

PRELIMINARY ANTICIPATIONS ABOUT THE CHANGES IN INFLUENCE AND INFORMATION FOR HEALTH CENTRE MANAGERS IN GALICIA

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Abstract

The autonomous regions of Spain have responsibility for healthcare. The Galician Health Service aims to achieve a higher level of health for Galicians with an appropriate primary healthcare system. Recent legal changes requires healthcare to be promoted within a system of participative management involving Health Centre Managers. These changes will include the provision of accounting data in the normal course of managing.

This paper is a preliminary paper to a study of the changes. It anticipates situations that might occur with an individual Health Centre Manager. This approach is to consider two constructs, one of influence, including participation, the other information, capable of including all financial management data. This framework will be tested for its validity with the future development of Health Centre Managers.

Introduction

Recent legal changes to the Galician Health Service are intended to have significant effects upon the management of its Health Centres. This law requires that those who administer the Health Centres, the Health Centre Managers, are provided with more information and a participative situation in which to manage. This paper contains our general anticipations to our approach to studying some of the changes which could occur with a Health Centre Manager.

The authors come from a background of working with frameworks which seek to explain the interactions of individuals with financial management data and the effects of these. Here we use our experience to elaborate our earlier work. This provides a basic framework with which we have anticipated some events, and with which we can compare the actual events when these have occurred in the future.

This paper starts with an explanation of the mainly legal background, which sets out the legal situation. From this point, the paper provides a framework, which anticipates how changes might occur for the Health Centre Manager.

Background

Since 1981, the Spanish Government has decentralised a wide range of healthcare matters to its 15 autonomous regions. The Galician Government has had the right to determine many aspects of healthcare, can organise and administer its own healthcare and to legislate for these (Article 33 of the Law 1/1981, 6th April). It cannot legislate for the financing of health as funds come from the Spanish State.

The Galician Health Service was created in 1989 to improve and achieve a higher level of health amongst Galicians. Primary Healthcare is the first level, and is based upon the traditional trust between doctor and patient. Healthcare, the prevention of illness, individual and group health education, social work in the health area, and any other community groups concerned with health matters will generally be based upon a Health Centre.

Legal Matters

In July 1993 a modernising Decree (Decreto 200/1993) was issued to achieve primary healthcare, and included the following (abbreviated) features:

High Quality Care. Easy Access to a Primary Healthcare Unit, appropriately located, functioning with appropriate demographic ratios and types of care. Unity will be promoted among the different healthcare professionals. Each Health Centre will be free to provide a variety of advertised services, but will have a minimum group of activities, which are common to all Health Centres. A working day will include the healthcare needs of the professionals involved. There will be a reasonable distribution of resources and workloads. Professionals will keep up to-date with their knowledge.

All of the healthcare will be promoted within a system of participative management which uses objectives, and is evaluated by the attainment of results.

The professionals will have a suitable environment and the opportunity to change their roles.

Changes to the remuneration system will take into consideration the types of people treated and the health characteristics of the Centre's population, so these factors have a more direct impact upon remuneration.

The Decree noted this kind of reform cannot be achieved quickly, and there will not always be funds. The legal reforms were after a study and that a consensus had been achieved. The reforms represent a substantial change for healthcare, its organization, the use of its resources and its subsequent development.

The 1993 Decree indicated what will occur. This is abbreviated in the following areas taken:

- The Health Centre will be staffed by, medical, nursing, non-healthcare and general service people.
- A Health Centre Manager will be responsible for its functioning and organization.
- The Health Centre Manager will be appointed by, a Senior Manager of the Primary Healthcare Service, after consultation with tenured doctors at the Centre, the Medical Manager of Primary Healthcare and the Chief of Primary Healthcare. The Centre will have adequate technical support for health education, promotion, assistance, in the community, with legal and administrative functions.
- The Primary Healthcare Service will be the upper level of management, planning and support. Amongst other things it will: provide and develop healthcare, evaluate the activities it develops and the resources obtained, evaluate the annual objectives, prepare an annual report.
- The Health Centre Manager's functions include the allocation of tasks and responsibilities, to facilitate a smooth-running service, to improve the planning and the running of the service. Some managers will be full-time administrators.
- The remuneration of those employed in Primary Healthcare is regulated by the National Law RDL 3/1987.

- The Health Service and the Health Centre will facilitate the real and effective participation of the immediate community in achieving the objectives of Primary Healthcare following the structure defined by law.

The Decree in April 1996 modified some aspects of the 1993 Decree, noting that existing personnel will be offered the opportunity to join the new system. People in the new system will not earn less than before, but any promotion will not carry an increase in salary until that point when pay in the new system exceeds the old. There are provisions for doctors who do not want to enter the new system.

The Upper Management Structure

In 1995, the Galician Government organised the upper management of primary healthcare into five areas. The decree (Decreto 252/1994; Orden 11 Mayo 1995) grouped different cities according to geographical and population criteria.

These five areas are: A Coruña-Ferrol, Santiago de Compostela, Lugo, Ourense and Pontevedra-Vigo. A Senior Manager was made responsible for each area. This manager's functions are: (a) to guarantee the adequate development of the services, (b) to manage, co-ordinate, supervise and evaluate the activities, (c) to adopt measures oriented to achieve the objectives which are set out by the regional government, (d) to make proposals aimed at a better achievement of the general objectives, (e) to manage the human and economic resources, (f) to elaborate an annual proposal of expenditures, (g) to produce an annual report of activities along with periodic reports, and (h) to produce for, and submit to the Spanish Government, data about healthcare management.

Figure 1 A Generalised Structure of an Area

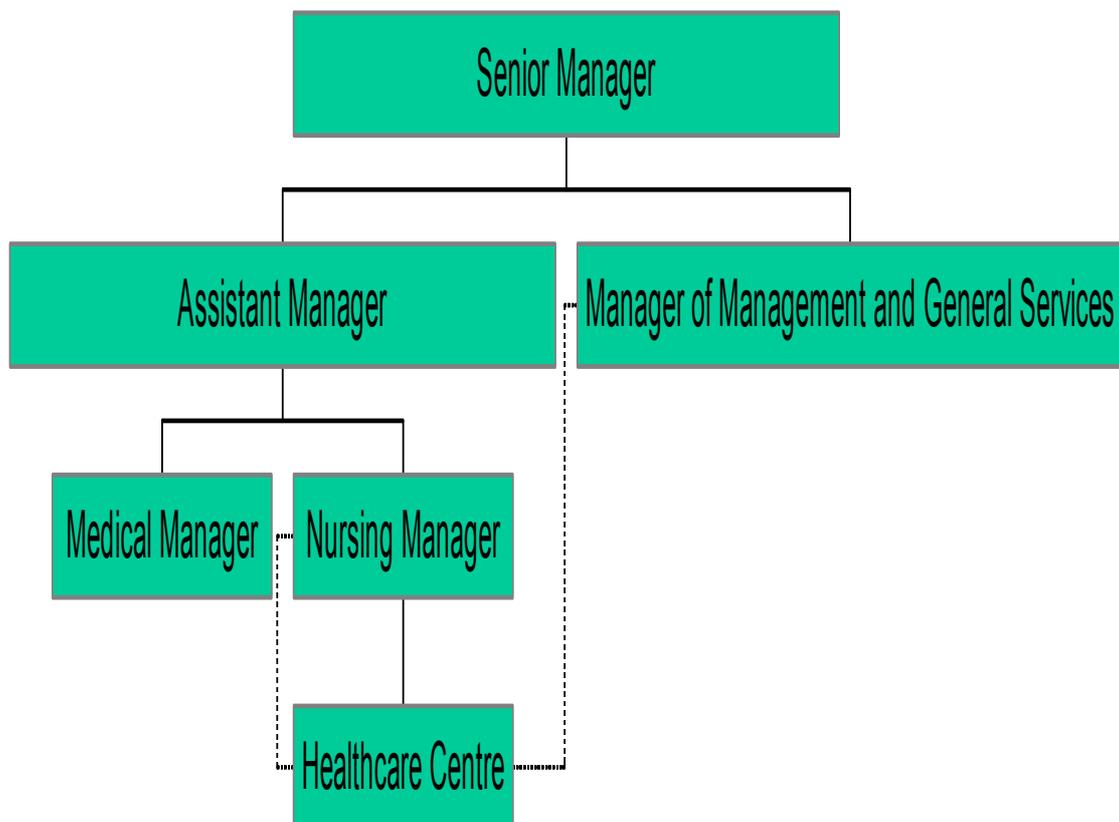


Figure 1 is our simplified version of one of these areas. There will be a Senior Manager with two subordinates, an Assistant Manager and a Manager of Management and General Services. This means a separation of the medical and management functions. The Assistant Manager is responsible for: (a) managing, co-ordinating, supervising and evaluating the services of primary healthcare and the management of its implementation, (b) collaborating in the development of the services offered by the Health Centre, (c) evaluating the quality of healthcare, and (d) taking the position of the Senior Manager in case of that manager's illness, absence, etc., and for the delegated functions. Subordinate to the Assistant Manager there is a Medical Manager and a Nursing Manager, respectively responsible for the management, co-ordination and supervision of the medical and nursing activities and for the delegated functions.

The Manager of Management and General Services is responsible for: (a) managing, co-ordinating and supervising the economic-administrative activity, (b) providing administrative-technical support to other managerial levels, (c) human resources management, (d) technical-administrative support for producing the annual proposal of expenditures, (e) managing, co-ordinating, supervising and evaluating the areas which support the healthcare activity (such as maintenance, cleaning, security, etc.), and (f) replacing the Senior Manager in case of illness, absence, etc., when the Assistant Manager is not available to act for the Senior Manager, and for the delegated non-healthcare functions.

A New Model of Management for Basic Structures

The basic structure for offering primary healthcare services is the Health Centre, one of which is established in each municipality (Decreto 352/1998). There are nearly 500 Health Centres in Galicia, distributed among the five areas. Doctors, nurses, non-healthcare and general service personnel compose a Health Centre. The Health Centre Manager is responsible for the running and organisation of each Health Centre. The Health Centre is controlled by the head of the Primary Healthcare Service. The Primary Healthcare Service is an upper level of management, planning, healthcare and non-healthcare support, which integrates one or more Health Centres (between 15 and 45 professionals). It is located in the most appropriate healthcare centre, following geographical and structural criteria (Decreto 200/1993).

The Primary Healthcare Service has different functions, healthcare and non-healthcare (for example, planning and execution of healthcare programmes, self-evaluation of the activities and the results obtained, establishment of annual objectives). The head of the Primary Healthcare Service is responsible for co-ordinating the Health Centres and managing the Primary Healthcare Service, distributing tasks and responsibilities among the Primary Healthcare Service's members, controlling the achievement of objectives, harmonising criteria, etc. The Primary Healthcare Service has a co-ordinator of nursing who organises training courses and the allocation of personnel.

The Health Centre's work is based on interrelationships and mutual support of a group of professionals, which include doctors, nurses, social workers, and others. This work is co-ordinated both in the Health Centre and in the patient's home. In the development of their functions the professionals will have the participation of the community and the Health Centres will be co-ordinated with the other levels of healthcare and services.

The purpose of modernisation is to achieve primary healthcare which fulfils both health criteria (high quality, respect for the patient, etc.) and management criteria. The management approach should be oriented to the participative management of objectives, which should be mainly evaluated by the achievement of results. This modernisation promotes a labour climate in which professionals have not only a suitable environment and adequate conditions for developing their tasks, but also has incentives for remunerating the people who work more, better, and are able to assume different "retos". Retos is an objective which is difficult to develop or carry out, and for these reasons constitutes a stimulus for the people who are trying to work in this area.

From Legal Context to Anticipated Activity

The previous section has provided essentially the legal and formal background to the anticipated changes in Galician Primary Healthcare and its management in Health Centres. This is before we have conducted any individual and organizational studies. These formalities indicate that much is expected from a Management and General Services Manager (here after General Services Manager), in terms of creating a more participative situation with any particular Health Centre Manager, and also to provide financial management data to that Health Centre Manager.

The authors' consider that a range of situations is likely to occur with these General Services Managers. Following Kelly (1955), we accept that each person is different, so that, General Services Managers with the same job title, are unlikely to act in exactly the same way as each other. Also, any one General Services Manager will have to deal with a different individual manager at each Health Centre, so that each of these individual interactions will be different. This is because the personal construct system of each individual is different.

The paper now considers some of the authors' constructions about the realities of management with individual managers. Of course the realities of management are open to a variety of interpretations, because of the potential diversity of each individual approach. We are interested in both the individual diversity, as well as the commonalities, which exist between the General Services Managers and the Health Centre Managers.

When we hold a conversation with any individual manager we will aim to be open to all aspects of the developing situation, in order to appreciate as much as we can about the issues which have allowed the sound development of "participation and information provision". However, our personal construct systems are limited, especially in relation to medicine and healthcare, and we will focus upon influence situations and information positions, because we are interested and have experience with these notions in relation to the financial management.

Influence and Information

The issues associated with influence and information are many. Here we present some of our personal constructions about some of these issues, developed from Purdy's framework (1993). Thus, we have a framework within which we can attempt to anticipate what we construe could develop between General Services Managers and Health Centre Managers. In particular our general anticipations are about the Health Care Manager. However, the same framework will be used to interpret the findings from the conversations we will hold with these managers.

This paper has been conceptualised and written in English. There could be notions, which are culturally related to the English language and institutions, and which are the basis of evidence for the personal constructions here, but which do not have the same validity in Spanish contexts.

The approach recognises a construct of influence, which exists for everyone in relationships with others. (Clearly influence cannot be separated from information but initially we will ignore it.) Influence is related to the construct of power, and on some occasions these are very close, and on other occasions these are less close. Here, we will only consider the outcomes of a relationship between two people. This is, essentially, the relationship between a General Services Manager, who is currently responsible for, and a Health Centre Manager.

Here the construct of influence is a matter of exercising influence over another person, or with that other person, to bring about change to a situation. At this point it is impossible to detail the precise situation in which influence will operate. Formally there is the anticipation that there will be "more

participation” from the Health Centre Manager so this suggests that the Health Centre Manager will influence more in the particular situation. When we collect data, we will be able note the views of both the General Services Manager and the Health Centre Manager, and to place their stated positions onto the appropriate parts of Diagram 1.

The Influence Construct

The possible ends of the influence construct for any individual are anticipated to be a position of “No Influence” to “Total Influence”. This latter position may be a situation of power for the individual to take the decision without any obvious influence from others. Also, the “No Influence” position may be where the individual perceives no obvious influence in the situation. Although such points are likely to exist at various times in life, for this framework, in the context of health care, these absolutes appear to be unlikely.

The English literature indicates a widespread use of the word “participate”, in a variety of situations. Also, this whole area of organizational activity, with a variety of types of influence, can be unclear. Given the diversity of relationships that could exist, perhaps this is not surprising. Accordingly, it seems sensible to provide markers about different areas along this anticipated construct of influence (Purdy, 1993). Although we will explicate three other areas relating to influence, we do not consider that each of these areas are either totally circumscribed by the explication, or that these explications of areas are complete and not capable of challenge. Of course, personal construction always includes the possibility that another individual could construe an event in an alternative manner. The markers of influence run between “No Influence” and “Total Influence”.

In the specific context that we are examining, there is the formal notion an increase in influence for the Health Centre Manager. Moving from “No Influence” towards “Total Influence”, the first marker is the area of “Communication from the General Services Manager”. It is anticipated that the Health Centre Manager perceives data coming from the General Services Manager, but does not have any opportunity within the organizational setting to influence affairs.

Essentially, “Communication” is a situation where the General Services Manager tells the Health Centre Manager about a decision already taken, for example, by the General Services Manager. The Health Centre Manager may not have directly influenced the situation and could exercise influence only outside of the organizational context. For example, the Health Centre Manager could simply provide an opinion to the General Services Manager after the data has been received, or could carry out any other action, such as leaving the organization.

The next marker is “Consultation” by the General Services Manager. Here the General Services Manager provides data to the Health Centre Manager about a situation and the Health Centre Manager has an opportunity to express an opinion about matters under consideration. The extent of the Health Centre Manager’s influence will vary, but the General Services Manager will take a decision after the opinion has been provided.

The third marker is “Participation”, the area within which the Health Centre Manager has the most opportunity to influence a situation, and is close to “Total Influence”. In this situation the Health Centre Manager and the General Services Manager exercise influence together over a situation, in some manner which they agree to. For “Participation” to occur there is the need for interaction between the two managers, for them to be involved with the matters at hand, and, for there to be information which has the possibility of arising from either the Health Centre Manager or the General Services Manager. There are likely to be more varieties of “Participation” than in any other area of the influence construct.

The Information Construct

The notions of information distance used here are based upon Purdy's adaptation (Purdy, 1993) of Wall and Lisher's (1977) typology about decisions. In a manner similar to Influence, the Information construct for the perception of the Health Centre Manager has the range from "No Information" to "All Information". It seems unlikely that either of these conditions is likely to exist for the Health Centre Manager. There are also three markers in different areas between the two extremes of "No Information" to "All Information".

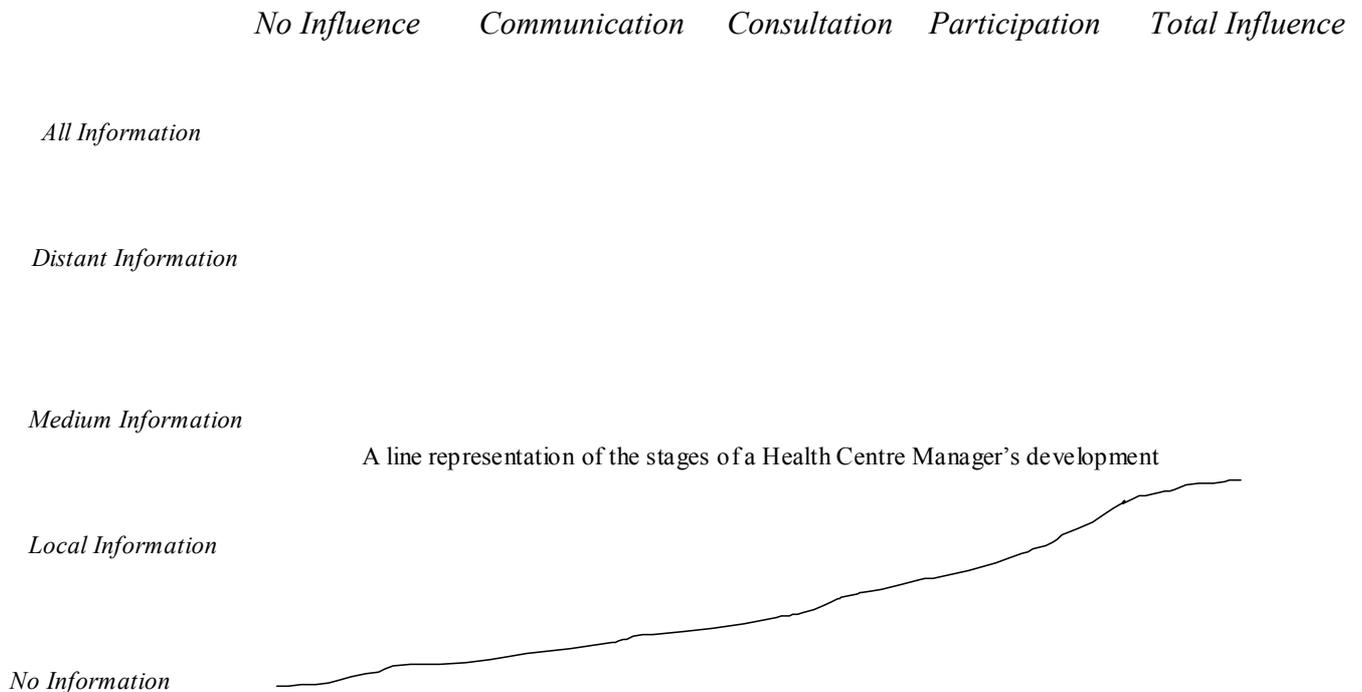
Moving away from an absence of information, the first marker is "Local Information". "Local Information" is that which exists for the current and immediate job at hand. It is likely to be the smallest quantity of information in relation to the anticipated development of the Health Centre Manager.

The next marker is "Medium Information". This marker is information which, at the commencement and before changes, the Health Centre Manager perceives as data which is not immediately related to the initial work activity. It is data, which relates to decisions, which initially, appear to be taken at a medium distance from the manager, or is the data for decisions taken with a medium amount of the available data.

The final marker is all "Distant Information", and the one most closely associated with the construct of "Participation". This is information which, at the commencement and before changes, the Health Centre Manager perceives as data which is not immediately related to the initial work activity. It is data, which relates to decisions, that initially, appear to be taken at the furthest distance from the manager, or is the data for decisions taken with a maximum amount of the available data.

The Anticipated Changes in the Health Centre Manager

Diagram 1 Influence and Information



It is anticipated that the Health Centre Manager will start in a situation, which will encompass the two markers, "Communication" and "No Information" (or some "Local Information"). Over an

unspecified period the General Services Manager will allow the Health Centre Manager access to an increased range of both influence and information. If the context of the relationship between the individuals is conducive, then the Health Centre Manager's personal construct system will gradually change until the issues discussed are in terms of the constructs of "Participation" and "All Relevant and Distant Information". Also, it is anticipated that before reaching these markers, forms of the other stages will be experienced. The line on Diagram 1 is a representation of the stages of an individual's development of constructs of influence and information.

Conclusions

This paper has dealt with the legal changes expected in the management of Galician Health Centres. Before the changes, Health Centres were administered by a General Services Manager. After the changes these Health Centres will be managed, partly, by a Health Centre Manager. The law requires Health Care Managers to be provided with financial management information and to manage in a participative manner.

We have used some of our previous frameworks (Purdy, 1993) to anticipate what might happen to the Health Centre Manager, in a general manner. We have used our experience to elaborate a basic framework about information and influence, and how these might affect the Health Centre Manager moving towards participation. When we collect data about the future events, from our field work, we can use these results in comparison with this framework.

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