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What might the English NHS learn about quality from Tuscany? Moving from financial and bureaucratic incentives towards 'social' drivers

PATRICK BROWN
Assistant Professor, University of Amsterdam, The Netherlands; Honorary Research Fellow, Centre for Health Services Studies, University of Kent

MILENA VAINIERI
Researcher, Laboratorio Management e Sanità; Scuola Superiore Sant'Anna, Pisa, Italy

ANNA BONINI
Researcher, Laboratorio Management e Sanità; Scuola Superiore Sant'Anna, Pisa, Italy

SABINA NUTI
Associate Professor of Management and Director of Laboratorio Management e Sanità; Scuola Superiore Sant'Anna, Pisa, Italy

MICHAEL CALNAN
Professor of Medical Sociology, School of Sociology, Social Policy and Social Research, University of Kent, UK

Abstract

Governance systems which are based on assumptions of purposive-rational action have received significant criticism. For example recent quality and performance frameworks of the English NHS have tended towards incentives and sanctions, and have been critiqued in terms of both the logic on which they are run as well as a lack of evidence for their success. Yet the limitation of much of these critical appraisals is the failure to propose concrete, empirically-grounded alternatives. Thus as a means of adding to the literature, this discussion paper seeks to perform three functions. Firstly it reviews the theoretical and empirical literature around governance in the English NHS as a basis of understanding the limitations of this 'standards and sanctions' dominated system. Secondly, it discusses findings from research into the governance system applied in Tuscany, Italy as evidence of the effectiveness of using the reputation of professionals and departments as a basis of facilitating quality development. Implications – for the English NHS and governance more widely – are then considered. A theoretically

grounded alternative to purposive-rational approaches based on a more normative oriented understanding of human action and the 'civilising processes' of moral obligation is accordingly outlined.

Keywords: Clinical governance; Italy; moral obligation; performance; trust.

Introduction

Economic and socio-political pressures towards greater levels of efficiency, quality and performance are common across late-modern welfare states, yet are manifest in a range of different forms (Burau and Vrangbaek, 2008). The prefix *late-* is applied here to denote a sense of institutional crisis or strain (Habermas, 1976). Such tension is apparent in an economic sense through the basic economics of problem faced by healthcare systems (rising demand, expectations and potential treatments *versus* limited resources) and welfare states more generally (Bonoli *et al*., 2000). There is also a crisis of legitimation faced by healthcare institutions regarding specific failures of individual practitioners (Alaszewski, 2002), a change in the way the professions are perceived and trusted by the public (Calnan and Rowe, 2008), and a heightened awareness of the uncertainty and fallibility of expert knowledge systems (Beck, 1992) – not least that of medicine (Alaszewski and Brown, 2007).

Alongside these crises and partly in response to them, a 'New' Public Management (NPM) has emerged over the past quarter century (Hood, 1995; Gruening, 2001). A more explicit accountability of performance – and the introduction of levers to effect an on-going development of quality, efficiency and organisational learning – are central 'doctrines' of this approach yet the NPM-umbrella includes a vast array of methods and strategies. The governance of quality and performance thus varies across different public sector organisations within individual states and indeed between countries (Hood, 1995; Ferlie *et al.*, 1996). Sectors and states differ in the extent to which the NPM paradigm has been predominant as well as in terms of the particular paths chosen.

The teleology and effectiveness of these different NPM strategies have received significant attention, not least those relating to the governance of quality and performance (e.g. Dunleavy and Hood, 1994; Pollitt and Bouckaert, 1995; and in relation to healthcare: Scally & Donaldson, 1998; Ferlie and Shortell, 2001). Typically, empirical work in this area has been carried out through in-depth evaluations/appraisals of specific individual systems, thus allowing only tentative inferences to be made about the likely effectiveness of alternatives. Comparative studies on the other hand do exist, however those which compare a number of countries (for example, Burau and Vrangbaek, 2008) unavoidably lack the detailed assessment of nuanced frameworks (Clarke *et al.*, 2007), developments over time (ibid), and analyses of "the meanings embodied in political activity" (Bevir *et al.*, 2003:193). The specific, local manifestations of this latter feature are especially salient for understanding the governance of healthcare systems, and especially the reactions of healthcare professionals working within such policy frameworks (Gray and Harrison, 2004; Bevan and Hood, 2006a; Brown, 2008). To this end, useful examples of more detailed (small-*n)* comparative work within the domain of healthcare also exist (e.g.

Moran, 1999); though due to the publication date of this study Moran does not specifically address the more recent performance frameworks which explicitly focus on clinical *quality*.

The purpose of this paper is to develop understandings of what constitutes effective governance of quality in healthcare – both theoretically and empirically. This will be undertaken through a discursive comparison of tendencies within the English and Tuscan public healthcare systems. The lack of systemically comparable data precludes the possibility of a more rigorous comparative study. Nonetheless this discussion paper draws together research into governance in the English NHS, and evaluations of quality mechanisms in Tuscany, as a basis for a broader consideration of different approaches to developing quality. In so doing the paper also points towards the possibility of more systematic, in depth comparative research in the future.

Whilst the size of these two systems is quite different, there are a number of important similarities between the two systems which assist their comparability: both are publicly funded by the tax payer; both have been engulfed in particular concerns about their efficiency and effectiveness (Smith *et al.*, 2001; Formez, 2007) within a wider circumspection of the public sector (Moran, 2003; Rapporto CEIS Sanità, 2008); both utilise gate-keepers as one means towards efficiency; and both have faced apparent crises of trust (Smith, 1998; Nuti and Vainieri, 2009). As a result of the above, and of more specific relevance for this article, both systems have embarked on policy ventures towards assuring the quality and performance of their healthcare provision – on a system-wide basis, at the level of local healthcare organisation (Primary Care Trust or Local Health Authorities), and indeed at that of the individual professional.

The format of a more typical comparative paper might consider data in directly relating and contrasting aspects of the two governance systems, as a means of coming to a conclusion as to one being more effective in some areas than the other and understanding why. This article however will follow a somewhat different approach – beginning instead with the assumption that the English system of quality development and assurance has been largely ineffective in achieving significant change in a wide number of areas. The first section will use the existing literature to develop an understanding of these limitations, whilst also noting areas of achievement. This more nuanced account is imperative, both in offering a more balanced and accurate description as well as drawing on examples of 'good practice' as a means of establishing the refinements necessary for effective governance.

The second section will discuss findings from research into the effectiveness of a different form of governance within the Tuscan healthcare system. If the English system can be generalised as operating through standards, directives and sanctions (at least as it is experienced by the professionals working within it), then the Tuscan alternative can be said to function around heightening the visibility of the work of local teams. Correspondingly an onus is placed on the *reputation* of the local organisations and individual professionals (Nuti, 2008) – not least their fiduciary role of acting in the best interests of patient care and public funding. A third 'discussion' section will then extrapolate from these findings a number of theoretical themes around individual behaviour, organisational functioning and social cohesion – applying these to develop a theorisation of effective governance in terms of legitimacy (Parsons, 1949), the relational qualities inculcated (Black, 2008), and the corresponding feature of normative obligation (Elias, 1982). It is argued that the role of *reputation* in creating normative obligation (Brown, 2008; Nuti, 2008) towards quality and performance – a 'civilising process' (Elias, 1982) – is more effectual than appealing to purposive-rational tendencies through stipulations and sanctions.

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The limitations of quality frameworks in the English NHS: multiple distractions from 'quality' and learning

Notions of quality assurance are intrinsic to the very practice and refinement of medicine (Maxwell, 1984) and indeed were clearly visible within initial processes of professionalisation (Donabedian, 1978). Post-1997 health policy in the UK has made this quality imperative more explicit and indeed has sought to place quality and the development of effective performance at the very centre of NHS policy and organisational considerations (Department of Health, 1997; 1998; Scally and Donaldson, 1998). The lynchpin of this quality strategy is clinical governance – "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Department of Health, 1999: 4).

Clinical governance essentially operates through the setting of standards and corresponding methods of verification to ensure these standards are met (Halligan and Donaldson, 2001). Thus the 'goals' can be identified as National Service Frameworks (strategic long-term goals) and a vast array of protocols and guidelines as disseminated by the National Institute for Health and Clinical Excellence, the various Royal Colleges and other elite professional bodies. The 'incentives' within recent governance arrangements have entailed systems of monitoring and surveillance in accordance with performance frameworks. These were designed to ensure the meeting of standards and the following of procedures – working at the local organisational level as well as through external processes such as those enacted by the Healthcare Commission.

Prima facie the quest for quality in the NHS would appear to function through delegated autonomy, and yet such is the 'comprehensive and systematic' manner in which performance and other outcomes are monitored that many have characterised the developments as movements towards a 'machine bureaucracy' (Flynn, 2002: 168). Regardless of differences between the rhetoric of governance and its manifestations in praxis, there has been a general consensus that these quality frameworks have had a decidedly limited impact (Smith *et al.*, 2001; Thomas, 2002; Degeling *et al.*, 2004; Neale *et al.*, 2007; Gask *et al.*, 2008). Hence while many healthcare professionals are in accord with the general aim of pursuing quality (Shakeshaft, 2008), there are a number of attributes within and around clinical governance which limit its effect on professional action and therefore clinical performance.

One means of understanding these weaknesses is the multiple and conflicting priorities of governance systems. Quality is most usefully understood as a multi-dimensional concept (Maxwell, 1984) and indeed frameworks require professionals not only to serve many masters, but moreover to pay heed to some (most notably efficiency) more than others (Klein, 1998). Sheaff and Pilgrim (2006) argue that the efficiency concerns reinforced within purchaser-provider quasi-markets obstruct and distract from organisations' learning function, thus rendering quality (in its wider sense) compromised as a result. In this sense 'complexity and contradictory processes' (ibid: 27) may well consume the attention and efforts of healthcare professionals in a Simonian sense (Simon, 1971), and thus act to undermine quality at its most fundamental – that of patient-centred care (Brown and Calnan, 2010). More specifically, the use of monitoring and surveillance may develop distracting and therefore problematic tendencies at three distinct levels: the extent of information produced (Degeling *et al.*, 2004); the focus of

what is being measured and moreover which measurements/targets are related to sanctions (Bevan and Hood, 2006a); the very nature of measurement itself (Brown, 2008).

These latter two aspects are inherently linked, in that some aspects of quality are by their very nature easier to quantify, and therefore monitor, than others (Kennedy, 2004). This variation in generalisability/visibility within the organisation, and moreover the politicisation of certain sub-facets of quality (such as waiting times), means that certain such components come to be disproportionately significant in considerations of quality (Brown and Calnan, 2010). Perverse incentives are likely to develop around these (Bevan and Hood, 2006a) given their bureaucratic importance. It is this innate disjuncture between quality which is *bureaucratically* significant (for the administrative 'system') and that which is *clinically* significant in a more holistic sense (within the interactive experiences of clinicians), which is at the heart of the limitations of the governance system. Approaches to governance have typically failed to capture holistically, proportionately and therefore accurately what quality really represents to professionals (*Degeling et al.*, 2004). This lack of synchronicity, and thus legitimacy, undermines their support and cooperation in the system.

It is vital at this stage to underline that clinical governance, as it has been applied in the English NHS, is far from wholly deficient. Whilst the analysis above has been set out as a basis for understanding the limitations of this governance, and its apparent lack of effectiveness in a generalised sense, it would be overly schematic to ignore areas (both geographical and within certain clinical specialisms) where significant enhancements in quality have been achieved. Arguably it is primary care where levels of professional cooperation (McDonald *et al.*, 2009) and improvements in quality outcomes (Campbell *et al.*, 2005) have been more visible. Although it must be recognised that these outcomes are understood within a predominantly bio-medical paradigm and therefore can be criticised in terms of broader notions of what is holistic practice, this paradigm is nonetheless that which is most capable of developing consensus and support amongst the medical professionals whose cooperation is vital.

Aside from the financial remuneration which is attached to Quality Outcomes Framework (QOF) in General Practice, the ways in which quality is assessed are highly intricate (135 separate indicators – 2007/8) and holistic (reflecting clinical and organisational priorities, patient experience and the provision of additional services). In this sense the monitoring and surveillance applied is capable of reflecting the complexities and multi-dimensionality of professional performance and therefore minimising the gap between bureaucratic significance and clinical significance as discussed above. Moreover, whilst the extent of monitoring and recording is considerable, the office-based environment of General Practice is perhaps more conducive to allowing GPs to deal with the bureaucratic burden in a way which minimises its interference on the holistic practice of clinical interactions (Checkland *et al.*, 2008).

General practice aside, there have also been a number of more recent innovations within the governance of more acute healthcare service provision in the English NHS – often in response to many of the failings noted above. 'Star ratings' enacted a 'naming and shaming' (Bevan and Hood, 2006b: 419) approach which functioned alongside a threat of dismissal of the senior managers of poorly performing trusts, as well as the 'carrot' of autonomy for those rated highly within the system. This framework has been criticised however for the extent to which a small number of relatively crude, performance-oriented indicators either neglected large elements of practice or elicited gaming behaviour and dysfunctional outcomes (Bevan and Hood, 2006a).

If the star ratings approach – with its threats and rewards focused on administrators – can

be understood as a hierarchical-bureaucratic approach to quality, then more recent ventures such as the 'Advancing Quality' initiative in North West England and the national Commissioning for Quality and Innovation (CQUIN) payment framework (Department of Health, 2008) tend towards market-oriented payment-by-results format, as applied within the QOF example discussed above. CQUIN involves rewards which are agreed locally by services and their commissioners within the quasi-market of the purchaser-provider system. The relatively small financial rewards used within 'Advancing Quality' – and the initially successful impact of comparing trusts in a more nuanced, patient-focused way (Kmietowicz, 2008**)** than enabled by Star Ratings – points towards the potential utility of social/reputational drivers as a method of enhancing and assuring quality.

The Tuscan experience: the Performance Evaluation System as a collaborative learning tool

In contrast to the English NHS, recent organisational tendencies within Tuscany's healthcare system reflect an emphasis placed on *cooperation* between the key actors in the system rather than on *competition* via systems of purchasers-providers. Following this trend, when considering how governance systems might be established to enhance quality, it was seen as important to plan and develop a framework that could be shared and owned by the various health authorities themselves as well as the regional administration.

In order to support the running of the health system as a whole, as well as its specific local components, a method of highlighting areas of excellence and of improving areas shown to be critical or weak (Jones, 2000) has become a key feature of the Performane Evaluation System (PES). Through a mutually agreed set of indicators (as opposed to top-down stipulation), PES has sought to start a 'best practice' enhancement process amongst the local healthcare institutions via a system of benchmarking (McNair and Leibfried, 1992).

The inauguration of PES in 2004 saw the introduction of a multidimensional measurement system in order to assess and monitor the Health Authorities (HAs) of the Tuscany Region - consisting of 12 Local Health Authorities (LHAs) and 4 Teaching Hospitals (THs). PES consists of 50 measures, made up of more than 130 indicators overall, classified in six dimensions of assessment, including: population health; regional health strategies; quality; patient satisfaction; staff satisfaction; efficiency/financial performance. In order to simply and graphically represent the performance of each HA, a "target" chart with the six dimensions represented was designed, divided into five bands associated with different levels of performance. An indicator with a high score is displayed as close to the centre (dark green), and one with a low score is displayed as far from the centre (red).

The application of PES has been appraised as facilitating a number of improvements across the Tuscan healthcare system (Censis, 2008; Neri, 2009). Its utility suggests that targets can usefully change the behaviour of individuals and organisations if applied in the right manner (Bevan and Hood, 2006a) – vitally where there is a high level of congruence between what is bureaucratically significant and that which is clinically significant. That the benchmarking and advancement process associated with PES is based on local involvement and agreement, and moreover encourages local services to learn from the data (of their own outcomes as well as those of their colleagues) in understanding what 'good' or 'best' practice might look like, would appear to be contributing factors to the framework's success. After four years of PES being in

operation, and in its running alongside a payment reward system for CEO's (of HAs), improvements were achieved in most of the indicators monitored: over 50% of the 130 indicators registered improvements year-on-year (Nuti, 2008).

Although the use of monetary incentives would seem to signal the existence of a market-linked management of quality (as opposed to hierarchy and trust), the size of these financial rewards makes evident their relatively minor nature. Process evaluation of PES suggests that the greatest incentive is through local health authorities wanting to improve their publicised performance in relation to other HAs, especially where these authorities are rated as very weak. An annual publication of HA rankings within the regional press – with a naming of CEOs according to levels of achievement – creates high incentives to avoid being listed 'worst', while regular meetings of CEOs, where indicators are reviewed, allow for a sharing of good-practice and a peer-recognition of improvement. Moreover, explanations for improvements are provided amidst the scrutiny of an audience of peer CEOs and this helps ward against gaming (Nuti *et al.*, 2008). These interactive means of checking are much more effective at illuminating gaming practice than the mere use of distant auditing methods (Bevan and Hood, 2006a).

Indicators that received more attention were those concerning quality and appropriateness. This choice is explained by some empirical studies on the Tuscan PES data. This research highlights that financial sustainability is more closely linked to the capacity to control appropriateness and quality than efficiency (Nuti *et al.*, 2010, Nuti *et al.*, 2011).

Other Italian regions joined the Tuscan PES in 2008. The 2007-2008 data shows that only the Tuscany Region, the region that had included the indicator in its PES since 2005, significantly improved its performance while the other regions, which more recently introduced PES, registered a stable performance (Nuti *et al.*, 2012).

In analysing the functioning and utility of PES in more detail, at least five significant factors become apparent:

The first element to be considered is the participation of the clinical professionals and local managers within the wider process (Abernethy and Stoelwinder, 1995; Jones and Dewing, 1997)– PES was in fact designed and developed in close collaboration with healthcare professionals and managers (Nuti *et al.*, 2009). It is important that all actors within the healthcare system – clinicians, local managers and regional administrators – participate and share their opinions in developing the evaluation indicators. This collaborative and inclusive basis is vital in order to avoid the risk that local managers may manipulate data, or that they will not use the performance evaluation system because they do not believe in the relevance and significance of the indicators proposed by the regional government. On-going training activities[4] involving HA coordinators, senior- and middle-management have facilitated the development, diffusion, comprehension and refinement of PES. This input further stimulates ownership.

The second point is that benchmarking helps local organisations to learn from others' experiences - overcoming the limitations of merely self-referential evaluations and driving improvement even in the absence of a marketised form of competition. The information produced within PES and represented uniformly has enabled an efficient and constructive comparison amongst the system's local health authorities (though the comparability of budget allocations remains problematic). This has made it possible to highlight the aspects where problems are of a regional nature, and those which derive from an individual authority's behaviour. For instance, if a particular indicator shows a negative performance for all the local health authorities surveyed then this is clearly a more general problem that requires attention at a regional level. When, instead, performance varies greatly between authorities, it becomes clear

that some authorities could learn from others and that collaboration (via 'good practice' sharing) between them could help to overcome certain localised issues of poor performance. In this way the means of assuring performance is intrinsically and closely tied to the vital role of local HAs as learning organisations, rather than the more conflicting priorities which exist across many NHS contexts (Sheaff and Pilgrim, 2006).

The third factor is the strong emphasis on reputation. According to some research (Mannion and Davies 2002; Hibbard *et al.*, 2003; Hibbard *et al.*, 2005), the key driver of changing performance in the health sector is the threat of reputational damage. The Tuscan experience suggests the utility of comparing performance amongst individual HAs, but above all through highlighting and communicating the good results obtained by the 'best practice' examples. In harnessing this lever of reputation, the Tuscany Region decided not only to publish the levels of performance achieved but also to show how HAs improved their performance when these developments are more pronounced. Performance indicators are monitored every three months – being presented and discussed at individual meetings between the Regional Health Councillor and the CEOs of each LHA. These meetings have become forums of knowledge development and dissemination, where successful approaches are able to be discussed, adopted and transferred to other settings. It also works as a deterrent factor to certain gaming phenomena (Nuti *et al.*, 2008).

The fourth hallmark of the PES is the graphical reporting system: its striking visual approach is easy to understand (Bevan 2009). This effective graphic representation is a way to empower the transparency of the system that can be understood also by citizens. In fact all data and results are available to citizens through a publicly accessible website and a report published annually. In this way citizens become involved in the accountability process as to how public resources are used to deliver value for patients/service-users. The extent to which citizens are willing and/or able to use this information may be contested and should not simply be assumed (Entwistle *et al.*, 1998), nonetheless the visibility and transparency of these data publications within the public sphere amplifies the reputation-based effect (and corresponding moral obligation) on the behaviour of LHAs and the system as a whole.

Finally, it is vital that the relative effectiveness of PES is not understood as a disembodied or a-political process. Other measurement tools, developed in the Tuscan healthcare systems with the involvement of clinicians in designing it, have not been implemented because the pressure and support from senior managers was lacking (Cinquini & Vainieri, 2008). These are determining factors in the favourable outcomes of the implementation and use of measurement systems. In this context, a coherent political long-termism, personified by certain innovative advocates (e.g. the Regional Health Councillor) has been vital to the 'change management' that has been enacted over a number of years. This political commitment is visible in the funding which sustains the 'learning organisation' aspects of quality development. This sits in contrast to quality frameworks in the English NHS, where the introduction of institutional apparatus has not been mirrored by substantive improvement/learning implementation on the ground (Freeman and Walshe, 2004; Sheaff and Pilgrim, 2006).

Given the features described, some limitations continue to emerge: The aspects that PES takes into account include, among others, efficiency, quality and appropriateness, but still there is too little evidence regarding 'outcomes'. Further development is required in order to identify and share outcome indicators.

Regarding the balance of PES indicators, a further weak point also lies in the fact that PES only measures primary care activities thorough indirect information - since data from

primary care physicians are not available. This limitation results in a lack of data (and understanding) relating to clinical pathways.

Although the Tuscan PES comprehends a large number of indicators and covers many aspects of healthcare services, there is still the risk of cream skimming and the risk of a lack of attention in sectors which are not monitored by PES.

Discussion: From purposive-rationality to fiduciary-obligation - via a social and 'civilising' process

Table 1 (below) briefly summarises some of the main characteristics of governance systems in Tuscany and England as discussed above. Given the peculiar caveat of QOF, and its relative success, this is discussed as a separate case to the more common format of quality governance in the NHS. The systems are briefly described under three of the key facets of governance legitimation which have emerged as salient in the analysis above: whether the system was imposed from the top-down or consulted from the bottom-up; the extent to which the indicators applied reflect the subtleties and holistic imperatives of clinical practice; and (as potentially influenced by both of the above) the extent to which the format, and the incentives applied, is compatible with (or enhanced by) professional norms and values.

Table 1 – Summary of findings

Type of governance framework:		Prevailing quality framework in English NHS	Quality and Outcomes Framework – English NHS	Performance Evaluation System - Tuscany
Characteristics of the governance framework:	**Enactment - as bottom-up (consent) or top-down?**	Top-down	Top-down (high levels of remuneration linked to QOF may act to win over clinicians)	Bottom-up / consensus based
	Intricate and holistic indicators? congruence between bureaucratic and clinical significance	Varies and gradual refinement – but typically criticised as crude	Intricate and holistic (135 separate indicators – includes 'patient experience' and 'holistic care')	Intricate and holistic (130 indicators – across 6 dimensions of healthcare provision)
	Compatible with, and makes use of, norms and values?	Typical findings suggest problems in both senses	Financial incentives – but often compatible with holistic narrative	Uses reputation as a form of normative obligation. Modest incentives for CEOs.

At the centre of the apparent success of both PES and QOF is their relative legitimacy amongst the professionals whose practice they seek to influence. All forms of governance and accountability mechanisms must be perceived as legitimate if they are to be effective (Black, 2008) and this might most simply be understood as - the behaviour which governance seeks to elicit being congruent with prevailing norms and values (Parsons, 1949). Or, as has been articulated above, where there is minimal distance between what is bureaucratically and clinically 'significant'. Whereas QOF (like PES), through its reflection of the complexities of clinical work and relative compatibility with narratives of holistic practice (Checkland *et al.*, 2008), is thus able to achieve such legitimacy – the limitations of governance in many other areas of the NHS might be most effectively understood through a basic lack of ownership (Brown, 2008): governance fails to reflect quality in its more complete sense (as understood by professionals) and therefore the juncture, as referred to above, between bureaucratically significant quality and clinically significant quality undermines legitimacy.

More profoundly still, human conduct and social cohesion is not explainable merely via responses to threat of sanctions and/or rewards in an instrumental sense (Locke, 1960; Habermas, 1987). Rather, non-contractual, normative and affective aspects are decisive in influencing individual behaviour and shaping organisational dynamics (Durkheim, 1984), and thus governance is always inherently relational (Black, 2008). Yet by appealing simply to purposive-rational action (of reaching targets and avoiding sanctions) and ignoring the relational, socialised basis of organisational order – and moreover clinical work – clinical governance often detaches compliance (with governance) from the norms, values and relations of meeting patient needs and driving professional morale (Brown, 2008). QOF can also be seen, in part, as appealing to purposive-rational interests in its payment-by-results format. Yet its multi-faceted and intricate approach to quality would nonetheless seem to facilitate a narrative of holism amongst GPs (Checkland, 2008) – i.e. instrumental and normative interests remain compatible with one another (Brown 2008).

Where professionals see such divergences between the satisfying of bureaucratic stipulation and the moral value of their work, the former comes to be perceived as a-moral. Therefore no normative obligation exists towards cooperation, and ignorance or subversion of governance becomes likely (ibid). In this light it is apparent that effectual governance of healthcare work is that which is able to reflect the holistic, clinical interests of patients – as perceived by professionals – and therefore achieve legitimacy. Moreover the most effective and efficient systems will be those which account for, and ideally function through, relationships and normative obligation. For an on-going monitoring and surveillance is not only ineffective, through only appealing to purposive-rational motives, but moreover is highly costly. The opportunity costs of healthcare professionals' time in complying with governance recording systems are also considerable (RCN, 2008).

The financial incentives attached to QOF may well have assisted the engagement and relative lack of resistance the framework has encountered. Yet the economic burden of the new General Medical Services contract on the NHS, of which QOF is a costly part, would seem to limit the transferability of this approach to other contexts. Means of managing transactions which apply normative obligation through trust and cooperation, as opposed to financial incentives or bureaucratic stipulation, are cheaper (Arrow, 1974; Fukuyama, 1995) as well as more effective in managing and refining knowledge within learning organisations (Adler, 2001). Accordingly this final section will close by proposing that an effective and efficient governance system should be:

professional-led; based on cooperation rather than monitoring and sanctions; and one which facilitates the role of normative obligation in 'civilising' clinical work. These three components would help assure a high level of congruence between bureaucratic and clinical significance (see Brown and Calnan, 2011 for broader discussion of this framework).

As already clarified, governance systems which are truly professional-led will be more likely to acquire legitimacy through the on-going involvement (design, application and refinement) and corresponding ownership of the professionals over whom control is sought. Growing out of this, the role of professionals in developing and refining how quality and performance are assessed will ensure the system's accuracy in reflecting the subtleties of clinical practice and the wider, holistic patient experience. Rhetoric behind clinical governance in the UK pays lip-service to such 'grassroots' participation, but mere involvement is not sufficient (Degeling *et al.*, 2004). Local professionals must participate in the design of how their practice is assessed and provide on-going input into such a system in order to ensure continuing legitimacy (congruence between the bureaucratic and the clinical) and thus commitment.

It is partly in this sense that cooperation, rather than standards and sanctions, is a powerful mode of obligation because norms and values (within the social group) are a compelling force on human praxis which is driven by far more than purposive-rational interests. Systems based on this latter logic tend towards the *de-moralisation* of work in the sense of alienation and an undermining of control (Brown, 2008). In contrast systems rooted around the former are more effective at refining, sharing and applying expertise in knowledge intensive organisations such as medicine (Adler, 2001).

This advocating of governance formats which are professional-led and cooperative should not be mistaken as suggesting a return to the previous system which was noted to have failed in England in the late-1990s (Smith, 1998). The previous system functioned behind a shroud of relatively blind trust placed in the broader profession (Dixon-Woods, 2009); hence there was only limited effect of socialised, normative obligation in that a professional's value was attributed through group status as opposed to individual performance. By making individual or local-team work more *visible* through using outcomes data (as deemed appropriate by local stakeholders), the socialised influence of norms and values is made more potent and is effective on the individual clinician. CQUIN has been noted as one notable (local) example in England where such an approach is evident.

The crucial contrast with the much of the current system in England would be the absence of sanctions. Less than ideal performance would instead engage discussions as to how improvements could be reached and thus promote learning and cooperation rather than defensive practice and gaming. It is in this sense that the role of the social (as opposed to the bureaucratic) in governing and civilising behaviour becomes apparent. The visibility of the self (or the team) in the public sphere, in terms of *reputation*, therefore generates "'continuous reflection, foresight and calculation, self-control, precise and articulate regulation of one's own effects' (Elias, 1982: 271).

Although empirically grounded, this paper is very much a discussion piece. More substantive research is required to explore the themes raised here and in particular the various caveats and nuances (variations within services between effective and poor outcomes; differing relations with managers; cultures within specialties more or less conducive to quality foci; and so on) which undoubtedly exist across the English and Tuscan systems. The development of research designs and conceptual frameworks which are capable of comparing (quantitatively and qualitatively) the perceptions, behavioural changes, and longer-term outcomes across different

approaches to healthcare governance are necessary. These might even be possible based on existing secondary data, as an alternative to new primary research.

Based on the discussions above, it could also be contended that – given the centrality of prevailing norms and values to the successful legitimation of governance frameworks – there may be a degree of cultural specificity to the effectiveness of normative obligation (and governance more generally) within the contexts discussed (Burau and Vrangbaek, 2008). The dominance of certain forms of *habitus* within specialisms (e.g. General Practice) or regions (e.g. Tuscany) may make forms of coping (McDonald, 2009) or cooperation more likely; thus emphasising the utility of further, socio-culturally sensitive, comparative research.

Endnotes

The population size of England is slightly over 50 million, whilst Tuscany's is marginally below 3.5 million.

Though a novel policy in its explicit centring round quality, clinical governance is best viewed not so much as a new, post-1997 creation but rather emerging out of several pre-existing trends. Some of these emerged within the new public management of the 1980s and 90s (Flynn 2002; Brown 2008).

Indeed such has been the success of GPs in developing quality and meeting QOF targets that the remuneration of GPs, via points which are related to the indicators, has put considerable financial strain on the NHS. Whilst this is evidence of naivety in terms of economic planning, it can be considered further evidence of quality improvements.

Not only is QOF a form of performance related pay, but it is also associated with a new GP contract which has led to improved working conditions (e.g. reductions in work outside office hours) (Whalley et al., 2008). This may also impact on the popularity of the new 'system' and corresponding legitimacy.

Interestingly little data exists as to the precise costs of implementing quality frameworks across the NHS. It is likely though that these are significant and underestimated (Walshe et al., 2003).

The use of the term *civilising* is applied not to suggest a current predominance of barbarism, but rather a process towards more modern and systematically enlightened practice of clinical work and organisation.

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