasingly composite structures, intensifying the ambiguity of their missions. The plurality of missions invites no simple answers and gives rise to many debates, in particular over the articulation of teaching and research (Musselin, 1997). Hence in universities, because of this functional interdependence, a balancing and hierarchising of the divergent objectives is rarely achieved. As a consequence, the objectives may be pursued in parallel without any one of them durably prevailing. The singularity of organised anarchies stems partly from this problem of the emergence of action logics or stabilised local orders (Musselin, 1997).

In hospitals, poles have been set up to involve doctors and carers in medico-economic management. T2A and budget constraints have brought to light contradictions between treatment objectives and the control of expenditure. With T2A, prescriptions are generated by the medical activity. It is therefore necessary to make doctors and carers responsible in generating prescriptions and aware of the financial impact of their decisions (Vallet, 2012). The subsidiarity principle underlying the new governance requires directorates to agree to implement a delegation of management, which presupposes that they trust the pole leaders. And on their side the doctors must agree to manage, which means being trained in and devoting time to management (Vallet, 2012). As a consequence, doctors expect greater autonomy associated with the principle of delegation, while the directorates expect from these same doctors greater professionalisation in the job of manager or administrator. These expectations vis-à-vis organisation in poles underline the difficulty for hospitals of agreeing on shared preferences and objectives. All the more so because the current monitoring tools are not sufficiently refined and the convergence of interests between doctors and management is not sufficient for a real delegation to be set up. The agency costs are too high. Delegations remain limited and often contested (Gouffé & Cargnello-Charles, 2014).

Moreover, the hospital is a large structure bringing together a multitude of actors, as shown by Glouberman and Mintzberg (2001), who present not one organisation but the grouping of

four entities which function independently.<sup>6</sup> The fragmentation of the actors results in a difficulty in asserting clear preferences for the institution. The carer-clinician duality is complex because it relates to multiple hierarchies which do not make it possible to present a single, coherent strategic line, since they are always pursuing different objectives. Moreover, for some intermediate managers, the positioning between staff and directorate is uncomfortable (Detchessahar & Grevin, 2009). This can create areas of uncertainty and information asymmetries that lead to the pursuit of contradictory objectives. Furthermore, some doctors and heads of services also have powers and may sometimes pursue objectives different from those desired by the directorate. In addition to their symbolic power, some of them sit on the Establishment medical committee (*Commission Médicale d'Établissement*, CME), or have connections with members of the supervisory bodies, which can sometimes lead them to act in parallel to the official deliberative assemblies.

In short, the director is not alone in making decisions, and the specificity of hospital governance means that hospitals contain many actors capable of intervening and weighing on decision-making. These are all aspects that lead one to think that the hospital organisation is an organised anarchy whose strategies are not uniform.

## **I.2 Unclear technology**

In organised anarchies the procedures are not understood by all members of the organisation. They nonetheless muddle through and carry on producing and surviving. This trial-and-error operation is based on the lessons of past experience and pragmatic invention born of necessity (Cohen et al., 1972). The lack of clarity is due in particular to unexplained processes linked to personal qualities that are hard to transmit and which make the evaluation of results a complex matter (Musselin, 1997). The notion of procedure used here is not set out in detail by the authors, who leave this item open to interpretation. One can therefore refer to the main activity of the organisation, the specificity of which makes it unclear for all the actors. But one can also see in this concept the processes put in place to conduct this activity. And then all the elements contributing to these management processes: the various trend indicators or other management tools which, again, from a certain level of specificity, may be abstract for some actors; and so, as defined by Cohen et al., they are not understood by all members and are thus akin to an unclear technology.

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<sup>6</sup> Glouberman and Mintzberg (2001) develop a theory showing that the hospital is divided into four distinct worlds according to their mode of management: *down, up, in, out*.

Musselin describes the technology in universities as “soft”. The processes through which the results are produced are difficult to describe, reproduce and evaluate. The softness of the technology remains however the most discriminating criterion because it is the least widespread in other forms of organisation and feeds into the two other criteria (Musselin, 1997). For Musselin, it is not so much the criteria as their combination which is decisive.

Hospital technology is more ambiguous: there are numerous medical and treatment protocols and standard tools have been developed around quality certification. But alongside this very formal and standard technology, the management tools which are supposed to aid decision-making and the steering of activity are still today very little shared by all the stakeholders.

In Mintzberg’s sense, the contractualisation resulting from new governance in hospitals presupposes a shift from a professional bureaucracy to a divisional configuration requiring the implementation of control by results. This control by results presupposes the existence of a negotiation of pole contracts with the definition of indicators and objectives, combined with a system of incentives and sanctions (Angelé-Halgand, 2012). Control by results would favour the motivation of the actors if they were able to agree on the objectives, the means of action, and the system of measurement and incentivisation (Bérard, 2013). Studies show that the implementation of this control by results encounters numerous difficulties. The provision of treatment is intangible and individualised, and therefore hard to grasp in figures. Control is opposed to the freedom of exercise of professionals who defend their power and their values (the quality of the treatment or the relational dimension of the care). It also comes up against technical problems: the IT system of the human resources department (*Direction des Ressources Humaines*, DRH) does not make it possible to monitor in real time the allocation of staff costs by pole (Bérard, 2013). Rastouil et al. (2012) also note that delegating human resource management to pole level requires indicators on workload, staffing and means of replacement that would allow for comparisons between poles; and these are rarely available.

The various devices for financial control (dashboards, analytical accounting (CREA), etc.) have had little impact on medical decisions (Doolin, 2001). As has been seen, delegations remain limited and often contested. As a consequence, the definition of performance targets by pole has not yet been applied. It would imply further integration of non-financial data so as to come closer to the activity of the services. Not only are financial measuring activities very time-consuming, but also current information systems do not allow for integration of non-



financial data, which would require an advanced interconnection among the databases of the hospital (income, expenditure, quality, consumption, etc.) (Dos Santos et al., 2014).

There is a growing gap in hospitals between the managers and the other actors in decision-making. The limited tools give the users an impression of lack of clarity, which accentuates the gap between managers and doctors. The managers for their part are not in a position to grasp the totality of the medical technology. Returning to the parallel with universities, one notes that the plurality of missions identified is not so dissimilar to the issues found in the CHUs, where activity is divided between treatment, research and teaching, not forgetting the whole administrative sphere. There is a diversity of missions pursuing different objectives. One finds in hospitals the weak functional interdependence which is identified in universities and is the key element of understanding of an unclear technology.

Thus, regarding management tools, we are indeed dealing with an unclear technology. The actors in decision-making cannot collectively grasp all the tools that would enable them to adopt a rational position.

### **I.3 Fluid participation**

Typically, in organised anarchies the participants provide a quantity of time and work that varies according to the various domains of activity. This gives the organisation shifting, uncertain boundaries, with fluctuating degrees of commitment. As a consequence, there are many changes of decision-makers and audiences for the different types of choice (Cohen et al., 1972).

Musselin (1997) brings to light the weak functional interdependence among the actors in the pursuit of their activities. In a university, one person's work has little impact on or consequences for that of another person. Finally, the rate of attendance in decision-making bodies is low and the turnover from one session to another is high. This fluctuation further weakens the functional interdependence.

Weak functional interdependence among actors is also found in hospitals. The functional division into specialised services does not favour cooperation and coordination of treatment. Health professionals are very constrained by clinical and treatment tasks which remain their priority, and cannot take part in all the governance and coordination meetings. From one pole to another, for the same type of meeting, for example the weekly pole steering committee

meeting, one does not find the same actors around the table to take part in the decision. Finally, the doctors, and especially the PU-PH<sup>7</sup> heads of services, must divide their time between treatment, teaching, research, and organisation of their service. They then make strategic choices to take part in meetings that seem relevant to them. We thus find here what is found in universities, a low rate of attendance and high turnover in deliberative bodies.

While many elements are found in the literature that lead one to think that the hospital is an organised anarchy, few studies have directly mobilised this notion as a grid for analysis of the hospital. I propose here to use this grid to analyse the decision-making process in three poles of a CHU. The aim is on the one hand to confirm its heuristic pertinence and on the other to identify the specific place of poles in this organised anarchy. Does a pole make it possible to reduce the anarchy by bringing the actors' objectives together and clarifying the technology? Or, on the contrary, does it help to increase the anarchy by adding a further layer to already multi-layered decision-making? In the light of the literature, I formulate the following research propositions: new governance, i.e. operation in poles, reinforces the three characteristics of organised anarchy: problematic preferences, unclear technology, fluid participation. This framework of analysis will thus also make it possible to understand the context in which decisions are made and to identify new hindrances to delegation. Beyond these descriptive criteria of an organised anarchy, Cohen, March and Olsen (1972) make a linkage between these particular forms of organisation and a decision-making model which they see as specific to them. Beyond these characteristics, in their article of 1972 they present two essential aspects of organised anarchies: the way that organisations make choices without coherent shared objectives and the way the members of the organisation are activated. Thus decision-making situations are described as having ambiguous objectives, and problems are resolved without recourse to negotiation or an explicit market. Based on this observation they develop the garbage-can model, a decision-making specific to organised anarchies. It is therefore pertinent to apply this model here in order to understand decision-making in poles, by making its organisational form explicit. Thus, identifying whether the criteria of an organised anarchy are found in the pole, through analysis of decision-making processes, will enable us to understand the difficulties of decision-making and therefore of management delegation, although they are at the heart of the new governance. Thus I shall try to demonstrate whether one finds in the pole the characteristics of organised anarchy that can

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<sup>7</sup> *Professeur des Universités-praticien hospitalier*, a post combining teaching with medical practice.

constitute a hindrance to this delegation. These difficulties would then be linked to the intrinsic properties of the structure of the organisation.

## **II. METHODOLOGY**

The establishment studied is a large French teaching hospital (CHU) It is a “public health establishment”, governed by the Code of Public Health, managing hospital sites and general services that together constitute one of the largest CHUs in France. In 2013 this establishment embarked on a new phase of internal contractualisation, which was seen as the opportunity for reflection and work on the management tools made available to the poles and the use made of them. This project was suspended following the arrival of a new general director in late 2015. The establishment is in a very difficult financial situation with an annual deficit of several tens of millions of euros and very heavy debts of several hundreds of millions of euros, which has led the General Directorate to undertake joint actions to reduce expenditure, especially staff costs, and increase income. In 2014 the establishment had a chronic annual deficit equivalent to 3.2% of its budget.

To study the process of delegation of management and decision-making to the poles of activity medical in public hospitals, I am carrying out a process case study. This thesis constitutes a research programme running from November 2013 to November 2016. It involves comparative observation of three medical poles with different specialities. These poles were chosen by agreement with the General Directorate (DG) and Establishment medical committee (CME) from among the poles that offered themselves for the study. They are poles with services located on several geographical sites and with patient trajectory logics. The poles selected are relevant to the object of study because they are advanced poles in their organisation, carrying out pole projects and therefore confronting questions of delegation of management and decision-making. Moreover, they are all faced with questions of staff reduction and targeting, and transfers of services to bring together scattered services as far as possible on single thematised sites. These service groupings are based on two principles: thematisation of sites, which is part of the medical project of the establishment; and patient trajectory logics, hence fluidity of routes in the structure.

**Table 1: The three poles of medical activity observed**

A	B	C
Medical specialisms of cancerology 700 full-time equivalent (FTE) staff 170 beds	Medical specialisms of neurology 490 FTE 162 beds	Medical specialisms of gynaecology and obstetrics 500 FTE 237 beds

The CHU studied has seen many changes of director general. There have been two new ones in two years. The objective of these new directorates is rescue the structure financially and conduct a plan for a return to equilibrium. The study started when the establishment was embarking on a phase of new internal contractualisation. In this establishment the first pole contracts were signed in 2009 and were coming to an end. A new round of contractualisation was therefore under way. It was to be the opportunity for the directorate to make a number of organisational adjustments with a view to regaining financial equilibrium, improved quality of treatment and greater medico-economic efficiency. Shared diagnoses were made in the poles so as to identify priority projects for their activity, both in terms of improved treatment quality and medico-economic efficiency. The objective pursued in this new contractualisation was to attain efficient poles based on a “pole trio” (pole leader, senior health executive and administrative executive) together with a delegate director representing the director general. These relationships will be the basis for a first phase of devolution, to be piloted in a few poles. All this is being done in order to arrive, eventually, at a greater devolution of management. This project must now wait, following the departure of the director general who had initiated this internal contractualisation and the arrival of a new DG who will define his priorities in the months to come. Within the structure, a change can also be observed in the logic of the aggregation of poles, around a disciplinary dimension. This question points to the importance of the patient circuit in the structure, with the possibility of redefining the organisation on the basis of the patient route. Finally, another major undertaking of the establishment is to introduce project management to structure activity. By institutionalising these project approaches, working on their emergence, validation and monitoring, this raises questions of delegation and subsidiarity. To summarise the vision of the directorate, at the time of our observation, it was a question of “recentralising to better decentralise” (Director General) subsequently, with the right tools and the right indicators. As for the aims of the new director, our continued observations will reveal more in due course.

The particular context of this establishment makes it a singular object of study. The successive directorates have tended towards recentralisation, at the expense of the poles, leaving them in a not very advanced and even not very efficient state, especially in terms of delegation and autonomy. With contractualisation there was potential for a real revolution, in its original sense of a return to the beginning, with a radical change. Further observations will show how it turns out with the new directorate. In addition, this CHU has to take account of a significant effect of scale. This very large health establishment is spread over four large sites in different parts of the conurbation. This scattering is key to understanding its structure. Historically these sites have been very autonomous, each with its own culture. The site culture is deeply rooted in the actors, with a strong sense of belonging, and a “site power” reinforced by the recentralisation set in motion by the past directorates. Such a situation seems antagonistic to the setting-up of poles and an aim to delegate. This socio-cultural context creates particular power issues and strategies on the part of the actors. So for this establishment the creation of poles and management delegation are a profound organisational and, above all, cultural change.

The data are collected in several ways:

- **Semi-structured interviews:** 30 interviews with all the actors. In a first stage the staff of the general directorate: the director general, the secretary general, the quality directorate of the organisation, the internal audit director, management control, the chair of the CME, and an external consultant playing a part in the structure. Then, the staffs of the poles: the pole leaders, the senior health executives, the administrative executives, the delegate directors, and the management controllers attached to the poles. Finally, with the clinical heads of services, and the neighbourhood nursing executives. These interviews last between an hour and an hour and a half on average, up to two hours for the longest. They were carried out on the basis of an interview grid drawn up with the aim of understanding the overall operation of delegation and the organisation of the poles. They are focused on the actors around the pole so as to gain a first grasp of the structure and understand the issues within this organisation. They will be complemented later by interviews with other actors gravitating around the decision-making processes, at the interface with the poles. These interviews have made it possible to enter into the poles and to meet the actors of these poles in order to understand their reality, the problems and therefore the decisions they face on an everyday basis, and so to get their vision of management delegation. The interview guide was constructed on the basis of the themes

arising from the literature and the first observations. The themes chosen were: presentation of the pole, the actor's role in and vision of the pole, relations with the various actors, contractualisation/delegation, the functioning of the pole, the instruments for management of the pole and the service, projects in the pole, and finally resource pooling.

- **Non-participant observation:** for nine months, from March to November 2014, I attended meetings at several levels within the hospital. These were: three directorate seminars, 45 meetings in the poles (weekly steering committee meetings), four meetings between the poles and the directorate (management seminars) and finally three meetings in the services. This was *in situ* observation where the researchers do not intervene. In these meetings the researcher sits at the back and makes notes on what he observes according to a pre-established observation grid targeting certain aspects. The themes chosen were: the persons present, the purpose of the meeting, its various phases, the communication and collection of information, the functioning of the group, the participants (management of space, who speaks, relational problems), and finally the stages in the decision-making.

- **Document analysis:** in the course of the study various documents have been collected, such as pole contracts, or management tools such as pole projects, analytical accounts and tables of indicators.

Based on the collection of observation data, a thematic analysis was carried out, which made it possible to make a comparison between the three poles observed. This comparison consisted in a search for regularities, common elements, and also the specificities and singularities of certain situations. The themes of analysis chosen are: the actors (pole trio, delegate director, management control, general directorate, supervision), management processes, development of practices desired by the general directorate, the different types of meetings, the organisation of meetings, the subjects addressed, and the management tools. The analysis was conducted in two stages. The first was a comparison among the three poles, with comparative tables for each theme. The second stage was a synthesis common to the three poles according to the themes of the analysis. This report on the analysis was presented to the teams of the three poles observed, and was discussed in greater depth with the pole leaders. The presentations to the teams made it possible to enrich and back up the work done.

Following this analysis, the data resulting from the synthesis of the observations was remobilised to apply the model of organised anarchy to it. The aim was to verify in the field

whether one could find the characteristics identified in the literature: problematic preferences, unclear technology and fluid participation. These are characteristics that lead one to think that the pole, within the hospital, does indeed resemble the model of organised anarchy. These data from observation *in situ* are supported by the remarks made by the actors in the interviews. Those illustrations make it possible to account better for the elements arising from observation through the remarks and vision of the actors concerned. In the processing of these data, attention is focused on two specific management processes: staff management and accommodation management (number of beds per treatment unit). These two processes emerged as the most pertinent for work on decision-making, because they were the two subjects most often raised in discussions in the pole meetings. On the one hand this is because the establishment has embarked on a complete overhaul of its staffing with the definition of a staffing target, and on the other hand the CHU is in a major phase of transfer and regrouping of services in single-site thematic poles. This geographical regrouping underlies an operation of redistribution of beds and harmonisation of the units. These processes have thus become priorities for the poles, around which decisional-making is focused, and from which the majority of problems emerge.

To continue this data collection, I shall track the setting-up of the delegation of the management of staff replacements in the poles observed on a particular site. This is a pilot project of the new directorate designed to lead the poles towards more autonomy by supporting them in this process. The aim will therefore be to focus on an aspect of the staff management process, which is the most relevant according to the directorate. This project will give an opportunity for new non-participant observations, data collection and interviews with new actors. Once the interview corpus is completed, this phase will lead to a thematic analysis of the interviews using software such as NVivo.

### **III. SOME INITIAL RESULTS**

The analytic grid of organised anarchy is applied to the data collected in the three poles studied.

#### **III.1. Problematic preferences**

Several times, situations were observed on the ground in which the agents' preferences were not always certain and could sometimes be mutually opposed.

The CHU has embarked on a **staff reduction** campaign involving the definition of a **staffing target**. In this regard the senior executives of the pole criticised the way the DG had calculated the staffing targets:

What I would like is always to have the possibility of assigning staff on the basis of the treatment load and work more on an overall staffing and not staffing by service, because, quite simply, depending on whether you have 15 beds in neurosurgery or 15 beds in ophthalmology, the treatment load is not the same, you can't assign the same number of staff. Except that the people who work on the organisations or whatever in some fictitious way talk about the number of beds and don't include the treatment load. I hope we'll be able to do that. In what we're going to be given they don't take account of the treatment load (senior executive, pole B).

The directorate had indeed opted to apply a ratio of the number of carers per bed: "It's one nurse for 12 beds, whatever the service and the speciality" (senior executive, pole B) without taking account of the workload; and according to the health executives this would be very variable from one service to another depending on the specialism. One thus observes a divergence of objectives between the health executives and the care staff. The senior health executives are in charge of the pooling of nursing staff (qualified nurses and auxiliaries). They have the power to move and re-assign care staff from one service to another within the pole, generally with their consent: "When it is difficult for a carer to be on a certain post we senior executives have more autonomy, so we can move them within the pole", "I can move the carer, swap them around more easily" (senior executive, pole A). But this process is not always unanimously approved by the care staff. For example, to oppose a pooling decision taken in a neurology service, a whole team of nursing staff "declared themselves sick", which forced the closure of a unit that had just opened. The executive had had to pool teams who normally worked on quite different pathologies, which increased their workload according to the nurses, who opposed this decision. This situation shows the limits of a process: the staff are not all interchangeable. And while the objective of efficiency that lies behind this staffing target and the pooling scheme is clear for the functional directorates, it does not make sense for the nursing staff, whose priorities are the quality of care and the maintenance of decent working conditions.

Thus, in the current situation of the establishment, staff management is a complex process. Seeking to reduce the wage bill, the DG centralises decisions whereas the poles would like to



have more autonomy to run their services. The pole then has to reach a compromise with the realities on the ground to find the means to pursue its activity. However, staff management is not the only issue for the pole; another important issue is the management of the accommodation within the services and the pole.

Indeed, if there is one subject that is as prominent in the exchanges in the pole steering committee meetings as the staffing target, it is **accommodation**. In fact, the two go together. The staffing target set by the DG is defined by a ratio of the number of carers to beds. The staffing target sets this ratio at the legal minimum of one nurse for 12 patients. So there is wish to have units of 25 beds, operating with two FTE nurses by day, and one FTE at night. This trend towards the harmonisation of units is not anodyne but corresponds to the will of the directorate and represents, according to the actors, the critical size for optimising the use of resources. Thus the definition of the staffing target in relation to the accommodation has been decided by the DG, and it is up to the pole to apply this ratio. As regards accommodation, it is a question of defining the destination of the beds of the units, in terms of treatment. These beds are divided between treatment scheduled as conventional hospitalisation for several consecutive days, beds for outpatients (patients accommodated only for the day), those reserved for emergency patients and finally those for patients “housed” from other services short of beds. This distribution of beds is again the object of discussions between the pole and the DG which indicate a lack of convergence of interests. In this discussion, the DG imposes a number of choices on the pole, such as the development of outpatient handling of surgical activities. By reducing accommodation expenses and increasing the rotation of patients per bed, because they arrive in the morning and are discharged in the evening, outpatient surgery is financially more efficient. However, the consultants who worked on the CHU showed that the proportion of outpatients in this CHU is lower in many specialisms than in competing establishments. Another point of debate is the role of the beds reserved for emergency patients. The emergency wards need to be decongested by transferring the patients rapidly to the treatment services. The establishment loses activity if transfers are made to competing hospitals. The leader of pole A talks about an “emergencies psychosis”, which in his view leads to a reduction in the number of beds available for scheduled patients requiring more technically sophisticated treatment. He points out that the vocation of a CHU is to develop “cutting edge” medicine and research. These imposed decisions are resented by the pole leaders, who feel they are working against their convictions in the face of much supervision and control: “There is no power of decision in the pole, I’m just the scribe, sometimes I feel I

am working in a void” (leader of pole A). Here again one observes that the recentralisation that has taken place has left the pole leaders with few levers to pull, which they deplore. This is also the case for the management of patients “housed” for other services: “Until then, the system ran in a pyramid pattern. That’s to say that all the decisions went through the heads of services. That is no longer the case” (leader of pole C). This point again divides the doctors and the directorate, because the imperative to accept “housed” patients further reduces the beds available for scheduled patients. “Some medical decisions are taken without consultation with the doctors” (leader of pole B). On his own initiative, the leader of pole A carried out a survey on the proportion of “housed” patients in the services of his pole, to quantify the scale of the phenomenon and inform the directorate.

So there is an increased centralisation of decisions resulting from the DG’s fear of losing financial control. This centralisation hinders delegation and is in contradiction with the objectives of new hospital governance which precisely aimed to promote the delegation of management. This contradiction generates disillusionment and frustration among the medical and nursing teams regarding the poles. The pole trios regret that their decisions are severely constrained and sometimes rejected by the functional directorates. They have the impression that they are simply passing on the financial pressure exerted by the DG and the supervisory body on the medical teams: “I have the impression that they decentralise the decisions that the DG does not want to be responsible for, and then the pole is in the front line to receive complaints and handle the difficulties” (leader of pole B).

However, this uncertainty of preferences has to be nuanced. The actors do agree on some common objectives. They all share the notion of public service, and serving the public. Going further, some actors speak of an “ongoing cultural shift” (leader of pole A). As much among the administrators as the nursing staff and the doctors, it seems that an awareness has emerged in hospitals of the cost of treatment and the need to make savings. And it is this need for medico-economic efficiency in the pursuit of the quality of treatment that brings all the actors together. However, if for the moment all agree on this point, they are far from sharing the same vision of how it is to be achieved.

From these results it can be concluded that ultimately it is financial pressure that accentuates the uncertainty of preferences rather than the new governance itself.

### III.2. Unclear technology

As mentioned above, to reduce the deficit of the establishment, the DG has put into effect a policy of **reducing the wage bill** which concerns both the administrators and the medical and nursing staff. It is planned to replace only one administrator in five and to reduce the caring staff by about 20 persons per month. For each service a staffing target has been defined based on the number of beds. The senior health executives have thus been given the task of drawing up tables of the staffing of the pole so as to carry out a revision of the number of its agents to meet the targets set by the DG. This operation has been an opportunity to uncover anomalies in staff assignment: agents are notionally assigned to a given service when they have in fact been working for months, even years, in another service. These agents are called “ghosts” by the actors of pole A. Another example: many nursing staff who, for various reasons (illness, incapacity), have benefited from restrictions on their activity, are then assigned to administrative posts (secretariats, archives). But these agents are mostly still counted among the nursing staff. These are situations which previously had not seemed to perturb the activity, but they have become problematic at a time when a staffing target has to be reached. Again one has the impression that the management tools are not mastered by all the actors. When one adds to this the problem of absenteeism (17%) which weighs on the staff, the agents perceive a discrepancy between the staff counted by the information systems and the agents actually present in the services. The services are often understaffed in reality when the official staffing numbers show them as being overstaffed. A complete review of staffing was therefore needed, and the medical teams had to be given an explanation of the reasons for this discrepancy, which gave rise to much incomprehension in the HR directorate. It was the senior executives of the poles who had to take on this role of “translation”, in particular in the pole steering committees, not without difficulty.

There can no medical projects without staff and no medical projects with patients but without beds or places to put them. As has been seen, **accommodation** represents the size of a unit. A large proportion of the discussions and medical projects aim at acting on this accommodation, whether for the development of an activity, by increasing it, or when it is a question of the transfer of services. When this arises, the teams scrutinise the tables of treatment activity (number of stays, admissions, discharges, average length of stay, rate of occupation) to prove an increase in activity that would justify an increase in accommodation. Everything is then a question of square metres and of space to be recovered from the transfer of a neighbouring

service or gained from the construction of a new building. While in the everyday life of the poles the monitoring of activity through indicators and dashboards does not take place, medical projects around accommodation nonetheless mobilise the actors around these figures. Nonetheless, in meetings there are long discussions about the errors in the calculation of the figures in these dashboards, or long explanations so that everyone understands how the data are constructed. The intangibility of the provision of treatment associated with increasingly complex technologies (all the more so given that, for the empirical part, we are in a teaching hospital) produces a multitude of data, managed by a multitude of actors (administrative, nursing, clinical), which are not always coordinated. This complexity makes the evaluation of the results and monitoring of performances particularly difficult, and it is exactly these criteria that are referred to when unclear technology is discussed in work on organised anarchies. The impossibility of evaluating by results does indeed indicate the hard-to-measure character of the results produced.

Thus the lack of information with which to make decisions or to argue with the DG represents a further hindrance to delegation. The staffing data do not reflect the reality of where staff work. There are no data on bed management. Insofar as decisions have to be made by integrating information situated at several levels of the establishment, in the vertical plane for staff management (service, pole, geographical site, establishment) and in the horizontal plane for bed management (treatment routes), it is essential for decision-makers to have information from these different planes. For the moment it is often lacking.

A final hindrance is the lack of managerial competences in the poles. The doctor-pole leaders perform this role in addition to their medical activities and their responsibilities as heads of services. They devote limited time to management and have often had only short training. The administrative staff of the pole are engrossed in the operational tasks of the secretariat of the steering committee of the pole and management of the medical secretaries; they devote little time to processing and analysing management data.

I try to work on management tools periodically. I might devote eight hours' work in the month to them. Otherwise, that's not my daily activity. I'm not one of the management controllers. On a daily basis I have a lot of regular business to deal with, for example emails, request management, requests for intervention... And then I have a lot of secretarial management every day. Sometimes I spend the whole day in meetings. I also have to write reports for the regional health agency (administrative executive, pole A).

They manage all the medical secretariats, which takes up a lot of their time, but also they support the pole leader on a whole range of tasks. They really have multiple tasks. They are constantly engaged in sorting out multiple problems. They should have more time to give the pole leader a clearer view of all these indicators. They should have something of the profile of management controllers. Right now they are drowned in lots of tasks (delegate director, pole C).

Based on these results, it can be said that the complexity and multiplicity of the tools set up with the new governance accentuates the effect of unclear technology.

### **III.3 Fluid participation**

Regarding the fluid participation of the actors in the deliberative bodies, it is difficult to dissociate the practices on the basis of the types of management process. The practices observed derive more from the organisational structure and the functioning of these bodies, than from a question of staff or accommodation management. Hence this part presents the elements of response collectively, without distinguishing the processes, in contrast to the two previous parts.

While the actors of the poles agree that the pole is the right level to conduct staff management operations and that in particular it allows for a distribution of means by virtue of its sufficient critical size, they would like to have greater autonomy in managing their human and financial means. Because the actors cannot take part in all the deliberative assemblies, especially in a context of strong centralisation, in the remarks made in meetings one notes a great expectation of decentralisation of human resource management. The actors regret for example their lack of influence over recruitment; they must systematically resort to the HR directorate. This is a situation which, in an establishment of such a size and with an overall policy of staff reduction, entails long procedures that often take the form of *battles* for the senior health executives waiting for a response for their teams. One consequence is a sometimes chronic understaffing in the units. For example, les secretariats accumulate backlogs of typing and low rate of response to telephone calls.

Out of six secretaries I only now have four, and it is beginning to show. We are accumulating delays on typing correspondence, answering the telephone and receiving people. You get girls who have the medical secretary diploma and yet type rather slowly. The big point of delay is

in receiving people and answering the telephone. Lots of patients don't manage to get through to us. We have a response rate of 25 percent (administrative executive, pole C).

They have the feeling that they must *pester* the HR directorate to get answers.

If there is a long illness, or a pregnancy, I have no latitude to get a replacement. I have to make do with what I have. I have no delegation to decide on a recruitment. I have no scope for manoeuvre. Right now, when I have an unfilled post, I inform the director of patient care of the vacancy, and then I wait for Human Resources to make up its mind. Central HR decides. That greatly extends the recruitment lead time. It also restricts the choice of the person (senior executive, pole C).

In this multi-layered administrative structure, it is sometimes difficult for the actors to identify the right interlocutors to respond to their requests:

There's an incredible number of layers – the general directorate, the functional directorates, the site directorates, next the delegate directors and then the pole directors and then the service directors and then there are the UFs [functional units]. Layer on layer on layer. The life of the services is in the UFs (leader, pole C).

I have the impression that for things like this I'm all alone in my corner. Who do I have to go and see to put things right? I have the impression that I am a bit isolated. The poles have enabled us to meet people we would never have met otherwise. But there are areas where I don't know who to turn to (senior executive, pole C).

The multiplicity of meetings and the impossibility of being present at each of them make the situation complex, especially since participation in some meetings is not encouraging. Let us take the example related by the pole C team. They took part in a meeting with members of the functional directorate, on an important question regarding the proposed transfer of a service. It lasted half a day and led to a report written by a member of the functional directorate, whose conclusions regarding the project were different from what had been said by the pole members in the meeting. They felt they had not been at the same meeting. Such a situation accentuates the “feeling of working in a void” expressed by the leader of pole C. Thus the leaders of the three poles share the sense of a lack of levers to pull, a lack of operational means, and therefore of powerlessness in their position as pole leader, owing to the recentralisation. They would like some more direct link with the DG and the CME so as to better understand the strategic orientations of the establishment (leader of pole A). According

to the actors on the ground, such a link is lacking. It should go through the delegate director of the pole, who represents the DG on the steering committee. This job has evolved recently but it does not yet make it possible to create a two-way link between the pole and the DG. Initially it was that of Referring Director of the pole within the directorate. He thus represented the pole and reported its projects and problems to the members of the directorate. Now he has become a delegate director, in other words the opposite: he is the spokesman of the directorate and his role is to relay the messages and directives of the DG to the pole trio. This new function remains rather unclear, and differs from one director to another, as could be observed in the weekly steering committee meetings. For example, the delegate director of pole A, who had another function in the directorate requiring him to travel abroad frequently, was rarely present in the pole on a day-to-day basis. This situation was not appreciated by the pole team. He eventually left the position of delegate director and was replaced by another director who was more present. In pole B, the delegate director has had long experience as a hospital director and is therefore the guarantor of the procedures. The teams often turn to him to confirm the feasibility of an action. Finally, the director of pole C is also the director of the treatment branch (paediatrics) to which the pole belongs, which means he can support large scale projects together with the pole. However, the circulation of information is essentially top-down and the delegate director, who should have the role of translator, the interface between two bodies, struggles to transmit information upwards. He too encounters administrative inertia and the difficulty of finding the right person to speak to. So he is at once the translator of the DG towards the pole, and a screen for the pole vis-à-vis the DG.

Finally, each member of the hospital takes part, in a very random and fluid way, in decision-making. For example, in the case of the CHU observed, the list of the participants in the pole steering committees can vary greatly from one pole to another, one week to another, depending on the subjects discussed and each person's availability. A fluid presence of the actors is thus observed. This random participation reflects variable involvement in the business of the pole. Because it lacks a real delegation of management and budget, some actors (doctors, heads of services) who are already engaged in numerous activities do not entirely invest in the pole. Their involvement is intermittent, depending on the subjects. The effects of the creation of the pole seem limited at present for some heads of services: "The effect of the pole is that we are a little closer than before, but there is no room for manoeuvre" (head of service, pole B). This weak impact of the poles, and consequently on investment (incentive) does not encourage these actors to involve themselves at the expense of their other

activities of treatment, research and teaching. This fluctuating involvement, reflected in random participation in the deliberative assemblies, complicates decision-making and corresponds well to the criteria of an organised anarchy.

#### **IV. DISCUSSION AND CONCLUSION**

From observation of the decision-making processes regarding management of staff and accommodation, it was clear that for the moment the establishment has opted for strong centralisation. This was adopted to cope with the difficult financial situation, but has nonetheless been conducted in parallel with a new internal contractualisation aimed at making the medical teams feel responsible regarding the costs of treatment. This recentralisation of strategic decisions seems to complicate operational decision-making within the poles, since decisions are slow and are perceived as out of phase with the operational constraints experienced in the treatment services. The pole does indeed have to reckon with a set of external constraints, which are sometimes not understood. This “blind” centralisation induces a sense of isolation, lack of support and even abandonment among the leaders of the three poles. This is why the actors of the poles await a delegation to their pole of the management of certain activities, such as human resource management (replacements, training, assignments), and recurrent expenditure (medical devices, catering, etc.), and a better information system. Although the poles are granted a degree of independence, which is an opportunity to create a specific functioning and set up a pooling process, according to one of the pole leaders, the members of the pool steering committee want more scope for choice and more autonomy for the pole. According to the actors encountered, the pole should be able to organise itself as it wants, whereas now everything is imposed on it. The empirical research highlights the place of the decision-making processes at the heart of the problem of delegation.

On the basis of the empirical work it can be said that the hospital does indeed correspond to an organised anarchy, characterised by unclear objectives and technology, and a fluid participation by the actors. The hindrances that have been identified – strengthening of the centralisation of decision-making, a lack of information to make decisions, lack of managerial competences in the poles – are so many limits on the delegation of management to the poles. It is this lack of delegation that hinders the objective of the poles of bringing decisions closer to the point where they take effect, and which does not allow rational decision-making. The hospital remains therefore, despite the setting-up of a new governance, in a situation of



organised anarchy. At the present time, the pole presents itself more as a further source of complexity.

It is possible to bypass the pole. At present I think the pole is an extra layer which has little meaning and not much of a specific role. There have been some changes but all that would have happened without the poles. At present the creation of poles has brought nothing or only very marginally, and I couldn't even tell you what (leader, pole B).

In this context of organised anarchy, Cohen, March and Olsen (1972) consider the decision-making processes, which, in the reality that they observe, do not correspond to the theoretical conceptions drawn from the classic models. For the authors, the solutions brought to a problem do not always flow from a rational decision-making process. For them, the process is much more complex than it seems: decision-making processes are like garbage cans, into which problems and solutions are dumped as they are discovered. A decision then consists in fitting together pre-existing solutions and problems.

The works of the behavioural school make it possible to cast an interesting light on decision-making processes, which are at the heart of the delegation of management. The case study brings to light decisions imposed by the directorate general on the poles: one on the staffing target, the other on the size of the services in number of beds (accommodation). The poles are often ill-equipped for decision-making and do not have the tools, especially the dashboards, that would enable them to make a completely informed decision. They improvise with solutions drawn from their immediate environment: staff pooling when possible, patching and fixing between services or poles.

For the continuation of the thesis, I shall aim to understand how the decision-making process is structured. For the moment, the results give prominence to the viewpoint of the poles. For this reason, interviews will be conducted with other actors: purchasing officers, treatment directors, the HR directorate, site directors. The objective will now be to break down the process into historicised stages by meeting all the actors involved in a project. If it is identified that our object is an organised anarchy, does it necessarily correspond to the garbage-can model as presented by Cohen et al. (1972), or can the two notions be dissociated as Musselin (1997) suggests? According to her work, decision-making is more structured and regulated than Cohen et al. suggest. This is an idea shared by Friedberg (1997), for whom the organised anarchy model is “never reached or realised”. Musselin also states that an

organisation can meet the criteria defining an organised anarchy without the decision-making processes necessarily corresponding to the garbage-can model. She therefore suggests that there could be a dissociation between organised anarchy and garbage-can decision-making, which might not be equivalent notions. In her view there is therefore still much to be learned about decision-making in organised anarchies. The continuation of my research will make it possible to enrich the following debate: does the organised anarchy model come hand-in-hand with a garbage-can type of decision-making? The question of the operationalisation of the chosen field, to take my conclusions further, remains open for the moment. This complex theoretical model has evolved since its creation. It will now be necessary to decide from what angle it will be used to extract the greatest pertinence from my data, by constructing an effective model.

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