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The impact of central government steering and local network dynamics on the performance of mandated service delivery networks.
The case of the Primary Health Care networks in Flanders[1]

EGPA 2013, 11 – 13 September – Edinburgh, Scotland

Permanent Study Group XIX: Public network policy and management

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Abstract

This paper focuses on the impact of central – local relations on the performance of local service delivery networks set up by central government. Analyzing network literature leaves us with some questions about the impact of coordination strategies of central government as a possible determinant of network-level effectiveness for this type of network and the possible interaction between central government coordination (as part of the network context) and internal network dynamics and the combined effects hereof on the effectiveness of mandated service delivery networks in particular. Our analysis shows that both levels are important to explain the outcomes of the Primary Health Care networks in Flanders. Our study also leads to some important observations about the meaning of 'central government coordination' in this context.

[1] This text is based on research conducted within the frame of the Policy Research Centre on Governmental Organization - Decisive Governance (SBOV III - 2012-2015), funded by the Flemish government. The views expressed herein are those of the author(s) and not those of the Flemish government.

1. Problem statement

During the last decades, new governance arrangements like networks and partnerships became increasingly popular in various policy domains (Teisman and Klijn, 2002). Main driver of the public sector to create and engage in such arrangements is to maintain and create government capacity *"by bringing together coalition partners with appropriate resources, non-governmental as well as governmental"* (Stone 1993:1, cited in Agranoff and McGuire 2003:25). One such type of governance arrangement is a mandated service delivery network on the local level, installed by central government to achieve efficient and effective service delivery for citizens (Agranoff and McGuire 2001; O'Toole 1997).

With the increased use of such arrangements by governments around the globe, the question of their performance(s) also became increasingly popular to study. Provan and Milward (1995) pioneered with a preliminary model of network effectiveness, focusing on the impact of network structure and network context determinants on the performance of mental care networks in the U.S. This model was later updated (Provan and Milward, 2001) and has been expanded by Turrini et.al. (2010), based on an extensive literature review. The integrated framework of network effectiveness by Turrini et.al. lists a range of structural, functional and contextual determinants. Some of those determinants are explicitly focused on external relations ('external control'), while others appear internal but can also be affected or arranged by external actors like central government (e.g. 'formalization' or 'accountability'). We are interested in both sets, because in the Flemish context under study in this paper, the Flemish government has a reputation for creating a whole set of frameworks that create local networks in different policy domains.

Provan and Milward (1995) found that direct mechanisms of control lead to better performance. In a more moderate vein, Scharpf (1997) defined 'the shadow of hierarchy' – essentially the threat of government to intervene in the network - to make networks work and perform. Yet, in practice, partnership and network arrangements are commonly considered as requiring sufficiently high levels of autonomy to deliver local services, fitting the local context (Struyven and Van Hemel, 2009). More importantly, while the work of Provan and Milward shows (among other things) that external control matters, the literature is relatively poor in showing how it matters exactly, and how different frameworks, including

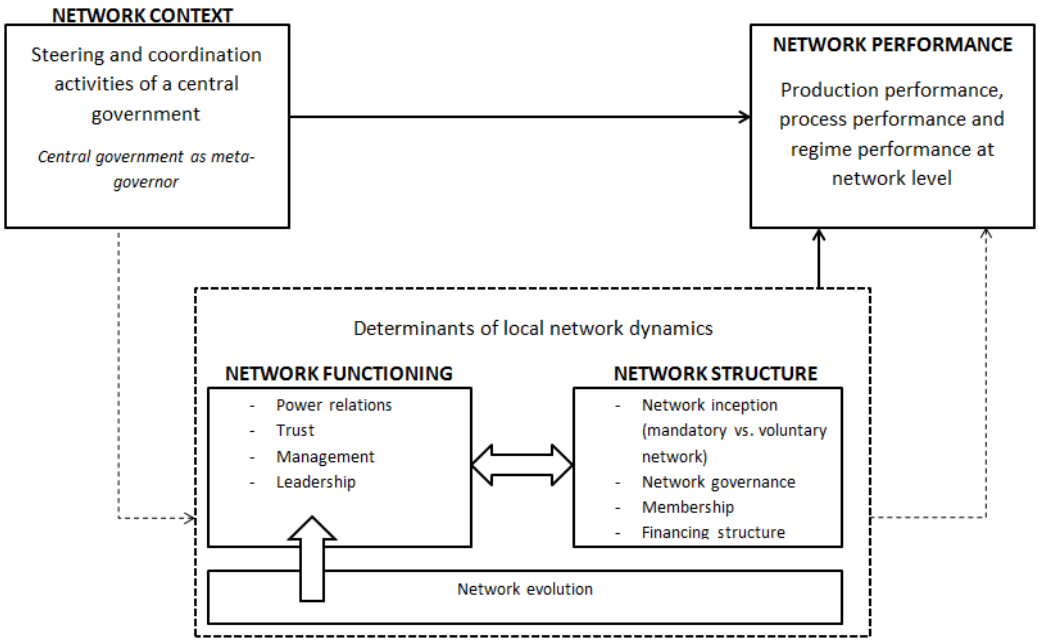
possible control strategies, are used by central government, under which conditions, and with what effect. We need to learn more about the interaction between direct and indirect effects of actions of central government (clustered in one or more roles) and the local network dynamics, and the combined effects hereof on the effectiveness of mandated service delivery networks at the local level. Hence, we address the following research questions in this paper: 1) How can we measure the performance of mandated service delivery networks in Flanders; 2) What are the roles of a central government in this type of network; 3) What is the impact of those steering and coordination activities in the central – local relations on the performance of those networks; 4) What is the relation between metagovernance roles used by central government and local network dynamics and what are the combined effects hereof on network-level effectiveness?

The questions will be answered using a single case, analyzing the case of local primary health care networks in Flanders ('Samenwerkingsinitiatieven Eerstelijnsgezondheidszorg', SEL). Primary health care networks are an example of a mandated service delivery network, set up by the Flemish Government to improve the quality of collaboration in the field of primary health care services.

2. Conceptual framework

In order to answer our research questions, we developed a conceptual framework consisting of three main building blocks: network context, network dynamics, and network performance. The framework is presented in the figure below and each block will be discussed in more detail in the next sections. The framework is used in a larger research project (see below). In this paper, we only report one sub-case.

Figure 1 – Framework of network performance in central – local relations



Network context or the steering and coordination activities of a central government

The network context, in this research, equals primarily the steering and coordination strategies of a central government, because these strategies make up (part of) the context for the local networks, affecting (in part) its dynamics and performance. Imposing mandated networks implies automatically a certain classical government steering activity, dominated by regulation and systems of control. But those activities and control systems cover a range of different instruments and even then it remains to be researched how those instruments are applied in the daily interactions with the local networks.

Besides the 'traditional' government steering, the network literature provides the concept of meta-governance to define different roles that governments can play vis-à-vis networks (Jessop 2003; Kooiman 1993; Sørensen and Torfing 2009). Meta-governance is linked to the fact that traditional ways of steering society (by means of direct regulation and control) do not match with the so called self-organizing character of public networks. Even in the context of mandated networks, imposed due to a policy dictate, the installing authority could and (according to the network scholars), also should take a step back of hierarchical steering mechanisms and rely on more subtle forms of governance permitting government to let go without losing control (see also Kelly 2006).

Sørensen and Torfing (2009) identify four distinct meta-governance roles that state actors can adopt in policy networks. The meta-governance tools range from more distant hands-off tools (design and framing) towards hands-on approaches (management and participation) in which there is a close interaction between public actors and the network members. The first tool in the meta-governance tool-box is hands-off *network design.* Following the authors, this role aims to "*influence the scope, character, composition and institutional procedures of the network"* (p. 246). In the network design role, government seeks to create social and political meaning and identity for the network. The second role is *network framing*. Hereby government sets out the political goals, financial conditions and legal basis for the network. In practice, *network framing* can include a range of different activities. *Network management* focuses on facilitating and guiding interactions in the network. In this role governmental actors try for example to settle conflicts or reduce tensions amongst network members. In the fourth role, *network participation*, the public metagovernor becomes one of the members of the network. In network participation, state actors do not take on a hierarchical position. Sørensen and Torfing state that public metagovernors should best adopt a mix of hands-off and hands-on meta-governance tools.

Although one might argue that the concept of meta-governance does not fit mandated service delivery networks because of their imposed character, we need research to come to this conclusion because only the reconstruction of the daily implementation can reveal the real nature of formal instruments. That is also the case for the meta – governance set: it is possible that the implementation of so – called meta – governance style instruments, reveals government – like type of steering. It is worthwhile to see to what extent those government and meta – governance roles can be linked to actual coordination strategies (Temmerman et.al. 2013). We use the well-known trinity hierarchy – market – network to address the actions of the Flemish government in its role as network designer and network framer. The three mechanisms and associated instruments are all part of the everlasting challenge for central governments to achieve coordination of actors, resources and activities to achieve public goals (Bouckaert et al. 2010).

Table 1: The features of hierarchies, markets and networks

	Hierarchy	**Market**	**Network**
Base of interaction	Authority and	Exchange and	Cooperation and

	dominance	competition	solidarity
Purpose	Consciously designed and controlled goals	Spontaneously created results	Consciously designed purposes or spontaneously created results
Guidance, control and evaluation	Top down norms and standards, routines, supervision, inspection, intervention	Supply and demand, price mechanism, self-interest, profit and losses as evaluation, courts, invisible hand	Shared values, common problem analyses, consensus, loyalty, reciprocity, trust, informal evaluation – reputation
Role of government	Top-down rule-maker and steering, dependent actors are controlled by rules	Creator and guardian of markets, purchaser of goods, actors are independent	Network enabler, network manager and network participant
Resources needed	Authority Power	Bargaining Information and Power	Mutual Cooptation Trust
Theoretical basis	Weberian bureaucracy	Neo-institutional economics	Network theory

(from Bouckaert, Peters & Verhoest 2010; based on Thompson et al. 1991, O'Toole 1997, Kaufmann et al. 1986, Peters 2003)

It is clear that the impact of central government on local networks can vary, due to those sets of coordination instruments set up by central government. One extreme on the continuum are mandated networks that are nothing more than 'executing shops' with little or no autonomy, in which external partners are more or less forced by central government by law or through subsidies to be part (hierarchical coordination). Some would not even call them networks, but multi-actor agents. The other extreme on the continuum are voluntary networks that experience high levels of autonomy, and which central government does not try to control or rather stimulates and facilitates (more market or network like). The latter 'group' are the networks that most clearly fit the general network definition of multiple autonomous actors that are interdependent and engage in resources exchange to acquire their own goals, but contribute to a 'higher' network or collaborative goal as well (Koppenjan and Klijn, 2004; Huxham and Vangen, 2005). The challenge for researchers and government is then to know for which goals a very strong control or a more 'laissez faire' strategy is optimal/most likely to lead to success.

It is important to make a distinction between the nature of the formal coordination mechanisms and instruments on the one hand, and their actual use on the other. Verhoest et al. (2010) for instance show how the governance by the public actors in public-private partnerships in Flanders can appear to be more hierarchic, market, or network like from the outside, while the actual control mix is quite different from the inside.

Network dynamics or the interplay between network functioning and network structure

On the one hand, the roles and coordination strategies of central government have an impact on the dynamics at the local network level. On the other hand, networks themselves will have a dynamic of their own that cannot be fully explained by or attributed to that strategy. According to Bryson and Crosby (2006), local network dynamic is the result of the interplay between network structure and network functioning.

The topic of *network structure* as a determinant of network effectiveness receives of lot of attention in existing literature (Provan and Milward 1995 and 2001). However, there is a lot of variation in the criteria scholars use to measure network structure. In the context of this study we focus on four criteria of network structure. The first component is the origin of the network and how they are conceived (mandated and top-down or voluntary from the bottom-up (Kenis and Provan, 2009). The second component is network governance at the level of the network itself. Provan and Kenis (2007) distinguish between three forms of network governance (participant-governed network, lead organization-governed networks and network administrative organization). In participant governed networks, the coordination role is conducted by the members themselves. The authors state that this form is mostly suited for small networks in which direct contacts are relatively easy to organize. The shared authority form switches to a lead-agency network when one of the members takes a lead position in the network. The third governance form is the NAO, where *"a separate administrative entity is set up specifically to govern the network and its activities"* (Provan and Kenis, 2007:236). The other criteria under attention are membership (composition and size) and financial structure (i.e. the funding of the network).

With regard to the topic of *network functioning*, we focus on four criteria. The first element is the division of power. The study of power is a key issue in networks since power is more often than not unequally distributed amongst members (Agranoff and McGuire 1999). We

make a distinction between sources of power and the use of power. Following resource dependency theory, we regard having and controlling resources and their provision as sources of power. Koppenjan and Klijn (2004) define five types of resources in policy networks: financial capacities, production capacities, competences, knowledge and legitimacy. Huxham and Vangen (2006) distinguish between three types of use of power: power over, power for and power to. Power to reflects a view of working in networks, whereby actors use their power resources for the purpose of collaborative advantage and not at the expense of others (Voets, 2008). The second component of network functioning is the level of trust among network participants. In fact, the level of trust can be both a performance measure as a determinant of network success. In this study, we use the concept of trust as a condition of network functioning. Nooteboom (1996) distinguishes between competence trust and behavioral trust. Competence trust is based on the expectation that all actors are competent in light of the objectives the network should achieve. Behavioral trust is of a more relational nature and rests on the expectation that all actors will act faire and predictable (Van Gestel et.al. 2009).

In recent years, the study of network management as a predictor of network success has received considerable attention (Kickert et.al. 1997; Agranoff and McGuire 1999 en 2001; Koppenjan et.al. 1993; Milward and Provan 2006; Klijn 2005; Klijn and Koppenjan 2004; Klijn et.al. 2010; Meier and O'Toole 2001). A well-known and often used classification of network management activities is that of Agranoff and McGuire (2001), who distinguish four sets: activating, framing, mobilizing and synthesizing. Activation activities focus on selecting the right participants and resources for the network. In the context of framing, network managers influence the perceptions, norms and values of the network. Mobilizing behavior is aimed at building commitment and support for the network. The last role is synthesizing. In general, the aim of synthesizing is to *"lower the costs of interaction, which can be substantial in network settings"* (Agranoff and McGuire, 2001: 301). Turrini et.al. (2010) also point to the importance of traditional managerial work, stating that a network manager is also responsible for the correct implementation of administrative systems and processes. The fourth component under study is leadership. In networks, both formal and informal leadership roles are important (Agranoff and McGuire, 2003). Some important capacities of a good leader include authority, vision, long-term commitment, relational skills and political

skills (Bryson, Crosby and Stone 2006). In this study, we focus both on the position of the formally appointed network manager and network leader (i.e. the president, director, …).

Network performance

We assume that central governments' coordination strategies and the local network dynamics have an impact on network performance. Analyzing performance of networks is however not a simple task, because different stakeholders of the network can have different expectations about the network benefits. Central government itself should have some ambitions regarding its performance, since central government took the initiative to install those mandated networks. But maybe other arguments than performance inspired central government initiative? And it certainly is possible that local networks have a different view on the effectiveness of their network. So the key question in network performance is effectiveness from whom? (Provan and Milward 1995; Milward and Provan 2001). To answer this, we need to identify performance criteria at three levels of analysis: community, network and organization (Milward and Provan, 2001). In the context of service delivery networks, a fourth level is that of the individual customer, client, citizen or company. In this paper we focus on the second level, namely the performance of networks at network level or whole-network effectiveness (Provan et.al. 2007; Provan and Lemaire 2012).

The question then is what relevant performance measures or criteria might be. Hard performance measures focus on content outcomes or 'product performance' (Voets et al. 2008). In service delivery networks these are, for example, the number of services provided or the number of clients reached. Soft performance measures focus on process-oriented values, like the quality of relations between actors. They are mostly measured through the perceptions of participants (Head, 2008). As service delivery networks are created to provide their services, but since the relationships between network members are also important for successful service delivery, we consider both hard and soft performance measures in this study (Caplan en Jones 2002; Sørensen en Torfing 2009; Mandell et.al. 1994; Mandell and Keast 2008). In this paper, we focus on three common studied process outcomes. The first process value is the development of a shared vision and language amongst the network members (Mandell and Keast, 2008). The second criteria is internal legitimacy. Following Human and Provan (2000), internal legitimacy refers to the degree of network commitment

or the level of support of the members for the network goals. Finally, we consider the number and strength of long-term relationships that are built in the network (Kenis and Provan, 2008).

3. Methodology and case description

Methodology

The research questions dealt with in this paper are part of a wider research project analyzing the impact of central – local relations on the performance of mandated service delivery networks. The research project follows a multiple, comparative case study design (Yin, 1994), consisting of three cases (in three different policy domains to control for sector-specific features), and three embedded cases in each case to control for local context factors and specific network dynamics. Each network in each policy domain under study (health care, social economy and water policy) shows a different mix of control strategies by the Flemish government. In this paper we present the results of the first subcase in the case of primary health care networks, namely the network in the region of Ghent (being the second biggest city of Flanders -230.000 inhabitants - and the network having a regional range of 900.000 inhabitants).

Data are obtained using a mixed method approach. In a first step we conducted a comprehensive analysis of written material like policy documents, evaluation reports, meeting reports, internal notes, etc. Secondly, in this case, we conducted nine semi-structured interviews with partners of the network.[2] Respondents were contacted and selected using strategic sampling. Network members represent different disciplines, different professional positions and different positions in the network (core vs. periphery). As such, we guarantee a representative sample of perceptions and opinions. In addition to the interviews respondents were asked to fill in a survey on a 5 point Likert scale.[3] The aim of the questionnaire is to standardize perceptions about the steering and coordination activities of the Flemish government. Also, we conducted two interviews with civil servants of the Agency of Healthcare. All interviews were recorded and transcribed. Afterwards, data has been coded using Nvivo software (Miles and Huberman, 1994).

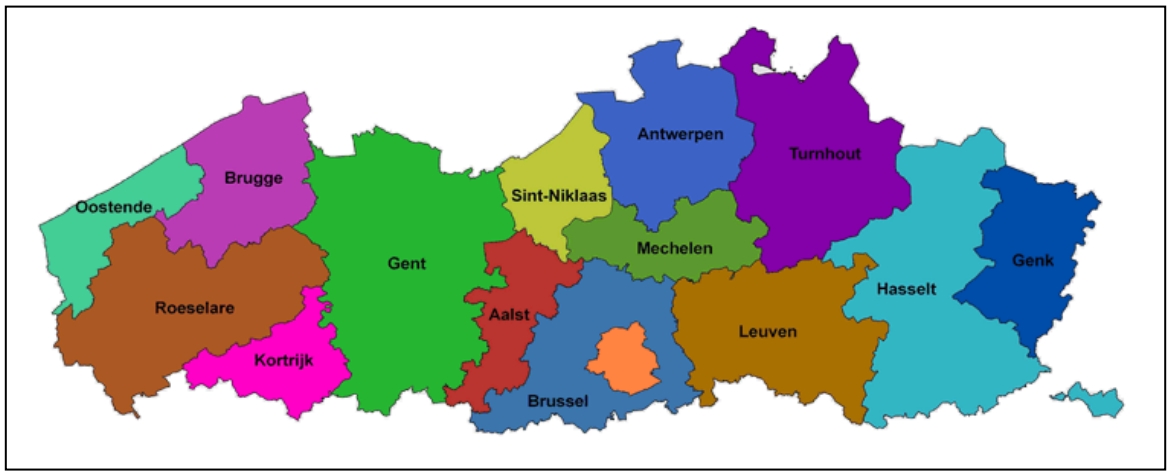
[2] See annex 1 for an overview of the respondents
[3] See annex 2

Case description

The empirical setting of our study are the primary health care networks ('SEL') in Flanders. Since 2010, 15 SEL are established in the Flemish region of Belgium. They are the successor of the former home care networks ('Samenwerkingsinitiatieven inzake Thuiszorg' 'OVOSIT') so they are not entirely new and perhaps this path dependency has an impact on the new structure and functioning. In this paper we conduct a single case study of one primary health care network in the region of Ghent ('SEL Gent')

According to the Primary Health Care Decree (2004), a SEL is 'a partnership acknowledged by the Flemish government and composed of representatives of professional care tenders and possibly also of representatives of care givers and care users and/or volunteers, aimed at the optimization of care in a demarcated geographical area' (Art. 2). For this end, SEL's need to implement 12 concrete tasks (Art. 10). The working area of the partnership needs to match the welfare and health regions, which are administrative areas used for welfare planning demarcated in the Decree on Healthcare Regions of 2003. Map 1 gives an overview of the SEL regions in Flanders.

Map 1 – Health care regions in Flanders



4. Research findings

Network structure of SEL in general and of SEL Ghent

In the decree, the Flemish government sets out some rules regarding the structure of the network, discussed here following the criteria of Kenis and Provan. First of all, the SEL's are

mandated by a top-down decision of the Flemish government. Secondly, each network needs to be a nonprofit organization ('VZW'). In Belgium, this type of association has an own legal status. The organization is constituted by three separate board structures with representatives of the network members. The board structures are authorized to take decisions and to define the guiding lines for the functioning of the partnership. As such, the governance structure of the SEL is of a NAO type. Thirdly, the decree identifies seven mandatory network partners: health insurance organizations, general practitioners, home assistance services, local service centres, local social offices, retirement homes and nurses/midwifes. Legislation also states that a general practitioner needs to be chosen as president or vice-president of the network, because this person is regarded as a key figure in the delivery of primary health care. The Primary Health Care networks receive public funding from the Flemish government. Annually, the Flemish government donates 60.000 euro, increased with 0.20 euro per inhabitant.[4] To get this funding, SEL's have to make an annual budget that is controlled by the Agency of Healthcare. Afterwards, the actual achievements need to be accounted for in an annual report. The partners do not bring in own financial resources. At first sight, the network structure of a SEL is subject of a hierarchical coordination strategy, since the local networks have no formal autonomy to decide on their creation, composition, governance structure, and financing.

With more than 900.000 inhabitants in the area, SEL Ghent is the second biggest SEL in Flanders. SEL Ghent is a split off of the previous home care network ('OVOSIT') that was active in the whole province of East-Flanders. However, the hierarchical decision for the transition from SIT to SEL has activated some tensions in this region. This was mainly due to the fact that some local partners feared the loss of the local embeddedness in the new structure, as OVOSIT functioned as an umbrella organization that covered 26 local SIT partnerships. The local partnerships were only populated by care workers active in the field, whereas the board structures of OVOSIT were composed out of executives and managers.

The Primary Health Care decree defines the possibility for the SEL to split up their working area in smaller areas "*if this seems necessary to optimize the quality of health care"* (Art. 13). SEL Ghent used this opportunity and is internally decentralized in five units. However, this

[4] The SEL also receive allowance from the federal government for the administrative support of home care (Geïntegreerde dienst voor Thuiszorg, 'GDT'). This is however a small part of the annual budget and is not the focus of our study.

decision is merely the outcome of a compromise between the partners in which the Flemish government did not intervene. Some local partners were not very positive about the transition from local SIT units to five decentralized SEL units in the region. *"One has destroyed some local spontaneous partnerships there"* (respondent 8). A general practitioner states: *"Even the decentralized SEL units are too big. I do not have affinity with the head nurse of a home care organization from the neighboring community because she does not share the same patients as I do. So it has become too big"* (respondent 6). The hierarchical intervention of the Flemish government to change the network structure and to establish it on a larger scale, clearly affected some local dynamics in the network in a negative way.

The decentralized SEL units join a mix of field workers and executives from organizations. At central level, SEL Ghent is directed by a General Assembly, a Board of Directors and a Management Board. In the board structures, all partners are – at least on paper - equally represented. The mandatory partners of SEL Ghent also made the decision to invite five additional partners. The Board of Directors is authorized to take the strategic decisions, whereas the Management Board is responsible for the daily operation of the partnership. The General Assembly gathers twice a year and approves the regulations of the organization, the composition of the board structures, the annual budget and annual report, … The president of SEL Ghent is a general practitioner. The network counts 2 network coordinators (1,5 FTE) and 1 management assistant. The staff is paid with SEL resources.

Network context: steering and coordination activities of central government

The position of central government is analyzed using the toolbox of meta-governance (Sørensen and Torfing, 2009). The authors distinguish between hands-off and hands-on roles. In the context of the primary health care networks, the Flemish government does not act as a manager in the network nor is it an active partner. As such, the central level does coordinate the network from a distance, in a hands-off manner and mainly by designing and framing. But how does the central government coordinates and what are the effects of the mix of possible coordination strategies (hierarchy, market and networking)?

As explained before, The Primary Health Care Decree (2004) and the Administrative order (2008) set out a number of rules regarding the network structure. Some of those regulations are part of a strict hierarchical coordination strategy (for example the VZW structure, the

NAO model, the number of mandated partners, the working area of the SEL, …). On the other hand, the policy makers leave some room for the SEL to make own choices about their internal organization (i.e. more network like). For example, the Flemish government does not determine the division of mandates in the board structures. Also, it leaves the question open whether a general practitioner will be chosen as president or vice-president. A civil servant states: *"And then you see that some networks do not have a general practitioner as president but as vice-president. That tells you something about the internal dynamics of the network"*. Thirdly, the SEL are free to allocate the financial resources to the different tasks. Finally, the partners are free to decide if they want to set up local units or not.

Secondly, the Flemish government takes up a role as framing entity. The objectives and tasks of the SEL express the vision of the Flemish government about the position of the SEL in the field. As such, the policy maker wants the SEL to be a point of mutual interest in the region. Also, the SEL needs to activate the cooperation between professional care tenders and stimulate the coordination of multidisciplinary consultation in home care (Primary Health Care Decree, Art. 9). However, the respondents state that the Flemish government lacks vision. This is for instance reflected in the tasks of the SEL. *"In fact this is a ridiculous way of spending public resources. You get an amount of money and deal with it. There's not much vision behind that. The SEL have a number of tasks, receive money to do this and each SEL implements the tasks in a different way"* (respondent 8). Another respondent states: *"I sometimes have the feeling that the Flemish government passes the responsibility to the field with the so-called reason we want to give them a say. But that's not correct in my opinion"* (respondent 3).

The Agency of Welfare and Health is responsible for the external audit of the network (Administrative Order, 2008: Art. 30). For instance, the SEL are required to make an annual budget. The Agency checks the allocation of the financial means over the different tasks. This could be a straight hierarchical way of intervening in the network. At the local level, this is merely felt as a technical type of control. At the end of each year, the SEL present a report in which is described how the 12 tasks are implemented. However, the reports are mainly of a quantitative nature. Interviewees state that this type of inspection does not cover the real functioning of the SEL. One respondent states: *"But the reports will be positive because it is really easy to write a lot of good-looking nonsense and repeat this every year."* In the

questionnaire, 75% of the respondents does agree that the evaluation of the annual report is only a formality.

Impact of central coordination on local network dynamics

The first component of network functioning is the division and use of power amongst the network members. The analysis shows great differences in the way power is distributed in SEL Ghent. It is clear that the health insurance organizations and the related services (i.e. home help/care services) possess most resources. *"If you ask me who has the power I say the big organizations. If you ask me for a reason, I say this is because they are way better organized than we are"* (respondent 8). More specifically, respondents refer to the power of the organizations linked to the Christian grouping or pillar.[5] First of all, these organizations have a lot of internal expertise, knowledge and capacity (both financially and in terms of work force). In Flanders, the delivery of home care has always been a fundamental part of the work of these organizations. Also today, they are still the biggest partner in the organization of MDO. Partners state that the field workers do a good job and some are glad that the health insurance organizations accomplish this task. However, the fact that the SEL are free to determine the compensations that are given to participants of MDO has led to some major discussions in the board structures. *"And then the power games begin of partners who claim a certain reward for participation in those consultations"* (respondent 10).

Externally, the health insurance organizations are also well organized. They are represented in a lot of board structures and have a lot of contacts, also at the political level. *"You can try to ignore them but they are everywhere. They have staff members at all the right positions"* (respondent 2). They use these channels to defend their interests. *"They have a lot of money, a lot of influence and a lot of expertise. They can go to the minister and argument why they need money for this of that. The Agency has also expertise, but not so much as they have"* (respondent 2). Respondents (except those of the powerful organizations) criticize their dominant attitude in the board structures of SEL Ghent. For instance, they claim the role of MDO-coordinator to get the extra subsidies attached to it. This is confirmed by a

[5] Traditionally, health care in Flanders is organized by plural ideological groupings or so-called pillars (divided in the Christian, the liberal and the socialistic grouping), whereby the Christian grouping is the biggest.

member of a home help service. *"It gives extra opportunities for our organization. Our funding [from the Flemish government] does not fully cover our expenses. That's why we search for additional financial resources so we can work properly"* (respondent 5).

The second criterion is trust. Competence trust refers to the relevance of the partners in the context of the network goals. In general, respondents judge the presence of the other disciplines as useful. Behavioral trust is measured by perceptions of fairness and goodwill. We make a distinction between the level of behavioral trust in the decentralized SEL units and in the board structures of the SEL. In the decentralized units the field workers do not see each other as concurrent but as colleagues, all going for the same goal. This is however not the case in the board structures. Some respondents state there is mistrust, others choose their wording more carefully not mentioning the word 'distrust' but noticing an 'attentive and alert position' amongst the partners.

With regard to the topic of network management we analyzed the activities of the network coordinator. In SEL Ghent, the coordinator is more an administrator than a network manager. Amongst other things, his tasks include the registration of activities, sending invitations for meetings, taking notes during meetings, making reports, .. Some respondents support the fact that the coordinator does not take up more process oriented activities as included in the four management roles of Agranoff and McGuire. *"Of course, the more he or she gets to know this matter, the more likely it is that he or she will develop a vision of his or her own. And that vision is then also brought in during meetings, while I think the following: this is not your place or mandate,"* (respondent 3). Other respondents however welcome a more proactive attitude of the coordinator. *"It really is the coordinator that needs to put things in motion and help to lead and monitor, to give some direction."* (respondent 7). However, respondent 1 and 2 explain that the coordinator gets strict orders from the Management Board, limiting the possibilities to take own initiative . Respondent 2 states: *"From the moment he takes own initiative he is impeded by the Management Board. By some persons of the Management Board."* Following the coordinator, some partners are very eager to keep things the way they are. Especially, those who do not want to shift the balances in the expenses. Amore active attitude from the coordinator leading to new initiatives would also require money for them. Since the annual subsidies are more or less stable, this means that existing expenditure items would be economized or redistributed -

there would be less money for the support of MDO (49% of the annual budget). Since the health insurance organizations get the bulk of this money, they are the partners who block an independent position from the coordinator who might develop new initiatives.

The last component is leadership. Art. 8 of the Administrative Order requires a general practitioner to be chosen as president or vice-president of the network. In general, partners from SEL Ghent are convinced about the added value of this directive, because a general practitioner is seen as a key figure in situations of home care. One of the important roles of the president of SEL Ghent is to seek coherence between the partners and trying to bridge the different opinions. Respondents also state that the president of SEL Ghent has a clear vision and that he has a lot of commitment for the network goals. However, he lacks authority to make decisions that matter to keep the network going. The president explains: *"I'm always rebuffed by the major organizations. Usually, they already block me in the executive committee, so that my ideas not even get on the agenda of the board meetings. As a chairperson, for certain matters, I am able to point to the fact that the network has certain legal responsibilities. But for now, I can only point to the vision and state that we have developed that together."*

Performance of SEL Ghent at network level

A SEL needs to aim for the optimization of primary health care in a specific region through the implementation of 12 concrete tasks. The intensity and work load of the tasks ranges from giving advice and organizing multidisciplinary schooling to give administrative support for home care and closing partnership agreements. [6] The latter are intended to facilitate the transition from home care to residential care and vice versa.

The annual reports of SEL Ghent (2010 – 2012) show that not all tasks are equally implemented in this network. Respondents indicate several explanations. A first explanation mentioned by the network coordinator is the lack of budget and work force. *"If you do new things you have to do it next to the things you already do so you cut yourselves in the fingers because as I already stated we have a lack of work force so that we cannot give full effort for all tasks"* (respondent 2). In general, this quote is supported by the other respondents. One of the statements in the survey is the following: *The Flemish government gives my SEL*

[6] See annex 2 for a full overview

adequate funding to accomplish its mandatory tasks. 7 out of 9 respondents does not agree with this statement. One respondent has no opinion. Another statement measures if the SEL has enough staff to fulfill its tasks. Here the opinions are divided. 50% agrees and another 50% does not agree. One respondent has no opinion

Secondly, the board of directors decided to give only little attention to task 1 (provide an electronic overview of al care takers in the region) and task 5 (stimulating the implementation of e-health). The overall statement of the partners is that those tasks need to be taken up at central governmental level. Thirdly, some tasks formulated are so vague in wording that none of the partners really knows what they actually mean. Subsequently, the added value of these tasks remains unclear. This is for example the case for task 4 ('supporting multidisciplinary care paths') and 7 ('monitoring procedures for the evaluation of the capacity of self-care and the qualitative elaboration of care plans'). As such, only little attention is given to these assignments.

In SEL Ghent, most effort is put in tasks 9 – 11: the administrative registration and control of the organization of multidisciplinary consultations in specific home care situations (multidisciplinair overleg, 'MDO'). In an MDO, care workers from different disciplines (general practitioner, nurse, home help services, …) need to synchronize their actions around the aid of one patient. The administrative support of MDO is of particular interest for the organized partners (i.e. health care insurance organizations and home care organizations) who are the main organizers of MDO. In 2012, 49 % of the annual budget was spent to a total of 463 MDO's. For each MDO, a compensation of 200 EUR is donated to the organization who delivers the coordinator. In 2012, 51,4 % of those meetings were organized by organizations linked to the Christian health insurance organization (Annual report SEL Ghent, 2012). The other share is reserved for staffing costs.

Analysis shows that the coordination of the mandatory tasks considered a hierarchical coordination strategy at first sight, is in fact more of a network based nature. The SEL have (or take?) the autonomy to give more attention to certain tasks, based on local dynamics. Besides the mandatory tasks, a SEL has the possibility to start up local projects. In the case of SEL Ghent, the competence to take initiative has been given to the local SEL units. However, the Board of Directors needs to give its permission to start up a project. If so, the

decentralized unit receives financial means from the central SEL level to implement the project. Respondents from the local SEL units criticize this procedure for being too strict. In the SIT period, local units had full autonomy to start up projects and implement them with own financial means. Now, local members feel a dominant attitude of the SEL board. This is the reason that local units take very little initiative (in general limited to one or two proposals a year).

A more fundamental reason for the modest number of content or substantive outcomes provided by this network is the lack of process oriented values. A first process value is the development of a shared vision. Already in 2010, SEL Ghent formulated a vision statement that is supported by the partners. However, the formulation of this text was a real balancing act. *"And then one person stumbles across one word that has as specific meaning in their context and then they search for another word. Finally, the mission and vision are formulated in such general terms that they have no power"* (respondent 3). The interviews made clear that also today the different disciplines do not speak the same language and do not share the same vision about the way primary care should be delivered. *"There are opposing visions in a lot of matters"* (respondent 5). The question is then if partners are willing to exceed their own vision for the benefit of the network as a whole. The president made clear that this is not the case. *"I wrote as a title 'vision of the network'. The members of the Management Board have ripped the text immediately and said: 'this is not true. It is a network composed out of different organizations and some organizations confirm that this could be a vision.' I think this is a great example of the fact that we do not have a real network here. The organizations 's interest will always come first."* In the questionnaire, 85% of the respondents indicate that the functioning of their SEL is hindered by opposing visions and concerns.

The second criteria used to analyze the process values of this network is internal legitimacy. Internal legitimacy refers to the degree of network commitment. We make network commitment tangible by examining the presence of the partners in the board meetings. Usually, the representation in the Board of Directors is rather low. *"It is always a struggle to find enough people to vote. It is always counting mandates, recruiting representatives so there can be a legal vote"* (respondent 7). However, we find a clear difference between the presence of independent care takers on the one hand (for example general practitioners and

independent nurses) and representatives of organizations at the other. One representative of a home care organization states: *"It is our job, we get paid for it. But I can perfectly imagine that it is a 'far from my bed situation' for self-employed persons"* (respondent 7). A respondent from a local social office notices: *"Of course, the big organizations drive their representatives to go to the meetings. Their concern is a lot bigger than ours"* (respondent 8). Also at the level of the field workers the enthusiasm for the partnership is rather low. This is for instance reflected in the number of project initiatives and the representation in local meetings.

The third process outcome is the degree of 'networking'. Some respondents state that the network has an added value because people get to know each other. This is both mentioned by members of the board structures and members of the local units. One field worker of a health insurance organization explains: *"You sit together with people from other organizations and services who are also active in the field of home care. It is important that you see each other and sometimes do things together. It all starts with getting to know each other"* (respondent 4). However, as explained before, this statement is not supported by disciplines who are active on a local scale. Another nuance is the fact that four respondents clearly state that the network has no added value for them at all. *"The general opinion in our organization is that the SEL can be shut down. We do not see the added value of this network. For my organization, the most important thing is the optimization of care around the bed of a patient in a home situation. In the SEL, a lot of money is going to things that for us do not lead to a better care for the patient"* (respondent 7)

We conclude that the opinions of the partners about the added value of the network for the optimization of care are rather moderate. However, we notice a clear divergence between different groupings. For instance, there is a clear partition between the centrally organized partners on the one hand and the locally embedded ones on the other. Also, there are different viewpoints depending on the position in the network (board member vs. field workers). In general, board members are more positive about the value of the network. According to some respondents this is because they have no contact with the field.

5. Discussion & conclusion

The focus of this paper was on the impact of central – local relations with regard to the performance of local mandated service delivery networks set up by central government. We now draw some conclusions about the way the Flemish government coordinates the Primary Health Care networks and what effects are on the functioning of the network on the one hand, and about the way politics and power affect both the coordination practice and the networks' performance on the other.

Strong formal control, little actual control, and the impact thereof on performance

In terms of the coordination practice by the Flemish government, it is clear that the central level coordinates in a hands-off manner, by designing and framing the network and its operations. In doing so, it relies heavily on hierarchical instruments, most notably legislation to define the network structure and to outline the network objectives and its concrete tasks. However, despite limited autonomy from a formal point of view, our qualitative case study shows that the local partners still have and use some actual autonomy to make own choices with regard to their internal organization and functioning. That autonomy is increased by the fact that the Agency of Healthcare, which controls the functioning of the SEL hierarchically via annual reports and budget control, does only focus on compliance on paper. Most network members consider delivering these documents only a formality. While this enhances the actual autonomy of the network to a certain extent, respondents also criticized central government for lacking vision and responsibility for the networks' activities, rather hampering than improving network performance. For most actors, central government should be a more active partner in the network, rather than an absent landlord, if all network goals should be achieved. Hence, the actual coordination mix impacts the local dynamics and also effects the performance of this network. SEL Ghent implements some of its legal tasks, but not all. Most effort is put in the administrative support of MDO consultation, since this clearly affects the (financial) interests of the partners. The position of the Flemish government also acts upon the process outcomes of this network. The lack of vision and support for the SEL causes some major discussions between the partners.

Coordination practice affected by institutional power and politics

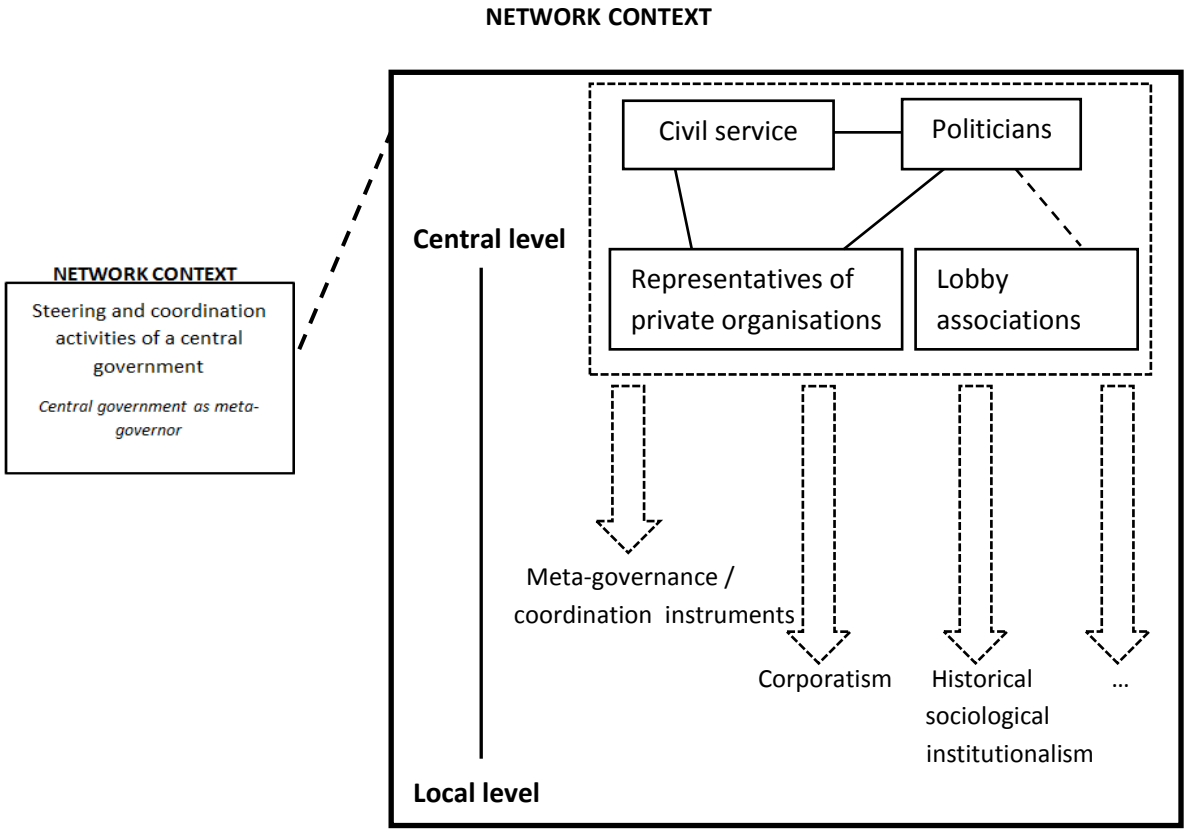
In terms of the importance of power and politics to understand the coordination practice and the network performance, two main observations can be made. The first observation is

that the Flemish government is not a uniform entity in this case. Although a lot of network research refers to government as a single entity, our analysis shows that the concept covers multiple levels. Each level plays its own role and has an impact on the functioning of the network. First, we need to make a distinction between the public administration level and the political level. This is because the coordinating role of network designer and network framer is the result of the interplay between civil servants of the Agency of Healthcare and the political leaders (i.e. the Flemish Minister of Welfare Public Health and Family and his administration). Secondly, and of particular importance in the Flemish context, we notice the presence of powerful private organizations that are active on both the central and local level, but also try to play at the political and the administrative (or service) level. These organizations are not only service providers, but have representatives in the political system and have an important vote in the formulation of policy directives. As such, they have become an institutionalized part of 'government' in the domain of welfare and health. Moreover, the political level is lobbied by different interest groups, all trying to defend their concerns at the central level. These are for example the lobby of health insurance organizations ('Zorgnet Vlaanderen'), the lobby of the general practitioners, the partnership of cities and communities ('VVSG') that defends the concerns of the local social offices, … Our ongoing research will make clear if this practice is also the case in other policy domains.

The second observation is about the meaning of 'steering and coordination'. In the original framework we use the concept of meta-governance and the H-M-N trinity to conceptualize the coordination activities of central government. However, our analysis shows that the meta-governance roles and the coordination instruments, are in fact the outcome of more fundamental (power) relations. Hence, the study of C-L relations in the context of local mandated service delivery networks cannot be limited to an analysis of the rather technical instruments (as written down in the Decree and the Administrative Order), being the first and most visible layer. We need to dig deeper and unravel the underlying mechanisms of these regulations if we want to come to a full understanding of steering and coordination and the impact hereof on local dynamics and network performance. It is clear that (political) power should be a key component in the analysis of meta-governance if we want to understand why certain coordination strategies are developed or not, and why they work or not. In this case, it is for instance clear that the central and local levels are connected

through policy networks – in which local organizations and their parent and umbrella organizations join forces with political allies - that shape the legislation that ultimately defines the service delivery networks capacities and autonomy. These observations result in an adapted framework of central – local relations and network performance in this context. We will use this elaborated framework in our ongoing research.

Figure 2 – Adapted framework of network performance in C – L relations



Annex 1 – Overview of respondents

No.	Discipline	Name of organisation	Position of member	Date of interview
1	/	/	Coordinator	30/05/2013
2	General practitioner	Huisartsenvereniging Gent vzw	President / member AV, RvB and DB *	31/05/2013
3	Health insurance organisations	Bond Moyson Oost-Vlaanderen - DMW	member AV/ RvB	15/05/2013
4	Health insurance organisations	Christelijke Mutualiteit Midden-Vlaanderen	member AV	16/05/2013
5	Home help services	Familiehulp vzw - Zorgregio Gent	member AV / RvB	23/05/2013
6	General practitioner	Huisartsenvereniging Groot-Lochristi	member AV/ RvB	17/05/2013
7	Home care services	Solidariteit voor het Gezin - dienst thuisverpleging	member AV / RvB	24/05/2013
8	Local social office	OCMW Nazareth	member AV/ Rvb/ DB	15/05/2013
9	Hospital	AZ Deinze	member AV	27/06/2013
10-11	/	Agency of Welfare and Health	Civil servant	21/11/2012 19/12/2012

* AV: General Assembly

RvB: Board of Directors

DB: Management Board

Annex 2 – Survey (translation of original Dutch version)

		Totally disagree	*Disagree*	*Agree*	*Totally agree*	*No opinion/ N/A*
1	Internal decentralization gives a SEL enough room to adjust its actions to local needs					
2	My SEL gets sufficient subsidies from the Flemish government to carry out its legal tasks					
3	The switch in financing policy from an output based system (SIT) to input based financing (SEL) turned out to be a good decision					
4	I support the synchronization of the working area of the SEL to the regional care areas (15 regions) instead of the local care areas (60 regions)					
5	The audit of the annual reports is merely a formal/technical type of control					
6	I think there are too little personal relations between my SEL and civil servants of the Agency of Welfare and Health					
7	The annual seminar between the SEL and the minister is a 'talking shop' – it has no impact whatsoever					
8	The number of annual supported MDO is a good indicator for the functioning of my SEL					
9	In my opinion, civil servants of the Agency need to take up a mediating role if discussions or conflicts arise between the partners of my SEL					
10	It's nonsense that the Flemish government only allows actors in primary care to be a partner of the SEL					

		Totally disagree	*Disagree*	*Agree*	*Totally agree*	*No opinion / n/a*
11	If the coordinator would be a civil servant of the Agency, this would enhance the strength of the SEL					
12	My SEL has insufficient staff to carry out all 12 legal tasks					
13	I support the obligation to choose a general practitioner as president or vice-president of the SEL					
14	The policy choices of the Flemish government correspond to the needs in the field					
15	The Flemish government gives insufficient financial incentives to make collaboration agreements between my SEL and individual or associations of professional care givers					
16	Representatives of care users and care givers should be obligatory partners in the General Assembly					
17	Compensation fees for the participation to an MDO should be anchored in legal instructions					
18	The functioning of my SEL is hindered by conflicts of interest					
19	As a result of the open definition of the 12 legal tasks, opposing visions arise with regard to their actual implementation					
20	In my opinion the next state reform will strengthen the position of the SEL in the care sector					

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