Department of Health Management and Health Economics, University of Oslo

Ole Berg – September 2013

HMAN4100: Fundamentals of Management

Plan for the course

Health (Care) Governance and Management: A Conceptual Introduction

1. Governance and Management: The Roles

Politicians govern society, managers manage organizations. Both activities are fundamentally hierarchic activities. They are based on power. Thus to govern or to manage is to exert power. But how hierarchic, how power-wielding, the governance and the management are, may vary substantially. At one extreme governors, and sometimes managers, may resort to force – that is, threaten with extreme sanctions, even death, and, if the threats do not work, apply the sanctions, and by doing so show others who might not yield to the threats, that the governor or manager means "business". But governors and managers may also use milder sanctions, sanctions that at one point turn into incentives. We may then say that the governor or manager is governing or managing more through temptations than through force, or indeed that s/he is "buying" the support or subservience of the governed and the managed. In the first case we may call the influencing power-based, or political, in the other case economic. In the political case power may have a legal (juridical) foundation or a directly physical (police, military) foundation.

More generally then, we may say that to govern and manage is for some to *influence* others from a *hierarchical* (i.e. superior) position – but we should add, for one or more *collective purpose(s)*. Thus Peter Northouse, in his textbook (p. 5), says, about leadership (which here may be said to encompass both governance and management):

> "Leadership is a process whereby an individual influences a group of individuals to achieve a common goal."

He adds: "Influence is the sine qua non of leadership. Without influence, leadership does not exist".

But governors and managers may also influence in other than politico-legal and economic ways. They may do so also through persuasion (reasoning) and other more or less diffuse social and cultural means and through architectual and technical means. Indeed, any measure that can have an influencing effect can be used for purposes of governing or management.

Since “anything” can have such an effect, “anything” can be governance and management. In principle, therefore, the role of governor or manager is an existential role.

2. Governance vs. Management

Governors and managers are both influencing from a position of superior authority. They are, however, influencing different kinds of objects, and that makes an important difference. Governors govern, or influence, societies, local, national or supranational such. Managers manage organizations of all sorts. Influencing thus becomes different. Governors try to influence whole societies, that is very general phenomena, and in principle in potentially all kinds of respects. Managers try to influence more or less specialized parts of society, organizations, often for a fairly limited set of purposes. The primary social objects of governors’ governance are individuals (families, clans) and organizations. The primary social objects of managers influencing are employees, but can also be members. Northouse talks, collectively, about them as “followers”. (He does so for reasons that are also normative: By calling those who are governed, or lead, or managed, followers he emphasizes the interactive nature of leading (governing, manageing). For him “coercive “leaders”, like Hitler, are not really leaders.

In liberal societies citizens and organizations, the objects of governance, are in large measure free actors. The governance they are subjected to encompasses only parts of their behavior and dispositions. Governors, or governments, may for example define many of the “rules of the game” of a given society, but leave the “players” free to avail themselves of these rules. In many organizations, but especially in productive organizations, “businesses”, employees are in principle “unfree”. They have sold some of their competence and part of their time to an employer, and are, in principle not at liberty to decide for themselves how to, and when to, fill their roles as employees. Some “producers” may, in certain organizations, however enjoy a considerable amount of freedom regarding how to operate. This is the case for members of some partner-based professional organizations, often called practices, but can also be the case for certain professionals, like physicians and professors, working for (or in) hospitals or universities. However, their work is specialized and they are free only to the extent that they use their freedom for the good of the organization (and its clients, customers etc.). Thus, there is a clear distinction between the freedom of the citizen and the “unfreedom” of the employee (and often the member). The employee’s “unfreedom” is underscored when we talk of the non-working time of an employee as his or her free time, or leisure time.

In some societies the governance may be so extensive that it encompasses all aspects of life. Then citizens have lost all their freedom; they are like state “employees”. All productive organizations are then also state-owned. Where the governance becomes “total”, or intendely “total”, socities are totalitarian. Western societies are normally characterized as free societies; the governance is not total. In these societies employees normally also has some degree of freedom. There are legal limits to the powers of business owners and executives. Over several

decades, however, the scope of the governance, and of the management, has increased. This is also the case within health and health care. It is especially the case in the northern and north-western European countries (the so-called Beveridge countries). Here the governance has become more and more ambitious. On the health side we have gotten more of “the management of lives”, or “medicalization”, as Ivan Illich, forty years ago called it. On the health care side we have gotten increasingly integrated health care systems: Management is more and more becoming the implementation of governance, the will of the national health policy-makers. Health governance is less extensive on the European continent and the health sector is more loosely coupled than in the Beveridge countries – though there are important variations across the nations (France more integrated, the (mostly) Germanic-speaking countries less so). In southern Europe the role of governance was fairly moderate up until the 1970ies. From then on it became more penetrating; the countries (tried to) introduce Beveridge type models. This trend has to some extent become reversed again after the coming of the financial crisis of 2008 and 2009.

The expansion of the role of governance in most European countries, and even in countries like Canada, New Zealand and Australia, and now even to some extent the United States, but especially in the Beveridge countries makes it important to start out by saying something about governance too.

3. Leadership, governance, management and administration

I have so far distinguished between governance and management. Northouse talks about leadership (only), but tends, in contradistinction to some other management theorists, not to make much of the difference. He makes it clear, though, that leadership is something that precedes management. We may say that he portrays leadership as the primary (or primal) form of more or less hierarchic activity (steering), (goverenance and) management as the secondary. I shall also do so in this course. Thus leadership has to do with defining the values or purpose of a society or a sector, and an organization, and of beginning the concretization of these values and of devising the overarching strategies to realize the relevant values and purposes. As the content of the activity is being made more and more concrete – that is, as it is becoming operational – it turns into governance and management. Thus, making a general plan (reflecting values and strategies) is leadership, concretizing and implementing it is management and in the final analysis administration. Hence exercising leadership is to a large extent a holistic and artistic activity while governing, managing and administering are increasingly specialized and technical tasks. We have leadership both at the overarching political level and at the institutional levels; indeed, in the latter case, in principle at least, both at the CEO and at lower levels. At lower levels managers will often become more and more managers and administrators – though some more than others: Some will try to avoid the seemingly “scary” leadership and seek some degree of “protection” in the more technical roles of managers and, especially, administrators.

4. Fundamentals of management: The structure of the course

The major textbooks are very different in topics and in approach. One of the books is about management, or leadership, in general, one about health care management as such, one about management accounting in health care organizations and the last one about health management. The first is organized according to approaches to management, and is very tightly structured: It shows that it is written by one author. The other is organized after health care management topics, though without a tight a collection of essays, written by many authors. This is also the most elementary of the books. The third book is a well integrated book about accounting, written by one author. The fourth book is about health governance and management only. Some of the chapters, those written by David Hunter (in one case with coauthors), constitute a well integrated whole – and an ambitious philosophy of health promotion – while the remaining chapters, though being about management for health, are more stand alone chapters. The Buchbinder and Shanks book, the simplest of them, covers the topics we are to treat best and is in that way the most important textbook. The Northouse book is more theoretically sophisticated and is therefore also extensively relied on, especially with respect to the top and downstream sides of the management cycle. Young's book on management accounting will be used much less. It is relevant for only a part of the downstream process, namely that part which has to do with resource management. The Hunter book, finally, which is about health management, will only be treated in one session. The major topic of the course is health *care* management.

Instead of going through one book at a time – which would make the course fairly disintegrated and thus non-managerial – I will organize the course based on a model of governance and management I have developed, and use the textbook material as it fits into this model.

I see governance and management as circular processes, processes where we have an upstream process, charazterized by decision-making, a top process, characterized by management performance – and the role of governance and management, a downstream process, characterized by the carrying out of management decisions, or the "translation" of management decisions into more and more concrete practice and finally a feedback process, where data about and viewpoints about the effects of previous management, and of what I call the preclinical and clinical cycles, are made into input premises for the next cycle, i.e. for the decision-making process etc. The model, in a simplified form, is presented below.

At the bottom we have the clinical (and preclinical) cycle – where the final values are created. The purpose of the managerial cycle(s) and the cycle(s) of governance above it (them), is to make the (pre)clinical cycle function well (better).

We will start the course with a general introduction, where the model as a whole is discussed and the textbooks' relationship to the model-based presentation is accounted for. We will then proceed with health governance and management, using the model, and referring particularly to Hunter's book. During the remainder for the course we will go through the governance and

management of health care, following the cycle – starting with the upstream side and ending with the downstream side. We will, as is done by the textbook authors, place special emphasis on the top of the cycle and the downstream side. We will start this review by saying something about the role of cycle of governance – since this is creating premises for the clinical cycles – but not dwell long on this, since this is a course on management, not on governance.

Figure 1: The clinical cycle and the cycles of management and governance

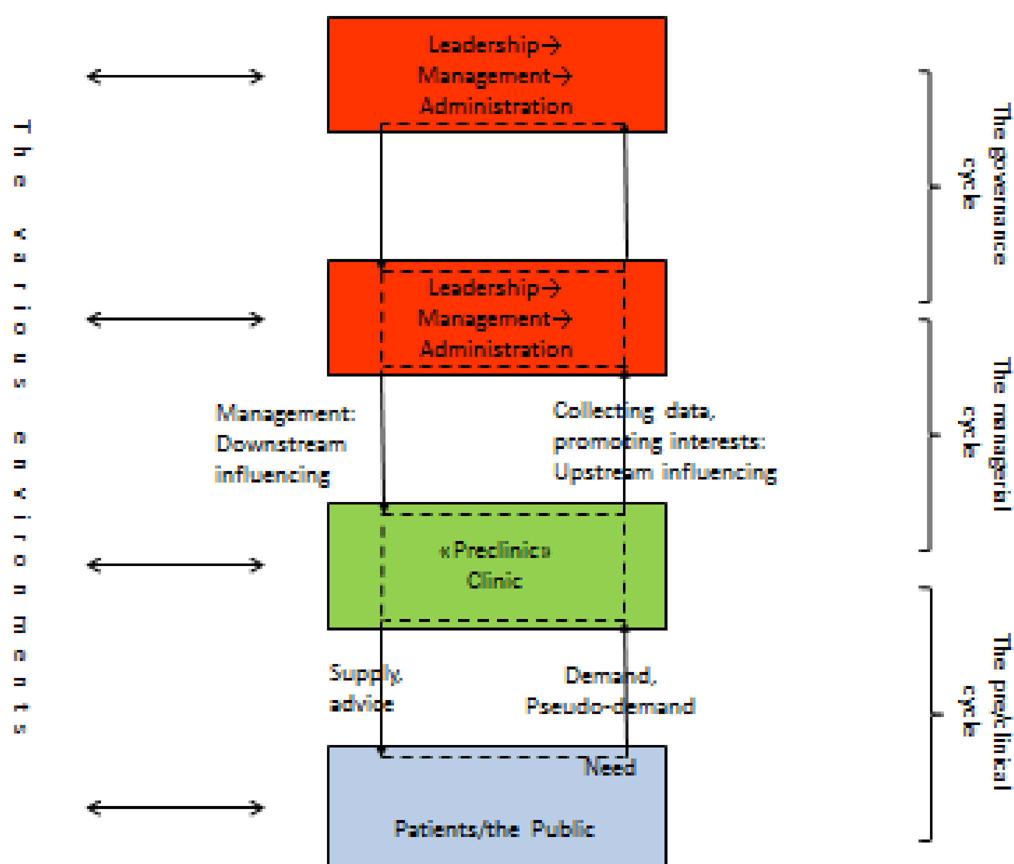

Table 1: The course schedule

Date	Time	Auditorium	Topic	Literature
October 16	1015-1200	Aud. 1, HSH	Introduction to the course. Health care governance and management: A historical introd.	The course plan; Buchbinder & Shanks, ch. 1, 2

October 22	1015-1200	Aud. 3, HSH	Health governance and management: the entire cycle	Hunter
October 24	1015-1200	Aud. 2, HSH	The managerial decision-making process: planning and the politics of decision-making (the upstream process)	Buchbinder & Shanks, ch. 5
October 29	1015-1200	Aud. 3, HSH	The role of manager and management (the top part of the process)	Northouse
October 31	1015-1200	Aud. 2, HSH	Managerial practice (the downstream process): Defining values and goals, crafting strategies	Buchbinder & Shanks, ch. 5
November 5	1015-1200	Aud. 3, HSH	Managerial practice (the downstream process) : Organizing the clinic	Buchbinder & Shanks, ch. 4
November 7	1015-1200	Aud. 2, HSH	Managerial practice (the downstream process): Managing the various types of resources	Buchbinder & Shanks, chs. 8-12; Young

November 12	1015-1200	Aud. 3, HSH	Managerial practice (the downstream process): Motivating the personnel. Building culture	Buchbinder & Shanks, ch. 3; Northouse, chs. 9-11, 13, 15
November 14	1015-1200	Aud. 2, HSH	Managerial practice (the downstream process): Managing change vs. managing current operations	
November 19	1015-1200	Aud. 3, HSH	Management and ethics. Health and health care perspectives: Anticipating the future. Summarizing the course	Buchbinder & Shanks, chs. 15-16; Northouse, chs. 10, 11, 16
December 2	0900-1300	Domus Medica	Examination	

Additional, optional readings, including short papers by me, may be included as the course proceeds. They will then be uploaded on Fronter.

Given its scope, this is a very compact course. Since the readings are so diverse, the lectures become important. It is through the lectures that a more integrative perspective on health (care) management is created. Lectures are followed up with classroom discussions. Students should therefore be well prepared for each lecture.

5. Evaluation

At the end of the course there is a written examination. It is based on broader and somewhat complex, not short, very concrete and fact-reproducing problems – let alone on multiple

choice problems. Students are to write reflective essays. Examples of the kind of problems that will be given will be presented, and discussed in class, during the course. At the examination several problems will be given, but students are only to choose one.

The grading of the esssays is based on three broad dimensions:

-Knowledge – knowledge about theories discussed in the literature and in the lectures and about empirical facts about health and health care management.

-Systematics – that is, how well the essays is structured and how clear and stringent the reasoning and formulations are.

-Understanding – that is, how deep and (perhaps) original the understanding is and how much independence (willingness to defend own viewpoints) that is shown.

Students will be given individualized, written comments to their examination essays.

6. Literature

As has been suggested, the lectures must be looked upon as an integral part of the syllabus. Some extra papers and memos may be passed out (i.e. uploaded). They are intended just as recommended (optional) readings.

The formally required readings are:

Sharon B. Buchbinder and Nancy H. Shanks, *Introduction to Health Care Management*, Burlington, MA: Jones & Bartlett Learning, 2012, chs. 1-5, 9-13, 15, 16. (Used in many lectures.)

David J. Hunter, ed., *Managing for Health*, London: Routledge, 2007, chs. 1-4, 7, 8. (Used in one lecture.)

Peter G. Northouse, *Leadership*, 6th ed., Los Angeles, CA: Sage, 2013, all chapters. (Used in many lectures.)

David W. Young, *Management Accounting in Health Care Organizations*, 2nd ed., San Fransisco, CA: Jossey-Bass, 2008. (This is an extensive book, a book that is more adapted to a separate course in cost accounting than to an introductory management course like the present course. The first five chapters are the most important. It is used only in one lecture.)